Cities of (In)Difference:
A Mixed-Methods Analysis of Place and Wellbeing in Later Life

A Dissertation
SUBMITTED TO THE FACULTY OF THE
UNIVERSITY OF MINNESOTA
BY

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

Dr. Susan Craddock

June 2018

Acknowledgements

This dissertation is testament to the patience, care, and kindness of a large number of people. I am grateful to the enthusiastic and inspirational participants who readily welcomed me into their homes and workplaces. Thank you, in particular, to the six ethnographic participants who allowed me to become a part of their lives. Their tolerance for a curious and probing "youth" was remarkable.

Thank you to friends and colleagues for listening to my half-formed ideas, responding to early drafts, and providing moral support. At the University of Minnesota, I am grateful to Kwame Adovor, Kai Bosworth, Jay Bowman, Ding Fei, Joe Getzoff, and Melinda Kernik in the Department of Geography, Environment, and Society for helpful feedback in the development stage. Particular thanks are due to Joe Witek, who has provided written comments on numerous draft papers over the years, and to my writing partner Hillary Waters for the countless cups of tea and coffee, loaves of fresh bread, dog walks, and productive conversations throughout our many days spent together. Thank you to the Geography faculty members and staff who provided sound guidance and enthusiastic support throughout the process, particularly Sara Braun, Dan Griffin, Kurt Kipfmueller, Lorena Muñoz, Glen Powell, and Abdi Samatar. I was fortunate to have fantastic research assistance from Jay Bowman, Wendy Chao, Jessa Hohnstein, Joann Khong, Naomi Klionsky, and Alec Trenda.

On the East Bank of campus, I am grateful to Heather Davila, Eric Jutkowitz, Rosalie Kane, Ellen McCreedy, Mary Whipple, and other members of the Aging Studies Interdisciplinary Graduate Group. Hayley McCarron, Lauren Mitchell, Colleen Peterson, Tamara Statz, and Rachel Zmora quickly transitioned from professional acquaintances into wonderful colleagues and co-authors. All of the above individuals provided warm support throughout dissertation fieldwork and writing. Beyond the University of Minnesota, I am indebted to Derek Gregory, Anne Martin-Matthews, Heather McKay, and Joanie Sims-Gould at the University of British Columbia. Thanks are also due to inspiring colleagues and mentors across the globe including Francesco Emiliani, Anne Godlewska, Robin Kearns, Lindsay Kobayashi, Mark Rosenberg, and Graham Rowles.

I am fortunate to have committee members that provided a unique and challenging blend of intellectual stimulation and multidisciplinary critical commentary. Beyond their thought-provoking and helpful substantive inputs, my committee also provided a depth of emotional support. Thank you to Abby Neely for her unwavering faith in me from my early days as a Master's student, and for the opportunity to spend a wonderful semester at Dartmouth College post-fieldwork. It was a productive and stimulating writing retreat amidst New England's fall splendor. To fellow Canadian Bruce Braun, thank you for encouraging me to think through ideas while away from my desk. Bike rides and runs provided unexpected clarity during this journey. I am deeply grateful to Bob Kane, who was a tireless advocate for applied critical learning and staunch supporter of emerging gerontologists. He instilled in me the confidence to pursue gerontology. Joe Gaugler generously stepped in after Bob's passing and quickly became a trusted mentor and guide. His upbeat encouragement and genuine enthusiasm in the final "lap" of my PhD was greatly appreciated. To Susan Craddock, my advisor and friend, it is difficult to express the depths of my gratitude. I greatly appreciate her considerable time investment, patience, support through my stumbles and 'aha' moments, thoughtful and critical guidance, and commitment during every stage of the journey. Most of all I will remain indebted to Susan's encouragement to pursue this daunting project, especially during the times when I felt unequal to the task.

I was able to complete my research through generous funding from the University of Minnesota Doctoral Dissertation Research Fellowship, Interdisciplinary Doctoral Fellowship, Joseph-Kordell Scholarship, and College of Liberal Arts and Department of Geography, Environment, and Society research grants. External sources included the National Sciences Foundation Geography and Spatial Sciences Doctoral Dissertation Research Improvement Grant (grant number 1558577), Queen's University Alfred Bader Fellowship, Minnesota Gerontological Society Gerald Bloedow Scholarship, and Philanthropic Educational Organization Scholar Award.

Finally, it is a pleasure to acknowledge the unwavering support of my family, friends, and community. Thank you to Mill City Running for hosting weekly group runs just a block away from my home through which to unwind and recharge. My running

buddies provided countless therapeutic miles together along the Mississippi River, lakes, and greenway trail system – even on dark, cold, snowy winter nights. I am grateful to friends across Minneapolis, Vancouver, Edmonton, Hanover, and Ontario for constantly checking in. Thank you to my parents, brother, grandparents, and wonderful Tiampo family members for providing unwavering support from all sides. Finally, thank you to my husband Matt who has been the steadfast anchor throughout this process. Over the past five years he bore my range of moods throughout the research process that ranged from sadness and overtired crankiness to exhilaration and pure joy. I am forever grateful for his unfailing encouragement, patience, and love.

Abstract

Where one lives constitutes an important determinant of health and quality of later life. Yet few studies to date focus explicitly on the everyday experiences, contexts, and needs of individuals to age well within their physical and social environments. While aging in place represents a widespread goal of individuals, service providers, and policymakers, it remains an ambiguous, problematic, and uncritical concept. This can have devastating consequences as it is frequently applied with little consideration of the places themselves. This study investigated aging in a harsh continental climate with a strong focus on underrepresented low-income and racially diverse older adults. Three case study areas across the Minneapolis (Minnesota, USA) metropolitan area purposefully contrasted socio-demographic and geographic characteristics. Seated and mobile interviews were conducted with independent-dwelling men and women (n=125, mean age 71 years) from May to October, 2015. A geospatial audit evaluated participants' homes at the dwelling, street, and neighborhood level. Ethnography with six participants over twelve months (September, 2015 – August, 2016) and semi-structured interviews with ten local policymakers and community service providers (May – October, 2016) deepened understanding. The findings depict how built, social, and natural environments contribute to aging in very particular ways. Older bodies literally express structured advantages and disadvantages of their surrounding contexts. Aging in place efforts can exacerbate the deeply uneven conditions of American cities and the vulnerabilities of those aging 'in the margins'. Theoretical analyses unpack and unsettle discourses about aging in order to address problematic assumptions, blind spots, and unchallenged and unconsidered modes of thought upon which geography rests. The chapters engage political, economic, feminist, critical race, disability, health, and urban theories to enrich not only geographic scholarship, but also the lives of older adults. The dissertation destabilizes the foundations of age-friendly governance and generates novel possibilities for more just and inclusive modes of urban form. It creates more room for alternative ways of 'being in the world' based upon a richer understanding of people, place, and space across the life course.

Table of Contents

List of Tables viii
List of Figures ix

Chapter 1. Introduction 1
Prologue 1
The Aging Context 3
The Appeal of Aging in Place 3
A Not-So-Perfect Fit 5
Opening Up Possibilities for Aging in the Right Place 6
Geographies of Aging 7
Spatial Distributions and Contexts of Aging 7
Place, Care, and Embodiment 9
Ripe opportunity 12
Project Overview 13
Figures 23
Chapter 2. Methods 24
Analytical Framing 24
Research Objective and Questions 25
Case Study Areas 26
Phase I (May 1, 2015 to October 31, 2015) 27
Recruitment 27
Seated Interviews 28
Seated Interview Fieldnotes 30
Mobile Interview 31
Mobile Interview Documentation 32
Phase I Participants 33
Phase II (September 1, 2015 to August 31, 2016) 35
Phase III (May 1, 2016 - August 31, 2016) 37

Analysis 38
Methodological Considerations 39
Study Setting 39
Seated and Mobile Interviews 40
Ethnography 42
Interviews with the Professionals 43
Personal Capacity 43
Closing 44
Tables 45
Figures 56
Chapter 3. Intimately Old: An Embodied and Emplaced Feminist Geography of Aging 58
Spatializing Feminist Thought on Later Life 58
Fixed on the Body 60
Local Biologies 63
Multiplications of Difference 65
Unpacking Geographic Privilege 66
Putting Theory Into Practice 68
My Ethnographic Approach 69
Old Age: A Feminist Phenomenon 69
I. Denise (72 years old): Intertwining Body and Place 69
II. Thomas (67 years old): Countering Decline and Decay 73
III. Christina (78 years old): Exposing Intersections of Power 76
IV. Frank (77 years old): Navigating Landscape Privilege 79
V. Emancipatory Possibilities 81
Building A Feminist Geography of Aging 85
Figures 88
Chapter 4. 'Walk Like a Penguin': A Critical Investigation of (Non)therapeutic White Space 89
Introduction 89

Potentially Therapeutic Landscapes 93
Navigating White Space 96
Bodily Histories and Embodied Present-Day 97
Duality of Vulnerability and Durability 100
Psychological Responses: Exacerbations of Fear and Stress 102
Satisfaction and Self-Worth 105
Social Strains: Struggles with Exclusion and Isolation 107
Strengthening of Bonds 109
White Space's Dual Potential for Health and Harm 110
Towards a More Critical Approach 112
Chapter 5. Aging in the Margins: Person-Space Negotiations in Search of 'a Good Place to Grow Old' **117**
Introduction 117
Interrogating Place Attachment 118
Striving to Age Well 'in Place' 121
Safety and Comfort 122
Service Access 133
Social Connection 139
Stimulation 144
Negotiated Place Attachment 148
Risk 148
Durability and Adaptability 150
Conclusions and Next Steps 151
Chapter 6. City of (In)Difference: Invigorating the Urban **153**
Looking Backwards to Move Forwards 153
Whose City Is It? Advocating for Spatial Justice Through a Politics of Difference 154
Up to the 30th Floor: Engaging the Decisionmakers 157
Seeing Through the Cracks 158
Opportunity to intervene 160
Ageism and the Built Environment: Longstanding Reciprocity 160

From Industrialization to Urbanization 161
Expansion of Suburbia 164
Age-Segregated and Gated Retirement Communities 166
The Age-Friendly City 170
Crisis Management 171
The Next Generation of Gentrification 172
Uneven Development 175
Age-Friendly Minneapolis 177
Persistence of ableism 179
Moving Forwards 181
Chapter 7. Critical Geographies of Aging 182
Opening up the age-friendly city 182
I. Theoretically- and Empirically-Engaged Geographies of Aging 182
II. Urban Complexity 184
III. Elderly Voices 186
IV. Emancipatory Possibilities 189
V. In Pursuit of Justice 190
Conclusions and Next Steps 191

Bibliography 195

Appendix 219
Neighborhood Design Characteristics Checklist 219
Semi-Structured Phase I Interview Protocol 222
Semi-Structured Phase III Interview Protocol 225
Thematic Analysis Framework 226

List of Tables

Table 1. Case Study Areas in Comparison to the United States, State of Minnesota, and Hennepin County 45
Table 2. Summary of Phase I Seated Interview Topics and Questions 46
Table 3. Summary of Mobile Interview Data 47
Table 4. Mobile Interview Fieldnote Prompts 48
Table 5. Phase I Study Participants 50
Table 6. Phase I Residential Environmental Audit 52
Table 7. Participant-Reported Wellbeing 53
Table 8. Phase I Entire Sample and Mobile Interview Sample Comparison 54
Table 9. Summary of Phase III Semi-Structured Interview Topics 55
Table 10. “Aging in the Right Place” Semi-Structured Phase I Interview Protocol 224
Table 11. “Aging in the Right Place” Semi-Structured Phase III Interview Protocol 225
Table 12. Framework for Thematic Analysis 235

List of Figures

Figure 1. Geographical Gerontology Thematic Diagram (Skinner et al., 2014, p. 3) 23
Figure 2. Case Study Areas in Hennepin County, MN..... 56
Figure 3. Summary of Positive Perceptions of Self-Reported Health, Safety, Happiness, and Social Connection 57
Figure 4. Woodshop ‘trophy’ project in-progress (Jessica Finlay, 2016)..... 88

Chapter 1. Introduction

Prologue

When I began graduate studies, for the first time I began to feel *old*. Moving to a new city and country with newly-minted bachelor degrees in-hand, I felt knowledgeable and much more grown up than the undergraduate students that I taught. Then a community organization asked if I would consider volunteering with older adults instead of children, and my entire life course shifted. Through weekly visits with older adults in a wellness outreach program, I found myself completely immersed in their stories and lives, the joys and vulnerabilities that they experienced nearing the end of life. For the first time, I really observed older people in my community; my previous contact being limited to visits with grandparents. I now noticed the woman struggling to cross the street in time with her walker laden with groceries and began waving to the older man who sat on a shaded bench across my street. As I waded through snow drifts and navigated treacherously icy sidewalks, I reflected on the dangers posed to those less-mobile. So often invisible and relegated to the margins, older adults took on a new role at the center of my life. Over the next seven years they became essential teachers, mentors, and friends. I embraced intricacies of age wrapped up in queries regarding the body, home, health, space and place, vulnerability, sociocultural norms, race, sexuality, income, interpersonal relationships, and the political economy.

In this journey, I have come to understand aging in new ways.[1] I better appreciate the significance of social support (and the extreme stress for those without a 'safety net' to fall back on), a comfortable and secure home environment, stability in one's life, and autonomy regarding wellbeing and the many ways of living and dying. I closely watch my parents and in-laws navigate the unrelenting march of time as they approach their sixties. I am now the resident 'aging expert' in my family, and we regularly discuss

[1] Meika Loe's (2011) rich ethnographic work in *Aging Our Way* was a seminal text that guided me when reflecting on my experiences and positionality as a young female scholar conducting intimate research with older people. Parallels between our personal-professional journeys are remarkable.

minute reminders of aging that once remained under the surface. They all actively love and care for both elderly parents and still-maturing children, and eagerly anticipate entering the role of grandparent. Their bodies and purposes are in transition as they begin to peer ahead to retirement. With well-accomplished careers, they endeavor to craft fulfilling routines and balance work with other passions: music, book-writing, teaching, gardening, skiing, travel, and family. Both sets do not consider moving to a tropical climate; instead, they are waiting to see where their children settle to establish new family configurations. Our family networks are spread across two countries, and at moments the tables turn: those who cared for us now look to us for care. My grandparents on both sides have become members of the 'oldest old' as they advance through their eighties. They confront progressing health issues, grief over the loss of loved ones, and declining mobility. Some moved closer to children and downsized to one-story living, while others remain in multi-story cherished homes. We deliberate how to balance independence and risk; when to enter senior-specific housing and nursing homes; creative forms of caregiving, companionship, and community; and how to maintain purpose and fulfilment at the end of life.

Through the dissertation I expanded and embraced the network of older generations in my life. So many individuals welcomed me into their homes and helped me to appreciate their experiences firsthand. A phone call and first visit with numerous participants led to incorporation into daily activities and regular conversations. Together we spent days in senior centers, laughed while lost in a tangle of highways, toured art galleries, shopped, swapped emails, played with grandchildren, and discussed our lives over innumerable cups of tea and coffee. This dissertation is a product of my personal journey as a young female scholar keen to better understand aging and the contexts that enable or disable a fulfilling life. Older adults are at the center of this project: they are the teachers and I the student. They are not a cursory focus group nor an afterthought. Rather, older adults represent starting points to appreciate aging and wellbeing in one's body, home, neighborhood, and city. They convey vitality, resourcefulness in facing challenges, and empowerment possible in later life.

The Aging Context

The number of Americans aged 65 and older is projected to more than double from 48 million today to over 98 million by 2060. By then, nearly one-in-four Americans will be over the age of 65 (Administration on Aging, 2016). The implications of this unprecedented demographic shift are among the United States' most pressing socioeconomic and healthy policy issues. Most attention focuses on economic forecasts, healthcare demands, and a shrinking workforce. The everyday experiences, contexts, and needs of individuals to grow old well within their social and physical environments are critically overlooked.

Are residential areas in the United States (US) adequately structured to meet the needs of a rapidly aging population? What makes a home, neighborhood, and city a good place to grow old, and for whom? Where one lives constitutes an important determinant of quality of later life. Over 95 percent of older adults in the US live in private homes (Administration on Aging, 2016), the majority in single-family houses designed for the physically mobile and cognitively able. Many neighborhoods are unsuitable for aging residents, but a growing number either choose not to or cannot afford to move to the limited supply of accessible supportive housing (U.S. Department of Housing and Urban Development [HUD], 2013). These numbers will increase as many Baby Boomers 'age in place' (Firestone, 2015).

The Appeal of Aging in Place

The Centers for Disease Control and Prevention (CDC) defines aging in place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level" (2009, n.p.). This is a central tenet of the age-friendly city movement promulgated by global entities such as the World Health Organization ([WHO], 2007), national organizations including the American Association of Retired Persons ([AARP], 2014), and local municipalities that include the City of Minneapolis (2014). The *Global Age-Friendly Cities: A Guide* (WHO, 2007) document, for example, provides checklist items to enable aging in place, such as housing located close to services and facilities. The AARP supplies resources to age in place,

including a *HomeFit Guide* (2015) that details modifications ranging from small do-it-yourself fixes to large-scale home modifications designed to improve mobility, comfort, and safety. There are 231 communities presently listed in the AARP (2018) Network of Age-Friendly Communities as the organization partners with municipalities to develop infrastructure that supports older people staying in their homes and communities for as long as possible. Private industries provide lists of services for-hire to assist those aging in place, including adult day care, cleaning, financial management, fitness, in-home care, occupational therapy, insurance, interior design, home remodeling, technology, and transportation. They encourage homeowners to hire contractors to install accessibility features such as entrances without steps, single-floor living, and wide hallways and doorways that can accommodate wheelchairs (National Aging in Place Council, 2018).

Aging in place represents a popular cost-savings mechanism for individuals, governments, and health systems. In Minnesota, for example, a Wilder Research Report (Warren et al., 2016) commissioned by the Minnesota Housing Finance Agency compared home-based and institutional facility-based costs for low-income older adults. Average monthly costs of aging in place (determined by home rehabilitation and in-home care services) were reported to be significantly cheaper: $3,346 per month, in comparison to $4,357 in assisted living and $7,567 in a skilled nursing facility. The US Department of Housing and Urban Development ([HUD], 2013) document "Measuring the Costs and Savings of Aging in Place" similarly advocates for cost savings at individual, state, and federal levels. Of the $203 billion spent in 2009 for nursing home, home health care, and other long-term services and supports, Medicaid covered 62 percent, Medicare 4 percent, 23 percent was out of pocket, and 11 percent paid for by private insurance. HUD encourages states to expand their home and community-based services waiver programs to those eligible for institutional care because it is more cost-effective long-term than nursing home care. This move shifts the burden of care onto individuals and their families. One study (Chari et al., 2015) estimated the cost of informal caregiving for elderly people in the United States to be $522 billion annually. Replacing that care with skilled nursing care would cost $642 billion annually. Instead, 90 percent of those aging in place who need long-term care rely upon a family member, relative, friend, or

volunteer as their primary source of assistance with daily activities (HUD, 2013). The monetary value of aging in place to minimize costs is thus a major incentive underlying the model's widespread promotion.

A Not-So-Perfect Fit

In the rush to promote aging in place, the barriers to staying in one's home and community may be overlooked or ignored. This includes lack of main-level bedrooms and bathrooms, lack of handrails, heating/cooling issues, large house sizes, intensive yard work, and aging housing stock (Scharlach et al., 2012; Johansson et al., 2008; Fausset et al., 2011). Homes that once served a resident's needs can become inadequate or inappropriate as everyday tasks become burdensome, home maintenance costs less affordable, and services more difficult to access (Golant, 2015). In Minnesota, Warren and colleagues (2016) report that 16,400 households (32 percent of households with extremely-low-income older homeowners) need home rehabilitation or improvement work for residents to remain in their homes for the next five years. These improvements will cost an average of $15,749 per household.

For those who do want to move to more accommodating settings *to* age in place, there is a distinct lack of affordable one-floor housing with access to services and amenities. Section 202 Supportive Housing for the Elderly Program has not received funding to construct any new buildings since 2012 (HUD, 2018b). The federal government cut funding to maintenance levels in a period when the waiting list for each Section 202 unit was 10 people (Ramnarace, 2011). Aging in place promotional materials do not mention the rapid rise of older homeless populations. People over the age of 50 make up more than 30 percent of the nation's homeless population (Nagourney, 2016). By 2050, there are expected to be 95,000 elders living without stable housing (Knopf-Amelung, 2013). Outdated and inadequate government assistance programs fail to meet the housing, health, social, and psychological needs of a growing number of vulnerable and marginalized older adults.

Large-scale built environmental barriers to aging in place include automobile-centered suburban communities with inadequate transportation networks to access

services (Johansson et al., 2009). Recreational investment and neighborhood social networks focused on younger populations limit opportunities for physical activity, sociocultural connectedness, and education in old age (Wahl & Weisman, 2003; Wiles et al., 2012; Gardner, 2011). Broader structural health policies and social services, such as the expense of private services and lack of government-subsidized home-based care, further impact individuals' experiences 'in place'. Unforeseen circumstances, such as losing the ability to drive, bankruptcy, illness, or family relocation, can drastically change one's relationship to home (Cutchin, 2003; Andrews & Kearns, 2005). These fluid personal contexts coupled with inadequate surroundings make staying in one's home for as long as possible challenging and unrealistic for many individuals (Oswald et al., 2011; Wiles et al., 2012). Static and unrealistic notions of 'staying at home' may interfere with more creative and realistic approaches.

Opening Up Possibilities for Aging in the Right Place

While aging in place represents a widespread goal of individuals, service providers, and policymakers, it remains an ambiguous, problematic, and uncritical concept. This can have devastating consequences as it is frequently applied with little consideration of the 'places' themselves. What about cultural minorities with differing residential expectations, longtime renters, those in unsafe housing, and the homeless? How does this model address their situations? I argue that widespread uncritical promulgation of this model has contributed to millions of older Americans inhabiting inappropriate residential areas, and even aging on the streets.

This dissertation probes the critical and deeply troubling gap between firsthand experiences and needs of older adults, particularly low-income and minority elders, and what is promised and promoted in the policy and public realm. My unique training in geography and gerontology situated me to conduct a rigorous and much-needed critical analysis of aging in place. Carefully unpacking the largely-unmet needs of my participants and tying them to structural inequalities of the sociopolitical economy exposes the superficiality and inadequacy of the catchy slogan. This reveals how aging in place is a tool for the government to shift responsibility for aging further back on to

individuals. The model minimizes public reliance on social models of housing and institutional care that rely heavily on tax dollars and are costly for municipalities and states. It exacerbates the deeply uneven conditions of American cities and the vulnerabilities of those aging 'in the margins'. Ultimately, aging in place is not the 'one-size-fits-all' solution to pressing housing and care needs. This dissertation employs the strengths of geography to destabilize the foundations of age-friendly governance and generate novel theoretical and applied possibilities for more just and inclusive modes of urban form.

Geographies of Aging

The still-nascent field of geographical gerontology emerged with the landmark studies of Golant (1972), Rowles (1978), and Warnes (1982). These authors intersected a number of subdisciplines including social geography, health geography, population geography, and development geography (Figure 1). Warnes (1981) established an initial broad agenda focused on spatial aspects of older populations, including the location and movement of older adults and associated services. Rowles (1986) expanded beyond empirical studies to highlight the complex relationship between older adults and their environments at multiple scales. He stressed the need for scholarship on the meaning of place, especially the home. Harper and Laws (1995) endeavored to 'rethink' the field through its potential to integrate social theory bridging human geography and social gerontology. They advocated for greater empirical and theoretical inclusion from other disciplines in geography, particularly health and medical, cultural, and historical geographies.

Spatial Distributions and Contexts of Aging

Geographical studies of aging in the 2000s coalesced around empirical studies of the distribution of older people and identifying spatial patterns and characteristics underpinning demographic aging (e.g., Phillips, 2000; McCracken & Phillips, 2005). Attached to developments in population geography and demography (Ogden, 2010), attention to spatial concentrations and distributions of older people proliferated. This

included demographic profiles from local, national, to global scales (e.g., Moore & Rosenberg, 2001; Heleniak, 2003; Cook & Halsall, 2011; Davies & James, 2011). Skinner and colleagues (2014) observe that such spatial studies of aging frequently involved mapping mortality and morbidity, such as rates of cancer and heart disease. This work often drew upon negative connotations of aging and the qualities of spatial contexts that put older people at risk, such as relationships between deprivation and mortality (Warnes, 1999). Environmental characteristics that generate vulnerability, accidents, and harm were analyzed, such as lack of access to services and the presence of physical hazards (Andrews & Phillips, 2005). Multi-level modelling, spatial statistics, and geographic information sciences (GIS) approaches enabled new analytical ways to understand and map population trends (Bailey, 2008, 2011), including the implications of the changing distribution of aging populations at various scales (Wiles, 2018). Researchers demonstrated how trends in poor health, technologies, and social environments influenced population aging from regional to global scales (Davies & James, 2011; McCracken & Phillips, 2005). Attention to spatial patterning spurred longstanding studies on aging and migration. Beyond quantitative models, this included some qualitative investigations of personal and cultural contexts that push and pull older adults to and from different locations, particularly distance from relatives and children (e.g., McHugh & Mings, 1996; Joseph & Hallman, 1998; Smith, 1998). Studies examined the movements of wealthier populations, such as Swiss and British retirees in Spain (Huber & O'Reilly, 2004) and seasonal 'snowbirds' travelling to warmer climates for winter months in North America (Happel & Hogan, 2002; King & Newbold, 2009).

An ongoing area of focus attends to health care services and infrastructure, and the living arrangements and environments of older people. This includes access to local resources such as primary care facilities, a variety of shops, and services (e.g., Cagney et al., 2005; Kobetz et al., 2003; Moore et al., 2004). With generally limited spheres of mobility, older adults tend to rely more on local services and facilities than any other age group. When unable to overcome obstacles such as poor access to public transport and icy sidewalks, urban form can lead to negative consequences such as falls and social isolation (Andrews, 2009). Geographers have begun to debate methods of

implementation, exclusions, and potential harms of current urban development strategies predicated upon the age-friendly model. This includes environmental barriers (Golant, 2014), especially in rural and remote areas (Skinner et al., 2008), among frail elderly people (Joseph & Cloutier-Fisher, 2005; Milligan, 2009), and through unequally-available provisioning of services (Skinner et al., 2014). There is an underlying imperative within geographical gerontology to find constructive ways to make living environments more enabling for older adults.

Place, Care, and Embodiment

Advances parallel deepening interest in health geography over the past 25 years since Kearns' (1993) seminal publication advocating for a reformed medical geography that was attentive to place and wellbeing. Geographers of aging have since zoomed in to examine the ways in which space and place influence wellbeing in aging populations (Cutchin, 2005; Hardill, 2009; Wiles, 2005; Wiles et al., 2009; Williams, 2002). The home is a site of rich scholarship given how it influences lives and experiences through physical access and location, implications for independence, and experiential qualities such as identity, meaning, and place attachment (Brickell, 2012; Dyck et al., 2005; Milligan et al., 2005). Boundaries between the public and private can blur, especially when the home comes to situate health and social care (Blunt & Dowling, 2006; Milligan, 2009; Peace & Holland, 2001). The home is a frequent site for growing efforts to examine relationships between care, caregiving, health care, and health through a humanist, feminist, or other critical theoretical lens. Geographers such as Dyck (2005), Hardill and Baines (2009), and Milligan (2000) question how care is supported or constrained in everyday contexts.

More than twenty years ago, Harper and Laws (1995) advocated for a more nuanced geographical scholarship informed by feminist scholarship. Since then, some geographers have applied this lens to extend beyond static and rigid understandings of old age. This includes recognition of aging and old age as influenced by culture and underpinned by a range of socioeconomic and political processes, lived experiences, and spatial practices (Hopkins & Pain, 2007, p. 287). Caregiving, the body, and emotion are

key themes linking much of the feminist-oriented focus in geographical gerontology. Mowl, Pain, and Talbot (2000), for example, explore cultural constructions of space (leisure spaces in particular) and the aging body. They demonstrate the centrality of the body in older adults' definitions and identifications of old age, as well as how gender, class, and ability influence navigation of space. England and Dyck's (2011) study on home healthcare unpacks social relationships between frail older people and both professional and family caregivers. With the rise of home healthcare in Canada, they explore how bodywork (such as bathing, toileting, and catheter management) is negotiated through intimate practices between caregivers and care recipients in the home. In these physical and affective processes, the homespace is constituted and reconstituted. They advocate for new ways of understanding bodywork in contemporary landscapes of care. In rural contexts, geographers such as Herron and Skinner (2013, 2012) investigate farmwomen's emotional geographies through their perceptions of caring roles and responsibilities. They examine how care is situated and performed through negotiation of multiple, overlapping identities and scales in rural settings. Drawing upon a feminist approach, they argue that ethical care is dependent upon recognizing and valuing the situated emotions involved in care work, sustaining care relationships, and asking for care.

While most literature focuses on women, men have also come into focus through studies on embodied and emotional masculinities of aging. Tarrant (2013, 2015), for example, studies grandfathers to explore interconnections between space, time, and gender. Through an exploratory study nested within social and cultural geographies, Tarrant demonstrates how grandfathers navigate sexism and ageism in caregiving landscapes and home environments. Some men purposefully position themselves in ambivalent ways regarding cultural stereotypes of grandparenthood, masculinities, and aging. By studying them and the objects in their homes, Tarrant's participants reveal the complex ways in which the material cultures of their homespaces were shaped by, and reproducing, diverse family relationships and associated politics. Age structures socially constructed and spatially experienced identities.

There is a small but emerging literature around older gay men. Pilkey (2013), for example, investigates the importance of material possessions in the homemaking of older gay men. In his study of gay Londoners and their negotiations of domestic materiality, household objects were essential to the construction of subjectivity. Pilkey's empirical analyses demonstrate the apparent, subtle, and even hidden ways that participants subverted heteronormativity through relating to possessions in the home, such as a male nude calendar in the kitchen and small figurines in the bedroom. This article complements and extends the small body of literature situated at the intersection of feminist work on domestic materiality, geographical gerontology, aging masculinity, and queer theory.

Altogether, there is increasing attention to aging as embodied, emotional, and relational (Milligan and Tarrant, 2018); both shaped by and shaping deeper cultural phenomena. There is some exploration of the influence of neoliberal values of independence and mobility on bodies, and how promulgation of 'active', 'productive', and 'successful' aging impact on perceptions and embodied experiences of old age. Cardona (2008), for example, explores the ethics of responsibility for health care pushed through 'healthy aging' and 'successful aging' narratives in Western countries. This notion of citizenship for aging individuals is based upon principles of agelessness, health, independence, and consumption power. Cardona interviewed consumers of biotechnological 'anti-aging' medicines and clinics that offered services such as hormone replacement therapy, antioxidant analysis, skin de-aging and repair, lifestyle modification, and musculoskeletal rehabilitation. Participants exhibited some tensions and contradictions within the model of self-constitution, and potential forms of resistance and contestation. Cardona (2008, p. 475) argues that a 'war on anti-aging medicine' is part of larger contestations of institutional competition for control over knowledge and management, and the desire to govern aging through the language of universal science, reason, and market rationality. Biomedical models of 'successful' and 'healthy' aging attempt to control and monetize aging processes. They present aging through medically reductionist terms that require technological interventions and the consumption of anti-aging products. Powerful commercial interests of pharmaceutical and biotechnological

companies then prey upon fears such as wrinkles, osteoporosis, and hormone deficiency. These broader structures permeate everyday spaces, practices, and how people come to identify themselves as old and enact aging (Hardill, 2009). As I discuss in Chapters 3 and 6, these evolving cultural ideals underpinned by the political economy compete with traditionally pervasive 'decline and decay' normative assumptions of aging in industrial societies.

Ripe Opportunity

Despite some progress, geographical attention to aging and old age remains underdeveloped. As demonstrated above, deep critical engagements with parallel advancements in human geography are still both limited and somewhat diffuse. Malcolm Cutchin (2009, p. 440) observes, "The study of geographical dimensions of aging has never reached its full potential… Only a fraction of the depth and scope of the collected theories, concepts, and methods of geography has been applied to gerontological thinking and research." For me, this holds true today. Aging and old age still have a relatively low profile in geographic research, which is surprising given the ever-increasing diversity of older people across the globe. What scholarship does exist tends to remain relatively insular where key scholars such as Gavin Andrews, Joseph Skinner, Malcolm Cutchin, Christine Milligan, Graham Rowles, Rachel Herron, and Janine Wiles continue to cite and build upon each other's (excellent) work. I echo previous calls from geographical gerontologists to enrich studies of aging by applying advances in human geography and related disciplines. My dissertation aims to do justice to Harper and Laws' (1995) call for theoretical and empirical advancement made over twenty years ago. I demonstrate that sustained engagement with political economy, feminism, critical race, disability, and urban theories enrich not only our scholarship, but also the lives of older adults through meaningful commitments to knowledge advancement and socio-spatial change. This engagement directly tackles how embodied oppressions in old age are consequential of a system of deep structural social, economic, and political inequality.

I go further than my peers to argue that scholarship on aging and old age critically needs to be incorporated into broader geographical agendas. Otherwise geography risks

becoming out of touch with our current aging world. Though not 'sexy' topics, aging and old age represent essential, underutilized lenses to re-examine and interrogate place, space, critical sites, and scales ranging from the body to home, neighborhood, city, nation, and globe. Novel critical geographic attention to aging invigorates issues of spatial justice and welfare and stimulates new conceptualizations of identity, flows of capital, mobilities, and the changing dynamics, forces, and structures literally borne by older bodies. I unpack and unsettle discourses about aging in order to address problematic assumptions, blind spots, and unchallenged and unconsidered modes of thought upon which geography rests.

Project Overview

We all grow old. Yet we do so at different times and rates, and in distinct places and unique ways. Aging is both universal and inherently heterogeneous. It transcends and intersects all structured social differences. Aging is not a rigid or frozen essential identity. Rather, it represents a fluid complex of positionalities: a temporal situatedness in relation to gender, class, race, and sexuality. The particularities of aging expose privileges and oppressions that individuals accumulate over the life course. Built and social environments contribute to aging in very particular ways, in which older bodies literally express structured advantages and disadvantages of their surrounding contexts.

Geography at-present largely fails to understand and address the fluid situations and relationalities of older adults. The academy's marked silence on this subject perhaps reflects unconscious systematic ageism in geography. To our detriment, we are far too comfortable pushing old age to the periphery in our personal and professional lives. Gerontophobia shelters problematic silences regarding the ideologies and practices that shape our cities and structure life from birth to death. It cripples geography's theorizations of power and inequality given that the discipline currently expects a limited set of bodies, economies, and spaces.

To address this critical gap, I situate aging as an intersectional lens to investigate urban life and transform geographic thought. My chapters draw upon literatures from urban geography, human geography, health and disability geography, feminist

geography, science and technology studies, critical race theory, and political ecology. This dissertation provides methodological tools, theoretical lenses, and relevant queries to motivate a breadth of geographers to substantively engage with and ask vital questions about old age: its effects upon their own theories and place within their scholarships. I push the discipline to consider how bodies and spaces acquire new and different meanings over time. Aging disrupts neatly-defined 'boxes' and exposes where existing literatures fall short, such as the powerful white heterosexual male body that can become weak, leaky, or no longer useful to capitalism in old age. A home that once enshrined privacy, independence, and comfort might become a site of degrading personal care, a walled prison of social isolation, an exhausting workplace to informally care for grandchildren or elderly parents, or a crumbling hazardous structure. The bustling urban center can transition into a lonely space of invisibility or a threatening social environment where passerby shun visible signs of infirmity. Time fundamentally shifts our relationships with our bodies and the multi-scalar environments around us.

Critically-informed geographies of aging can disrupt normative narratives of the city and geographic theory which are notably silent on the topic of old age. This scholarship can problematize current modes of urban and residential development, such as exposing socioeconomic exclusions enforced by the age-friendly city and political motivations underlying age-based segregation. Geographies of aging can interrogate how people are ordered and known across space and time through age's overlap with analytics of race, gender, sexuality, and class. This dissertation addresses theoretical blind spots in the discipline by bringing new environments and people into sharp focus. The chapters push geographers to think more creatively, self-reflexively, critically, and productively.

Outline of Chapters

In contrast to existing studies on affluent and resourced populations living in moderate climates, my project investigates aging in a harsh continental climate with a focus on underrepresented low-income and racially diverse older adults. Theoretical interventions are based on three case study areas in the Minneapolis (MN) metro region that purposefully contrast socio-demographic and geographic characteristics. In Chapter

2, I describe how I conducted seated and mobile interviews with 125 independent-dwelling older adults; geospatial audits of participants' homes, streets, and neighborhoods; ethnography with six participants over twelve months; and ten interviews with local policymakers and community service providers. The application of multiple methods generated a robust and geographically elastic approach resulting in more nuanced portrayals of aging in place.

I examine how race, class, and gender intersect with age to generate multiple and distinct privileges and oppressions. Intervening specifically in feminist scholarship, Chapter 3 focuses on the aging body as a pivotal site and scale to enrich analyses of structural inequalities and power relations. Indeed, one of the arguments of this chapter – and my dissertation, more broadly – is that aging should be added to race, class, gender, and sexuality as an equally significant actor. Ageism is engrained in the fabric and systems of our society. In housing, urban form, education, employment, and culture, institutional ageism remains largely unproblematized and unchallenged. There is a collective failure to provide adequate and accessible services, social supports, and appropriate contexts for those aging in the periphery. Marginalized older adults are maimed physically, emotionally, and socially because of conditions of poverty and discrimination. An important opportunity exists for feminist geography to concentrate on aging with the same awareness of marginalization, intersectionality, and structural injustice that feminists brought to previous studies of reproduction, employment, racism, gender, and sexuality-based violence.

Chapter 3 spatializes feminist thought on old age, questions modes of understanding and experiencing old age, and reconsiders the bodies, practices, and spaces of inquiry in aging research. I advocate for an epistemological rethinking of aging: its symbolisms, discourses, and limitations. This chapter points to opportunities for more complex understandings of local biologies (Lock, 1995) through the aging body's dynamic relations with built, social, cultural, economic, and political environments. Physiological processes of aging are socio-spatially shaped. An accumulation of life experiences impact materially upon how someone ages, such as whether or not a person

benefited from sustained access to affordable and varied foods, adequate health care, safe and clean streets, and supportive social networks.

Narrative excerpts from my ethnographic participants illuminate intimate experiences of aging in place. This deepens understanding of factors underpinning expectations and rules of what particular bodies can and should do in particular spaces. My findings produce an opening for alternative readings of culture and power based upon differential embodiments of old age. Aging is not an individual question of health or ability, nor is it simply a cause worthy of sensitivity and compassion. Rather, aging is a question of politics and power. Some bodies age faster than others because of intersecting social differences.

Aging represents a dense matrix of biosocial processes in which oppressions and privileges interact and intersect. Multiple fluid axes of difference are realized in and through space and time as old age temporally intersects race, gender, class, and sexuality. How we experience age-based privileges or disadvantages varies based upon these other inhabited vectors of power. Old age thus cannot be separated or rationalized through a single framework of oppression. This relational mode of thinking reconceptualizes feminist theorizations of intersectionality and extends the field's commitment to conceptual pluralism.

In Chapter 4, I apply an aging lens to critique the often-celebratory and uncritically analyzed role of therapeutic landscapes developed within health geography. This chapter builds from an earlier article published in *Social Science & Medicine* (Finlay, 2017) to critically examine the ambiguity of white spaces – environmental snow and ice – with their potential to both heal and harm. Snowy and icy conditions exposed embodied vulnerabilities that were generated and exacerbated by unequal urban and suburban contexts. Inadequate snow plowing and de-icing produced inaccessible destinations, frustration, and isolation. These observations overlap with disability scholars who identify physical and psychosocial challenges of negotiating environmental obstacles. My participants with a long-term disability were already familiar with exclusions of unaccommodating urban design. Their statements differed from participants who were physically and cognitively able their entire lives. Those who had developed

physical, mental, and sensory impairments with aging endured newfound exclusions and challenges navigating the urban environment. Most members of this group did not openly self-identify as disabled. One participant stated: “I’m not disabled, I’m just old.” The timing of the onset of impairments mattered.

People with early-onset work-limiting disabilities experience lower rates of employment, lower household incomes, more time living alone, and poorer health outcomes (Clarke & Latham, 2014). Critical disability scholars observe that disabled people face uneven harms and oppressions given restricted economic and social benefits. They do not have equal access to sites of power and privilege, including transportation, housing, health, education, or employment (Gillies, 2014). This can result in ‘accelerated aging’ through secondary conditions, increases in impairment, and more total impairments than non-disabled peers of the same age (Verbrugge et al., 2017). My participants who experienced disability for the first time in later life lamented their loss ability but still benefited from social and economic benefits accrued earlier in life. Furthermore, impairments were also an expected and normalized part of aging. Using a walker or hearing aids did not generate the same type of stigmas or powerlessness that younger disabled people often endure.

Regardless of disability, the isolation and hardships generated by winter weather conditions were generally more acute for low-income participants. Affluent participants had more resources to avoid white space hazards, such as sheltered household parking, money for taxis and ride services, and opportunities for ‘snowbird’ travel to warmer destinations during the winter. The chapter focuses on underlying structural factors that impacted susceptibility to harsh climactic conditions including uneven urban design, service access, government support, income, perceptions of safety, and class-based and racial segregation. Weather conditions crystallized structural inequalities and the underservice of the elderly poor. Resulting hardship and harms borne by participants’ bodies thus reflect the social fault lines for which we, not nature, are responsible. Participants suffered from the lack of political will and public commitment to provide basic resources necessary to protect them.

These observations address a lacuna in health geography where underlying structural inequalities, contested histories, and politics of landscapes remain unexplored. I demonstrate in the chapter that health geographers need to shift their optic to become more attentive to ambiguous, contradictory, political, and 'messy' experiences and embedded histories of landscapes. The expectation that city residents (including elderly and frail people) will be active consumers of public goods and responsible for their own wellbeing has devastating consequences. There is space here for health geographers to be *against* health and investigate how disparities in the incidence and prevalence of disease and harm are tightly linked to spatially-fixed disparities of race, income, gender, and social support (Metzl, 2010). Participant navigations of wintry urban and suburban landscapes speak as much to power, privilege, and inequity as they do to wellbeing. The chapter refocuses health geography's theoretical framing to better address the hierarchies, assumptions, relationalities, politics, and histories bound up in health and place.

Chapter 5 focuses on 38 low-income Phase I participants. They represent a marginalized and often-ignored group who exist outside of normative expectations of aging in stable housing with secure financial resources. Their nuanced responses evaluating relevant physical and social environments form the empirical focus of this chapter. I unpack how their local contexts are co-produced through institutional systems, structural politics (including class and racism), and the availability of resources (or lack thereof). Participant navigations of place attachment, including the 'local and particular' (Lefebvre, 1991) problems of aging in place, are shaped by the political economy and sociocultural norms. I draw upon critical approaches to urban space, race, and disability to demonstrate *why* particular residential contexts are underserved and *how* this produces highly uneven contexts of aging in place.

Critical race theory's analytical lens was particularly useful to unpack the experiences of African American participants who inhabited degraded, underserved, violent, and hazardous residential areas. Those in racially diverse subsidized housing tended to report higher incidences of crime, degraded conditions, and restrictions to autonomy. They were more likely to have a weak sense-of-place living in close proximity to drug trafficking, crime incidents, and foreclosed lots. These patterns exemplify how

racism is endemic and engrained not only legally, culturally, and psychologically (Winant, 2015; Harris et al., 2012; Tate, 1997), but geographically as well. Racism stratifies and structures urban form to which minority older adults (given their embodied vulnerabilities and often-limited resources) are highly susceptible.

In addition to instances of systematic victimization and harm, the chapter also documents unexpected and resourceful ways that participants navigated around structural deprivation and longstanding neglect. Black women's homes, for example, could represent a site of resistance to white privilege and supremacy. Reflecting bell hooks' (1990) work on the homeplace, these participants cultivated a space to love and respect blackness and shelter from discriminatory society. Home represented a site of empowerment and positive identity. Paying attention to unexpected and non-normative methods of placemaking, in tandem with a critical approach to space and place, reconceptualizes theories of place attachment.

This chapter documents terrain that is often overlooked or marked as unimportant. I highlight invisible crises and unspoken dignities to critique and re-position the theory of place attachment given the harms and exclusions it can produce. In an era of privatization, extreme inequalities, and concentrated zones of affluence and poverty, people face everyday dangers in their homes and neighborhoods. Home in the traditional sense – a connection and rootedness to one's place of dwelling – is routinely denied to minorities and low-income people in American settings. Unaccommodating and degraded infrastructure, violent crime, commercial depletion, and family dispersion undermine the viability of public life and strength of local support systems. My participants' diverse navigations of placemaking represent a productive vantage point to question fundamental assumptions of everyday urban life and extend geography's address of socio-spatial injustice.

Old age is a necessary lens to understand how and why the state bears violence upon its most subordinated groups. Well-designed lifelong places remain exclusive and often unattainable. Chapter 6 considers the multiple ways in which some older adults are explicitly and implicitly barred from full participation in civic life because they are no longer useful to capitalist growth. I unpack the mutually constitutive relationship between

neoliberalism, ageism, and urban governance in this chapter from three historical eras to present day. Current modes of urban development largely cater to able-bodied and affluent older individuals. Except, instead of residing in gated suburban retirement communities, people now increasingly desire to age in place. Affluent Baby Boomers have become a new niche for the generation of capital investment and profit. Even when their bodies are no longer useful in the typical Marxist focus on value added through physical labor, resourced older individuals are so numerous now that they have become important to capitalism in a different value-added way: through their demands for particular kinds of age-friendly housing. This has led to widespread application of age-friendly city development, a language used widely by the Phase III policymakers and community service providers during their interviews. On the surface, this model aims to make cities more convenient and comfortable for resident aging populations. Digging deeper, however, reveals economic motives that minimize expenditures on health care and social services while generating new forms of capital investment and growth.

The eras of urban-economic formation described in Chapter 6 demonstrate how capitalism as a system is expansive and dynamic. It is also inherently unstable and prone to period crises that lead to the reconfiguration of relations of production and reproduction (Harvey, 1982a). Capital can move back and forth among places indefinitely in multiple rounds of investment: sequentially building up, abandoning, and reinvesting in the same areas (Smith, 1996). The age-friendly city deepens gentrification efforts to profitably reinvest in urban areas.

The theories of David Harvey, Neil Smith, and other theorists, however, fall short given their lack of attention to aging. Capitalism ‘uses up’ a laboring body during its working years and then may discard it in old age. Time makes bodies disposable. Temporality is a critical lens needed to advance understanding of the political urban economy at its present conjecture. The disposability of some older bodies enables the state to be intentionally absent in providing services and supports to low-income elderly and frail people. State agencies best positioned to redress inequities and protect the most vulnerable do little. Instead, they delegate key health and supportive services to paramilitary organizations (Klinenberg, 2002). This stark model of urban governance

means that individuals with the least resources and greatest needs are least likely to get them. I observed on-the-ground consequences of this among homeless and disenfranchised participants devastated by the critical scarcity of subsidized housing, lack of supportive social services, and the closure of a downtown senior center. Their abandonment goes unnoticed and unheard given the lack of political will and public commitment to protect elders. This is possible because they are not 'useful' to our capitalist society. The cycle of investment in working-age bodies and disinvestment in retired ('used-up') bodies is essential to the ongoing accumulation of capital. This chapter pushes geography to re-conceptualize the political economy given how capitalism uses up and discards particular bodies.

Given that the age-friendly city is only gaining in popularity and implementation, Chapter 7 provides five recommendations to unpack and reposition current modes of urban development. I pose these interventions to advocate for more just methods to recognize and celebrate diversity, sites of difference (Young, 1989), and the thrown togetherness of people in space and place (Massey, 2005). This includes establishing a stronger and more coherent link between research and policies on urban aging. We need critical and interdisciplinary approaches that address the complexity of age-friendly urban development. This will involve putting older adults firmly at the center of research practices and policymaking interventions. They are the best-positioned to identify areas of need, prioritize urban issues, and guide appropriate implementation.

Inspired by critical race and disability theorists, I advocate for a self-consciously politicized approach to aging. The goal is "not theory for the joy of theorization, or even improved understanding and explanation; it is theorization in the pursuit of empowerment and substantive, not just formal, equality" (Devlin & Pothier, 2006, p. 8). I outline methods for emancipatory knowledge production and highlight the value of academic inquiry closely aligned with community-based methods of questioning and knowing. This includes integration with multiple voices and different constituencies.

Old age is not a single political identity. As discussed earlier, it represents a fluid complex of positionalities: a temporal situatedness in relation to gender, class, race, and sexuality. There is no universal age-friendly city that can accommodate all older person's

needs. This parallels Davis' (2013) observations that supporting disabled people can be incompatible because different impairments require different solutions. Blind people, for example, tend to prefer steps, defined curbs, and indented pavement; while wheelchair users need ramps, dropped curbs, and smoothed surfaces. Sometimes individuals with the same impairment require different solutions, such as visually impaired people who variously prefer to access text in braille, large print, audio tape, and electronic files. In the same manner, different groups of older people require different solutions. A society without group difference is not a realistic possibility, nor desirable (Vehmas & Watson, 2014). I advocate for critical geographic attention to aging that incorporates multiple voices with representation from a range of constituencies in an inclusive, but not homogenous, ideal of urban form.

The culminating intention of my dissertation is to create more room for alternative ways of 'being in the world' based upon a richer understanding of people, place, and space across the life course. It represents a crescendo towards thicker, deeper, intersectional understandings of the previously-unrecorded histories and geographies of older people's voices and socio-spatial experiences to invigorate the discourse of geography. To generate greater equality and wellbeing in later life, older adults require more than recognition of their needs. We need to tackle aging's rootedness in the sociopolitical structures of our society. To address oppressions of old age demands the redistribution of goods and services, wealth, and power.

Figures

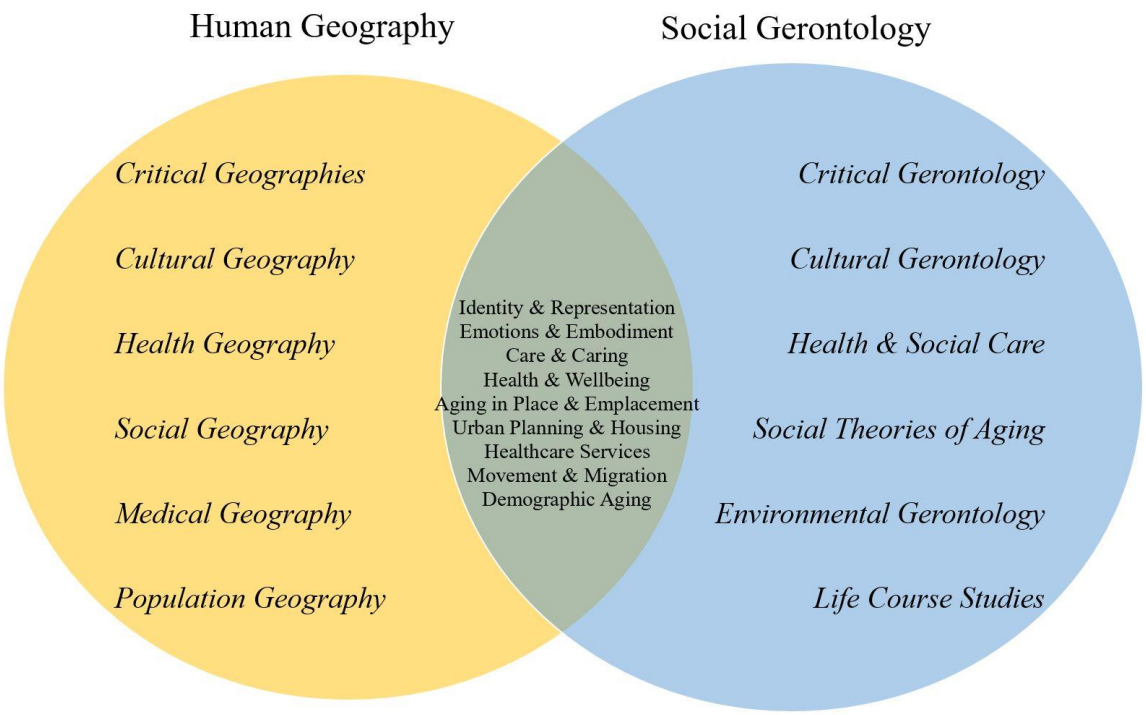

Figure 1. Geographical Gerontology Thematic Diagram (Skinner et al., 2014, p. 3)

Chapter 2. Methods

Analytical Framing

I initially formulated my doctoral project from a health geography framework to investigate relationships between wellbeing, place, and space. I sought to incorporate numerous interconnected factors that may affect wellbeing in older adults including gender, class, race, ability, age, culture, the built environment, social support, weather, and the political economy. Given my graduate school training, I approached wellbeing as situated within tangible, negotiated, and embodied contexts (Kearns & Gesler, 1998). I set out to study the varying contexts of older adults' lives to enhance understanding of how geography is salient to wellbeing across the life course.

My dissertation in part retains a health geography framing to apply a relational approach to space and place. Informed in particular by Cummins, Diez-Roux, and Macintyre (2007), I consider geographic context as flexible and relational – an operational living construct that can shape lives and opportunities while being uniquely navigated and shaped by individuals and communities. In other words, the characteristics of people and the contexts in which they live are highly interrelated. An older adult living in a socioeconomically deprived neighborhood, for example, may not walk outside for a variety of reasons. This could include a lack of resources (e.g., they still work full-time to cover costs of living, cannot afford to travel to parks or other desirable destinations to walk), poor accessibility (e.g., there are very few public parks and poor public transportation links to those that exist, low mobility makes walking on uneven sidewalks dangerous), and/or sociocultural reasons (e.g., it is unsafe to walk outside in the local area). It is impossible to isolate 'independent' contributions of spatial- and individual-level factors. I do not seek to control for or overlook intervening variables which might mediate causal pathways between place and wellbeing (Macintyre et al., 2002). Rootedness in a relational theory of space thus enables deeper understanding of reciprocal and mutually reinforcing relationships between wellbeing and place, wherein older adults' contexts and lives are inextricably linked.

I endeavor to link my fieldwork observations at the scale of the individual to broader socioeconomic and political factors. My analytical approach has become more sensitive to the significance of uneven power relationships and intersectional social categories such as age, class, gender, and race. Intellectual framings from feminists, disability advocates, critical race scholars, and urban theorists now infuse my conceptual approach. Starting at the scale of the body, I investigate how age intersects gender, race, class, and sexuality to operate as an organizing principle of socio-spatial structures and power relations (see Chapter 3). I consider everyday impacts of the uneven distribution of services and quality of infrastructure that result from these dynamic social relations and power struggles. Snowy and icy conditions, for example, expose embodied vulnerabilities that are exacerbated by unequal access to accommodating urban design and support (see Chapter 4). The everyday spaces in which participants resided are co-produced through institutional systems, structural politics, and the availability of resources – or lack thereof (see Chapter 5). These structures explicitly and implicitly bar older adults from full participation in civic life. Ageism is spatially fixed, which meaningfully limits opportunities for wellbeing in old age (see Chapter 6). As analyses deepen, I interweave critical consideration of how built, sociocultural, economic, and political contexts shape – and are shaped by – the lived experience of old age.

Research Objective and Questions

My primary research objective is to understand the ways in which older adults engage with urban and suburban environments to pursue their wellbeing. I conceptualize 'environment' in the broadest sense to include built, social, natural, political, economic, and cultural contexts. I understand 'wellbeing' in a similarly holistic manner. Wellbeing is how an individual perceives that their life is going – their condition of existence and overall level of satisfaction with life. However, there is no single definition. According to the CDC (2016), common applications of wellbeing include the presence of positive emotions and moods (e.g., contentment, happiness), the absence of negative emotions (e.g., depression, anxiety), and sense of fulfillment and positive functioning (CDC, 2016). When participants individually defined wellbeing according to how they understood and

navigated it in their own lives, they covered combinations of these elements. As I discuss in the following chapters, participants vocalized wellbeing in terms of physical and mental health, psychological and emotional wellbeing, economic security, depth of social networks, fulfilling routines and habits, residential satisfaction, and purpose.

My interest in investigating environment-wellbeing transactions led to the development of my research questions. Three overarching questions guided my fieldwork:

1. What individual, household, neighborhood-level, and broader structural factors contribute to or diminish older adults' abilities to live in ways that are suited to them? [Phase I]
2. How do older adults negotiate and enact aging within the contexts of their everyday lives over time? [Phase II]
3. To what extent can civic governments and service providers address and accommodate the needs of older adults to support their wellbeing? [Phase III]

Case Study Areas

Situated in the midwestern United States, Minneapolis is known for its cold winters, abundant lakes, extensive park system, craft beer, and cultural arts scene. The metropolitan area is home to approximately 3.5 million people (76 percent white, 8 percent black, 6 percent Asian, and 6 percent Hispanic). The average age is 36.9 years, with 13 percent of the population aged 65 and over. Median household income is $73,231, and 8.8 percent of the total population (7 percent of those aged 65 and over) live below the poverty line (U.S. Census Bureau, 2016).

My observations are based on three case study areas of the Minneapolis metropolitan area: Downtown Minneapolis, North Minneapolis, and Eden Prairie (Figure 1; Table 1). The purposive design of the case studies selected for socio-demographic and geographic characteristics. Eden Prairie is a low-density, car-oriented, outer suburb largely settled in the 1960s and 1970s. It is the wealthiest of the three case study areas with a median gross rent and household income well above the national average. At time of data collection, over 80 percent of Eden Prairie residents identified as white (U.S.

Census Bureau, 2015). North Minneapolis is a medium-density, inner suburb principally settled by Jewish immigrants from Russia and Eastern Europe alongside African Americans in the early 1900s. Post-World War II, the region became predominantly African American following 'white flight' of wealthier Jewish residents to the suburbs. A wave of Asian immigrants joined the community during the 1970s (Lamke, 2011). North Minneapolis has high levels of unemployment and socioeconomic disadvantage, including household incomes substantially lower than the national average. Over half of residents identify as black, and nearly one quarter Asian (U.S. Census Bureau, 2015). The final case study area, Downtown Minneapolis, is a high-density, pedestrian-oriented city center. It is socioeconomically polarized between affluent condo-dwelling individuals and low-income populations residing in subsidized housing and homeless shelters. The median gross rent and median household income are closest of the three case study areas to the national average. Nearly 65 percent of residents identify as white, and 20 percent identify as black (U.S. Census Bureau, 2015).

The study was approved by the University of Minnesota Institutional Review Board (1410P54782). I entered into fieldwork in May 2015.

Phase I (May 1, 2015 to October 31, 2015)

Recruitment

I employed nonprobability sampling, a method of recruitment that does not involve random selection (Feild et al., 2006), by asking for volunteers. Potential participants volunteered in response to project flyers and advertisements placed in senior centers, gyms, community centers, coffee shops, sites of worship, residential buildings, and health clinics in each case study area. Key contacts at these sites helped to distribute flyers and advertise the study. Eligibility criteria included: over the age of 55, not institutionalized in a care setting, residence in a case study area, and demonstrated cognitive capacity to participate in the interview.

It is important to note that the project's initial age minimum was set to 65. However, recruitment materials simply stated that participants self-identify as an older person (there was no specific age range stipulated). Within the first two weeks of

recruitment, I was contacted by numerous individuals aged 55 to 64, particularly from Downtown Minneapolis and North Minneapolis, who self-identified as an 'older adult' and desired to participate. This was surprising as I never before considered someone 'elderly' in their 60s. I traditionally considered 'old' to be 70s and over. Individuals told me, however, that "I'm not going to live to be 65. Everyone that I know is dead." The uneven mortality rates amongst socioeconomic and racial/ethnic groups that I previously read in public health reports 'came alive' to me. I heard firsthand about struggles borne by their bodies over the years that literally resulted in being 'old' at 55 (discussed further in Chapters 3, 4, and 5). This was particularly common from individuals who suffered from severe poverty, mental health conditions, and long-term disability. I thus submitted a change in protocol to the Institutional Review Board (IRB) in order to include these individuals in the study (see Chapter 3 for additional discussion on the topic).

The response to participate was overwhelming. Over 300 people contacted me to express interest. Respondents who met eligibility criteria were enrolled in order of response in each case study area: 42 participants in Downtown Minneapolis, 42 in North Minneapolis, 41 in Eden Prairie. Recruitment concluded at 125 participants when maximum capacity was reached (i.e., my grant funds to purchase participant gift cards were entirely depleted). I had to change my voicemail when capacity was reached in a particular case study area given abundant enthusiasm from local community members to participate. It became clear to me that these older adults wanted to be heard because they had things to say, and because they felt that others rarely listen to them. Interview sessions were conducted from June to October, 2015.

Seated Interviews

I conducted qualitative seated interviews with a research assistant (RA) – a geography Master's student – in participants' homes or a nearby public place of their choosing (e.g., coffee shop, senior center). They could interview alone or co-interview with a family member or close friend who lived nearby. Before meeting, I applied the Neighborhood Design Characteristics Checklist (Burton et al., 2011) to produce fine-grained geographic information for each participant at the dwelling, street, and

neighborhood level (see the Appendix for a detailed description of this methodological application). At the start of each session, I gave every participant a $25 gift card to a large-chain retailer to compensate them for their time. Many were unaware of the gift card in advance and expressed gratefulness at receiving compensation. Participants often told me how they planned to spend it, such as on groceries, presents for family members, and home maintenance materials. Some affluent participants tried to return the gift card to me immediately, in which case I politely refused. I explained that it was already allotted to them and suggested providing it to someone in need instead if they wished.

I was required by the IRB to assess each participant's capacity to provide informed consent through the Mini-Cog exam. The Mini-Cog is a well-accepted screening tool in health care settings that takes approximately 3 minutes to administer. The tool can detect cognitive impairment and allows researchers to quickly assess a number of cognitive domains including cognitive function, memory, language comprehension, visual-motor skills, and executive function (Borson et al., 2003). Three potential participants resulted in a positive screen for dementia. They were therefore excluded from the study. I still conducted an abbreviated set of interview questions (without taking formal notes or recording the conversation) in order to alleviate any distress at being excluded. At the conclusion of these sessions, I provided handout materials regarding local dementia identification, treatment, and support resources. Potential participants with a negative screen for dementia were accepted into the study.

I began the interview with background questions to assess participants' demographics and living situations. Semi-structured questions considered daily routines, social interactions, service provision, the quality of the residential environment, and perceived wellbeing (see Table 2 for an overview of interview topics and Table 10 in the Appendix for a list of all interview questions). The semi-structured format had a general predetermined order of questions, but still enabled me flexibility in the way that I addressed topics with participants (Dunn, 2005; Bernard, 2000). After the first few interviews, I tweaked the interview guide to eliminate any ambiguity, jargon, and leading questions.

The recorded interviews lasted anywhere from 30 to 90 minutes. In addition to the usual greetings, small talk, and sincere thanks, I also provided a brief overview of my dissertation project before we began and answered any questions after we concluded. This put participants more at ease. Participants were often eager to talk, in which I had to subtly keep the conversation moving forwards. I tried to strike a balance between saying enough about myself to be responsive and stimulating, but little enough to preserve the autonomy of the participant's words. The intent was to keep attention focused on their experiences and perspectives rather than mine (Seidman, 2013).

The RA and I applied a professionally-friendly and polite manner with participants. We both recorded notes – me with pen and paper, the RA on his computer. This was primarily to help us keep track of questions answered, jot down notes to organize and formulate follow-up prompts, record key words and phrases, and document any important movements, expressions, or gestures. We relied upon two audio recorders (one was a backup in case the primary ran out of batteries or failed while in-progress). More than half of the time, we – the interviewee(s), RA and I – were the only ones present in our location. In other instances, partners, children, grandchildren, and friends could be in another room. Pets – including dogs, cats, and the occasional bird or fish – were often present. On the occasions that we met in a public location such as a coffee shop or senior center, strangers were present in the ambient surroundings but could not overhear our conversation.

Seated Interview Fieldnotes

Within 24 hours of completing an interview, the RA and I each recorded in-depth fieldnotes. I developed a template to track the interviewing process (e.g., length of interview, interruptions, location, any technical problems). Recording elements such as the weather and setting, who was present at the interview, and body language crafted a more complete picture. For example: heat, rain, lightning, and other climate conditions may factor into whether or not a participant decided to participate in the mobile portion. The presence of another individual at the interview – such as a family member in another room – may impact on how the participant answered some questions.

I provided six prompts to stimulate in-depth reflections and critical observations from me and the RA: (1) Description and impressions of the neighborhood; (2) Description and impressions of the home environment; (3) Content of the interview (e.g., summarize content; highlight key words, topics, or phrases that stand out); (4) Interviewer's impressions (e.g., discomfort of participant with certain topics; emotional responses to people, events, or objects); (5) Nonverbal behavior (e.g., tone of voice, posture, facial expression, eye movements, forcefulness of speech, body movements, hand gestures); (6) Preliminary analysis (e.g., interviewer's questions, tentative hunches, trends in the data, emerging patterns, insights, interpretations, working hypotheses). These structured observations provided detailed descriptions of events, behaviors, and artifacts (Marshall and Rossman 1989) in participants' socio-environmental settings: a 'written photograph' (Erlandson et al. 1993). Recording impressions and perceptions about major themes, surprises, speculations, and connections promptly after each interview enhanced the rigor of the study and became a useful starting point for future coding and analyses.

Mobile Interview

Immediately following the seated interview, I asked participants to conduct a mobile interview: a short tour of the home and/or neighborhood to anywhere they thought appropriate for fifteen to twenty minutes. Guided by the notion that place matters, this method generated rich spatial observations and theories grounded in lived experience. I could experience places that mattered to participants *in situ* (Kusenbach, 2003). The RA and I asked questions and observed while exploring participants' stream of experiences and perceptions with the surrounding environment (Evans & Jones, 2011). The flexible format created a rich nexus of narrative, geographic, and visual data (Bergeron et al., 2014). As discussed in Finlay and Bowman (2017), it provided five methodological strengths: the ability to (1) produce spatially grounded and place-specific data; (2) access subtler and more complex meanings of place; (3) create opportunities for flexible and collaborative conversation with participants *in situ*; (4) build rapport and adjust participant-researcher power dynamics; and (5) efficiently produce rich geographic data.

Ultimately it offered a valuable way to explore the co-constitutive relationship between participants and their surrounding contexts.

Participants determined the route, speed, and mode of travel. The majority of interviewees (n=96) participated in mobile interviews and walked unaided (Table 3). While many participants chose to go outside, I found interior mobile interviews to be just as interesting and valuable. Downtown-living participants in the study that were unable to navigate exterior environments often chose instead to tour us through the Minneapolis 'skyways' network. Others chose to stay inside and gave interior tours of their home and building. When participants did *not* go outside was, for my research purposes, as interesting as when and where they did because they shared intimate observations with me of their environments 'closest in'. It provided unique opportunities to probe deeper into why they might be largely-homebound, such as disability, chronic pain, depression, and anxiety that made navigating the local built and sociocultural environments difficult.

To balance the formal nature of the seated interview, I purposefully chose an open-ended and non-structured format for the mobile interview. In contrast to the seated interview, I did not have any prepared questions and did not use an audio recorder. Instead, the RA and I employed a hybrid of unstructured conversation and participant observation (Marshall & Rossman, 2016). Putting away the recorders after lengthy targeted questioning provided relief in the session's intensity, and deeper immersion into participants' worlds (Emerson, Fretz & Shaw, 1995). This generated more natural behavior, spontaneous social situations, and events unhindered by an audio recorder (Finlay & Bowman, 2017). Participants did not receive instructions on what to discuss, and the RA and I only occasionally pointed out nearby features to prompt conversation. The open format put participants at ease and more 'in charge' after extensive targeted seated questioning.

Mobile Interview Documentation

We (the RA and I) used notebooks to record observations, a Global Positioning System-enabled watch to track the route and duration, and a digital camera to document features and scenery. We both individually wrote comprehensive notes within 24 hours to

describe the interview setting, mobile interview route, participant behavior, observed features, interactions, and discussion. The fieldnote guide included location and route, people present, and fifteen prompts (see Table 4). Prompts included how the participant prepared for the mobile interview, level of mobility, weather, route selection, environmental features of note, engagement with other people, anything new learned during the mobile portion, and any discrepancies or confirmation between the seated and mobile interviews. The fieldnotes enabled deeper consideration into the contexts of aging: participants' biographies and everyday experiences framed by geography. Overall, moving through space together revealed tacit knowledge and taken-for-granted practices of engaging with and connecting to one's local built, environmental context.

Phase I Participants

The 125 Phase I participants exemplify a broad range of older adults inhabiting a variety of residential contexts (Tables 5 and 6). Participants were 55 to 92 years old, and two-thirds female. Reflecting each case study area's demographics, most Downtown Minneapolis and Eden Prairie participants identified as white, while over two-thirds in North Minneapolis identified as black/African American. Participants were largely affluent in Eden Prairie (with the exception of ten residents in subsidized housing), while North Minneapolis participants were generally low-income. Downtown Minneapolis participants were socioeconomically polarized: highly-resourced participants resided here (e.g., affluent Baby Boomers in condos), as well as the most vulnerable (e.g., homeless and transient).

Dwelling patterns varied across the three case study areas. Participants generally lived in their homes the longest in Eden Prairie (19 years median), followed by North Minneapolis (15.5 years median) and Downtown Minneapolis (8 years median). Close to 60 percent owned their homes, while over a quarter across all three case study areas lived in subsidized housing. Downtown Minneapolis participants lived in highrise buildings, while North Minneapolis and Eden Prairie participants generally resided in detached houses and smaller apartment buildings. Downtown Minneapolis and North Minneapolis

participants lived on higher-traffic roads, gridded avenues, and mixed-use streets, while those in Eden Prairie lived on looping residential streets and cul-de-sacs (Table 5).

Participants generally perceived that they were in good health physically and mentally (see Table 7 and Figure 2): 73.2 percent in Eden Prairie, 69.1 percent in North Minneapolis, and 54.8 percent in Downtown Minneapolis rated themselves as having good or very good health. Half of participants reported fewer than five physical and mental health conditions, the most common complaint being overweight or obese (60.0 percent). Two-thirds felt generally happy and content, with the highest proportion reported in Eden Prairie (78.0 percent), followed by North Minneapolis (66.7 percent) and Downtown Minneapolis (45.2 percent). Three-quarters of all participants felt safe in their home: 92.7 percent in Eden Prairie, 71.4 percent in North Minneapolis, and 64.3 percent in Downtown Minneapolis. More participants reported feeling lonely and/or socially isolated in Eden Prairie and Downtown Minneapolis (51.2 percent and 42.9 percent, respectively) in comparison to lower levels in North Minneapolis (21.4 percent). I delve into variations in sense of wellbeing and perceptions of aging experiences in the following chapters.

As stated earlier, the majority of participants (76.8 percent; n=96) engaged in the mobile interview: 73.1 percent of men (n=30) and 78.6 percent of women (n=66). More white interviewees participated (83.1 percent; n=59), in comparison to 67.7 percent of African Americans (n=21) and 69.6 percent of other racially self-identified participants (n=16). African Americans as well as African immigrants were more likely to report that they were unavailable for the mobile interview given other pressing personal commitments, notably childcare. Most mobile interview participants walked unaided (90.6 percent; n=87), while others walked with a cane or walker (7.3 percent; n=7) or seated in a motorized wheelchair (2.1 percent; n=2). The mobile interviews lasted on average 17 minutes for 0.86 kilometers. The vast majority of participants led us through their homes and immediate neighborhoods (90.6 percent; n=87), with the remainder (9.4 percent; n=9) staying within the home and residential building area (often due to mobility limitations or bad weather). See Tables 3 and 8 for additional information.

Phase II (September 1, 2015 to August 31, 2016)

The Phase I sessions were intense, but relatively brief, two- to four-hour snapshots into participants' lives. In order to better understand older adults' experiences and perspectives through multiple spatial and temporal scales, I focused in-depth on intimate experiences with a subset of six participants over 12 months. I chose an ethnographic approach to capture individual lived experiences nested within broader societal and cultural contexts (Marshall & Rossman, 2016). This involved spending time in people's daily lives for an extended duration to watch behaviors and events over time and in different places, listen to what was said, ask questions, and make conversation (Hammersley & Atkinson, 2007). My time with participants involved multiple research methods, including participant observation and unstructured interviewing, which produced rich data (Walford, 2009). Patterns of everyday later life 'in place' were the focus of my inquiry.

I typically began with extended tours of participants' living spaces, sharing food and drink, and looking at pictures of family members. As we became better acquainted, I asked to accompany each participant to places outside the home that were fixtures in their everyday lives and routines. These sites included grocery stores, senior centers, cultural events, coffee shops, faith services, and parks. Additionally, we cooked, shopped, exercised, completed household chores, took care of grandchildren, socialized with friends and family, and engaged in lengthy conversations. In this manner, we became intimately familiar. For those with few family members nearby, my presence in their lives became magnified. They got to know me and Matt (my husband) and asked after my grandmother. My roles overlapped as researcher, friend, and pseudo-grandchild. I visited participants at least once a month (some much more frequently), and we conversed often between sessions by phone and email. For some with busy routines and already-crowded social lives, I was simply a recurring monthly appointment. They were happy to answer questions and engage, but our level of closeness remained limited.

These sessions were, for the most part, a breath of fresh air. Participants did not put up a front; they clearly and directly told me about their joys and sadness, good days and bad days. I learned how participants navigated chronic pain, bouts of loneliness and

depression, widowhood, and losing control over your mind and body. Sometimes participants were joyful and exuberant, other times they were unhappy and cantankerous. I witnessed ups and downs. These participants each had a lifetime of embracing their own vulnerabilities. Many had honed their living spaces and routines. Participants generally embraced the opportunity to reflect upon their present and past lives and enjoyed our regular meetings (see Chapter 3).

I employed unstructured interview techniques to seek personal accounts of significant events, perceptions, and contexts as determined by participants in their own words (Dunn, 2005). These interviews approximated to normal conversational interactions and gave participants ample scope to direct our interactions. I did not use an audio recorder, but frequently wrote notes in a small notebook while we talked and took photos during some of our activities together. In the process of observing their lives, I also shared stories and personal experiences about my life when appropriate. I provided updates on my ongoing research and checked in about my own opinions and analyses in-progress. This was important to my capacity to accurately capture the details that formed my data, interpretations of this data, and representing the lives of others and my own accounts of fieldwork.

Through this intimacy I could better understand the nuances of their lives, attitudes, and circumstances. Our interactions were meaningful on numerous levels. From the exceptional to the mundane, I gleaned valuable insights through their narratives, perceptions, and behaviors. Following all interactions (including impromptu calls), I recorded reflections in my digital journal. This included detailed recalls of events as well as my hunches, evolving understandings, doubts, fears, concerns, feelings, and so on. I reflected on my positionality, power relations, expectations and motives, and how various aspects of the research experience made me feel and act (Crang & Cook, 1995). For each photograph and event, I wrote about the underlying circumstances (e.g., the location, people present, how participants behaved with me and others). I relied heavily upon these fieldnotes in subsequent analyses to build more rigorous understandings.

I chose six participants to reflect the diversity of the sample and represent a variety of socioeconomic backgrounds, health statuses, and locations. In Downtown

Minneapolis, Ellen (73 years) lived alone in a comfortable condo along the river. Frank (77 years) resided alone at the other end of downtown in a subsidized highrise. June (66 years) and Christina (78 years) both resided in older houses in North Minneapolis. June lived with family members, while Christina resided alone with her dog. Thomas (67 years) resided in a longtime Eden Prairie house with his wife and numerous pets, while Denise (72 years) lived alone in a subsidized apartment building. June and Christina were African American; Frank, Ellen, Thomas and Denise identified as white. All participants were retired except for Frank, who worked a janitorial night shift in order to "keep the lights on" at home. Ellen, Christina, and Thomas each owned a car and drove; while Frank, June, and Denise relied on public transport and friends/family for rides.

Even though sessions formally concluded nearly two years ago, three of the six participants remain in contact via emails, calls, walks, meet-ups, and meals together. I describe my experiences and relationships in-depth with each participant in Chapter 3.

Phase III (May 1, 2016 - August 31, 2016)

Phase I and II prompted critical questioning regarding to what extent municipal organizations address and accommodate the needs of aging citizens. How do the perspectives of policymakers compare to those of older adults? In order to address these questions, I conducted semi-structured interviews with ten civic staff and community services providers in the Minneapolis metropolitan area. Phase III 'zoomed out' to the broader metropolitan scale regarding senior housing, services, care needs, urban infrastructure, and policies.

I contacted policymakers and community service providers in each study area to participate in a 30 to 60-minute interview. I utilized existing professional contacts and employee directories at the City of Minneapolis, City of Eden Prairie, Hennepin County, and Minnesota State Department. I recruited participants through local organizations including senior centers, the state board on aging, and AARP. I purposefully sampled participants to represent a range of employee positions at municipal offices and community service provider organizations.

An undergraduate RA and I travelled to the participants' places of work. I asked all questions in a semi-structured format. After introductory questions regarding participant training and professional position, my prompts focused on identifying how the needs of older adults were incorporated into planning and programs. I asked for participant definitions of and organizational efforts surrounding aging in place. I probed for their opinions on quality of life among resident aging populations and areas for improvement (see Table 9 for the full overview of topics, and Table 11 in the Appendix for a list of all semi-structured interview questions).

Similar to Phase I, I used two audio recording devices to capture the interview. The RA and I both recorded handwritten notes throughout the interview. Immediately following each interview, the RA and I wrote fieldnotes reflecting on the experience. This template was identical to the one I used in Phase I, except that I changed wording of "home and neighborhood" to "work environment". As with Phase I, recording fieldnotes was a useful tool to reflect on questions, emerging trends, and tentative analyses while immersed in the process of data collection.

The ten Phase III participants ranged in age from approximately 30 to 65 years old. Eight were women, and 9 were white. Participants had occupied their current position for an average of 10.5 years, with a range from 0.5 to 35 years. Three participants worked at the municipal level (including Minneapolis, which encompasses both the Downtown Minneapolis and North Minneapolis case study areas, and Eden Prairie), one at the scale of the metropolitan area (Minneapolis and St. Paul), one at the county level (Hennepin County), and five statewide (Minnesota).

Analysis

I organized all transcripts, photographs, and field notes using the software package NVivo (Version 11). The Phase I and Phase III interviews were transcribed verbatim by a professional service. In order to enhance the study's rigor, I cross-checked transcripts against original audio files for quality and completeness. Analysis was heavily based on and driven by original accounts and observations from study participants. I applied a phenomenological approach to the qualitative data to explore, describe, and

analyze the meaning of individual lived experience: "how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others" (Patton, 2002, p. 104). My focus was on participants' lived experiences to see where there were differences and commonalities between people and places. I favored intensity and depth, as well as exploring interactions between each individual and their socio-spatial context. This helped me begin to make sense of the massive amount of data collected.

I then worked with an undergraduate RA to apply Braun and Clarke's (2006) six steps of thematic analysis.[2] We coded the qualitative material by sub-themes captured under overarching themes of the environment (e.g., built, natural, service, sociocultural contexts); personal traits (e.g., attitude, preference, beliefs, habits, fears, vulnerability); interactions with friends and family; financial and career situations; mobility and activity levels; and physical, mental, and social health and wellbeing (see Table 12 in the Appendix for a complete list of thematic coding). During the process, member checking with participants (i.e., informally testing my interpretations with participants from whom the data were originally obtained); regular debriefing with RAs, mentors, and peers; and audit trails (clear pathways detailing how the data were collected and managed) enhanced transparency and credibility (Marshall & Rossman, 2016). I followed an iterative process to continually identify themes, linkages, and explanations.

Methodological Considerations

Study Setting

Because Minneapolis, Eden Prairie, and the state of Minnesota are highly supportive to older adults through heavy investment in services and support, parks, care provision, and active transit, my findings may or may not apply in other settings. The state has racial, ethnic, and geographic inequities in health status and incidence of chronic disease. This includes gaps among recent immigrants, American Indians and Alaskan

[2] Braun and Clarke's (2006) six steps of thematic analysis: (1) familiarization; (2) generation of initial codes; (3) search for themes; (4) review themes; (5) define and name themes; and (6) write up of themes analyzed.

Natives, African Americans, and Hispanic populations as reported in the Health Care Disparities Report (Snowden, 2017). Older adults' experiences may vary in other places with distinct political, economic, sociocultural, and natural climates. Although I recruited Phase I participants from a range of public settings to capture a diverse sample of older adults living in three urban and suburban case study areas, this study did not include rural areas, institutional settings, or care environments. Additionally, the interviews were conducted from June to October and did not occur during winter months; though many participants still discussed experiences of ice, snow, and frigid temperatures.

Seated and Mobile Interviews

The Phase I participants represented a breadth of white and African American older adults but did not include large numbers of other races or ethnicities (e.g., Hispanic, Asian and Pacific Islander, American Indian and Alaskan Native). There were also limited numbers of recent immigrants included in the study. Two participants self-identified as members of the lesbian gay bisexual transgender queer (LGBTQ) community, while the rest openly identified as heterosexual or did not discuss their sexuality. Lonely or isolated adults may have self-selected into the study in order to gain the social activity provided by the interview experiences. Conversely, they may be underrepresented given lower inclination or abilities to reach out and participate. Given that individuals with a positive screen for dementia (flagged by the Mini-Cog test) were excluded from the study, my observations on Alzheimer's and related dementias are limited.

Although the participant responses were overwhelmingly detailed and thoughtful, there is a possibility that personal experiences such as struggles with loneliness or health concerns may have been under-reported by individuals who did not feel comfortable sharing this information. Some alluded to mental health conditions or past abuse but did not want to disclose further information when I prompted them to elaborate. Though troubling to consider, it is also likely that some participants may have lied or exaggerated claims. I had no method to fact-check their claims and took them at face-value.

Regarding ethical concerns, there were limitations to the extent that the RA and I (both young, able-bodied, able-minded, resourced, white individuals) could personally relate to participants. I was aware of power imbalances between me and participants through factors such as race, income, education, and age. Given that I was the one asking questions, I was largely 'in charge' of the sessions. I remained actively concerned about social relationships during these sessions and endeavored to reduce potential negative effects through positive rapport, open and honest communication, and respect.

The audio recorders impacted our interactions and may have inhibited some participants' responses given the visible reminder. Participants may have been less forthcoming with off-hand or 'spur of the moment' comments given the audio recording (Dunn, 2005). If a participant ever expressed discomfort with the audio recording, I stopped the recorder and reverted to solely handwritten note-taking until given permission again to begin recording.

The mobile interviews were often unfamiliar and participants sought guidance. I tried to avoid prescriptive instructions and strict geographic boundaries as these can be limiting and diminish participant individuality. Instead, I aimed for a balance to provide enough guidance so that appropriate data could be obtained, but remain open enough to enable participants to guide me and the RA through spaces as they wanted them to be seen and understood (Gardner, 2011). Route selection was never completely spontaneous: as Bergeron and colleagues (2014) note, it involves some degree of co-construction between researchers (me and the RA) and participants. Our presence influenced their behaviors.

Time of day was another important methodological consideration. The mobile interview generally captured a brief snapshot of local daily rhythm – such as walking around a neighborhood on a calm mid-morning versus busy rush hour period. The mode of travel also influenced observations and findings. In this study, all participants chose to walk (either independently, with a mobility aid, or in a motorized scooter). Alternative modes of travel, such as driving, bicycling, or public transit, would have been interesting methods to cover more ground with participants. These methods may also be more

shielded from seasonal weather conditions, such as the hot and humid summer conditions frequently encountered.

When outside, the visible recording mechanisms could compromise participants' privacy and confidentiality. In some instances, the RA and I put camera and notebooks away for safety. As Carpiano (2009) notes, there can be fear of repercussions if a participant seen walking and pointing with outsiders is construed as reporting illicit activity. Confidentiality was a constant concern. The RA and I heeded participant direction when encountering others and, unless explicitly introduced, remained as inconspicuous and discreet as possible.

Ethnography

The ethnographic sessions produced distinct positionings of knowledge and ways of being in the world. Stories told during research sessions were not simply regarded as means of mirroring the world, but as the means *through which* it is constructed, understood and acted upon (Crang & Cook, 1995). The method was not an attempt to draw broad conclusions from a detached vantage point. Rather, intimate and largely taken-for-granted elements of older people's everyday lives came to the forefront. Participants were not 'typical' or 'representative', but instead they provided an immense depth and quality of information from their distinct positionalities.

The unequal relations of power and knowledge bound up in Phase I continued to pervade the research process in Phase II. Instead of denying the power imbalance, I openly discussed it with participants and reflected upon it in my fieldnotes. Participants took advantage of my positioning, in that I provided information, rides, and helped with tasks whenever possible. I felt immense responsibility to represent my participants appropriately in accounts produced. Together we brainstormed on how my research and future efforts might benefit them and their peers, such as communicating findings to key stakeholders, advocating for social justice to decisionmakers, and distributing resources to local community members.

In the ethnographic sessions, participants were at-times uncomfortable or unwilling to discuss contentious topics such as racism, class, sex, and intimacy. This was

in part impacted by the varying levels of contact that I had with participants. For some it was frequent calls, emails, and visits with open and deep dialogue; for others it was a monthly appointment. As noted in Chapter 3, the two North Minneapolis participants chose to end their participation early in the course of ethnographic sessions. It was difficult to reach Frank (a Downtown Minneapolis participant) whose phone was periodically disconnected. He was hospitalized several times during the course of our sessions due to food poisoning, falls, and health complications, and did not want me to visit him in-hospital.

Interviews with the Professionals

The power imbalances lessened in Phase III as I met with educated and generally-resourced individuals. We met in their places of work, which may have altered their responses given the ambient presence of coworkers and professional expectations. The interviewees focused commentary on their professional experiences (as prompted and reinforced by my questions), though some did volunteer personal opinions and experiences regarding aging (such as the challenges facing their elderly parents or personally approaching retirement). It was a small sample size of 10 individuals whose professional capacities ranged widely from the municipal to state level. It would be unfair to generalize their statements too broadly given the limited set of perspectives included. Given the need to preserve anonymity and confidentiality, I am also limited in the data that I can divulge.

Personal Capacity

On a personal note, data collection and analyses were at-times exhausting. I was naïve entering into the Phase I interviews and at first over-scheduled myself with two interviews per day, five days a week. This pace was unsustainable given the intellectual and emotional investment required in each session. As a result, I quickly scaled back my data collection schedule to interviewing no more than two to three days per week.

I was surprised at the high level of emotional intensity and vulnerability that many Phase I participants shared. At least one-in-five participants cried at some point

during the interview. As a result, I began carrying tissues with me and prepared myself mentally to provide caring attention respectful of their experiences. I was careful to, in the most basic of terms, back off from distressing subjects when needed. Many expressed how grateful they were to have someone willing to listen. I was careful not to promise more than I could deliver. For example, I do not have training as a counselor, social worker, geriatrician, or clinical gerontologist and cannot take on those roles. There are ethical implications to helping people explore issues such as violence, abuse, racism, and poverty and then leaving them without support once the research is completed (Bailey, 2007). I began to carry a list of resources with numbers and websites for interviewees to contact regarding specific issues (e.g., volunteer home maintenance programs, Meals on Wheels, mental health sites, affordable community health programs).

Closing

Given these considerations, my data illuminates a limited set of realities for older adults and aging-oriented professionals in the Minneapolis metropolitan area. These results should be considered hypothesis-generating and prompt further exploration in different geographic settings, purposefully-sampled communities, and longitudinal studies.

Altogether, the fieldwork amassed a rich breadth and depth of data. My analyses in each chapter following present overarching themes and key narratives, but there are many more stories to be told and observed phenomena unpacked. This is just the starting point as I expect to work with this material for many years to come.

Tables

	United States	**Minnesota**	**Hennepin County**	**Case Study Area 1: Downtown Minneapolis**	**Case Study Area 2: North Minneapolis**	**Case Study Area 3: Eden Prairie**
Resident population estimate [a]	318,857,056	5,457,173	1,212,064	31,353	6,681	63,228
Median gross rent, 2010-2014 [a]	$920	$835	$934	$879	$670	$1,154
Median household income, 2010-2014 [a]	$53,482	$60,828	$65,033	$49,922	$24,733	$95,697
Percent of population aged 65 years and older [b]	13%	12.9%	11.4%	11%	6.4%	8.6%
Race and Hispanic origin [a]						
White	62.1%	81.4%	70.3%	64.3%	11.7%	81.7%
Black	13.2%	5.9%	12.6%	20.2%	53%	5.6%
Asian	5.4%	4.7%	7.2%	6.1%	22.5%	9.2%
Hispanic or Latino	17.4%	5.1%	6.8%	4.9%	8%	3%
Other [c]	1.9%	2.9%	3.1%	4.5%	4.8%	0.5%

[a] Population estimates from July 1, 2014 (Data obtained from U.S. Census Bureau QuickFacts 2015)

[b] Population estimates from April 1, 2010 (Data obtained from U.S. Census Bureau QuickFacts 2015)

[c] Other refers to: American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, and Two or More Races

Table 1. Case Study Areas in Comparison to the United States, State of Minnesota, and Hennepin County

Section A: Personal Information	i. Background: age, gender, birthplace/ time in the US, self-identified race/ ethnicity, language, education, marital status, past employment, driving ability ii. Living situation: Housing tenure, length of residence, living arrangement
Section B: Physical & Built Environment	i. The local neighborhood: daily routines, perceived boundaries, level of satisfaction, (un)met needs ii. Availability and accessibility of services, mobility iii. Perceived safety and comfort in the home and neighborhood, fall history iv. Planning for the future; perceptions of "aging in place" - expectations, desires, (dis)advantages, barriers; suggestions for neighborhood improvement/investment
Section C. Neighborhood and Social Connections	i. Family, friend, and neighbor social interactions and connections ii. Sense of isolation and vulnerability iii. Perceived inclusion/ exclusion with family/ friends and in the community, experiences of ageism
Section D. Health and Quality of Life	i. Quality of life, sense of happiness, sources of sadness and/or anxiety ii. Perceptions of aging and getting older iii. Self-perceived health, any concerns, limitations iv. Sense of independence

Table 2. Summary of Phase I Seated Interview Topics and Questions

Mode of Transit	*Walking Unaided*:* 90.6% (n= 87) *Walking with a cane or walker:* 7.3% (n= 7) *Seated in a motorized wheelchair or scooter:* 2.1% (n= 2)
Duration	*Range:* 1:02 – 42:40 minutes *Average:* 17:07 minutes *Median:* 16:00 minutes
Distance	*Range:* 0.14 – 3.44 kilometers (0.09 – 2.14 miles) *Average:* 0.86 kilometers (0.53 miles) *Median:* 0.67 kilometers (0.42 miles)
Environments Toured	*Inside home area / residential building only:* 9.4% (n=9) *Inclusion of areas outside the home (i.e. around the neighborhood):* 90.6% (n=87)
* Of those walking unaided, 4 participants walked with his/her dog(s), 1 participant with coffee, and 1 participant with a fire poker for protection against neighbors' dogs	

Table 3. Summary of Mobile Interview Data

1	Description / impressions of the neighborhood.
2	How did the participant prepare, or get ready, for the mobile interview?
3	How was the participant's mobility? (E.g., Did they move fast/slow? Did they use a mobility aid?)
4	What mode of transportation did the participant choose?
5	What was the weather like at the time of the interview, and how did the participant react to this?
6	Where did you go?
7	Why did the participant select this route? (Is it part of their routine? Does it lead to a particular destination?)
8	What did the route look like? (What environmental features did you notice? What environmental features did the participant make note of?)
9	How did the participant engage with the environment? (Did they obey traffic rules? Did they break the rules? How did they communicate with other cars or pedestrians?)
10	Who did you see while out? Did the participant engage with or mention the other people? What did those interactions look like?
11	What does the participant like/dislike about his/her neighborhood?
12	Were there any environmental features that seemed difficult for the participant to navigate?
13	Look for strategies. If the participant talked about a particular challenge, such as a tricky intersection or steep hill, how did they manage these environmental challenges?
14	Is there anything that you learned on the mobile interview that you did not learn in the seated interview?
15	Were there any discrepancies between what you *heard* in the seated interview, and what you *observed* in the mobile interview? Or did they confirm each other?

Table 4. Mobile Interview Fieldnote Prompts

	Downtown Minneapolis (n=42)	North Minneapolis (n=42)	Eden Prairie (n=41)
Age (in years)			
Average / median	71.6 / 72	69.6 / 70	73.0 / 73
Range	55-91	56-91	60-92
Gender			
Female	61.9%	76.2%	65.9%
Male	38.1%	23.8%	34.1%
Race/Ethnicity			
White	73.8%	16.7%	80.5%
Black/African American	7.1%	69.0%	-
Hispanic / Latin American	2.4%	-	-
Asian	2.4%	-	-
Other [a]	14.3%	14.3%	19.5%
Education			
Less than high school	-	21.4%	-
High school diploma	52.4%	47.6%	48.8%
Bachelor's degree	21.4%	16.7%	34.1%
Graduate degree	26.2%	14.3%	17.1%
Marital Status			
Single (never married)	35.7%	14.3%	2.4%
Married (or common law)	26.2%	21.4%	53.7%
Divorced / separated	31.0%	33.3%	29.3%
Widowed	7.1%	31.0%	14.6%
Employment Status			
Working	21.4%	19.0%	17.1%
Retired	78.6%	81.0%	82.9%
Driving Status			
Current valid driver's license	69.0%	76.2%	95.1%
No (current) driver's license	31.0%	23.8%	4.9%
Living Arrangement			
Alone	57.1%	52.4%	43.9%
With a spouse / partner	31.0%	21.4%	53.7%
With another family member	-	16.7%	2.4%

With a Friend / Roommate	2.4%	7.1%	-
Other arrangement	9.5%	2.4%	-
Length of Residence (in years)			
Average / median	18.95 / 22	18.19 / 15.5	11.04 / 8
Range	0.5-48	0.5-45	0.5-50
Dwelling Tenure			
Own	45.2%	57.1%	73.2%
Market rental	14.3%	23.8%	2.4%
Subsidized housing	40.5%	19.0%	24.4%
Dwelling Type			
Detached House	2.4%	69.0%	56.1%
Condominium or Apartment	83.3%	31.0%	43.9%
Homeless Shelter	14.3%	-	-
[a] "Other" self-identified races/ethnicities include (in alphabetical order) African, American Indian and African American, Arabic, Bohemian, French, German, Irish, Jewish, Norwegian, Polish, Scottish, Swedish			

Table 5. Phase I Study Participants

	Downtown Minneapolis (n=42)	North Minneapolis (n=41)	Eden Prairie (n=42)
Dwelling			
Tenure			
Own	45.2%	57.1%	73.2%
Market rental	14.3%	23.8%	2.4%
Subsidized housing	40.5%	19.0%	24.4%
Type			
House	2.4%	69.0%	56.1%
Condo	42.9%	2.4%	19.5%
Apartment	40.5%	28.6%	24.4%
Homeless Shelter	14.3%	-	-
Age [a]			
Pre-1914	7.1%	4.9%	-
1915-1939	4.9%	31.7%	-
1940-1969	7.1%	22.0%	17.1%
1970-1989	54.8%	26.8%	70.7%
1990-2015	26.2%	14.6%	12.2%
Street			
Type [a]			
Main traffic artery	11.9%	2.4%	-
Mixed-use residential/retail	38.1%	-	-
Avenue (broad road with trees)	35.7%	29.3%	31.7%
Residential	9.5%	65.9%	43.9%
Cul-de-sac	-	2.4%	22.0%
Courtyard	4.8%	-	2.4%
Topography [a]			
Flat	90.5%	88.1%	68.3%
Gently sloping without steps	9.5%	11.9%	31.7%
Sidewalk [a]			
No sidewalk	-	-	39.0%
Sidewalk	35.7%	23.8%	36.6%
Sidewalk with vegetation	59.5%	76.2%	-
Sidewalk and bike lane	4.8%	-	24.4%

Neighborhood			
Predominant street pattern [a]			
Regular geometric grid	33.3%	59.5%	-
Distorted grid	59.5%	26.2%	2.4%
Curvilinear (looped)	-	2.4%	12.2%
Cul-de-sac (branched)	-	-	43.9%
Radial (radiating from center point)	-	-	4.9%
Ribbon (along shoreline or natural features)	2.4%	4.8%	12.2%
No discernible pattern	4.8%	7.1%	24.4%
Mix of Land Use [a]			
Residential	2.4%	14.6%	29.3%
Residential with occasional other uses	-	75.6%	43.9%
Vertical mix of residential/non-residential	38.1%	-	-
Clusters of residential/non-residential blocks	59.5%	9.8%	26.8%
Level of greenery [a]			
Very small to small amount	33.3%	2.4%	-
Moderate amount	38.1%	26.8%	26.8%
Large to very large amount	28.6%	70.8%	73.2%

[a] NeDeCC available for 124 participants; one North Minneapolis participant declined to provide a home address citing privacy concerns.

Table 6. Phase I Residential Environmental Audit

	Downtown Minneapolis (n=42)	**North Minneapolis (n=42)**	**Eden Prairie (n=41)**
Perceived health			
Very poor	4.8%	4.8%	2.4%
Poor	14.3%	9.5%	7.3%
Moderate	26.2%	16.7%	17.1%
Good	31.0%	54.8%	51.2%
Very good	23.8%	14.3%	22.0%
Number of reported health conditions			
Average / median	7.5 / 5	6.6 / 5	6.2 / 6
Range	1-20	1-18	0-19
Sense of happiness			
Feel happy / content	45.2%	66.7%	78.0%
Feel unhappy / discontent	54.8%	33.3%	22.0%
Sense of safety in the home			
Feel safe	64.3%	71.4%	92.7%
Feel unsafe / have concerns	35.7%	28.6%	7.3%
Sense of social connectedness			
Do not feel lonely or isolated	57.1%	78.6%	48.8%
Feel lonely and/or isolated	42.9%	21.4%	51.2%

Table 7. Participant-Reported Wellbeing

	Entire Phase I Sample (n=125)	Mobile Interviewee Sample (n=96)
Age	*Range:* 55-91 years old *Average:* 71.1 years (Median: 71.0)	*Range:* 55-91 years old *Average:* 71.1 years (Median: 71.0)
Gender	*Male:* 32.8% (n= 41) *Female:* 67.2% (n= 84)	*Male:* 31.3% (n= 30) *Female:* 68.8% (n= 66)
Self-Identified Race/Ethnicity	*White:* 56.8% (n= 71) *Black/African American:* 24.8% (n=31) *Hispanic/Latin American:* 0.8% (n=1) *American Indian:* 0.8% (n= 1) *Asian:* 0.8% (n= 1) *Other*:* 16% (n= 20)	*White:* 61.5% (n= 59) *Black/African American:* 21.9% (n=21) *Hispanic/Latin American:* 1% (n=1) *American Indian:* 0% (n= 0) *Asian:* 0% (n= 0) *Other*:* 15.6% (n= 15)
Self-Identified Debility	*Total:* 40.8% (n=51) *Experience One or More Physical Impairment(s):* 32% (n= 40) *Experience One or More Cognitive Impairment(s):* 8.8% (n=11)	*Total:* 36.5% (n=35) *Experience One or More Physical Impairment(s):* 27.1% (n= 26) *Experience One or More Cognitive Impairment(s):* 9.4% (n=9)
* "Other" self-identified races/ethnicities include (in alphabetical order) African, Arabic, Bohemian, French, German, Irish, Jewish, Norwegian, Polish, Scottish, Swedish		

Table 8. Phase I Entire Sample and Mobile Interview Sample Comparison

Section A. Introduction	Description of job, education and training, professional role
Section B. Issues and General approaches	Primary issues of concern to department/organization, planning and implementation to address issues, successes and challenges
Section C. Aging in Place	Familiarity with term ‘aging in place’, any initiatives to support ‘aging in place’, how accommodating wide breadth of needs and preferences
Section D. Looking Forward	Quality of life for resident aging populations, areas of improvement, strategic planning

Table 9. Summary of Phase III Semi-Structured Interview Topics

Figures

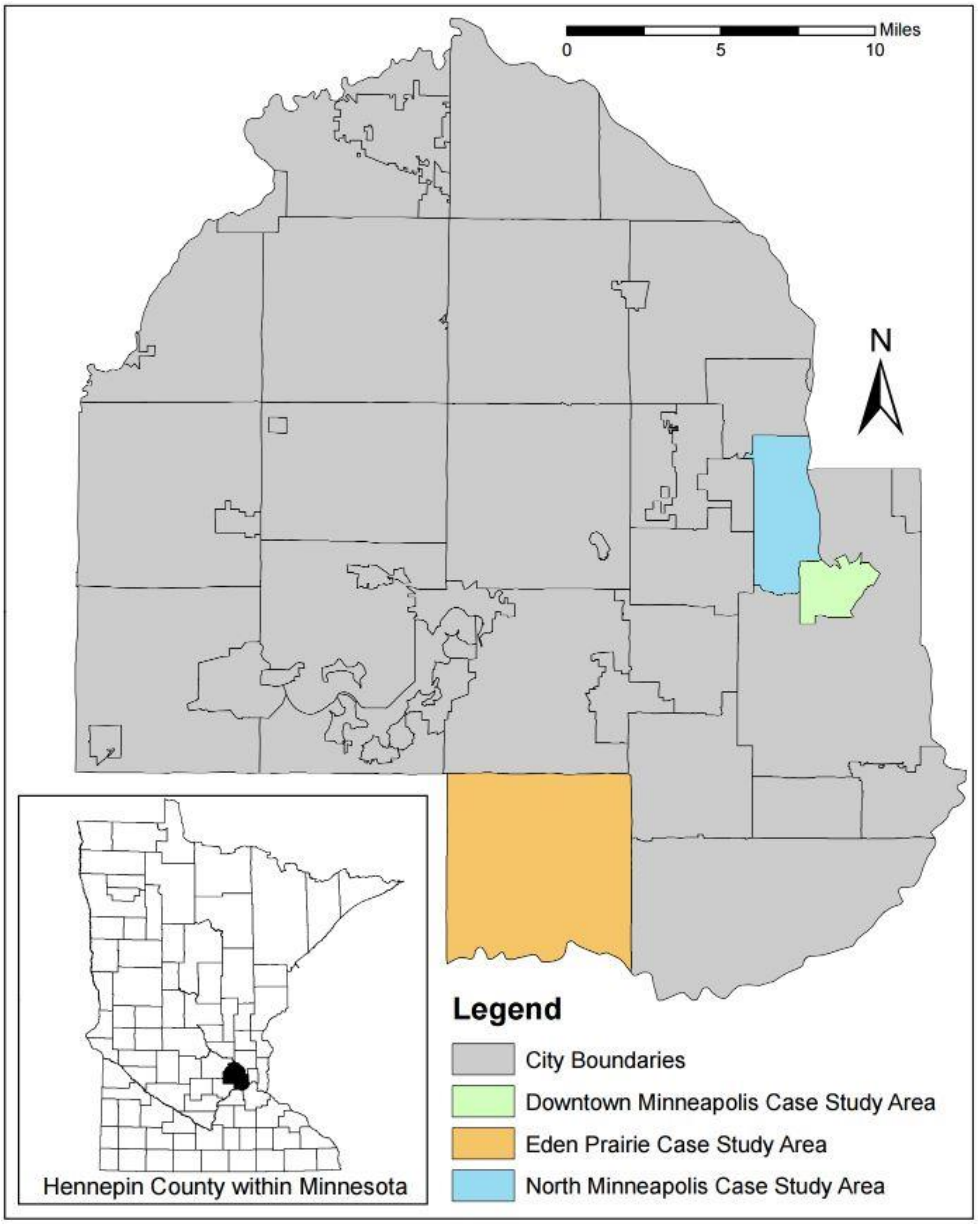

Figure 2. Case Study Areas in Hennepin County, MN

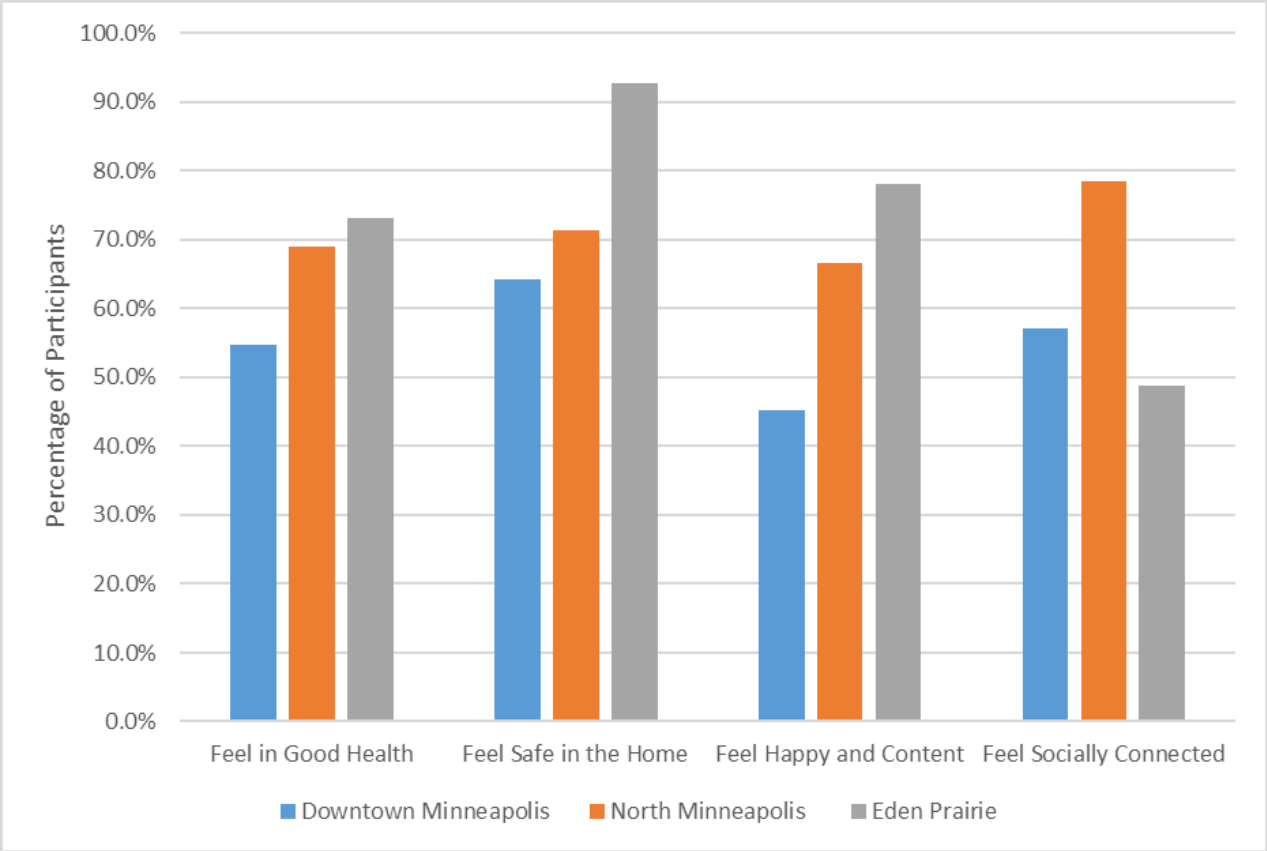

Figure 3. Summary of Positive Perceptions of Self-Reported Health, Safety, Happiness, and Social Connection

Chapter 3. Intimately Old: An Embodied and Emplaced Feminist Geography of Aging

Spatializing Feminist Thought on Later Life

Old age is rarely the explicit focus of any feminist canon, in stark contrast to enthusiastic attention exploring themes of gender, sexuality, reproduction, self-fashioning, bodily privilege and oppression, stigmatization, and desire among younger populations. Concerns with difference, representation, and identities arose in the 1990s with an initial focus on gendered relations and unequal experiences (e.g., McDowell, 1993; Bondi, 1992; England, 1991; Bondi, 1990). Investigations expanded beyond the dualism of men and women to consider race, class, sexuality, disability, and other markers of difference (e.g., Butler & Parr, 1998; Dyck, 1998; Valentine, 1996; Duncan, 1996; Butler, 1993; Katz & Monk, 1993). Attention to the body in early manifestations of feminist scholarship and related disciplines was marked by a focus on younger and sexier bodies. Aging was a lens generally absent from these literatures. Elderly bodies were not purposefully excluded from feminist scholarship; however, they were also not the explicit center of many projects (Twigg, 2004). This reluctance to tackle the aged body may reflect engrained gerontophobia of academia and wider culture. Pervasive ageism is visible in the media, workplace, retail, and personal biases through various social stereotypes of older people as senile, helpless, dependent, unproductive, and cute. Ageism encompasses subtler forms, such as ignoring or overlooking old age. These varying forms of ageism are evident across much of academia.

A feminist gerontology emerged in the late 1990s and early 2000s that drew upon personal perspectives and experiences of female scholars as they endeavored to make sense of their own and others' lives. Similar to earlier feminist projects, this body of work recognized that personal struggles and embodied experiences offered important opportunities for theorization. Grounded in the voices of those aging themselves, this scholarship resonated with themes of age oppression and social stigmatization. This work includes the National Women's Studies Association "Age and Ageism" issue edited by

Leni Marshall (2006). Contributions by Margaret Cruikshank (e.g., *Learning to be Old – Gender, Culture, and Aging*, 2009), Toni Calasanti and Kathleen Slevin (e.g., *Age Matters: Realigning Feminist Thinking*, 2006), Margaret Gullette (e.g., *Aged by Culture*, 2004), and Kathleen Woodward (e.g., *Figuring Age: Women, bodies, generations*, 1999) represent valuable voices in the small field of feminist-based gerontology. This scholarship intervened in dominant problematic conceptions of aging as biological 'decline and decay'. It challenged the foundations of biological determinism and unpacked how aging is socially constructed through beliefs, customs, traditions, norms and expectations. Feminist scholars depicted aging as a creation of time and place, and more cultural than biological (Cruikshank, 2009).

Feminist gerontology tackled ageism's dehumanization and Othering of older people in Western society. They addressed widespread societal issues including irrational fears of the aging population, the dominance of the sick role, lack of programs to preserve the health and wellbeing of older citizens, and the exhortation to 'keep busy' through active aging practices. Instead of seeing 'the elderly' as one homogenous group, this scholarship began to consider the dynamic interplay of class, race, ethnicity, and gender that produced distinct experiences of becoming old. This multidimensional approach thus resisted the all-encompassing category of 'old' that places such a strong emphasis on embodied difference from others. By placing old age as a socio-political location (Calasanti & Slevin, 2006), this scholarship opposed societal ageism to generate novel theoretical ideas for empowerment in old age.

A gap in this literature, however, is that it largely refers to late middle-aged years (roughly equating to being in one's fifties and sixties) instead of deep old age. It covers a period of the life course when physical markers such as menopause, wrinkles, and aching joints emerge, and the 'sandwich generation' of caring for both children and elderly parents occupies women's time (Calasanti et al., 2006). While these writings are passionate, subjective, and written from the inside, attention to deep old age (the final stages of life when someone self-identifies as old) remains remote, detached, and too-frequently couched in biomedical and policymaking terminology. Twigg (2004, p. 64) observes:

> Written from the outside, it is about them – the old – not us… These old remain eternally Other; and that sense of them as a wholly separate and fundamentally different category of being lies at the heart of how ageism operates.

While feminist scholars have expressed growing concerns about aging, they rarely study the truly old.

Intimate understandings of embodied old age thus remain under-theorized. This includes nuanced exploration of daily movements and representations of being old, as well as the advantages and disadvantages of particular groups, such as the tendency of women to have stronger support networks. Inequalities overlap with old age such that older black men are more likely to be poor than older white women (Calasanti & Slevin, 2006). Age intersects gender, race, class, and sexuality to operate as an organizing principle of socio-spatial structures and power. My purpose here is to suggest a critical lacuna in the literature. An important opportunity exists for feminist geography to concentrate on aging with the same awareness of marginalization, intersectionality, and structural injustice that feminists brought to previous studies of reproduction, employment, racism, gender, and sexuality-based violence. This attention would in turn enhance knowledge of and appreciation for complexities and ambiguities in later life, including the ways in which multiple oppressions interact and intersect. My intention goes beyond the project of simply adding in the voices of older people. Rather, I question modes of understanding and experiencing old age, and reconsider the bodies, practices, and spaces of inquiry in aging research.

Fixed on the Body

Becoming ‘old’ is not just chronological. I first realized this during project recruitment. While my IRB application approved the participation of individuals aged 65 and older, my recruitment flyers simply stated that participants self-identify as an “older person”. As stated in Chapter 2, to my astonishment I received multiple calls from individuals in their fifties and early sixties eager to participate in the project. Ian (60 years, Downtown Minneapolis) told me that he would not live to see 65. Years of transient living on the street and substance addiction accumulated bodily harms and

abuses that made him feel old at 60. The two youngest participants in the study, Jim (55 years, Downtown Minneapolis) and Karen (55 years, North Minneapolis), were both intent on entering assisted living as soon as possible. Younger than my parents, I was initially shocked by their self-identifications as seniors. During the interview sessions, I learned that both endured chronic pain and severe disability. Their embodied struggles were exacerbated by limited incomes and unaccommodating residential environments. Jim and Karen told me that they were exhausted, and simply desired to retire to comfortable home surroundings.

After receiving permission from the IRB to drop the study's age minimum from 65 to 55, I had a total of nine individuals aged 64 and younger participate. I learned firsthand that one does not simply "become old" at the age of 65 or any top-down marker of the life course. Rather, participants tended to self-assess old age as a bodily distinction with the onset of physical markers and impairments. It was the point at which they could no longer comfortably navigate their surrounding social and physical environments. Greying and thinning hair, wrinkles, and mobility limitations prompted them and others to evaluate and track the personal process of becoming 'old'.

The aging body is a pivotal site and scale of analysis. It is an entity through which identities are constituted, acted upon, 'fixed', and maintained (Dyck, 1998). The embodied categorization of 'old' is pivotal to differential power relations through biomedical and social constructions of old age. Older adults are routinely demeaned through overt and covert ageism. This includes describing forgetfulness as a 'senior moment', name-calling and patronizing (from negative stereotypes of hag, biddy, and geezer to 'he's so adorable' and 'isn't she cute'), staying 39 birthday after birthday, and blaming the 'silver tsunami' of Baby Boomers for socioeconomic issues. Old bodies are consistently identified with physical and mental decline, nearness to death, economic and physical dependency, and social isolation (Calasanti et al., 2006; Mowl et al., 2000). Most attention focuses on 'the problems' such as mobility limitations, incontinence, caregiving needs, and the implications of these bodily deficits for public expenditure (Twigg, 2004). Aging is presented as the slow and inevitable decline of individual bodies

with associated losses of strength, control and autonomy. This is used to justify the objectification, control, surveillance, and Othering of older people.

A feminist approach to aging is critically needed to consider what is overlooked when we focus on just the glaring physical signs – the deficits – of old age. Aging is not an inflexible or homogenous process of physical and psychological decay, as it has been understood for much of recorded history. Concentrating on the aging body need not be implicitly oppressive. Rather, a feminist approach can assert subjectivity, reflexivity, and empowerment to disrupt mainstream accounts and claim the territory of embodied old age. This would decenter prevalent decline and decay narratives of the old body as frail, leaky, and unbounded. Furthermore, it would problematize discourses of successful aging which rely heavily on neoliberal imperatives of activity, independence, and personal responsibility. Sandberg (2013) notes that the specific materialities of aging bodies are largely overlooked in successful aging discourses. Instead, the capacity of older adults to retain a youthful body (through the aid of pharmaceuticals and self-care regimes) is celebrated. In this chapter, I argue for a theorization of old age that goes beyond the binary of bodily success or decline. I advocate for an approach recognizing how aging is complex, differentiated, and experienced in a broad range of moments and places in people's lives. I advocate for an epistemological rethinking of aging to advance our understanding of its symbolisms, discourses, and limitations.

This project draws upon science and technology studies (STS) to recognize how knowledge of aging is always partial and situated. Haraway (1988) critically questions the validity of ostensibly objective scientific knowledge and endeavors to make room for alternative ways of knowing. She argues that masculine scientists and philosophers supplied with grants, laboratories, and publications represent a powerful body of scientific knowledge-makers. They embody a conquering "gaze from nowhere" through their unmarked positions as privileged white men (p. 581). Haraway insists on the embodied and subjective nature of scientific knowledge and introduced "situated knowledges" as a tool to deconstruct masculine doctrines of objectivity. Instead of a view from above, nowhere, and simplicity (p. 590), we need more complex, self-reflexive, engaged, and critical standpoints on aging. Practicing a feminist geography of aging

identifies partial objectivity in understanding biophysical and sociological aspects of aging. Further, it pushes scholars to tackle their own social locations and positionality vis-à-vis their objects of scientific inquiry, and the partiality of the knowledges that they produce.

Local Biologies

The aging body represents a dense matrix of biology, politics, and culture: a biosocial phenomenon that warrants greater attention and interest. Mansfield (2008) applies this term to articulate that biological processes at the scale of the body are as influential as the social context by which we understand and experience our bodies. Aging is a biosocial phenomenon given that it encompasses co-productions of biologies and social structures. The accumulation of one's life experiences impacts materially on how someone ages, such as whether or not a person benefited from sustained access to affordable and varied foods, adequate health care, smoothly paved sidewalks, and supportive social networks. Structural inequalities that limit access to material needs based on factors such as class and race (see Chapters 4 to 6) result in embodied consequences in the aging process. Negative stereotypes and pervasive ageism may even shorten lives. In a study of 660 people aged 50 years and older (Levy et al., 2002), individuals with more positive self-perceptions of aging lived 7.5 years longer than those with negative self-perceptions. Physiological processes of aging are thus socially shaped. Socio-spatial factors (the resources and supports available in our homes, neighborhoods, and cities; the safety and cleanliness of our streets; the nature of our social interactions) largely determine health and longevity.

There is a weighty materiality to aging bodies – physiological changes in skin elasticity, bone structure, musculoskeletal strength, cognitive function, and sexual drive, to name a few – that influence and are influenced by social discourses. Medical anthropology's concept of local biologies is a useful tool here to articulate aging as simultaneously biological, cultural, and social (Neely, 2015). Lock (1993) developed this concept in her groundbreaking work on menopause in Japan and North America. She argues that differential experiences between women in each geographic site resulted from

a mixture of diet, cultural norms, and social relationships. In contemporary Western biomedical discussions, accounts of menopause are dismissively reductive. Powerful scientific rhetoric lays claim to universal physiological processes, which are metamorphized as female bodily breakdown and deficiency. This medicalized approach to menopause differs considerably from the Japanese concept of *konenki*. The 'maturity' of aging Japanese women is realized through influential kinship obligations to aging parents and children. Their symptoms reported during menopause, and post-menopause disease profiles of heart disease, osteoporosis, stroke, and Alzheimer's (all impacted by changing hormone levels), vary markedly from women in North America (Lock & Kaufert, 2001). For most of the symptoms commonly associated with menopause in the medical literature, Japanese women report much lower rates than women in the US and Canada. Post-menopausal women are not at equal risk for heart disease, breast cancer, or osteoporosis. There is there no universal menopause as women navigate very different social and physical conditions. As Neely (2015) observes, Lock's combined approach to menopause as biological, social, cultural, and political emphasizes that nature and culture in human health are inseparable. Further, bodily processes reflect the very different social and physical conditions in which people live and die.

This conceptual grounding inspired calls to interrogate health as a nature-society question (Mansfield, 2008; Guthman, 2011) and coalesced into a political ecology of health and the body (Jackson & Neely, 2014). This scholarship aims to comprehend how environmental, social, cultural, political, and economic conditions – in addition to the materiality of bodies – shape health. Applying this lens to aging processes generates rich opportunities for empirical analyses and theoretical advancement. Continuous feedback loops between biology and culture (Lock & Kaufert, 2001) influence very real opportunities for health and wellbeing in old age. Where and how we live, work, socialize, eat, recreate, and generally engage in everyday life has manifest impacts upon our bodies from birth to death. My approach incorporates these theoretical developments to recognize aging as an intimately personal process influenced by the political, economic, cultural, and physical environment. Social categories of race, class, gender, and sexuality intersect these contexts to further impact on experiences of aging.

Multiplications of difference

Feminist geography scrutinizes how multiple axes of difference are realized in and through space. Intersectionality is a useful analytical framework to theorize the complex relationship between different social categories (Valentine, 2007). As Brown (2012, p. 542) observes: "by solely focusing on one axis of oppression and social inequality, researchers risked erasing or discounting other simultaneous ones that positioned individuals quite differently from one another." Intersectionality thinks through the breaks and overlaps of sociopolitical personhood, categorization, and positionality. Race, gender, and sexuality are specific vectors of power, and points at which identities merge to produce uniquely different harm. Ellison (2018) for example, identifies the burden of violence levelled against queer black women. She highlights historical patterns of race, gender, and sexuality in relationship to different kinds of places such as the welfare state, liberal humanist democratic state, and the carceral state. The 1996 Violent Crime Control and Law Enforcement Act, for example, managed and instrumentalized a racial politics of suffering to grow the carceral state. It employed a language of anti-violence and re-instantiated race, gender, and sexuality as knowable and categories through line-items such as The Violence Against Women Act, the Racial Justice Act, and the Hate Crimes Statistics Act. Ellison demonstrates that race and class form the criterion of difference between what kinds of gendered violence are legislatively actionable and which are not, such as domestic violence versus street harassment. Gender, race, and sexuality thus represent methodological axes to generate and exploit relational differential value among groups of individuals.

Age, as a system, is notably absent from most lists of intersecting inequalities that shape our lives. This is curious, because, as Loe (2011, p. 18-19) notes:

> [Age] is not all that different from gender, race, and class. Age organizes our lives and stratifies our society. The one difference is that it is temporal. We all pass through the privileges and disadvantages associated with aging; we all get old. How we experience age-based privileges or disadvantages varies, based on

other aspects of our social location, and how well we actively 'do age' in accordance with social norms.

Age overlaps and intertwines with social categories and markers of difference to operate as an organizing principle of socio-spatial structures and power. The experiences of an aging African American woman, for example, would differ from those of a white gay man living in a heteronormative nursing home. There is opportunity here to capture interlocking categories of aging experiences, and to recognize that old age cannot be separated or rationalized through a single framework of oppression. Ageism intertwines with other structural forces including sexism, racism, and capitalism.

Drawing on the traditions of feminist, queer, and sexual geographies (Wright, 2009), the aging body represents the nexus of global and intimate where individual navigations of the embodied self connect to multi-scalar processes of identity and power across the local-global continuum. Examining old age can challenge and broaden conventional feminist geographical readings of intersectional identities, spaces, and scales. Focusing on age broadens the field's commitment to conceptual pluralism, which understands individuals' experiences and subjectivities as fluid and overlapping rather than composed of distinct social locations (Longhurst, 2002). It exposes new varied and complex oppressions and landscape privileges or deficiencies intersecting with identities. I argue that new environments would come into focus, such as carceral nursing homes where elderly inhabitants are regulated and disciplined. In public spaces, older adults – like everyone else – are ordered and known through overlapping analytics of race, gender, sexuality, and class. This theoretical investigation broadens and deepens our understanding of factors underpinning expectations and rules of what particular bodies can and should do in particular spaces.

Unpacking Geographic Privilege

Subtle and complex interplays of power are deeply implicated in the social production of space. They influence who should occupy which spaces and who should be excluded. *Gender, Identity and Place: Understanding Feminist Geographies* (McDowell, 1999) examined the gendering of specific places and spaces ranging from the workplace

to nation-state. Challenges to the binary division between feminine and masculine space unpacked the basis of everyday social relations, institutions, and structures of power. The work untangled assumptions of public/private, outside/inside, work/home, and other such problematic binaries. Broader works have deconstructed and levelled powerful critiques at the production of space as heterosexual (e.g., Oswin, 2008), racial (e.g., Craddock, 2000) and able-bodied (e.g., Gleeson, 1999). These scholars demonstrate how physical and social environments reflect and reinforce unequal social relations.

To extend this line of argument, a feminist geography of aging can investigate how spaces are also age-graded. Built environment assumptions of able-bodiedness and able-mindedness permeate urban landscapes through features such as short-timed crosswalks, stairs and escalators, and complex transportation systems. These spatial frameworks explicitly neglect to fulfill the needs of many elderly individuals, and implicitly demean the acceptability of older adults to inhabit these spaces. Those who do not match the ideal body type are not welcome. There are pervasive societal expectations of where and how aging should occur. While mobile and affluent retirees are anticipated and advertised to in urban age-friendly communities, those in 'deep old age' are rarely accommodated. The 'messy business' of old age is expected to be done in the privacy of one's home or in an institutional care environment. The very old no longer meet neoliberal values of 'active', 'productive', or 'successful' members of society. Rather, they are now burdens on the state. Spatial manifestations of this logic – and attendant ageism – permeate the care and housing provision of older adults. This includes nursing homes relegated to distal and isolated locations, and distinct geographic separation between generations (see Chapter 6 for in-depth discussion on this topic).

There is an opportunity here for scholarship to be sensitive to underlying geographic mechanisms that marginalize older adults. More nuanced empirical and theoretical research could draw attention to the varied and active ways in which older adults occupy space. One vivid example from my personal experiences is observing the large daily gathering of elderly men and women spread across an urban park in San Francisco's Chinatown. They occupy this space to play mahjong, socialize, and claim it as their own. There are narratives of older adults caring for place and engaging with

communities through volunteering, activism, advocacy, and nurturing of others (Milligan & Tarrant, 2018). Thoughtfully questioning how older adults' social capital influence, and are influenced by, the contexts and spaces in which they operate, could generate opportunities for social, political, economic, cultural, and personal change. As I will address in Chapter 7, there is an opening to celebrate the city as a multigenerational site of difference (Young, 1989). Better appreciating the thrown togetherness (Massey, 2005) of life course identities could forge new cultures and ways of living together. This aspiration emphasizes the value of human experience, subjectivities, and agency. It involves methods of listening to older adults because they are best placed to reason and articulate their own circumstances and lives. Embedded knowledge of literally 'being in the world' as an older person will raise our collective consciousness of other humans and built environments in the world (Andrews et al., 2018).

Putting Theory into Practice

This chapter now operationalizes a feminist geography of aging by drawing upon six ethnographic research participants. Close and prolonged contact with these participants in broad socio-spatial configurations revealed important embodied and emplaced aspects of aging. Grounded in the lives and experiences of these individuals, I focus on their voices in tracing the unevenness of their wellbeing and varying abilities to pursue ways of being old suited to them. Starting from the intimate scale of the body, the first section examines the co-constitutive relationship between body and place in later life. The reciprocal roles of both escalate, in which older adults are more sensitive to their aging bodies and surrounding contexts. The second section counters prevalent decline and decay narratives and considers fluid biosocial experiences of aging. The third section generates awareness of and challenges power hierarchies as older adults inhabit intersecting identities, rely on various forms of capital, and navigate multiple oppressions. Analyses in the fourth section challenge body-privilege built into urban landscapes and enrich understanding of structural socio-spatial inequalities facing older adults. The fifth section coalesces a relational, context-sensitive, vibrant understanding of later life. Altogether, attending to the intimate and embodied perspectives of older adults

extends theories and conceptual frameworks of feminist geography. This generates valuable new insights into the experiences, embodiments, materialities, and places of growing old.

My Ethnographic Approach

As explained in the methods chapter, two participants per case study area underwent Phase II extended sessions over twelve months (September 2015 to August 2016). I chose participants to reflect the diversity of the sample and represent a variety of socioeconomic backgrounds, health statuses, and locations. In Downtown Minneapolis, Ellen (73 years) lived alone in a comfortable condominium along the river. Frank (77 years) resided alone in a subsidized highrise on the edge of the downtown. June (66 years) and Christina (78 years) both resided in houses in North Minneapolis. June lived with family, while Christina resided with her dog. Thomas (67 years) occupied his longtime Eden Prairie house with his wife and numerous pets, while Denise (72 years) lived alone in a subsidized apartment building near an Eden Prairie strip mall. June and Christina were African American; Frank, Ellen, Thomas and Denise identified as white. All participants were retired except for Frank. Ellen, Christina, and Thomas owned cars and drove; while Frank, June, and Denise relied on public transport and friends/family for rides. Altogether, these individuals represent the vast majority of Americans who, because of familiarity, comfort, social connections, and financial necessity, strive to – and are – aging in their own homes and communities. Each of the following sections include vignettes focused on just one participant. These brief glimpses into their lives demonstrate the utility of and need to advance an embodied and emplaced feminist geography of aging.

Old Age: A Feminist Phenomenon

I. Denise (72 years old): Intertwining Body and Place

> Denise awoke after back surgery to bright fluorescent lights overhead with her children strewn around the hospital room. They huddled in when she stirred, anxiously peering over the hospital bed bars. Denise's sense of time felt fuzzy…

> something was wrong. When she got up to use the bathroom, (*whop!)* Denise walked right into the door frame. When a nurse brought her a tray of food, Denise looked up expectantly and waited. "Could I please have cutlery?" she asked. Her daughter worriedly replied, "Mom, can you see the fork and knife? They're right there beside your plate." Denise looked down, but all she could see was the plate of food. She could not see the cutlery – or even her left arm. Denise began to panic.

Many of my conversations with Denise revolved around vivid memories of the stroke eight years ago that irrevocably changed her life. I wrote the above-narrative in my fieldnotes at Denise's request to record her story. After working right up to the day of her surgery, Denise was forced to move into a nursing home at 64 to receive care and physical therapy. 'Left neglect' caused her to be unaware of her body, things, and people on the left side. Denise was unexpectedly not able to return to work and she could not drive. Denise felt trapped in her own body, a prisoner of its deterioration. She repeatedly stressed that her experience of aging was not what she anticipated: "My life isn't what I pictured it was going to be *(chuckling)* when I was younger… I didn't realize my body was going to fall apart like it did."

For Denise and many others, later life is a period in life when the body biologically and culturally comes to play a different role. At the biological level, participants experienced notable embodied changes: their skin became less elastic and more wrinkled, hair greyed and thinned, joints ached, hearing and vision declined, metabolism slowed, memory changed, and sleep became more difficult. Outward manifestations of these bodily changes marked them as 'old' to themselves and others, which meaningfully impacted on their interactions outside the home. Participants noted some positive changes such as doors held open, offers of assistance when grocery shopping, and opportunities for senior discounts. Some mentioned less-positive experiences of ageism, including being ignored in public spaces. When spending time with Denise's neighbors, I fielded numerous comments on the attention that I "must receive as a pretty young woman". Some lamented that they were no longer the target of catcalls or appreciative glances and instructed me to enjoy the appreciation of others

"while it lasts." Daily experiences of being old pivoted around their bodies and external appearances.

Denise's experiences and graphic reflections advance exploration of non-standard bodies and disrupted trajectories of aging. Her cheery demeanor slipped when she discussed her body's deterioration: "I can't believe that I'm this age. I wish my body would be better. Then I could be more of myself. I have no freedom now – I am trapped." Denise was frustrated to not be able to engage in many social, physical, or recreational activities. "It never dawned on me I wouldn't be able to drive or walk. That's not fair *(chuckling).*" Due to limited personal income, Denise could not afford to use taxis or smartphone-based ride apps. Financial deprivation exacerbated her lack of mobility and independence (to be discussed further in Chapter 4). As recorded in my fieldnotes, Denise bore these limitations as best she could:

> Going to [the grocery store one block from her apartment building] is a major walk. She tires easily and finds it uncomfortable. Denise told me this without anger or bitterness, but a sadness permeated her words. These topics (clearly on her mind) are some of the occasions when I see her buoyant, friendly, and cheerful demeanor crack to expose a sadness and vulnerability underneath. Denise desperately wants to be independent and mobile, and I know she worries about being a burden on others.

The condition of her body marked her ability and level of independence to herself and others.

Denise's body mediated her relationship with the local environment. She engaged in a person-place dialog that was personal and contextual. An important place in Denise's life was her old nursing home's pool. She previously resided in this complex after her stroke to recover. She had enjoyed living there immensely and wanted to continue living in the assisted living portion but could not afford to do so. After moving into her subsidized apartment, Denise tried to go at least four times per week back to the complex to use the pool. Water exercise was the only activity she could do without hurting her back. She contentedly submerged herself in the warm water and socialized with friends:

> I saw how joyful Denise was in the water when her pain diminished. Denise was alight: laughing, chatting, and buoyant. For Denise it is a truly therapeutic experience to immerse herself in the pool for the exercise, temporary cessation of pain, and joy of socializing with her friends. These excursions cost a lot on her limited income (the bus trips each way and monthly pool dues are a significant portion of her budget) – but it's clearly worth prioritizing given the physical, mental, and social health benefits.

The women walked back and forth in the water and performed exercises on the wall. They checked in with each other, such as noting the absence of other regulars and making a point to call and check in. They supported each other through health issues and personal struggles. The water was an intimately immersive therapeutic landscape that minimized their bodily frustrations. It was a site where pains and physical disability diminished.

French philosopher Merleau-Ponty (1962, p. 146) observed that the "body is our general medium for having a world." Denise perceived that her world collapsed after the stroke. She had to relearn how to use spaces that ceased to be amenable to her new needs and abilities. Geographic challenges were exacerbated by lack of resources. Denise faced a spatial mismatch when unable to afford continued living in a nursing home facility. Her subsidized apartment did not meet her needs: she could not reach items in the kitchen, could not use the low bathtub, and experienced frequent mishaps due to 'left neglect'. Denise altered and adapted the environment as much as possible to fit her current physical and emotional needs, in line with Baltes' (1997) theory of selection, optimization, and compensation. Denise shaped her home to meet her bodily abilities, such as placing all food and dishes on accessible low shelving units added to her kitchen. Her 'control center' was a comfortable reclining chair: the central pivot point in her living room from which she could reach her books, knitting, phone, television remote, pile of mail, and look out the window. Denise organized and maximized limited space inside her small apartment, in addition to outside resources and community connections. Denise navigated around her lack of mobility in Eden Prairie's low-density suburban environment. She ordered books through the library's home-mail system and became an expert with assisted mobility transit. Denise modified her living space and daily routines

to maximize comfort, connection, independence, and ability in the face of severe disability.

II. Thomas (67 years old): Countering Decline and Decay

Bodies over time can become less physically reliable, durable, and flexible. This is not a disease, but rather a normal process of aging. Many of my participants expected and accepted some loss of bodily control. As discussed previously, they navigated stiff joints, balance issues, decreased energy, and vision/hearing problems. When I met with Thomas on a cold January morning, he told me that he stays sore now and feels himself tire more easily from physical exertion. Thomas was determined, however, to help his daughter move into her new house, sand and paint each room, and arrange furniture. He lamented that in the past he could have completed all these tasks without issue, but now it was more difficult. Thomas expressed sadness when considering his age-related bodily decline, but with humor and optimism tried not to dwell on it. He found workarounds, such as sitting on a stool when sanding and taking breaks after particularly-tiring tasks.

There is an undeniable materiality of aging given physiological changes that cannot be contributed entirely to culture. As Cruikshank (2009, p. 1-2) notes:

> The vigor with which feminists have challenged the notions of biological determinism leaves us in an awkward position with aging, because this process happens in / to our bodies. The spin of social construction offers non-deterministic ways to view aging, but for nearly everyone, aging means some bodily decline.

This includes Thomas, who experienced stiffening joints and decreasing energy. Yet Thomas' physical experiences were bound up in and influenced by cultural expectations. He wanted to remain a provider for his wife and daughter, and proudly maintained their house and cabin (including the sprinkler system, shoveling, firewood, and maintenance). Daily life intertwined sociocultural notions of masculinity with real bodily experiences ranging from pain and fatigue to strength and vibrancy. He preserved his sense of masculinity in retirement through gendered activities such as daily trips to the local senior center woodshop.

The woodshop was a primary site for Thomas to mobilize sociocultural resources to achieve self-care, well-being, comfort, and vitality. In this place he felt strong and in control. During many visits together, I witnessed social bonding, purpose, and masculine identity cultivated in this site:

> Thomas gave me a tour of the workshop and his buddies present. He proudly showed me their projects: cutting boards, coasters, pens, game boards, and decorative Minnesota state hangings. Thomas explained that "the guys" generally have a cycle – right now they're making items for holiday craft sales, fairs, and gifts for Christmas. This is the busiest time of their cycle. After that, they tend to make items more for themselves (though, as Thomas pointed out, "there's only so many things you can make for yourself!"). The guys aren't making much of a profit from their wares – they've calculated that they earn $1 per hour. It's clearly about the fulfilling activity and companionship with each other.

I witnessed Thomas' core group of eight men who spent their weekdays in the woodshop. They socialized as they worked, and clearly enjoyed the tasks at hand. Only a few had professional trades experience: these were the "experts" who provided advice and help in difficult situations. The rest were retired teachers, dentists, retailers, and businessmen. Each visit, the men excitedly showed me their projects. Several took turns teaching me introductory woodworking techniques and set me to work on basic tasks such as sanding, polishing, and staining. Once I exhibited enough awareness and precision in the woodshop, Thomas and his friends eagerly set me up with the most elementary of projects: making wood pens. They also helped me sand and stain a photo contest 'trophy' (Figure 4), during which they good-naturedly tried to out-do each other regarding the best stain and lacquer product. Thomas and the other men clearly enjoyed the attention and opportunities to demonstrate their knowledge and expertise.

Teasing apart the fluid sociocultural meanings that adhered to the men's bodies in the woodshop strengthens research practices and understandings. This was a comforting space for the men to positively navigate embodied sociobiological understandings of aging (Lock, 1993). By this, I mean that they found ways to be comfortable with their shifting bodies and societal roles. They were able to focus on aging in terms of

productivity (through the physical acts of building wood products) and companionability (in sharing these experiences with each other and bonding). They cultivated purpose and routine, and navigated around any age-related physical challenges by picking tasks within their abilities and asking each other for help. They were a team. Thomas reflected that this was the second-best time of his life (after college) given these new relationships and fulfilling activities. His experiences of being an older man were inextricably tied to this micro-environment and attendant cultural, political, economic, and social expectations.

Our sessions together created conditions for a fuller understanding of myself (the researcher), Thomas, and his biosocial context. Thomas' articulations of excitement, affection, pride, and comfort were mediated by his positionality as a heterosexual, resourced, white male. Thomas had benefited from accumulated years of easy access to fresh foods, adequate and appropriate healthcare, comfortable housing, steady education and employment, and financial stability. He had not experienced longstanding struggles with sexism, racism, or classism. Altogether, he entered retirement in fairly good health as an able-bodied and able-minded individual. During our sessions, Thomas had the personal finances and broader structural supports to pursue the retirement lifestyle of his choice. This included a comfortable home environment with speedy municipal snow plowing, well-maintained roads, abundant services, and nearby opportunities for recreation. Thomas' body functioned well enough to manage instrumental activities such as driving, shopping, and recreation with ease; and he and his wife took comfort in knowing that reserve resources could be applied to manage physical or mental decline if/when need be. A support system of stable family, friends, neighbors, and doctors generated physical, emotional, and social benefits. Sites such as the senior center woodshop enabled him to continue to self-identify as strong and industrious. Thomas thus experienced biological aging processes as embedded within broader supportive physical, social, cultural, economic, and political contexts. He recognized how lucky he was and acknowledged that his experiences would be quite different from low-income participants residing in North Minneapolis or the downtown. In the following section, I will turn to those who did not occupy the same position of biosocial privilege. I will

consider multiplications of difference and uneven power relations that can marginalize and harm individuals aging in the periphery.

III. Christina (78 years old): Exposing Intersections of Power

> From slavery to the caste system, we need to figure this all out. I believe that we are all from the same source. Unfortunately, in many societies, the darker the skin the lower the caste. We need to recognize that we're all human. (Christina)

In the bathroom section of a Home Depot, Christina provided her abbreviated life history. She grew up in a segregated southern state. Christina did not achieve a racial identity until later in life because as a child she was completely surrounded and sheltered by other black people – teachers, doctors, store owners, family, and friends. Christina instead identified as poor working class. It was not until young adulthood when Christina first read a book about slavery (she was not taught it in school) that she came to grasp the deep-rooted strength of racial discrimination in the US.

Christina was perceptively aware of differential privilege systems and overlapping matrices of power relations that influenced her experiences and opportunities. As an African American woman living in an impoverished area of North Minneapolis, she narrated struggles experienced over the years including racial policing, neglect of low-income individuals, and biased social programs. She described the police's longstanding disinterest in tackling crime or preserving safety in North Minneapolis. When the police did intervene, she felt that black people were unfairly and poorly treated. This included unfounded blame and arrests (particularly of young men), extended pre-trial incarceration, and unequal sentencing applied by the courts system. Christina described the lessons she instilled in her children and grandchildren at a young age because of their race, such as: "Always ask for a bag to carry your purchases out of the store so that you are not harassed by security or the police for shoplifting."

In recent years, Christina had experienced newfound challenges related to her aging body, such as being unable to accomplish necessary home modifications and feeling vulnerable after several break-ins. Christina increasingly relied on her children for

support. Christina's daughter, for example, began joining her medical appointments to help process information, fully hear answers, and ask questions. Christina recounted:

> I still think I'm 20 – not age-wise, but energy-wise. [Supportive family], I think, is something that I wonder how many other seniors have. How many seniors have someone who can take off work, or someone who is just available to them? That's going to be very, very important to me as I go through life.

Christina relied upon a strong familial support system to help with declining functional abilities and memory loss. Given a lifetime of advocating for herself and standing up to oppression, Christina was proud of her ability to vocalize her needs and ask for help. She had served on multiple community boards and organizations, led neighborhood block safety programs, and navigated social services for herself and others. She felt confident calling agencies and service providers directly to probe for further information, express gaps and failures in their systems, and secure her needs. Some of this confidence had diminished recently due to hearing loss and feared cognitive impairments, so she increasingly relied on her children and extended support networks.

As Christina and I became comfortable with each other, I increasingly helped her myself with household tasks. I reset her thermometer when she could not understand the digital system, dragged rugs and moved furniture when she could not bend over, and grabbed dishes that she could not reach. Christina also took advantage of my position of privilege and knowledge. I emailed her relevant resources after our conversations, provided contact information and brochures for service organizations, and promised to communicate findings to civic leaders. This was Christina's main motivation for participating in the ethnographic sessions:

> You're respectful, kind, and doing important work. You're not taking advantage of anyone – you're listening to and helping us. I wish more people would listen…There is a strong want and need for policymakers to understand seniors. Many studies do not include low-income and people of color. I am both. I want to have a voice.

Christina was concerned about older individuals who do not know how to speak or advocate for themselves. She felt frustrated by the lack of social services, advocacy groups, and formal structures to support the most marginalized older adults.

Age is an axis to extend feminist geography's tradition of challenging power relations and inequalities based upon bodily identities in different spheres of economic, social, political and cultural life. When Christina volunteered on the board of a nearby senior high rise, she felt it was "the saddest place ever seen in [her] life." She noted a complete lack of services; that the residents were forgotten. The majority of residents were black, and structural racism combined with ageism meant that no one provided necessary services or consulted with residents to ascertain and meet their needs. Christina stressed: "They don't know how to speak for themselves, they don't know how to advocate for themselves." Christina pushed me to use my dissertation research to challenge identity designations of old age that overlap with gender, race, and class to maintain and perpetuate exclusion, invisibility, and domination. Christina wanted not only her story to be voiced, but broader stories of older individuals experiencing overlapping oppressions. Feminist geography has an opportunity to develop differentiated understandings of aging and generate more inclusive and intersectional frameworks through lived experiences.

At the start of our ethnographic sessions, Christina was not involved in any volunteer causes. She was taking time to focus on herself and planned to volunteer again when she found something to care about. By the end of our time together, Christina was excited to begin a new project. We had talked at length about the homeless women in the study, and how marginalized older women embody a lifetime of accumulated harms. Our conversations regarding social differentiation stimulated her renewed focus on vulnerable women, as noted in my fieldnotes:

> Christina has a new plan that she is excited about: "I can take something and make it beautiful." She intends to meet with women in shelters to help them with furniture – teach skills of restoration, as well as positive speaking and mentorship to these women. She will find the furniture at Goodwill.

Christina aspired to support women young to old with home rehabilitation. She believed that by making a place feel better, people can gain self-confidence and feel better about themselves. She hoped that less older women would be forgotten in senior highrises if they received attention, care, and support earlier in life.

IV. Frank (77 years old): Navigating Landscape Privilege

Urban landscapes perpetuate bodily privilege and domination. Able bodies (Gleeson, 1999), monied bodies (Mitchell, 2000), and youthful bodies are expected to move through spaces at a synchronous speed. This top-down control accommodates those who meet able-bodied and able-minded norms (e.g., someone able to cross a street in 11 seconds, comfortably inhabit a multi-story mortgage-free house, and drive to the grocery store). Antoninetti (2007, p. 37) labelled these 'Peter Pan neighborhoods':

> Built for young people who will never age, will never face unexpected disabilities or economic downturns, will always be able to count on substantial affluence and valid driver's licenses, and will always act according to standardized habitudinal lifestyles which most residential neighborhoods have traditionally been built.

I witnessed firsthand the challenges and diminishment of those who could not meet normative environmental expectations. Frank lived in a low-income subsidized highrise near the edge of the downtown. Despite living in a high-density urban environment, he struggled to traverse the downtown for medical appointments, meal programs, socializing, and employment. Frank had to work night shifts out of economic necessity despite declining health:

> Frank talked at length about his custodial job at [the arena], which he has had part-time for 25 years. Frank gets paid $12.92/hour. He works after events to clean bathrooms and the arena. His employers don't give him as many hours as he'd like (only 4-hour night shifts a few times a week after events). Frank would like to work more than 12 hours per week because he needs the money "to pay the lights and phone." But he's happy to have what he can get and won't complain. Frank doesn't mind cleaning the bathrooms, though it is getting harder to sweep the steps given vertigo and balance problems. He doesn't want to cause any

complaints because of his age. He told me that they generally don't want older workers. He prefers to work alone so he can't be criticized for being slow.

Frank was fearful of losing his job. His precarious employment and living situation made him feel anxious and powerless. Frank, like all of us, existed in circumstances beyond his control. He endured extreme financial strain, expanding disabilities, and was hospitalized three times during Phase II for food poisoning and surgeries. Frank ate a sporadic and highly-varied diet based upon what free foods he could secure and the minimal items he could afford to buy in-store. This led to an inconsistent and malnourished diet that caused gastrointestinal issues, as well as occasions when he ate expired foods stored past their expiration dates in his kitchen. When I spoke to him about it, he was most concerned about missing work and being physically unable to travel to churches and charities daily for free meals.

Frank felt like a "second-class citizen" whose needs were unmet. Specific concerns included icy and unplowed sidewalks (see Chapter 4), a limited bus network (including lack of signage and explanation when buses were re-routed for construction), and inadequate security for low-income older adults. He felt vulnerable to crime given an inability to defend himself or run away and had been followed and "roughed up" several times on the way home from work. When I walked with him, he frequently commented on how enjoyable it was to have someone else for company and safety, in stark contrast to most of his commuting spent vulnerable and alone.

Frank's main site of refuge was the downtown senior center. Frank walked here every weekday to take advantage of the free coffee and cookies, socialize with peers, check in with the center staff, and enjoy a safe and supportive atmosphere. One morning I walked with Frank to the senior center:

> When I asked what the flowers were for as we walked, Frank replied: "Oh! They're for you or Sandra!". Sandra is the social worker that runs the [senior center]. He then handed the bouquet over to me. He explained that once every two months a local shop donates old bouquets to his building. He grabbed the best bouquet (least wilted) this morning… When we arrived at the [senior center], the front desk staff volunteer warmly greeted us, and Sandra came out from her

cubicle to say hello. Frank proudly gave her the flowers, which she put in a vase with water on the front counter.

The senior center was a unique site where Frank felt secure, accepted, and comfortable. It was a vital space for Frank and other local older adults, particularly those living in nearby subsidized apartments and homeless shelters. Since the time of data collection, the center has since closed due to lack of funding. The closure may have had disastrous consequences for vulnerable older adults whose lives pivoted around this safe, comforting, and welcoming community space (see Chapter 6 for extended discussion).

The daily crises of marginalized older people generally go unnoticed by policymakers and the general public (Klinenberg, 2002). Focusing on the micro-scale of everyday public encounters and interactions for older adults enriches analyses of structural inequalities and complex power operations (Doan, 2010; Valentine, 2008). The senior center's closure highlights the risks that marginalized older adults face. Underserved and unheard, their struggles and needs too-often remain inadequately recognized by policymakers and service providers. Frank did not feel comfortable or safe in the downtown environment, which generated anxieties and exclusions. A feminist lens provides tools to investigate the social production of space by questioning assumptions of public environments and the sets of regulations influencing who is empowered to occupy certain spaces, versus who is excluded (McDowell, 1999). Future scholarship dismantling the basis of everyday social relations, institutions, urban landscapes, and power structures will challenge the geographic foundations on which current ageism rests.

V. Emancipatory Possibilities

The chapter thus far demonstrated that aging is a universal human experience that is both embodied and emplaced. It is different for everyone. To our detriment, we largely remain in collective denial about aging. This context of ignorance and disrespect enables ageism to permeate our personal perspectives, culture, policies, urban landscapes, and scholarship. Ageist assumptions restrict the behaviors of older adults and abilities to inhabit certain spaces. Strong societal expectations of age roles and intergenerational mingling keep older and younger groups in their respective places. Yet older adults are

generating new communities, modes of socializing, and alternative spaces for desire, support, love, touch, and interpersonal connection. They are actively navigating the realities of their aging bodies and surrounding contexts.

June (66 years old): Center Stage. "I've still got pep in my step. I tell [my family]: there's no flies buzzin' around me. I dance." June was a funny, headstrong, and loving woman who wore edgy outfits and stylish boots. She faced bodily changes and overcame disadvantages as a low-income, African American woman. June countered long-term chronic pain and degenerative arthritis through her well-honed mantra 'just keep moving'. June noted: "I'm glad to be alive. There's some people who aren't as fortunate, who can't move around, who can't do things, who can't enjoy life, who can't do things that I can do." She recognized her struggles and disadvantages but refused to be a passive victim to her circumstances.

June was a central figure in her family, church, and community. She provided food and sewed blankets for those in need, distributed health information, and cared for sick family members and friends. One session together, I witnessed June in action as a cancer society volunteer at a regional health fair. She thrived educating individuals about symptoms, mammograms, and other cancer screening tests. In between conversations with me and fair-goers, June went around the other booths to collect free items such as cups, sweets, magnets, and toys for her grandchildren. June repeatedly checked her loot while naming each grandchild aloud to ensure that she had enough. She explained: "We've always been poor, but rich because we have family." June grew up on the south side of Chicago and was a member of the first graduating class from a high school for underprivileged youth. She marched with Martin Luther King Jr., met Mary Daly (a radical feminist philosopher, academic, and theologian), and even had her photo in Ebony magazine. June narrated her move to Minneapolis to raise her boys in a good place. She was immensely proud that all her children and grandchildren had grown into "good people".

As June aged, she refused to be sidelined to the periphery of her family or community. June's kitchen was a constant fixture of grandchildren snacking after school,

children stopping in to chat and receive a container of leftovers, and extended community members seeking advice and a warm hug. June was a central figure in many people's lives and routines. She extended care and comfort to anyone in need.

June desired to age in her vibrant community cultivated over many years in North Minneapolis. She was stressed by the scarcity of local supportive housing options: "There's nothing for us. The areas that they want to put you in are far away." June refused to be "stuck" in a suburban highrise far from her family and friends. She emphasized the need for older adults to have relevant health and social services nearby, and regular contact with younger people and children. June envisioned converting old North Minneapolis houses into communal senior housing dotted throughout the entire community. She described "homey, big white houses" with wide verandas out front to "watch the action." That way, June reasoned, older adults would not be a burden or hindrance on spouses, children, or other caregivers; but could maintain local connections. "Why would you want to put seniors way out there when you could put 'em in a community where there are children? We need youth to make us feel younger. It's like osmosis." June vividly envisioned multigenerational communities for elders to age 'in community'. She fiercely asserted her desire and intention to remain a central figure in her family and community well into old age.

Ellen (73 years old): Unexpected Intimacy and Affection. Ellen recently moved to Minnesota to be closer to her only child and two grandchildren. Unlike June, Ellen had only a small local network of family and friends. She was thoughtful, intelligent, and articulate, and applied her resources to live in a high-services downtown neighborhood close to the river, indoor and outdoor walking paths, and orchestra. Our sessions together frequently involved music, literature, and discussions of current events. Ellen checked in on me (regarding my grandmother's health, PhD writing progress, and my husband's job) as much as I inquired about her current and past life. We bonded with each other.

An unexpected element of my interactions with Ellen revealed the importance of touch and intimacy. While scholars are beginning to address sexual relations and romantic intimacy in later life, little has been done to investigate other forms of intimacy,

sensual pleasure, and tactile gratification. Attention on this topic largely focuses on contact between nurses and elderly patients, and the role of expressive touches in caregiving (McCann & McKenna, 1993). Intimacy in care contexts are discussed in nursing journals to examine topics such as privacy, emotional and physical closeness, sex, and trust (Mattiasson & Hemberg, 1998). Rights to intimacy among nursing home residents with cognitive impairments is an ongoing topic of debate in fields of medicine and law regarding ethical issues including principles of autonomy, informed consent, and appropriate levels of care (Casta-Kaufteil, 2004; Mahieu & Gastmans, 2012). The physical abuse of elderly adults from nursing home staff, in addition to family members and intimate partners, is common but often remains undetected (Nelson et al., 2004; Moyer, 2013). These remain critical systematic issues to address.

Scholars have investigated consensual physical intimacy through sexual desire and function, including the impacts of cardiovascular disease, diabetes, lower urinary tract symptoms, depression, and other chronic diseases that contribute to erectile dysfunction in older men (Camacho & Reyes-Ortiz, 2005; Kalra et al., 2011). Female reproductive health is also impacted by chronic conditions in old age, in addition to hormonal changes, vaginal dryness that can cause pain and irritation during intercourse, and self-perceptions of body image that affect female sexual responses (Rheaume & Mitty, 2008). In our ageist society, common stereotypes of older adults as unattractive, feeble, or sickly makes it even more challenging for widows and unpartnered others to receive embraces, touch, or even eye contact.

Ellen was widowed and expressed loneliness. While generally more reserved, Ellen's demeanor markedly changed with her grandchildren. She was lighthearted and affectionate, as witnessed one morning with her toddler granddaughter:

> I enjoyed watching Olivia affectionately follow Ellen around the kitchen. She often hugged Ellen's legs and tried to peer up to watch her cooking. Olivia was curious and loving, and it was truly delightful to watch these interactions between the two female generations. Ellen often smiled down at her and hugged back when Olivia patted at her legs.

Ellen was gentle and tender with her little granddaughter. It revealed how crucial physical touch and closeness can be, especially in later life when many older adults live alone.

Ellen subtly and strategically sought out opportunities for closeness and contact. She frequented a local coffee shop during her daily walk, where she conversed familiarly with the baristas:

> We walked over to the [coffee shop], where Ellen got her small coffee. She insisted on getting me a coffee as well for our walk. The staff clearly knew Ellen, and already had the coffee waiting for her by the time we got through the line to pay. They know her regular routine and were friendly and chatty. Ellen visibly enjoyed talking to them and being social with the young barista staff.

We frequently chatted with staff at the coffee shop. The manager was one of the first people Ellen came to know in Minneapolis. She referred to the coffee shop with affection as it affixed warmth, care, and connection. Even with resources to afford nearly any social and leisure activities of choice, Ellen struggled to develop friendships and meaningful social contacts.

The human need for affection and touch is not easy to study, nor even discuss. This may contribute to gaps in the literature regarding the need for sensory gratification in later life. Loe (2011, p. 216-217) reflects: “All too often, touch and affection get confused with sexuality, making it a difficult subject to broach, particularly among a generation encouraged to see intimacy as a private matter.” In Ellen’s largely-solitary life, she maximized opportunities for touch and affection with her grandchildren and frequenting the coffee shop. Future scholarship applying a feminist lens to aging could emphasize essential social aspects of touch and affection. This spans physical and emotional benefits derived from connectedness through a variety of family and non-kin relationships, to pets and inanimate objects.

Building A Feminist Geography of Aging

This chapter looked to older adults themselves to depict the realities of aging. Participants brought life stories, personality, ingenuity, and meaning to their experiences of aging; they made aging their own. It was not intended to be a romanticized perspective

of later life, but rather a critical investigation attuned to the ambiguities of later life. Close scrutiny exposed common underlying themes that impacted on participants' experiences of aging. The body was paramount as participants underwent very real bodily changes as they grew older. It was a dense matrix of biology, politics, and culture. Past and present experiences impacted the embodiment of aging, such as whether or not a participant benefited from sustained access to fresh foods, adequate care, supportive emergency services, and familial support networks. I witnessed progressing functional limitations, health complications, and loss. However, instead of depicting participants as dependent, depressed, and disabled, this chapter engaged with them as they really were: as agents in their homes, neighborhoods, family lives, and chosen communities. Far from passively accepting sociocultural notions of decline and decay, participants gained emotionally and materially in later life. Their lives were just as stimulating, dynamic, and mundane as those of younger people.

In building theory from lived experiences, this chapter spatializes feminist thought on later life and allows for the recognition of terrain that is generally overlooked or marked as unimportant. The aging body was both materially experienced and socially constructed, as exemplified by Thomas' navigations of masculinity and male bonding in the woodshop. My observations illustrate and extend the concept of local biologies (Lock, 1993; Neely, 2015) given that participants' bodily processes were highly responsive to the surrounding cultural, economic, political, and built environments. They materialized the very different socio-spatial conditions in which people live and die.

The aging body represents a critical site and scale from which to destabilize and challenge the objectification, control, surveillance, and Othering of elderly people. I involved intersecting identities to demonstrate how social categories such as race and gender can both empower and marginalize individuals through space and time. Christina, for example, voiced her experiences and observations of oppression generated through overlapping axes of sexism, racism, ageism. This translated into embodied and emplaced consequences, such as the abandonment of low-income seniors in a derelict North Minneapolis highrise. Hardship could also build individual resilience and utilization of other forms of capital, such as Christina's reliance on her children. Adversity earlier in

life could foster adaptability and strength in later life, as exemplified by June's optimism and perseverance. She recognized but refused to be meaningfully limited by her struggles with chronic pain or positionality as a low-income black older woman. One element that I did not engage with extensively in my ethnographic sessions was sexuality. All participants openly identified as gender-conforming, heterosexual individuals. Discussions of sex and intimacy were limited both because I was reluctant to broach the sensitive topic, and when I did participants generally did not want to discuss it in-depth. The changed demeanor of Ellen during interactions with her young grandchildren were welcome opportunities to glimpse intergenerational family care and the importance of physical touch.

Applying a feminist geography of aging develops more nuanced and sophisticated understandings of the physical, mental, and social components of aging. This chapter points to opportunities for more complex understandings of the aging body and its dynamic relations with built environments by drawing upon intersections with culture, economics, politics, and health. A feminist geography of aging pulls old age from a neglected category of Other into the forefront. Scholarly actions may trickle down into greater awareness of aging and new connections with older adults in everyday life. It does not take much. A friendly wave, greeting on the street, a phone call, an invitation to a community event can mean a great deal to older adults, especially those aging alone. This scholarship emphasizes the vitality, connectedness, resourcefulness, and empowerment possible in later life when socio-spatial structures accommodate the old. As I will discuss in the following chapters, most of our urban built environments assume a high level of ability that makes navigating old age difficult for many. The intersections of aging with race and class make these struggles largely invisible, particularly for marginalized older people struggling from the lack of supportive infrastructure and services. A feminist geography of aging provides necessary tools to better visualize and grapple with urban landscapes.

Figures

Figure 4. Woodshop ‘trophy’ project in-progress (Jessica Finlay, 2016)

Chapter 4. 'Walk Like a Penguin': A Critical Investigation of (Non)therapeutic White Space

Introduction

Winter weather was not an original dissertation focus. I conducted my Phase I interviews in bare-ground conditions devoid of ice or snow with questions focused on the built and social environment. Yet as I probed for socio-spatial underpinnings of wellbeing, participants repeatedly mentioned winter weather conditions that impacted on their abilities to age well. Winter was an integral part of everyday later life to my Minnesota participants, and a topic that they themselves brought to the forefront. During my conversations and observations, I witnessed firsthand the many challenges – and occasional joys – of enduring winter as an older person. Experiencing winter through their eyes and at their paces revealed complex person-place relationships with the surrounding urban landscape. Snowy and icy conditions exposed embodied vulnerabilities that were exacerbated by unequal access to supportive urban design. Both North Minneapolis ethnographic participants opted to end our sessions early because they "just couldn't keep up." Inadequate plowing, leaky and decaying homes, exorbitant heating bills, and lack of assistance and protection from the government left many low-income participants without the means or abilities to safely endure winter in progressing old age. This led me to deeper questioning of the capacity of government agencies to serve and protect an aging society composed of citizens whose personal finances and support systems (i.e., family and friends) often cannot provide for their needs. Their daily crises largely go unnoticed.

The seasonal experiences of my participants are not an isolated phenomenon limited to the Minneapolis metropolitan area. Every year, major North American cities including Boston, Buffalo, Detroit, Toronto, and Montreal receive an average of over one meter of snow. Winters across the upper northern hemisphere are characterized by snow on the ground for more than three months and temperatures well below freezing. The 2014 polar vortex affected close to 200 million people as dangerously cold Arctic air

settled across southerly parts of Canada and central-eastern regions of the United States (Owen, 2014). Extreme weather events grip media attention and public consciousness. The health effects of seasonal anomalies and global climate change are at the forefront of health policy and research (Joseph, Skinner, and Yantzi, 2013; Clarke et al., 2015). There is a sense of urgency to better understand environmental health in order to address individual health, population vulnerability, and emergency preparedness (McMichael, 2013; Harlan et al., 2006).

How mundane weather shapes health and wellbeing, however, requires more attention from both public health and social sciences researchers. This includes investigation of underlying social and structural factors that impact susceptibility to harsh climactic conditions such as urban design, service access, government support, income, perceptions of safety, and racial segregation. Sociologist Eric Klinenberg's (2002) seminal book *Heat Wave: A Social Autopsy of Disaster in Chicago* is a launching point for my analyses. He first drew my attention to investigate *why* low-income elderly people suffer more in extreme weather. Klinenberg traces vulnerability in American cities produced through social isolation and government abandonment. He advances the kinds of questions typically asked by epidemiologists to explain high mortality rates among sub-groups of older populations during the extreme 1995 heat wave. In his social autopsy, Klinenberg moves beyond individual risk factors that include not leaving the home daily, medical problems, bed confinement, living alone, and lack of air conditioning, transportation access, and nearby social contacts. Instead, he brings previously-unexamined social environmental conditions to the forefront to demonstrate how they elevate or reduce the probability that residents survived the heat. This includes land-use and development patterns, segregation, and violence. Rather than following the CDC's direction of attention to particular sets of vulnerable individuals, he concentrates on the places where such problems are more likely to be concentrated. The spatial distribution of mortality in the 1995 Chicago disaster shows that communities hardest hit were concentrated in the city's historic Black Belt where African Americans are concentrated and segregated (p. 82-83). Klinenberg introduces understanding of how contextual conditions imperiled or protected residents during the extreme summer climate

that traditionally lie outside the scope of public health. Each chapter painstakingly traces the systemic failings of public services, emergency responders (such as the Fire Department), and decentralized policymaking in the entrepreneurial state that made it possible for hundreds of elderly people to die during a one-week heat spell.

Klinenberg's seminal work inspired me to go beyond epidemiological impacts of weather to understand the calamitous consequences of inadequate structural conditions in urban America. Concentrations of grocery stores, pharmacies, healthcare sites, and leisure facilities in affluent areas, for example, endanger low-income individuals who cannot comfortably or safely access these locations. Travel for anyone is difficult in snowy or icy conditions, but even more so if you have to travel long distances to jobs, goods, and services – especially if you have low mobility and do not own a car. Lack of investment in deprived American neighborhoods, constituted frequently by racial and ethnic minorities, results in poor-quality roads, sidewalks, and public transit routes. Bus stops can be in disrepair and provide inadequate shelter from precipitation or severe cold. Some bus drivers do not even complete routes late at night in neighborhoods that are considered dangerous (Kanter, 2015). Harsh weather exacerbates disparities in the incidence and prevalence of disease and disability, which are closely linked to income and social support. Enduring a lifetime of poor access to health care, higher burdens of ill health due in-part to chronic poverty and the inability to afford pharmaceuticals, makes disadvantaged older adults more vulnerable to weather conditions. Weather conditions, in other words, crystallize structural inequalities and the underservice of the elderly poor. Resulting hardship and harms thus reflect the social fault lines for which we, not nature, are responsible.

The literature focused on older adults' experiences of winter weather conditions does not yet focus on these underlying structural issues. Research on snow and ice to date primarily investigates mobility limitations and physical activity levels. A Swedish study (Wennberg et al., 2009) found that ice-free pavements and gritted surfaces were two of the most influential factors regarding older pedestrians' needs during winter. Li and colleagues (2012) surveyed winter accessibility and evaluated common pedestrian facilities including sidewalks, street crossings, curb ramps, bus stops, and driveways in

Toronto, Canada. They found that snow and/or ice on the ground kept older adults at home, and that icy sidewalks and puddles at street crossings were particularly hazardous. Hjorthol (2013) investigated daily transport activities of older people in five Norwegian communities. The results indicated lower activity levels in the winter (as measured by number of trips taken and kilometers traveled) when compared to summer. Winter conditions were mentioned by all groups as barriers they have to contend with, including ice and snow on pavements, slippery footings on buses due to snow melting off passengers' shoes, and prolonged darkness. Rantakokko et al. (2014) found that snowy and icy winter conditions in Finland significantly increased odds for loneliness among community-dwelling older people, even after adjusting for mobility restrictions, living alone, and health. Car-dependent neighborhoods in Vancouver, Canada (measured by longer block lengths, fewer intersections, and larger distances to amenities) became inaccessible to older residents in snow. Even participants residing in pedestrian-friendly neighborhoods walked to 25 percent fewer destinations in snow (Clarke et al., 2017).

These studies demonstrate that snowfall and icy conditions affect the physical and psychological health of older adults. The consequences of snow and ice were at least threefold: (1) barriers to everyday activities, (2) reduced general activity levels, and (3) feeling socially isolated and not able to get out. Findings encompassed solely negative impacts of snow and ice and overlooked potential positive dimensions of winter weather. Furthermore, there was little to no mention of embedded governmental or socioeconomic structures that promoted or undermined health during winter. There was no mapping of the neglect, absences, or inadequacies that can exacerbate the harms of snow, cold, and ice on vulnerable populations. This chapter begins to address that gap by attending to how unequal distributions of power and privilege caused my participants to react differently to the same climactic conditions. I investigate often-contrary person-place navigations of winter weather conditions, and interrogate structural inequities and exclusions bound up in the popular concept of therapeutic landscapes. Older adults' experiences of wintry urban and suburban landscapes speak as much to power, privilege, and inequity as they do to wellbeing.

Potentially Therapeutic Landscapes

Wilbert Gesler (1992) first introduced the concept of therapeutic landscapes to explore why certain places or situations are conducive to healing. He draws attention to how physical and social dimensions of particular environments, coupled with human perceptions of these spaces, may contribute to physical, mental, and spiritual wellbeing. By incorporating theory from cultural and human geography (e.g., sense of place, symbolic landscapes), Gesler argues that scholars could examine sites of healing in health geography. Initial applications tended to focus on extraordinary locations including pilgrimage sites (Gesler, 1996), parks and wilderness (Palka, 1999). Subsequent scholarship critiqued that, while important, these exceptional spaces are generally encountered over short time periods and are not intended to foster long-term healing (English et al., 2008). Further, the literature was ahistorical and made assumptions regarding homogeneity in populations. It overlooked the fact that perceptions of any landscape are deeply shaped by factors such as gender, class, race, sexual orientation, bodily ability, social and political context, and the landscape's history. Early scholarship implicitly focused on white, heterosexual, middle to upper class populations.

The concept has since expanded and evolved to incorporate a broader range of people's landscape experiences. Milligan and colleagues (2004), for example, explore communal gardening plots as sites of comfort, achievement, and pleasure among older people. They illustrate how mundane, communally-shared spaces can be essential to combat social isolation in later life. Laws (2009) conducted ethnographic work to think through the spatiality of an 'alternative' psychiatric survivor self-help group. She engages with the meeting places and venues occupied by this group, with particular attention given to the dilapidated and reputedly dangerous city park where the group hosted meetings. In these unconventional spaces, survivors sought recovery through agency, appropriation, and having a space in the world. Laws' thoughtful critiques open up conceptual space to challenge the supposition that pleasant and professional spaces are the best backdrops for recovery.

A minority of more recent studies highlight inequalities, gendered assumptions, and uneven power relationships in the production and navigation of therapeutic

landscapes. Buzinde and Yarnal (2012), for example, draw upon intersections between postcolonial and therapeutic landscapes scholarship. Uncritical therapeutic landscape approaches could problematically facilitate understanding medical tourism as healing spaces which combine modern and alternative forms of medicine with travel and leisure. A postcolonial critique, however, attends to the moral, economic, and cultural tensions that result from private companies providing cheaper and more attractive medical services for Westerners in peripheral nations struggling to offer any form of medical care to their own local populations. Buzinde and Yarnal enact a critical dialogue to examine core/periphery relations and their influence on health provision. A privileged patient and local nurse, for instance, can reveal the underpinnings of racialized politics of power that are often entailed in the co-production of clinical experiences. Some nurses might feel disempowered or marginalized by the behaviors of a resourced Western client. The trans-cultural clinic setting, in this manner, can be regarded as a micro-replication of the global politics of difference (p. 785). Examining the dynamics that emerge in these types of landscape can offer valuable insights regarding the mediation and negotiation of power and privilege.

Health geographers increasingly appreciate that no space can guarantee a positive health experience for everyone. Landscapes are not intrinsically therapeutic. What constitutes therapeutic for someone may even harm another. The beach, for example, is often associated with relaxation, socialization, and exercise; but can also bring negative health outcomes given sun exposure risk, dangerous waves, or past negative associations (Collins and Kearns, 2007). Beaches may be sites of exclusion and exploitation: tourists access beaches for pleasure and leisure while local, low-income populations gain access only through their roles in waiting on these tourists as hotel and restaurant staff. Public parks may be perceived as pleasant and inviting, or conversely threatening and dangerous, depending on the individual (Finlay et al., 2015), other park activities and users present, and time of day. A family-friendly park during daytime, for example, may be the site of drug deals, solicitation, or other illegal activities at nighttime. When and how one engages with a place fundamentally impacts experiences of that space. Conradson (2005, p. 338) observes: “individuals clearly experience even scenic

environments in quite different ways, in terms ranging from enjoyment through to ambivalence and even anxiety." He conceptualizes therapeutic landscapes as relational: a complex set of transactions between people and their broader socio-environmental settings. Perception, circumstance, attitude, identity, and culture filter experiences of space and place. Particular localities encompass cultural values, social behaviors, politics, and histories embedded in that place.

Despite appreciation of therapeutic landscapes as disputed and negotiated, scholars still tend to focus on clear sites of healing and relatively straightforward health maintenance. These sites literally promote wellbeing through immersion in landscapes (e.g., walking, bathing, community gardening, enjoyment of scenic beauty, restoration in tranquil settings) and healing practices in salutogenic environments (e.g., hospitals, clinics, spas, yoga studios). There is therefore a need to apply the concept to more difficult and contestable examples. Medical anthropologist Jennifer Mokos (2017), for example, grapples with complexities of exclusion, systematic violence, and stigma in studying river-bottom homeless encampments in Southern California. She notes that health geographers previously described homeless encampments as 'unhealthy places' and 'landscapes of despair' (Dear & Wolch, 1987). Homeless encampments tend to be grouped in the health geography literature with other unmanaged rough-sleeping places that comprise an unhealthy and unsafe urban landscape. In contrast to these studies, and to mainstream attention to homeless camps as undesirable sites that provoke fear and insecurity for other members of the community, Mokos finds that these spaces were therapeutic for inhabitants because they provided elements of care through the fixed location of their belongings, access to nature, privacy, and social benefits. The river bottom was a place where social relations were forged, emotional support provided, and residents worked together to protect each other and procure resources such as food and water. Though homeless camps may seem like dirty and dangerous places, for those living there they can be highly therapeutic.

Embracing intricacies of landscapes, diverse examples of wellbeing, and less uniformly-positive sites generates opportunities for more just ways of promoting health. Mokos (2017) extends beyond Baer and Gesler's (2004) call to apply the therapeutic

landscape concept to difficult and contestable examples with potentially "less positive shades of meaning" (p. 406). Mokos (2017) demonstrates that the production of therapeutic landscapes tends to displace or exclude particular communities, along with their experiences and knowledge. Scholars tend to prioritize an ideal way to know and experiences landscapes, which excludes and devalues other understandings of these spaces.

Underlying histories and politics of landscapes remain underexplored in the literature to date. Access to national and state parks, for example, is limited to those who can afford the travel, accommodations, and entrance fees. Many of these parks, however, are built upon the dispossession of Native Americans who were forcibly removed from their lands. African Americans are frequently underrepresented regarding interest and engagement in nature, outdoor recreation, and environmentalism. Finney (2014) argues that the legacies of slavery, Jim Crow, and racial violence have shaped sociocultural understandings of the 'great outdoors' and determined who should and can have access to natural spaces. She exposes the perceived and real ways in which nature and the environment are racialized in the US and highlights existing efforts by African Americans to enable greater participation in environmental spaces and conservation concerns. Histories of colonial and racial violence and social exclusion dramatically shape present-day reactions to such so-called 'natural' spaces.

This chapter begins to rework and broaden the conceptual underpinnings of therapeutic landscapes in order to better align the scholarship with contemporary geographical critiques and theoretical advances. It draws upon my interview and ethnographic data to deepen conceptions of contradictory and exclusionary experiences of landscapes by attending to older adults' differentiated experiences and understandings of how and why white spaces are (non)therapeutic. This chapter delves deeper to unpack underlying issues of privilege and inequity.

Navigating White Space

As previously mentioned, winter conditions were frequently discussed and constituted a passionate topic of conversation across research sessions. Although Phase I

interviews occurred during summer and fall, over 83 percent of participants discussed their interactions with snow and ice at least once. I experienced winter weather with participants firsthand during Phase II to gain intimate knowledge of white spaces' impacts on behavior and wellbeing. Participants expressed both appreciation for and notable challenges with white spaces. White spaces were ambiguous (Collins and Kearns, 2007) and contradictory (non)therapeutic landscapes that could simultaneously boost and diminish wellbeing. The following sections detail how white spaces impact on the physical, mental, and social wellbeing of participants. I dig into underlying structural elements of both person and place that grounded differential reactions to wintry landscapes.

Bodily Histories and Embodied Present-Day

The topic of white spaces frequently arose when participants discussed mobility limitations and safety concerns. Pathways, sidewalks, and roads blocked by snow or slippery with ice posed seasonal difficulties. Echoing the experiences of youth with physical disabilities (Lindsay & Yantzi, 2014), participants particularly struggled with snow piled at street crossings. Exterior fall hazards, such as steps and slopes, were intensified by the presence of white space (Lockett et al., 2005). Snowy and icy conditions made walking even short distances challenging and tiring (Hjorthol, 2013). My observations differ from much of the existing therapeutic landscapes literature built on assumptions of normative, high-functioning bodies. Frail participants were hyper-aware of and susceptible to white spaces. Their embodied mobility challenges uniquely shaped (un)healthy place interactions.

Those most affected were often low-income individuals who had strenuous mobility needs and limited resources to cope with challenging weather conditions. Frank (77y, Downtown Minneapolis), for example, struggled to commute to and from his janitorial night shift:

> Frank: When I come home from work in winter, it's so slippery. It seems like they don't do anything for the sidewalks. One night we had a blizzard and it took over an hour to get home. I was walking on

pins and needles. Then the next day and the next, it snowed a lot more.

Interviewer: Do you go out less during the wintertime because of the ice and snow?

Frank: No, because there's more work in the winter.

I witnessed Frank's struggles firsthand during Phase II. He worked thirteen night shifts in December, and twelve nights in January to "keep the lights on." Frank was overtired and labored to commute safely in dark, treacherous white spaces. He could not afford a taxi to commute to/from work and did not have a driver's license. Harsh winter weather conditions exacerbated the challenges of Frank's limited health and economic resources.

Trudy (60y, Downtown Minneapolis) was disabled and relied upon assisted mobility for daily transport. She struggled to access the bus in winter: "The snow mounds get as high as me, and then I'm literally climbing a mountain. I don't know how many times I've fallen and [the transport staff] had to pick me up." Trudy felt further frustrated by the lack of adequate plowing in her low-income residential area adjacent to the downtown. She could not cross at street corners given snow piled high by perpendicular street plowing through intersections and was afraid on snow mounds when crossing instead in the middle of the block. Winter conditions caused Trudy to feel abandoned by the municipality. As I will elaborate on in Chapter 5, Trudy felt that the local government "doesn't care" about seniors or disabled people in her neighborhood.

Unequal levels of neighborhood investment and socioeconomic disparities became starker in winter. Participants in North Minneapolis felt that their streets were the last ones to be plowed. Some alluded to racial bias and the devaluation of their largely-black neighborhoods as a contributing factor. When the plows did eventually go through, their efforts to make the streets navigable for cars caused snow to become piled high on road shoulders and sidewalks. For those traveling by foot, bus, or bike, it could become even more treacherous. As mentioned by Trudy above, crosswalks at intersections were frequently unnavigable for extended periods of time. Numerous Eden Prairie participants, in contrast, noted the speedy and effective municipal plowing of streets after a fresh snowfall. Sidewalks were less of an issue given that participants primarily relied upon

cars for mobility. In affluent parts of the Downtown, most high-end residential buildings and retail locations meticulously maintained their sidewalks for residents and consumers by hiring landscaping maintenance businesses to plow and salt immediately after each snowfall.

Affluent participants had more opportunities and resources to avoid white space hazards. Those with underground heated parking and household garages, for example, noted the convenience of traveling entirely by car from interior garage space to sheltered parking at retail and service locations. Cars were mobility devices to overcome treacherous wintry landscapes. Participants could maintain commitments by relying on the shelter and safety of driving. Further, they were unaffected by severely delayed or even cancelled bus routes that wreak havoc on those travelling after a snowstorm. 'Snowbirds' spent weeks to months every winter in warmer southern locations devoid of any ice or snow. Altogether, affluent participants relied upon private financial resources and more supportive neighborhood conditions to handle challenging white space conditions.

One democratic element appreciated by high- and low-income participants alike was Minneapolis' skyway system, which connects downtown buildings through a network of enclosed pedestrian footbridges. The skyway system was a major aid to winter mobility and activity to those living locally. Homeless participants appreciated the warm interior hallways as they traversed the downtown daily in search of food and warmth. Those with mobility aids (e.g., wheelchairs, walkers, canes) and sight impairments expressed the necessity of the skyways for winter travel. Otherwise they would not be able to venture outside on icy or snowy sidewalks. I walked with Ellen (73y, Downtown Minneapolis) regularly during winter as she navigated the tangled web of indoor pathways with ease and familiarity. The challenge, however, was two outdoor blocks between Ellen's condo and the nearest skyway entrance. One particularly slick March morning, Ellen slipped on an icy slope. She caught herself quickly with my help and made note to remember that icy spot on the way back. Only upon entering the skyways did she relax and walk with a more comfortable gait.

Ellen benefited from a lifetime of resources to maintain her health and mobility. At 73 years old, she was still very agile and vigorous. Our pace of walking, for example, was generally evenly matched in the skyways. Younger participants in the study – those who felt 'old' in their late fifties and early sixties – were nearly-always low-income. Many had endured a lifetime of hardship and living in abject poverty, which produced more 'broken bodies' through prolonged lack of access to health care and affordable fresh foods, less leisure time, and a higher tendency to have physically-demanding jobs. Severe workplace injuries sustained by three participants, for example, resulted in destitution and for one a downward spiral into homelessness. Impoverished participants noted severe challenges of navigating winter conditions at much younger ages than many wealthier participants in the study. My sample of highly-resourced participants in the study below the age of 70 who did not have a long-term illness or disability is limited. They did not volunteer to participate in this study. Those that did generally considered the study to be a proactive measure as they were approaching retirement or early into retirement and interested in thinking ahead. Winter conditions were a seasonal nuisance, but they did not yet feel strong embodied vulnerabilities any more than their younger years.

Duality of Vulnerability and Durability

Most participants, though, expressed feeling more vulnerable as they aged, and extremely cautious in white spaces given above-mentioned mobility concerns. Those with health conditions, such as replaced joints and osteoporosis, particularly voiced susceptibility to white spaces. Pamela (71y, Eden Prairie), for example, felt helpless in winter conditions:

> It is a lethal weapon, living in Minnesota for seniors. Because of the ice, and because of the fear of falling. You break a pelvis, you break a hip, and you're bedridden. Pretty much your life goes downhill. Yes, I've fallen… Winters are horrific.

Pamela had no sidewalks in her suburban neighborhood, and mentioned falls entering and exiting a car on slick driveways and parking lots. As a result, Pamela and others in the

suburbs cut down active time in white space conditions. This increased their risk for being largely-housebound during winter months (Clarke et al., 2015). The same winter weather conditions thus affected Pamela differently in her position of relative privilege. While she was generally concerned about falling, Pamela was more preoccupied with missing activities at the senior center and being unable to get to the grocery store to buy fresh milk. I do not want to minimize her concerns (they are indeed valid), but there was a higher level of severity expressed by marginalized individuals. Homeless participants, for example, were worried about being unable to enter shelters and freezing while sleeping outside. On frigid evenings, Emma (58y, Downtown Minneapolis) recounted that she rides the light rail all night long to stay warm. Frank (mentioned above) had no ability to wait for snow clearance when he was scheduled to work janitorial night shifts. Winter conditions for vulnerable participants could be a matter of life and death.

We can compare this to spouses Michael and Penny (73y and 68y, Downtown Minneapolis), for example, who recognized their limitations in winter conditions but were able to address them. They discussed their divergent behavioral reactions to white space:

Michael: I walk in the wintertime as long as there is not a lot of ice. I don't want to fall down and break something. If the sidewalks and pathways that I use are fairly clear, I'll go out. I don't mind the cold that much because I'll put on a parka. I don't walk as far, although I have done the 4-mile [route] when it's not that cold

Penny: I, on the other hand, am extremely anxious about slipping and falling. My mother slipped and hit her head and, shortly after that, it triggered her dementia. For me – walking in the winter when it might be icy or snowy – I don't even want to take the risk. It terrifies me. That's why I'm driving four blocks. I just don't want to take the chance.

Michael: I, on the other hand, don't like to drive in the wintertime. I just don't like to.

Penny: Yeah, so he's more afraid to drive, and I'm more afraid of walking.

They were both able to address their fears and overcome them by choosing the safest mode of transportation. The same white spaces could produce a variety of emotional reactions depending on the perceptions, circumstances, physical abilities, attitudes, identities, and socioeconomic contexts of each participant. An accumulation of life experiences, personal histories, and embodied identities shifted participant behaviors and levels of confidence.

Despite mobility and vulnerability concerns, participants accustomed to many years of white space conditions felt that snow and ice were manageable parts of everyday life. Similar to Novek and Menec's (2013) finding, some participants engaged in winter recreation and enjoyed snowy landscapes. Elizabeth (63y, Downtown Minneapolis) proudly stated her adherence to outdoor activities year-round. She memorized exactly which routes were safest to run with a local group through winter. Other affluent participants engaged in cross-country skiing, snowshoeing, ice skating, snowmobiling, and ice fishing.

Low-income participants in particular overcame mobility limitations in white spaces to remain active and busy. Janice (75y, Eden Prairie), for example, explained her strategy: "You take small steps. The motto around here is you walk like a penguin. I take my time. I have the cane because I have arthritis in my feet. I take the cane for an extra balance." In her subsidized buildings, neighbors further helped each other by providing rides to medical appointments and the grocery store. Gertrude (63y, Downtown Minneapolis) overcame falling fears to get outside: "I need that breath of fresh air for my endorphins to work. There's something about being outside, as cold as it is. I need it." Gertrude and others enjoyed walking in wintry landscapes with bright sun shining on pristine white snow. White spaces for some thus prompted physical activity, recreational leisure, and pleasure.

Psychological Responses: Exacerbations of Fear and Stress

The above physical health and safety concerns evoked psychological responses. Echoing the experiences of disabled youth in Lindsay and Yantzi's (2014) study, participants expressed seasonal angsts including fears of falling, getting stuck, or not

being able to get somewhere. Nadine (65y, North Minneapolis), for example, voiced her anxiety: “Be scared of slippin’ because of ice and snow on the sidewalk. I worry ‘bout slipping and falling because I have bad knees.” She reported fretting about the weather and sidewalk conditions, and feeling anxious regarding decisions to go to church, social events, and errands. In response to asking if there was anything unsatisfying about his daily life, Chris (70y, Downtown Minneapolis) replied: “Unsatisfying? The snow, the weather, seven months of sleet and ice. You get [ice crystals] around the corners of your eye in the winter because stuff blows around.” Chris once fell seven times while attempting to cross an intersection in knee-deep snow. Lifelong cognitive disabilities made it difficult for Chris to move around the downtown for work and leisure. He strongly disliked winter and felt uncomfortable and unhappy regarding the northern climate but did not have the resources to afford relocation to a warmer location.

Phase II participants extended white space concerns to family and friends. They often called in advance of scheduled meeting times if roads were icy or snowy, and routinely requested that I be careful biking and driving during winter. Denise (72y, Eden Prairie) particularly fretted, as noted in my fieldnotes from one February session:

> Denise called me to express concern about the incoming snowstorm. She had vague information from the morning television and phone conversations with her friends. She’d heard that schools were closing in anticipation. We agreed that I would still come for our session and sit by the window to watch the weather. I promised to leave early if we felt concerned…
>
> Once in her apartment, Denise fretted constantly about the incoming snow. During tea, it began to snow heavily. While I packed up to leave, Denise fussed and asked me to call her as soon as I got home...
>
> The roads were a mess: an icy, slippery nightmare. I witnessed four accidents, including a car directly in front of me that spun 180 degrees on the freeway. The drive took twice as long as normal. I finally got in the door and called Denise – she was close to tears with concern.

Denise and others expressed anxiety regarding winter weather and inclement conditions. Participants worried about themselves, family members, and friends traveling through white spaces.

These observations of the stress caused by hazardous urban conditions resonate with disability scholarship. This literature illuminates the marginalization that disabled people face in a society where the 'able' and 'healthy' body occupies a privileged position. The field originally identified challenges of negotiating environmental obstacles such as curbs and stairs (e.g. Golledge, 1993; Vujakovic & Matthews, 1994). A key conceptual contribution to the literature was Brendan Gleeson's (1999) *Geographies of Disability*. He investigates how certain environments can *dis*able rather than *en*able people with physical impairments. The 'disabling city' prevents full participation in city life for residents through exclusionary city design, employment patterns, and the distribution of land uses. Public spaces reveal and reproduce the privileged able-body norm, while also maintaining the 'Otherness' of disabled bodies (Wilton & Evans, 2009, p. 208).

Winter conditions exacerbated physical inabilities to access spaces and generated social anxieties of being stuck, stranded, or falling in front of others. This resonates with Pain and colleagues' (2001) efforts to move from a concern of 'stairs' to 'stares'. They advocate for extending beyond physical accessibility to examine deeper roots of marginalization through which disabled people are marked as different, unwanted, and 'out of place' in public spaces (Hahn, 1989; Butler & Bowlby, 1997). Many participants who were able-bodied their entire lives developed physical, mental, and sensory impairments in old age. This could lead to newfound social stigmas and exclusions. Disabilities became even more apparent and stressful in challenging winter weather conditions. This had meaningful impacts on everyday life.

Seasonal white space conditions caused participants to leave their homes less frequently (Lindsay and Yantzi, 2014), which generated feeling cooped up and bored. Participants missed outdoor activities that improved quality of life, including psychological benefits of stress reduction and life satisfaction (Hjorthol, 2013). Rebecca

(77y, Downtown Minneapolis), for example, lamented the mental hardship of winter given her limited mobility and fragile health:

> Before [the surgeries] I volunteered at [a hospital] for years, I volunteered at [a theatre], and I volunteered at the food bank. I was very active, but now I had to quit a lot of them because I had a knee replacement and a hip replacement. Now I'm going to get shots in me, so I'm a little afraid to be on the ice. Yet I'm bored to tears staying home.

Rebecca reported that she doubled her depression medication during the winter to combat woes of seasonal isolation. She blamed some of these troubles upon her limited income given that she could not afford to live in a more-stimulating residential building with regularly-scheduled social events. She could not afford to move, nor could she pay the cost of taxis to achieve safer mobility outside the home.

Lower-income house-dwelling participants lamented strains caused by financial burdens of white space maintenance. They stressed the need for affordable plowing services for driveways and sidewalks, especially as they became less able to shovel themselves. When unable to shovel and get out safely, some participants reported being confined to their houses until family members were able to shovel and salt driveways and walkways. This could lead to days spent unhappily "stuck" at home.

Satisfaction and Self-Worth

Participants also expressed satisfaction derived from seasonal routines and white space. Julia (73y, North Minneapolis), for example, shared her love of baking in the wintertime while viewing white space through the window. She was pleased to no longer commute during inclement weather to and from work. Retirement generated choice, satisfaction, and more autonomy to engage with white space according to participants' own preferences.

Lifelong Minnesotan Blanche (74y, Downtown Minneapolis) purposefully stayed in town to experience snow, unlike many of her 'snowbird' friends who travelled south seasonally to warmer climates. She mentioned her joy during the first snowfall each winter and feeling like a "little kid on Christmas morning." Participants enjoyed having

four distinct seasons, of which snow was an essential part of winter. Furthermore, many preferred cold weather to the heat and humidity of summer. Janet and Chandler (73y and 70y, North Minneapolis) unexpectedly enjoyed winter conditions and the pristine appearance of white space after moving to Minnesota:

Interviewer: What do you like about this area?

Janet: All the snow. We didn't know [before moving] about all the snow!

Chandler: I like that it gets cold. Down in [a southern state], it was scorching down there.

Janet: The first snow I went through, I was almost ready to go back. But Chandler wanted to stay, and now I love it.

Chandler cheerfully explained that they both enjoy watching it snow, and then he shovels the sidewalk for his entire street. While proudly able to shovel himself, he and his wife also knew that they had a large support network of children and grandchildren in regular contact who could help if Chandler became physically unable to maintain the shoveling.

Participants expressed pride in their toughness and capacity to endure – and even thrive during – Minnesota's long winters. It was part of their identity. This observation relates to studies of Inuit peoples living in northern Canada. Cunsolo et al. (2013) found that snow and ice were essential to emotional wellbeing given longstanding practices of winter hunting, trapping, foraging, and travel. One's sense of self-worth and identity were founded on these longstanding traditional practices. In Petrasek et al.'s (2015) study of Inuit youth, they found that the winter climate enhanced mental health, connected to Inuit culture, helped communities bond, promoted interpersonal relationships, and helped participants keep busy. In this study, participants exhibited their own attachments to white space, and discussed essential qualities of snow and ice for daily routines and seasonal traditions.

Whether lifelong or learned later in life, participants animatedly discussed experiences and strategies on snow and ice. Oliver (73y, Eden Prairie), for example, stated: "I was born and raised in Northern Minnesota, so I know what snow and ice are." He was proud that he had not fallen despite declining personal health and an active lifestyle. Ian (60y, Downtown Minneapolis), homeless, navigated snowy and icy streets

all through winter. He did not worry because "after fifty-nine some years of walkin' through Minnesota winters, you learn to take little steps so you don't spill (*laughter*). You don't fall." Ian was pleased and confident in his ability to endure winters and presented it as a mark of independence. Male participants in particular noted with pride when they shoveled and maintained driveways and sidewalks, such as Chandler mentioned above. Shoveling was a reassuring mark of masculinity and virility. It could also stimulate positive interpersonal connections with neighbors.

Social Strains: Struggles with Exclusion and Isolation

Participants' anxieties and mobility concerns could lead to prolonged periods of seasonal isolation. Consistent with the literature, altered travel patterns in white spaces constrained socialization and activity levels (Lindsay & Yantzi, 2014). Nancy (77y, Eden Prairie), for example, had recently moved to Minnesota given health problems and widowhood. She relocated to be closer to her only child for support and for access to the strong healthcare system. Since the move, she felt cooped up and alone during the winter as she lived in her child's suburban basement:

> I'm not going to drive in snow and ice. I don't trust myself enough. I wouldn't want to hurt anybody else on the road. That makes all the difference – the weather is a big factor in keeping me close to home. I'm afraid of driving on snowy, icy streets.

Nancy lamented that it was difficult to make and sustain local friendships given lengthy winters with abundant snow and ice. The low-density design of her daughter's wealthy suburban neighborhood limited opportunities for recreational activities and social connection. Suburban architecture and landscape design are *meant* to isolate. The built form provides residents with the promise of the American dream: large houses, fenced-in yards, and abundant privacy given the wide spacing between neighbors. The lack of sidewalks and front porches exemplifies purposeful planning for disconnection in the suburbs. The downside of low-density living environments is that older adults now seeking local social connections have less opportunities to do so. Isolation is amplified in

winter given that even less people are active outside their homes and it is harder to travel to socialize.

White space strained some participants' abilities to uphold social commitments. Two Phase II participants left the study during winter, as noted in my fieldnotes:

> Both North Minneapolis women opted to end their involvement in the study early. It is interesting timing: both became noticeably less communicative in winter. They are both matriarchs with busy lives and extensive commitments both inside and outside the home. I witnessed firsthand that life can be particularly hard during winter in North Minneapolis. June struggled to walk on the ice and snow and felt cold waiting for the bus. She was reliant on others to get around, and her network became less willing to help her during winter conditions. Christina also worried about the snow and driving. She even stopped walking her dog – just let her out into the backyard. Winter notably impacted both June and Christina's daily lives and ability to connect with others.

Phase II captured firsthand the stresses of maintaining social routines under challenging white space conditions. Psychological factors including depression, melancholy, and lack of energy became apparent. Winter was a "depressing time" where neither June nor Christina felt like they could escape. To preserve their mental wellbeing, they cut off recreational activities and limited social commitments.

Participants could feel especially isolated and defenseless during emergencies. Rhonda (85y, Downtown Minneapolis), for example, related:

> Once in the park, I was cutting through the park and it was solid ice. I had no traction. I ended up getting down on my knees and getting through the ice puddle. I couldn't maneuver through it. I thought 'oh my God'… And nobody came along to help. Just when you wanted somebody.

Rhonda was acutely aware of her aloneness and the necessity of relying on herself. In this moment she panicked, and it generated deeper fears of not having anyone to help.

Sites to counter isolation, especially for participants living alone across all three case study areas, were shopping malls and stores. Participants sought opportunities for social connection with staff, customers, and friends in retail locations. Reflecting Novek

and Menec's (2013) findings, some Eden Prairie participants described seasonal mall walking as an enjoyable opportunity in winter to exercise and socialize while avoiding outdoor snow and ice hazards. Others went to grocery stores frequently as free public spaces simply to view others and soak up ambient contact. With more people gathered inside, exterior white space provided different seasonal opportunities for social contact.

Strengthening of Bonds

Participants could use white space as an opportunity and excuse to bond further with family and friends. Lauren (79y, Eden Prairie), for example, lived with her sister in southern California every January. Several couples were 'snowbirds' with entire communities to re-connect with each year. White space was a reason to travel for those who could afford it, visit, and talk to family/friends.

Participants also used snow and ice as opportunities to bond and interact with neighbors. It represented an easy topic of conversation, and cause to connect and support one another. Spouses Robert and Linda (69y and 70y, Eden Prairie), for example, shared:

> Robert: We're blessed to live in a caring neighborhood. We know that we can count on these people if we have an issue. A good example is when I had to have surgery on my left toe. I could not put any weight on it for the month of January. Every time it snowed, there was two or three --
>
> Linda: -- neighbors were here. [The driveway] was clear just like that --
>
> Robert: -- neighbors to clean off the driveway, because they knew that I could not do that. We didn't call them and ask, they just showed up.

These social bonds meaningfully contributed to Robert and Linda's quality of life. Participants often recounted stories of neighbors helping them, or vice versa, given white space conditions. Betty (78y, North Minneapolis) narrated:

> We've got a neighbor on the corner who bought himself a little-- he calls it his little tractor toy. I love that man. He goes around every time it snows, and he clears the whole sidewalk around the block for everybody. That is so convenient

and so nice. He doesn't ask for anything. He said, 'No, I just like doing it.' The neighbors will go over and bring him a six pack of beer or something.

White space generated opportunities for some to bond and support each other given shared experiences, which in turn enhanced social wellbeing and overall quality of life.

White Space's Dual Potential for Health and Harm

Reflecting existing scholarship on snow and ice in later life (Clarke et al., 2017; Rantakokko et al., 2014; Hjorthol, 2013; Li et al., 2013; Wennberg et al., 2009), participants experienced some negative impacts on wellbeing. Harms included falls and vulnerability, mobility restrictions, worry and fear, boredom and stress, social exclusion, and isolation. Socioeconomic status and residential location could exacerbate or diminish harms, such as low-income North Minneapolis participants' increased exposure to mobility challenges of inadequate road and sidewalk maintenance. Participants also shared wellbeing benefits and positive therapeutic relationships with white spaces through adaptability, self-worth and identity, and strengthened social bonds. Positive experiences (e.g., pleasant walks in a snowy landscape, enjoyable changing weather conditions, the pride of being a 'tough Minnesotan', bonding with others) countered solely-negative assumptions of white space.

For the sake of clarity, white space impacts on physical, mental, and social wellbeing were often presented as distinct. However, in reality they were overlapping and fluid constructs. White spaces' physical mobility barriers, for example, generated health and safety concerns that in turn contributed to social isolation. Driveway and sidewalk shoveling stimulated physical wellbeing benefits for some through outdoor activity and could also produce social contact and bonding with neighbors. The analyses deepen understanding of how (non)therapeutic landscapes operate through dynamic, interactive, embodied, and emotional geographic experiences (Foley, 2015; Finlay et al., 2015). Sights, smells, sounds, and other sensations felt through the body filtered encounters of white spaces (Brown, 2017). The same white spaces could produce a variety of reactions ranging from enjoyment to indifference and anxiety. White spaces were both therapeutic

and untherapeutic depending on the relational outcome of individuals and their broader socioeconomic and environmental settings (Conradson, 2005).

Further scholarship on white spaces could involve a breadth of everyday to extraordinary locations and practices. This includes ski resorts, mountains, Indigenous communities, arctic regions, imagined spaces (e.g., through imagery, virtual reality, snow globes), and therapeutic practices (e.g., ice baths, snow meditation). Greater attention could be devoted to sub-characteristics of white space ranging from bright white snow to darker shades of black ice, brown slush, and grey snow melt. White spaces seasonally cover and uncover built and natural environments, which changes person-place relationships over time. Blue and green spaces take on new meanings when overlaid by snow or ice, such as a park frequented with grandchildren during spring and summer that becomes a solitary site in winter. These blurred palettes of place (Foley, in press) generate different temporal (non)therapeutic experiences and potential health impacts.

Deeper knowledge of positive and negative impacts of white spaces can be effectively mobilized within public health and urban planning. Although not possible to change seasonal weather conditions in northern regions, communities can invest in supportive design of outdoor built environments to minimize negative white space elements and maximize positive aspects. Participants identified the need for well-maintained sidewalks, roads, and parking lots with regular snow and ice removal; and affordable plowing services for low-income residents. Municipalities might consider alternative designs for curb cuts and pedestrian intersections to facilitate safer mobility in winter. Neighborhood shoveling programs could aid those in-need and boost socialization. Community service organizations could facilitate seasonal activities, such as transportation to events, indoor walking clubs, fall prevention classes, and check-in systems for more-isolated older adults. Outdoor winter recreation groups, winter landscape photography classes, storytelling groups, and other basic programs could enrich enjoyment of, leisure in, and shared social connection with white spaces. Being attentive to diversity and difference when considering who has access to and who benefits from white spaces enhances opportunities for wellbeing and quality of later life.

Towards a More Critical Approach

This chapter explores intersecting axes of socioeconomic context and embodied ability that underpin individual navigations of (non)therapeutic landscapes. It departs from previous studies of able-bodied, able-minded, and monied individuals. This highlights the contested and sometimes-exclusionary nature of therapeutic landscapes (Buzinde and Yarnal, 2012; Bell et al., 2017). Inadequate municipal snow plowing and de-icing, for example, produced inaccessible destinations, frustration, and isolation – particularly for low-income individuals. Some participants could not occupy public spaces in white space conditions as well as able-bodied and able-minded individuals. This observation follows the disability literature's move towards a social model of disability seeking to expose overlapping social and spatial dimensions of marginalization for those with disabilities (Barnes & Mercer, 2004). The chapter signals a conceptual shift away from uncritical assumptions of intrinsic values of place to embrace complexities of power, individuality, agency, and intersectionality (i.e., intersections of age, ability, race, and class).

The focus on diverse personal biographies illuminates underlying histories and politics of urban landscapes. White spaces exposed urban socioeconomic inequalities, though results were non-linear given that both affluent and low-income participants experienced distinct white space challenges and strengths. Eden Prairie's automobile-focused infrastructure generated fears of driving and experiences of seasonal isolation. Plowing could be burdensome for homeowners of large-lot houses with lengthy driveways and sidewalks. Friends and family were often inaccessibly far away. These participants, however, were generally able to apply personal financial resources to solve their problems and ameliorate winter experiences. Participants bought snow blowers and tractors, used app-based ride services and taxis when unable to drive, paid for exterior home maintenance services, and travelled to warmer climates for extended stays and family trips. Impoverished North Minneapolis participants did not have these options. They lived in poorer neighborhoods where services were predictably scarcer. Many struggled to keep up with heating bills and could not stay on top of sidewalk or driveway shoveling. After a snow or ice storm, participants could be stranded at home for days

waiting for over-burdened younger family members to arrive to shovel them out. The trifecta of (i) family and friends unable to provide rides, (ii) bus stops impossibly difficult to reach along unplowed sidewalks, and (iii) the inability to afford taxis or a smartphone for app-based services caused participants to be "stuck" at home. Those living in or near the Downtown could fare better with skyways, high-density services, and abundant transportation nodes nearby. Subsidized apartment buildings provided nearby social contacts – though participants often avoided socializing with neighbors who posed safety concerns (see Chapter 5). Winter struggles abounded given uncomfortable apartment conditions (e.g., ice on the inside of windows with improper insulation) and braving freezing conditions to queue for entry into homeless shelters. White space conditions crystallize that Minneapolis is no exception to unequal structural conditions that plague American cities. Given their embodied vulnerabilities, the city's history of racism and neglect of the poor is felt even more keenly by marginalized seniors than younger constituents.

These observations address a lacuna in the therapeutic landscape literature where underlying structural inequalities, contested histories, and politics of landscapes remain unexplored. This is in part because the research remains closely tied to white, Eurocentric, affluent contexts and experiences. The literature is dominated by scholars from Commonwealth countries (e.g., United Kingdom, Canada, Australia, New Zealand) who tend to uncritically celebrate positive wellbeing aspects of landscapes. Mokos (2017, p. 145-146) notes that scholars can unintentionally reproduce logics of exclusion and dispossession. There is a need to sensitize the therapeutic landscapes literature to the political ramifications of whose knowledge and experiences are deemed legitimate and taken into account. Health geographers need to seize opportunities to interrogate power relations that influence spatial experiences of healing and harm. Who has access to spas, yoga studios, national parks, homeless camps, and health clinics? Each of these spaces require investment and privilege through entry fees, leisure time away from work and caregiving, and embodied abilities (e.g., the norm of manicured thin bodies in many yoga studios). A critical approach attuned to privilege and inequality generates compelling areas of inquiry.

My observations interrogate overly-simplistic and uncritical assumptions built into the very term 'therapeutic landscapes'. Scholars too-often ignore ambiguous, contradictory, political, and 'messy' experiences and embedded histories of landscapes. While health geographers frequently observe that not one space is wholly therapeutic or beneficial, many fail to attend to structural reasons for *why.* A public park, for example, can be home to staggering diversity: from joyful childhood experiences of playing in the sandbox to bullying, drug deals, violence, policing of homelessness, and predatory sexual activities. It may also be part of municipal slum clearance or gentrification efforts. Thus, this park could be fraught with exclusionary practices, a history of displacement, surveillance, and policing that crystallize social fault lines including race, gender, class, sexuality, and age. Another example is how tourists enjoy majestic wilderness and restoration through contact with vast natural preserves, some of which exist as a result of the harmful dispossession of Native Americans relocated and removed from their lands. Finney (2014) questions the construction of nature as (racially) white space, pointing out the socio-historical imaginaries that have obscured African American experiences with the environment. Differential access to wilderness and parks due to segregation and continuing socioeconomic disparities limit the opportunities of African Americans and other marginalized communities to participate in these 'public' landscapes. The narrative of the 'great outdoors' (Finney, 2014, p. 28) is thus informed by and perpetuating Eurocentric and racist discourses. Scholarship on therapeutic landscapes needs to recognize these complex histories, politics, and relationalities embedded within each space.

Differential experiences of healing or harm are thus not simply a product of *personal* difference. That claim is apolitical and ahistorical in its failure to recognize the underlying structure of each landscape. Rather, the distinct histories and politics of spaces situate people to react differently. Visitors to a national park, for example, have contrary experiences depending on their awareness of the park's colonial history. A displaced person reacts differently to anti-homeless bars on public benches than affluent persons unaware of hostile urban design. Williams (2017) recently called for using the concept of therapeutic landscapes as a tool to mobilize change in the face of growing inequalities,

climate change, population growth, environmental injustice, and social exclusion due to race, religion, sexuality, gender, and other forms of diversity. She depicts therapeutic landscapes as a lens to uncover material and representational injustice and forms of social exclusion. For this to occur, scholars must devote careful attention to the fundamental politics, histories, and exclusions of landscapes that move away from existing simplistic and uncritical forms of scholarship.

As inequalities in access to health and wellness grow, the concept of therapeutic landscapes has the potential to vocalize and draw critical attention to vulnerable populations and marginalized spaces if applied appropriately. Scholars could focus on violent and deteriorated neighborhoods; hostile urban architecture; sites of surveillance, policing, and incarceration; and contrary experiences of home for refugees or victims of domestic abuse. Spaces of violence, exclusion, and harm deserve thoughtful attention. This includes the scale of the body – the most intimate of landscapes. Health geographers are positioned to interface with cognate fields such as political ecology and science and technology studies to critically investigate embodied encounters through space and time. This could include pregnancy, caregiving, aging, and dieting. The latter example would involve examining the cultural morality of fatness and unequal access to 'thin real estate' (Guthman, 2011).

There is space here for health geographers to be *against health:* to investigate how disparities in the incidence and prevalence of disease and harm are closely linked to spatially-fixed disparities of race, class, income, and social support. As Metzl (2010, p. 1-2) contends: "'Health' is a term replete with value judgements, hierarchies, and blind assumptions that speak as much about power and privilege as they do about well-being." Therapeutic landscapes are rife with sexism, cultural narcissism, moralism, racism, and capitalism's abuses. Many ground rhetoric of stigmatization, colonialism, and consumerism. Only by unpacking the histories, politics, and ideologies of therapeutic landscapes can we hope to develop a more effective, evolved, and empowering understanding. To advance a more just and inclusive form of scholarship, we must continually question: what is therapeutic, under what conditions, and for whom? Disparate and critical approaches to therapeutic landscapes are needed to stimulate

deeper, more productive, and indeed even healthier interactions with the contested spaces of everyday life.

Chapter 5. Aging in the Margins: Person-Space Negotiations in Search of 'a Good Place to Grow Old'

Introduction

> At 78, healthy but floundering, I really would like to know more about us and how to cope – or how we *could* cope if we knew how… [Because] I have been happy, but I'm having some concerns now. My neighborhood doesn't feel as safe. There's a house down the street that I'm pretty sure they're dealing drugs. [But] I still love North Minneapolis. I raised my kids in North Minneapolis. I love my home… My kids are ready for me to move, but I'm not moving (Millie, 78y, North Minneapolis).

Millie lived alone in a low-income part of the city where she struggled to drive to essential services, feared being robbed, and experienced worrying memory lapses. Despite the challenges of a dilapidated multi-story house on her arthritic joints, Millie insisted that she would only vacate her longtime home on a stretcher. Millie prioritized the comforting familiarity and independence of her house, valued nearby family and friends, and desired to remain rooted in her local African American community. She desperately wanted more information, resources, and assistance for low-income seniors such as herself to live comfortably and safely at home.

Millie exemplified the aging population that is rapidly becoming more racially and socioeconomically diverse. Minority populations over the age of 65 in the United States increased to 10.6 million in 2015 (22 percent of those 65 and older) and are projected to expand to 21.1 million in 2030: a 110 percent increase, in comparison to a 46 percent rise in white non-Hispanic populations. While the Baby Boomers are known for economic prosperity and spending power, over 4.2 million older adults (8.8 percent) were below the official poverty level in 2015, and 13.7 percent below the Supplemental Poverty Measure (which includes medical out-of-pocket expenses). These numbers were higher for minority populations (e.g., 18.4 percent of African Americans), women (10.3 percent), and those living alone (15.4 percent; Administration for Community Living,

2016). Those over the age of 50 now make up over 30 percent of the homeless population (Nagourney, 2016).

Despite the rapidly diversifying aging population, the voices of marginalized elders are frequently overlooked. In order to address the knowledge gap, this chapter focuses on 38 low-income participants residing across all three case study areas. They represent a marginalized and often-ignored group who exist outside of normative expectations of aging in stable housing with secure financial resources. Participants discussed advantages and disadvantages of their residential situations and described in their own terms what constitutes an ideal place to live. Their nuanced responses evaluating relevant physical and social environmental characteristics form the empirical focus of this chapter. The findings are grouped by four interrelated residential qualities: safety and comfort, service access, social connection, and stimulation.

Taken together, these qualities enabled participants to cultivate place attachment: an emotional connection to spaces that instills belonging and insider status. However, I argue that place attachment was not uniformly positive, attainable, or predictable. It could generate risk, vulnerability, and harm in underserved and hazardous areas. Disparate experiences of place attachment reveal underlying causes including commercial disinvestment, structural racism and ableism, and neglect of the elderly poor. Grounded in the realities of socioeconomically and racially oppressed older adults, my analyses intervene in uncritical theoretical assumptions of 'normal' and 'average' place attachment trajectories. I use participants' diverse navigations of place attachment as a vantage point to question fundamental assumptions of everyday urban life and extend geography's address of socio-spatial injustice.

Interrogating Place Attachment

Place and identity are inextricably bound together. They are co-produced as individuals come to identify with where they live and the places they frequent. People become attached to a variety of places (such as homes, neighborhoods, parks, sacred sites, and natural landscapes) at different stages throughout life, ranging from childhood to early adulthood and old age. Strong bonds with places often develop through positive

feelings of love and happiness – what Yi-Fu Tuan (1974) termed topophilia. Altman and Low (1992) describe how place attachment – the bonding of people to places – has rich implications for identity development, place-making, perception, and behavior. People affect and shape place, and are in turn affected and shaped by their environment. A location's ornamentation, materials, structures, and interpersonal exchanges thus tell us a lot about who lives, works, and visits there. Through these social and physical elements, places can generate a sense of belonging, construct meaning, mediate change, and foster identity (Proshansky, Fabian and Kaminoff, 1983; Gieseking et al., 2014). Place attachment can influence political actions as well as sociocultural formations and practices. Recent immigrants, for example, may establish roots to their new home by planting specific tree species and adhering to certain architectural ornamentation (Michell, 2004). Residents may rally around protecting local parks, preserving neighborhoods from gentrification, or NIMBY (not in my backyard) campaigns in objection to unwanted or hazardous development. At a broader scale, the United States' sense of nationalism influences popular culture (e.g., folk songs, media representations and imagery), immigration policies, and election outcomes.

Scholars note the development of rich cognitive and affective ties to the places we live, and the cultivation of spatial attachment to very specific ideas of 'my place' and 'my home' (Wahl and Oswald, 2016). One's home and community ideally enable everyday life 'in place': the feeling of embedded identity, purpose, and meaningful connection (Kyle and Chick, 2007; Scannell and Gifford, 2010). Everyday experiences in intimate physical settings generate defining "memories, ideas, feelings, attitudes, values, preferences, meanings, and conceptions of behavior and experience" (Proshansky, Fabian and Kaminoff, 1983, p. 59). Sense-of-place is constructed and negotiated within everyday home and community contexts. We develop strong place identity by developing ties to family and community, owning or renting a home, and participating in local daily civic life (Hayden, 1995). This is how we transform spaces into meaningful places, and the process through which we develop local insider status (Hay, 1998). *Insideness* is the level to which individuals perceive that they belong 'in place' (Relph, 1976).

Theories of place attachment and place identity permeate theoretical and empirical scholarship of geographical gerontology. A sense of 'being in place' is essential to wellbeing in later life (Rowles, 2017). Rowles (1983) identifies three dimensions of place attachment: physical, social, and autobiographical insideness. Physical insideness represents inherent body-awareness for details of the physical environment (e.g., the number of steps in a familiar stairwell, the location of a light switch in the dark). Social insideness refers to integration within local family and community networks. Autobiographical insideness incorporates not only present places, but also a series of remembered places accumulated over one's lifetime. Place attachment may at times seem to defy logic, such as a woman living alone in a run-down home distant from her children. Though her husband is gone and children live far away, the rooms are still 'inhabited' by her family who, years ago, made the house a vibrant place (Rowles, 1983). Strongly rooted place attachment may cause aging individuals to remain 'in place' despite suboptimal living conditions (Fang et al., 2016).

Low-income and racial/ethnic minority communities are the populations who more often inhabit and endure degraded, underserved, and unsafe residential environments (Sallis et al., 2011). There is a long history of socio-spatial injustice in the US regarding hazardous residential characteristics and community demographics. White privilege, for example, produces a highly structural and spatial form of racism through waves of urbanization and suburbanization. Through the case study of Los Angeles, Laura Pulido (2000) investigates how white people have secured relatively cleaner environments by moving away from older industrial cores. She examines a range of racisms that shape urban landscapes from hostile discriminatory acts to subtle patterns of hegemonic racism and white privilege:

> A focus on white privilege enables us to develop a more structural, less conscious, and more deeply historicized understanding of racism. It differs from a hostile, individual, discriminatory act, in that it refers to the privileges and benefits that accrue to white people by virtue of their whiteness. Because whiteness is rarely problematized by whites, white privilege is scarcely acknowledged (Pulido, 2000, p. 13).

Subtler forms of racial discrimination in our language, psyche, and social structures work in combination with overt and institutionalized racism. This then shapes places, such as the metropolis of Los Angeles where industrial land use is strongly correlated with pollution concentrations and minority populations. White people distance themselves from both industrial pollution and non-white populations. Pulido cites numerous examples of environmental racism through the placement of uncontrolled toxic waste sites; transfer, storage, and disposal facilities; and air toxins. Studies repeatedly find that non-whites are disproportionately exposed to pollution in Los Angeles, with the most vulnerable being working-class Latinos. These results demonstrate how racism is spatially expressed in the urban form. Pulido's pioneering work on environmental racism is a useful guide to my own analyses of race and space in this chapter.

The everyday spaces that older adults inhabit are co-produced by and actively reinforcing institutional systems, structural politics (including class, racism, and ableism), and the availability of resources (or lack thereof). In this chapter, I draw upon critical approaches to urban space, race, disability, and other vantage points to demonstrate why particular areas that study participants inhabited are underserved and how it produces highly uneven contexts of aging in place. I show how marginalized older adults are especially susceptible to underserved and hazardous contexts given their embodied vulnerabilities and limited resources. In addition to instances of place-based victimization and harm, I also pay attention to unexpected and resourceful ways that participants navigated around structural deprivation and longstanding neglect. I rely on the voices of these socioeconomically and racially marginalized elders to generate novel theoretical and applied opportunities for urban change along more socially just lines.

Striving to Age Well 'In Place'

Housing was not experienced simply as the presence of infrastructure and amenities; rather, it involved active and ongoing negotiation of physical and social dimensions of one's home and neighborhood (Heatwole Shank & Cutchin, 2016). Participants sought comfortable places for regular rhythm, routine errands, and connection to oneself and others. Qualitative analyses of participant statements regarding

desires and expectations of an ideal residential environment yielded four interrelated themes. First, participants stressed the importance of safety and comfort: a high sense of security from physical and emotional harm, and the ability to feel relaxed and comfortable. Second, access to services, facilities, and recreational amenities were considered essential. Third, participants valued social connection including everyday interactions, social support and cohesion, and sense of community. Fourth, participants vocalized the need for stimulation: an environment with opportunities for fulfilling and meaningful activity. These four broad ideals, when achieved, enabled participants to cultivate residential wellbeing and place attachment.

Participants exhibited broad-ranging suitability and unexpected opportunities to age well 'in place'. My findings pivot away from assumptions of 'normal' and 'average' place attachment trajectories to generate greater reflexivity and sustained recognition of difference. To do so, I analyze participants' local environments as contexts for everyday life and the expression of social relations of production. I draw upon Henri Lefebvre's conceptual framing from *The Production of Space* (1991) to think through how socioeconomic production is united with the 'local and particular' problems of everyday life. Participant navigations of place attachment were shaped by the political economy and sociocultural norms. I therefore attend to these underlying contexts filtering the search for 'a good place to grow old'. I expose structural barriers and exclusions to achieving the fundamental right to inhabit a safe, comfortable, and meaningful home.

Safety and Comfort

Feeling calm and safe in one's residential environment were considered essential. This encompassed sense of security (e.g., from crime and abuse), personal safety (e.g., from falls), and the ability to feel comfortable and relaxed.

Physical Safety. At the scale of the neighborhood, Downtown Minneapolis participants were the most attentive to micro-features of the surrounding environment. Noted elements included heavy traffic, uneven pavement, brief crosswalk timing, and

seasonal snow piles. Participants such as Trudy (60y, Downtown Minneapolis) explained the stress and danger of navigating difficult terrain:

> When you cross the street at the corners, you've got to climb the snow mounds. And then when you get on the snow mounds, it's icy... It's like the city doesn't care that there are senior people and disabled people.

At the time of our interview, Trudy had endured long-term physical and cognitive disabilities. She struggled to navigate her everyday context. The underlying ableism of our non-disabled society means that environments are built according to able-minded and able-bodied norms (Philo, 2009). Disability literatures elucidate how these norms are predicated upon political-economic forces, such as discriminatory dynamics of labor and housing markets, and deeper roots of oppression caused by the stigmatization of 'imperfect' bodies (Hahn, 1989). This generates pain, fatigue, rejection, anxiety, and simply 'getting by' among people with impairments (Philo, 2009), such as the hardships that Trudy endured.

Early disability literatures, as discussed in Chapter 4, considered the needs and experiences of wheelchair users and the visually impaired. They focused on the environmental obstacle courses of streets, sidewalks, curbs, steps, and stairwells (Golledge, 1993; Vujakovic & Matthews, 1994). These analyses of disabling environments enabled scholars to critique architects, planners, and policymakers (the designers and 'the state') for developing environments that effectively 'lock out' the disabled (Imrie, 1996). Gleeson (1999) employs a historical material perspective to reveal how modern capitalism reinforces ongoing processes of socio-spatial marginalization of disabled people and their exclusion from meaningful economic roles and social reproduction. Oppressions occur in the workplace, transportation networks, and education systems. The 'costs' of disability, for example, often include payments for special medical and transport services that are not reimbursed by governments or other bodies. Many employers are unwilling to hire physically impaired people due to (frequently baseless) fears that such workers would be unproductive and/or have employment needs that would disrupt workplace rhythms.

Disability takes many forms beyond visible physical immobility, such as psychological impairments resulting from trauma. Angela Carter (2015) argues that the misconstruction of trauma is reflective of larger patterns of indifference and discrimination towards disability, which serve to perpetuate ableist structures of inequality. Carter involves a feminist disability studies pedagogy to approach questions of access not only as means of inclusion, but also as critical analyses of systems of power and oppression. The traumatized bodymind and the disabled bodymind are not completely the same but overlap in their subjective embodiments. The flashbacks, nightmares, and other repetitive phenomena related to unexpected or overwhelming violent past events can create paralyzing emotional and physiological responses. Carter finds solidarity between the psychosomatic and affective experiences of trauma and other types of neurodiversity such as Autism, learning disabilities, epilepsy, Down's syndrome, and other mental health issues; and with communities who have experienced racial and postcolonial traumas. Her political move towards an intersectional approach reflects disability studies' growing breadth to critically analyze and unpack the experiences of marginalized groups who deviate from the highly-problematic, socially constructed, and exclusionary 'norm'. This includes increasing engagement with intersecting social categories such as gender, race, sexuality, and social class (see Goodley, 2017; and Davis, 2016).

Old age is another important intersection with disability. Many of my study participants who were able-bodied and able-minded their entire lives now experienced physical and cognitive disabilities. They faced newfound sources of marginalization, and powerlessness. Oppressions endured were similar to those identified by other disabled populations, including physically inaccessible built environments, harmful economic divisions of labor (where participants were viewed as less productive employees and/or disruptive to workplace rhythms), and social devaluation given the cultural and political norms that privilege non-impaired forms of embodiment (Gleeson, 1999; Wilton & Evans, 2009). Pervasive ableism prevented full participation in city life through exclusionary city design, employment patterns, and sociocultural norms. For my participants, ableism overlapped with ageism to doubly mark them as 'out of place' and

unwelcome. Strangers, professionals, and even family members made assumptions of senility based upon visible physical impairments. Some participants expressed frustration that although their mobility had declined, they were still entirely 'with it' cognitively and still able to make decisions for themselves. They rejected the confluence of ageist and ableist stereotypes that melded together to produce and reinforce marginalization, exclusion, and powerlessness.

Trudy identified that a major source of her mobility struggles was the walkway of her apartment entrance. It was routinely treacherous in rainy and snowy conditions given its uneven surface and slick bricks. After several falls while accessing disability transit, Trudy requested to switch her pickup location to the back door. She taught herself to navigate the three steps with a walker while laden with groceries and house supplies. Trudy and others navigated disability and enhanced physical insideness (Rowles, 1983) through proactive steps. Frank (77y, Downtown Minneapolis) taught himself the safest route to commute to and from the senior center. He learned exactly where the icy spots were to avoid and memorized the location of benches to rest on along his commute. With limited access to cars, participants like Frank relied heavily on buses and the downtown skyways to shield from weather and dangerous street traffic.

Residents from high-income areas generally report more favorable aesthetics, pedestrian and biking infrastructure, safety from traffic and crime, and access to recreation facilities in comparison to residents of low-income neighborhoods (Sallis et al., 2011). Deep structural inequalities in built form, including the lack of amenities and safe routes for low-income participants, limit wellbeing both outside and inside the home. The older housing stock of North Minneapolis posed physical safety hazards to residents as their dwellings literally aged around them. Participants worried about their multi-story houses and being unable to afford necessary modifications such as grab bars, sturdy ramps, and accessible furniture. Some participants implemented low-cost strategies to boost personal safety, including de-cluttering to remove tripping hazards, putting a chair in the shower, and wearing a fall pendant. They relied on physical insideness by memorizing home layouts and knowing spaces with intimate body-awareness (Rowles, 1983). Often unable to afford home improvements, participants pointed with concern to

crumbling stairs, mold, peeling paint, and poor ventilation that posed health and fire hazards. Participants were aware of mounting perils but could not afford to implement the home adaptations and modifications so-often advocated in geographical gerontology literatures to reduce risk of accidents, disability, and falls (Wahl et al., 2009). They could not purchase private services to remain safely at home, including cleaning, handy work, yardwork, and home-based care. These participants lacked control over having a safe and stable home environment given severely restricted resources. Participants weighed the benefits of remaining in their familiar home and neighborhood with the escalating risk of falling, burdensome home maintenance, and health hazards. Home could thus simultaneously represent a site of safety and refuge, as well as a site of danger and injury. Intimate observations on home as an ambiguous site of both wellbeing and harm are not frequently observed in geographical gerontology literature to date. What does exist largely does so from a detached, clinical perspective on rates of disability and functioning outcomes of household modifications (e.g., Wahl et al., 2009). There is a need to incorporate 'critical geographies of home' (Brickell, 2012) in work on aging.

Critical geographies of home counter an era of scholarship in the 1970s and 1980s when humanistic geographers considered place attachments to be largely affirmative (Manzo, 2003). The 'house as haven' mantra was heavily critiqued in the 1990s (Porteous, 1995). Scholars utilized case studies to highlight disparities between ideals and lived realities of home, including feminist analyses that depicted domestic spaces as potential sites of struggle, abuse, and conflict (e.g., Badgett and Folbre, 1999; Olwig, 1998; Young, 1997). Jeanne Moore (2000, p. 213) argues for the "need to focus on the ways in which home disappoints, aggravates, neglects, confines, and contradicts as much as it inspires and comforts us." In this study, home was a complicated physical space and affective experience. Its meaning could change over time: from a site that once comforted and supported participants in their younger years, to failing to meet their current needs. This observation in-part reflects Rob Imrie's (2004) work on disability, which focuses on how homes can become unsuitable with the onset and development of bodily impairment. He depicts ideal domestic habitation as always conditional and contingent. Where this study diverges from Imrie's work is attention to the home's physical changes as well, not

just its inhabitants. The home was not static. Floorboards rotted over the years and furniture progressively molded as homes literally aged around aging participants. Hazards could intensify as inhabitants became less physically able to address them, or even less cognitively aware of dangers inhabited over time. Incapacity and infirmity could be mirrored in both person and place. Attention to this reciprocal relationship in this chapter adds a more dynamic and longitudinal understanding of the home, and a more critical understanding of housing in later life.

Transient and Restricted Housing Options. Longtime renters, homeless participants, and those in transitional housing exposed the exclusive and unrealistic stereotype that older people reside comfortably in a long-term residence. Their experiences countered assumptions that older individuals desire and expect to age in place in a familiar home environment of their choosing for as long as possible (e.g., Wahl, Iwarsson & Oswald, 2012). Financial resources impacted the ability to stay put and choice of living situation (Wahl & Oswald, 2016). Participants without stable housing expressed statements of anxiety and insecurity because of their transient residential situations. Mary (66y, Downtown Minneapolis) had only recently secured a government-subsidized apartment after a workplace injury caused her to lose her job: "In a moment, your whole life changes. You lose your job, you lose your income, you lose your home, you lose your savings. It was a nightmare, all of it. I'm still recovering." Displacement was traumatic. Those in unstable situations desperately wanted more long-term, secure, and autonomous living accommodations. They exhibited unequal access to and uneven opportunities for place attachment given unexpected life circumstances and resource limitations.

Unsafe and insecure housing situations were more common among racial minority participants. In my study sample, I observed that subsidized housing buildings inhabited by majority white residents tended to have nicer and newer infrastructure, such as subsidized buildings in Eden Prairie and highrises on the edge of Downtown Minneapolis. Participants in racially diverse buildings tended to report higher incidences of crime, degraded conditions, and restrictions to autonomy, such as subsidized buildings

in North Minneapolis and the central Downtown. From my standpoint, quality of subsidized housing diverged notably by race and ethnicity.

Drawing upon critical race theory (CRT) helps to unpack these observations. This body of scholarship first emerged in American legal literatures in the 1980s as a product of political, intellectual, and sociological developments. Derrick Bell (1984), for example, aimed to dismantle problematic ideologies common to traditional civil rights language such as 'color blindness' and 'equal opportunity'. He provided a more cogent historical and legal analysis of race and law, which moved away from dominant claims of neutrality and objectivity that camouflage the self-interest of powerful societal entities (Tate, 1997). CRT scholars continue to engage in elucidating the realities of race in an ever-changing society. They expose how racism is ordinary in US contemporary society, and even integral to social practices and institutions (Delgado, 1994). CRT thinks through the paradox of racism's persistence despite its widespread condemnation by state policy and society (Harris et al., 2012). Institutional structures facilitate racism while claiming the objectives of racial harmony and equality (Matsuda et al., 1993). Following official desegregation of schooling, for example, American schools rapidly began unofficially re-segregating. Kwate (2014) reports that black-white dissimilarity rates among primary school children is as high as 85 percent in cities such as Detroit. This has meaningful consequences on the educational experiences of children, including unequal quality of teachers, school supplies, and built infrastructure. These systemic structures permeated the subsidized housing that I observed. Degraded infrastructure, restrictive rules, and safety concerns were more frequently cited by subsidized housing participants residing in racially diverse subsidized housing. They inhabited cheaply-built structures that were underserviced and neglected by municipal, private, and state agencies alike. These participants navigated racism on a daily basis through the disparate quality of environments inhabited.

Facing Adversity. Minority participants with a weak sense-of-place felt unsafe living in close proximity to drug trafficking, crime incidents, and foreclosed lots. Shirley (72y, North Minneapolis), a recent African immigrant in North Minneapolis subsidized

housing, noted: “The neighborhood’s no good. Too much drinking, fighting, smoking, using abusive language. It’s not good. People drive by shooting at things.” Shirley’s fearful situation represented a temporary situation while she tried to sort out a better residence. She did not feel that it was a good place for her or other older individuals but given severely restricted finances had no other options. Her observations reflect Talja Blokland’s (2008) study of place-making in New Haven (Connecticut) housing projects. Blokland investigates how housing projects in the US suffer from stigma and negative images. Some participants purposefully did not feel attached to neighborhoods because that would require consciously situating themselves in a “fucking depressing” place (p. 31). When asked about their dream place to grow old, her participants often responded with the idealized suburban dream: a porch, clean-cut lawn and white picket fence, family nearby (but not too close), and abundant greenery and water features. It represented a vision of stability, safety, and success.

Blokland’s (2008) study draws attention to the broad fact that home in the traditional sense – a connection and rootedness to one’s place of dwelling – is routinely denied to the poor and people of color in American settings. Structural racism in my study impacted opportunities to live in stable, safe, and comfortable homes as participants battled vermin-infested buildings, crime-embattled neighborhoods, and severe lack of healthful services and amenities. Participants such as Millie (78y, North Minneapolis) felt frightened and unsettled by house break-in’s. Her neighborhood had socioeconomically declined with the intrusion of transient renters, crime, and abandoned lots. Now alone at home in widowhood, Millie felt invaded and her sense of security reduced. She told me that the police were disinterested in her following up on calls and complaints. She felt ignored, abandoned, and fearful of escalating dangerous situations. Here Kimberle Crenshaw’s (1993) framework of intersectionality is useful to address the multiple systems of oppression that Millie endured. As an elderly African American woman, Millie faced a ‘triple jeopardy’ given vulnerability to the structural, political, and representational forces of race, gender, and age. These intersecting forces left Millie and other women feeling particularly vulnerable to violence and harm.

Minority male participants, in contrast, were more likely to express that a certain level of vandalism and petty theft was normal and feel unperturbed by minor incidents. Longtime resident Timothy (77y, North Minneapolis) explained: “Doesn’t make a difference what neighborhood you live in, you’re going to have some type of vandalism.” He strategically invoked memory and imagination to cultivate a sense of belonging and a re-assuring sense of living in a ‘good place’. Timothy overlooked local crime hotspots and dilapidated services to focus instead on the strengths of his community. He fondly pointed to worn-down storefronts during the mobile interview and remembered the corner store as a familiar sight of childhood summer trips for soda, teenage employment, and milk runs as a young parent. The now-closed barbershop was still vibrant in Timothy’s mind as it cohered warm memories and youthful ambitions. Timothy perhaps benefited from the agility and strength of his male frame. His embodied abilities enabled him to navigate environments with a degree of confidence and express psychological resilience in the face of environmental neglect. Timothy and others referenced a plethora of ‘incident places’ that spanned their entire lifetimes and contributed to a rich and comforting sense of autobiographical insideness (Rowles, 1983). The quality and intensity of these reflections helped Timothy maintain a largely positive connection to his local environment despite decline and disinvestment. He exemplified a strong sense of belonging (Wahl, Iwarsson & Oswald, 2012) through subjective evaluations and resiliently selective emotional interpretations of the immediate neighborhood.

Barriers to Home. Subsidized housing recipients emphasized prohibitive rules that restricted a ‘homey’ atmosphere. Apartments were not necessarily central gathering points or repositories for treasured memories (Gieseking et al., 2014). Some participants could not inhabit residential spaces in a way to make them feel like home. Personal space in subsidized housing was routinely violated with mandatory home inspections and restrictive rules against modifications and decorations. Participants expressed apprehension regarding landlord inspections for any damage, disrepair, safety hazards, and cleanliness. They disliked having their privacy compromised, feared that landlords would find reasons for lease termination or eviction, and/or felt apprehensive that the

landlord would enter their unit without adequate advance notice. Concerns of snooping or stealing aggravated anxieties. Altogether, inspections felt intrusive and insulting. Rules for personal decoration and furniture designed for health and safety standards amplified the lack of personalization, autonomy, and homeliness. Decorations could be disallowed, for example, because they were not made of fire resistant or fire-retardant materials. 'Excessive furniture' was not allowed due to tripping hazards and obstructions to safe emergency evacuations. Some residents could not risk damaging walls by installing pictures, mirrors, and other ornamentation. When I entered subsidized apartments, participants often apologized for the bare or outdated surroundings. They expressed frustration at the lack of autonomy and minimal level of personalization allowed in the home. Participants stated desires to replace carpeting, repaint, and refurnish to feel more comfortable, such as installing a softer carpet underfoot for arthritic joints. Rules and restrictions in subsidized housing thus limited the creation of a 'homey' autonomous space, and made some participants feel 'stuck in place' without the financial resources to relocate to more comfortable and secure living situations. Elective belonging (Phillipson, 2007) was not an option for all participants.

The concept of elective belonging was clearly expressed by Savage and colleagues (2005) in their exploration of lifestyles and identities in the context of globalization. They argue that people increasingly make conscious choices about where the want to live, and the lifestyles they wish to live by. One's place of residence is a prominent feature in announcing, reaffirming, and expressing identity. This conceptual approach is helpful in studying affluent older adults who migrate to retirement communities based upon their personal biographies and lifestyle preferences (Phillipson, 2007). It is not as relevant, however, to low-income older adults who have little autonomy to choose their residential situations. Limited finances restricted selectiveness in this study, with some participants living simply wherever they could afford or were accepted. As discussed above, racial minorities tended to inhabit more restrictive and degraded subsidized housing environments. Others were homeless without any personal site for expression. Many participants explicitly stated that their current housing

situations were not to their choosing, and contrary to their desires and needs. Homes were frequently a depressing and uncomfortable place where one would rather not be.

Emotional Insecurity. Ambient sounds of yelling, banging, and gunshots, as well as being robbed by neighbors, made participants feel defenseless and insecure. Richard (77y, Downtown Minneapolis) explained on his mobile interview: "There's been robberies and attacks right outside here. Right outside [the front of my apartment building]. In fact, one of the residents was severely beaten and robbed right here [*indicating the street in front*]." As a result of his fears, Richard was largely homebound and did not enjoy living in his apartment. He felt unsafe and desperately wanted to move back to southeast Asia in order to be closer to his friends and youthful aspirations. His situation countered assumptions of the home as an anchor of identity and source of wellbeing (Hay, 1998). These observations relate back to 'critical geographies of home' discussed earlier, in which one's dwelling can generate anxiety and fear (Brickell, 2012). As a result of violence, the home became a site of fear and danger (Mahoney, 2017). Socioeconomic barriers limited Richard's ability to achieve safety, continuity, and control over his domestic situation and optimize place attachment. Aging 'in place' for some was thus an isolated and precarious existence (Aldwin & Igarashi, 2012).

The homeless participants in Downtown Minneapolis felt keenly vulnerable to their surroundings. Their safety strategies included queuing for early entry to the shelter and going to sleep in the late afternoon to avoid rowdy nighttime crowds. Ian (60y, Downtown Minneapolis) locked himself in his small single room at the homeless center by dusk and did not use the communal bathroom at night to avoid the regular fights and crime just outside in the hallways. Iris (68y, Downtown Minneapolis) bounced between hospitals, group homes, and homeless shelters since eviction from her last apartment for hoarding. Living in her current shelter for the past seven months, Iris struggled to feel comfortable or safe. She had not showered due to the lack of secure women's facilities:

> They have one room for the men, and then way over there [*indicating a room approximately 10 meters away*] another room for the women. We eat together, but then men want to stay in the dining room and always come into the women's

> room. I have to walk from here all the way to over there [*indicating a room approximately 20 meters away*] to go to the bathroom. That's no privacy. I haven't taken a bath since I've been here because there's no privacy. [I'm] waiting [to shower] until I get a place because I don't trust it. There's no privacy.

As a result of physical and emotional insecurity, Iris stated that there was "no point" in conducting the mobile interview because "nowhere around here matters". She travelled daily around downtown in search of free meals from churches and charity organizations. The shelter was a constant source of distress and restricted autonomy: "I'm sad I'm in this shelter. I can't do what I want to do." Because of repeated evictions, Iris was barred from moving back into Minneapolis public housing. Lack of security and safety were constant sources of frustration, disappointment, and fear. Both Iris and Ian desperately wanted their own private apartments and reliable places to call home (Wahl & Oswald, 2016). The inability to own or rent a home, and thereby participate in normative civic life (Hayden, 1995), inhibited the cultivation of residential belonging 'in place' (Relph, 1976). Some participants also refused to develop place attachment to their housing because it would "imply a recognition that they are in fact the type of person the projects are 'meant' to be for in the dominant discourse of subsidized housing; losers with whom no-one wants to identify or be identified" (Blokland, 2008, p. 31). Homeless participants did not want to be associated with vagrancy or destitution. They had internalized ideas of shelters as places for the undesirable, unsuccessful, and unbalanced. Instead, participants shifted conversations during the interview towards future plans of securing long-term housing, achieving financial solvency, and becoming more stable. They longed to take care of themselves and their families, and "have a life". Homeless participants were attached to optimistic housing plans for the future that better matched their ideals of personhood and living situation.

Service Access

Participants discussed local amenities as essential residential elements, including grocery stores, medical sites, senior centers, gyms, coffee shops, retail locations, libraries, post offices, and public transit. They were important everyday reference points in

participants' lives (Gieseking et al., 2014), and imbued senses of belonging, interpersonal connection, and purpose.

Vital Locations. Retail and recreation sites were essential activities and destinations built into everyday habit. Service destinations not only functioned practically; they were also primary sources of entertainment, sites of comfort and belonging, and reasons to 'get out the door'. Senior centers in Eden Prairie and Downtown Minneapolis were valued locations to gather and interact with others, learn new skills, and have fun. Male participants especially mentioned these locations, such as spending every weekday morning in the woodshop "with the guys" seeking companionship and purpose. Frank (77y, Downtown Minneapolis) built his routine around daily walks to the senior center for a free cup of coffee and chance to socialize. Retail sites were vital to individuals such as Brenda (73y, Eden Prairie): "If I get really depressed or down, I leave the building. Get in my car and go. I go to a lot of thrift shops, [food shelves], Goodwill, or just browse around [the local department store]." Brenda felt 'at home' in these shops where she was greeted by familiar employees and storefronts. She transformed local retail spaces into meaningful places, and through regular visits developed insider status (Hay, 1998). For those who could safely and comfortably access them, stores and shops were sites of entertainment and connection. Participants often went every week. Such trips represented a stimulation strategy and method to connect with others: employees and staff, regular customers, neighbors, and ambient multigenerational contact. Opportunities to build social relationships cultivated a rooted sense-of-place in varying geographic locales (Low & Altman, 1992; Hay, 1998).

These observations follow Relph's (1976) research method of 'a phenomenology of place' to interpret human everyday experiences that go typically unnoticed. It intuitively makes sense that participants built a sense of community and belonging through local retail sites and recreational facilities. For low-income older adults, these are some of the only affordable and safe spaces available to them to see and interact with others. Yet this finding is rarely voiced in geographical gerontology and is frequently overlooked in aging in place literatures and policy documents. Just as suggested in

Relph's (1976) *Place and Placelessness*, geographical gerontologists must take a step back to call into question the taken-for-granted nature of places and their significance in later life. Participants experienced retail and recreation sites at a greater depth than the surface-level activities offered in each locale. Grocery shopping, for example, can involve much more than the act of buying food and household items. Participants relayed stories of catching up regularly with store employees to exchange detailed life information, feeling special and connected when the butcher already knew their standard orders, and soaking up the ambient contact of other shoppers. Participants purposefully went at specific times to see set people and were happily "known regulars" and "locals". They cultivated insideness by feeling safe, enclosed, and at ease. Sense of community and interconnection through these local sites that enabled everyday life 'in place' (Kyle & Chick, 2007; Scannell & Gifford, 2010) that was considered essential to wellbeing.

Affection and rooted connection to a local coffee shop shone through Rachel's (74y, Downtown Minneapolis) mobile interview. Rachel lived alone and was estranged from her children. She found community through the little coffee shop on her block. After walking in, the staff greeted Rachel with familiarity and warmth. An employee immediately began her usual coffee and cookie order while asking about her upcoming dentist appointment and opinion about a nearby art show. Rachel frequented the coffee shop daily, accumulating a monthly tab that she pays immediately after her welfare check arrives. This shop represented a site of comfort, care, and attention, and one of the primary reasons she enjoyed her apartment and wanted to remain living there. Rachel mentioned memory concerns and struggled to live alone. Rotting food, dirty surfaces, and perilous stacks of belongings flagged my attention to her perilous living situation. Despite these risks, Rachel planned to "live to 100" years old in the apartment. She was content with her situation given the coffee shop downstairs and two grocery stores within walking distance. These observations complicate assumptions that place attachment is fundamentally good. Due to a deep sense of belonging, Rachel put herself at risk to remain in her apartment. She and others prioritized rootedness and insider status even in suboptimal living conditions and hazardous residential situations.

Limited Options. In North Minneapolis, participants were frustrated by the lack of nearby grocery stores. Jeremy (72y, North Minneapolis) reported the dearth of nutritious food services: "If you're living on Mountain Dew and potato chips, you're fine. If you're looking for fresh fruit and vegetables, lean fresh meats… it's much harder to do." Fast food, convenience stores, and liquor outlets were dominant, with participants travelling downtown or further into the suburbs for groceries. Jeremy lived in a food desert. This term was first applied in the early 1990s in Scotland by a resident in the public housing sector (Cummins & Macintyre, 2002). Food deserts generally occur in poor urban areas where residents cannot buy affordable, healthy food. It encompasses the type and quality of foods available, in addition to the number, type, and size of food stores available to local residents (Walker et al., 2010). The growth of large-chain supermarkets in more-affluent suburban areas has led to smaller, independent neighborhood grocery stores to close given that they cannot compete with supermarket quality, variety, price, parking, and extended business hours (Guy et al., 2004). Areas of affordable varied food are therefore restricted to those who have access to a car or are able to pay for and manage public transportation.

Residential segregation, poverty, and neighborhood deprivation have contributed to food deserts. Many low-income and minority neighborhoods across the United States lack access to food outlets with a variety of affordable and healthy foods (Walker et al., 2010). These residents are instead exposed to higher concentrations of 'empty calorie' foods (processed food items that frequently contain high contents of fat, sugar, and sodium) in convenience stores and fast-food restaurants (Drewnowski & Specter, 2004). Maintaining a healthy diet can thus be difficult to achieve. This is especially true among disadvantaged older adults. They are less physically able to travel long distances for grocery stores. As discussed in Chapter 4, even a short walk can be intensely difficult. Participants were more vulnerable to the structural conditions of their local environments and acutely felt the effects of living in a food desert. Disability compounded the challenges of the built environment's physical inaccessibility, especially for those who did not drive and struggled on public transit. In the limited research to-date on disability and food deserts (e.g., Coveney & Dwyer, 2009), mobility limitations – especially not

able to drive a car – meaningfully impact access to food, and health disparities and inequalities more broadly. Disabled participants in the study frequently reported that the distant locations of supermarkets inhibited their abilities to achieve material needs, and generated feelings of exclusion and dissatisfaction.

Jeremy was focused on his health given recent scares: "I spend a lot of time trying to eat well, exercise, be healthy, and make healthy choices so that my quality of life will stay good for as long as possible. That's where I spend my energy." He felt increasingly unsatisfied by the lack of local healthy food options and pessimistic about the suitability of his neighborhood. This generated a growing sense of outsideness (Relph, 1976), in which Jeremy had begun to feel separate or alienated from his neighborhood. But it was a complex and conflicting experience, as Jeremy still felt immensely rooted to his community. Place attachment was not as simple as inside/outside or placed/placeless. Instead of a straightforward dichotomy, participants exhibited a gradient of place attachments in which they bonded with sites to varying degrees. While Jeremy was displeased with the lack of healthy food sites, he still treasured his neighborhood and felt 'at home' in his longtime community. He consciously weighed community strengths and shortcomings in his evaluation of North Minneapolis residence.

Participants repeatedly expressed frustration at the shortage of amenities and lack of investment in North Minneapolis' low-income areas. In addition to grocery stores, this included a dearth of coffee shops, cafes, and restaurants. Raquel (74y, North Minneapolis) noted:

> There are a lot of seniors that are our friends who are isolated. I think it's because we don't have places where you can just go sit down, have a cup of coffee, see who comes in, visit with one another.

The lack of services was a barrier to cultivating a sense of inclusion, belonging, and enjoyment in the community. It is well-documented that poor and minority neighborhoods have increased exposure to unhealthy advertisements for alcohol and tobacco (Morello-Frosch et al., 2002), fewer pharmacies with fewer medications (Morrison et al., 2000), and, as discussed above, limited access to affordable and healthy foods (Walker et al., 2010; Guthman, 2011). These patterns exemplify how racism is

endemic in the United States and deeply engrained not only legally, culturally, and psychologically (Tate, 1997), but geographically as well. It structures urban form as a fundamental principle of our society (Winant, 2015), to which minority older adults are highly vulnerable.

One exception to the underservice and disinvestment in North Minneapolis was a newly-opened YMCA with a senior-specific gym and exercise classes. Ingrid (66y, North Minneapolis) explained:

> They built a YMCA for us 50-plus… The people there, we're all older. It's just like a big social club. We work out, but we also laugh and have fun. It's just a bunch of old people getting together and hanging out. I always felt that laughter is very healthy for you. I feel rejuvenated going there, both mentally and spiritually. It's just like a safe haven to go to, plus we get healthy.

Participants visited "the Y" for exercise, and to socialize with fellow attendees and friendly staff. They appreciated the culturally-relevant and age-appropriate services offered to local African American residents. This site embraced the local black community in a shared space of love and empowerment (hooks, 1990). It was a space for participants to gather, socialize, and feel valued by their community.

Churches across North Minneapolis also provided meaningful connection and belonging through a network of services and support for residents. Members stated that their faith communities "look out for you" and "check in" on a regular basis. Participants both provided and received supportive services such as rides, meals, luncheons, organized activities, and grief counselling through their churches. Local organizations, shops, and centers catering to seniors contributed meaningfully to feeling able to age well in the home and community. Participants cultivated place attachment to multiple locations beyond their homes and immediate environments. They leveraged local community strengths, including the YMCA and churches, to overcome disadvantages such as the lack of grocery stores and coffee shops. African American participants sought out shared spaces where their blackness was celebrated and appreciated. Participants purposefully cultivated diverse place attachments to a number of positive places to create satisfying feelings of community.

Social Connection

Local social networks enabled participants to feel rooted in the community and happy with their living situations. Nearby family, friends, and opportunities for purposeful and ambient contact generated social insideness (Rowles, 1983).

Essential Community. Participants such as Raquel (74y, North Minneapolis) cultivated strong friendship groups and felt firmly embedded in the local social fabric. Raquel relied on a network of close friends during widowhood: "I have very good friends. I've been widowed since [the 1970s], and had I not had those friends, it would have been very difficult for me. And then they're like family… very close good friends that care about you." Overall, North Minneapolis participants reported the lowest levels of isolation and loneliness. Primarily African American, these participants were often deeply entrenched socially and enfolded within local multigenerational networks. They reported satisfaction from regular interactions with grandchildren, family, friends, neighbors, and community members.

Racial inclusiveness was a valued element. Participants purposefully chose homes in the diverse area and stated desires to continue living in a racially inclusive community. This was a top priority given negative racist treatment in previous living situations. Some participants recounted stories of social exclusion and derogatory remarks experienced while living in other parts of the Minneapolis metropolitan area. These observations reflect Delgado's (1988, p. 407) observation that "white people rarely see acts of blatant or subtle racism, while minority people experience them all the time." It was rare for white participants to substantively address race in their interview statements, whereas race was an undercurrent or overt topic of conversation in many interviews with minority participants. The quest for harmonious living to cultivate mutual identification with a community of shared group morals, norms, and expectations (Rowles, 2017) was perceived as quite difficult for black people to achieve outside of North Minneapolis. Minority participants were aware of widespread conscious and unconscious racism (Lawrence, 1987) that impacted on where they could comfortably and inclusively reside.

Longtime North Minneapolis residents were fiercely proud and passionate about their community, and expressly rejected what they viewed as unfair media portrayals and negative racial stereotypes of North Minneapolis. Reflecting hooks' (1992, 1994) observations of representational politics and internalized racism in popular culture, participants resented derogatory depictions of North Minneapolis portrayed in the media. They reported that news coverage, adhering to dominant white culture, sensationalized violent incidents (e.g., shootings, stabbings, drug busts) and applied harmful ghetto stereotypes. Participants resented unjust labels of North Minneapolis as homogenously dangerous and home to gangs. In strong opposition, both African American and white North Minneapolis residents felt that it was the ideal place to live given the robust multiracial and multigenerational community. This resilient attitude was common among long-term residents and those enmeshed within strong family networks. Sally (67y, North Minneapolis), for example, had supportive neighbors and immediate family that helped with chores, transportation, and watched out for each other: "I know everybody in [my neighborhood]. No one will mess with you, we're just like family, we really are. Everybody helps each other." These participants relied upon a web of supportive community connections and 'common sense' to feel secure and interconnected.

Participants benefited from intimate social and cultural networks built up over time. This led to concerns about having to move due to declining health and independence, and the incumbent social and emotional upheaval. In contrast to the social and familial benefits, suitable age-friendly housing stock (e.g., one-floor apartments), assisted living, and appropriate services in North Minneapolis were lacking, which led to physical difficulties for aging 'in community'. What was 'good' about the community – leafy streets, single-family homes, quiet neighborhoods – were age-specific to accommodate an earlier phase of life. While North Minneapolis was often described as an ideal location to raise a family, participants increasingly realized that it may not be a 'good place to grow old'. They worried that their neighborhoods could not physically accommodate changing needs and that they would burden family members. The lack of nearby services described previously exacerbated concerns about the inability to age 'in community'. Participants requested that affordable, age-friendly, one-floor apartments

and assisted living options with access to necessary services be built to enable them to remain in the community close to kin.

Staying Connected. Participants living geographically far away from family and friends struggled with loneliness and felt less rooted 'in place'. Several female participants in Downtown Minneapolis and Eden Prairie moved to be closer to their children and expressed the heartache of missing their 'real home' and longtime friends. They lamented at how difficult it was to be a transplant and break into already-existing social groups, which lowered residential satisfaction. The feeling of homesickness contributed to outsideness (Relph, 1976). Built form affected opportunities for socialization, such as shared hallways and courtyards in apartments to regularly interact with neighbors versus more-isolating single-family homes. Participants in subsidized highrise buildings took advantage of elevator conversations with neighbors and building staff to socialize.

Harsh weather, including intense summer heat and winter snow, challenged participants' abilities to stay connected and content. Participants curtailed activities to only necessary trips during inclement weather to ensure their safety, which diminished opportunities for socialization. Rebecca (77y, Downtown Minneapolis), for example, felt 'cooped up' and was afraid to venture outside:

> Before, I volunteered at [a hospital], I volunteered at [a theatre] and at the food bank. I was very active and social, but now… I had to quit a lot of them because I had a knee replacement and a hip replacement. Now I'm a little afraid to be on the ice, but yet I'm bored to tears staying home. I do take an anti-depressant, and I had to double it last year because of the winter and everything. I felt very trapped.

As discussed in Chapter 4, harsh weather decreased Rebecca's mobility significantly and she lamented her loss of contacts and opportunities for daily interaction. Her experiences reflect Klinenberg's (2002) observations regarding the prevalence of solitude and social deprivation suffered by older adults. His account of notes scribbled by Chicago police officers during the 1995 heat wave painfully exemplify the circumstances under which vulnerable older adults live and die alone in isolation and indignity. The deceased heat

wave victims were frequently described as recluses with no known relatives. Many bodies were in full rigor mortis after decomposing for days after death at home. Klinenberg (p. 41) articulates that these notes are "brutally succinct testaments to the forms of abandonment, withdrawal, and isolation" that elderly people endure. When someone dies alone and at home, it is a powerful sign of social abandonment and failure.

Elderly people living alone are more likely to be depressed, isolated, impoverished, fearful of crime, and lacking of sources of support. The combination of isolation and depression often form a vicious cycle (Klinenberg, 2002), as exemplified by Rebecca. She occupied a unique position: her building was previously entirely subsidized housing and then transitioned into high-end market rentals. Rebecca lived in one of twenty units still subsidized and knew that she had "won the lottery" to be a low-income woman living in a luxurious apartment building. Yet Rebecca was desperately unhappy and preferred the old entirely-subsidized model because of the organized social activities and sense of community. She previously felt 'at home' and connected to other residents, and all of her needs accommodated: existential insideness (Relph, 1976). Rebecca alluded to a previous context of deep, unconscious immersion in place. This flipped to existential outsideness when the building transitioned to high-end units: now she felt a sense of strangeness and alienation (Hubbard et al., 2008). Though not a newcomer to the building, in its socioeconomic upheaval Rebecca had become a stranger. She no longer felt involved or any sense of belonging. Rebecca expressed feeling foolish at her desire to move into less nice subsidized housing but emphasized that community and companionship were her top priorities.

A major fear for isolated individuals such as Betty (78y**,** North Minneapolis) was dying alone: "What I am most afraid of is that I die inside my home, without anybody else living here or coming to the house, and that they won't find me until I've been decomposing for a few days." To combat this, Betty and others developed buddy-systems with friends and family. They checked on each other regularly through phone calls and visits to feel more comfortable and safe. Pets also provided comfort and companionship. Participants stressed the importance of living somewhere that afforded regular social interaction and interpersonal connection.

A benefit to many in subsidized housing was having building staff nearby and resident social workers that provided socialization and bonding. When asked whom she sees on a typical day, Gertrude (63y, Downtown Minneapolis) replied: "The office staff. They are saving my life, and I tell them that. They are the key to keeping myself alive here." Gertrude praised specific front-office workers that provided warmth and social support as she battled mental illness. She was completely devoted to her building as a result and happy to live in a supportive atmosphere.

The Tipping Point. One's level of social connectedness often represented a 'tipping point' for participants dealing with challenges of the built environment. They did not have the resources of more affluent participants to invest in social strategies such as seasonal travel to warmer destinations, restaurant meals with family, and cultural events with friends. When low-income participants felt isolated and unsupported, they tended to feel unhappy with their residential situation and advocated for moving. Lack of social insideness (Rowles, 1983) was crippling. Shannon (71y, Downtown Minneapolis), for example, was fed up with the smoke infiltration and vermin infestation of her subsidized apartment building. Her frustration multiplied after her daughter moved out and she no longer had any friends in the building. Feeling separated, alienated, or excluded undermined residential wellbeing. Conversely, those with robust social connectedness overlooked and overcame built environment challenges. The elevator in Frank's (77y, Downtown Minneapolis) building often broke and he could not climb the seven flights of stairs safely. Though the building did not accommodate his physical needs, Frank thought that it was an ideal location for him because he had cultivated a valuable network of friends and relationships in the building and local area. He desired to maintain 'rootedness' despite suboptimal living conditions (Fang et al., 2016).

Ingrid (66y) lived in a dilapidated North Minneapolis house with molding walls, gapped floorboards, and broken concrete steps. She overlooked this and considered it a good place to live because of her longtime community: "I'm comfortable. I feel safe here. I was born here – I'm probably only 3 or 4 miles away from where I grew up. I know lots of people. My church is here; my whole life is here." The proximity and depth of social

connections were major factors in any sense of rootedness and satisfaction with living situation despite physical risk. These observations relate to bell hooks' (1990) conceptualizations of home and homeplace. She posits that the homeplace is a potential and often unrecognized site of resistance for black women and black communities. These environments are constructed by black women in order to provide a space for learning to love and respect blackness and heal from the wounds inflicted by white supremacy. Homes can be a shelter from the widespread lack of public open-mindedness and enduring legacies of race, racism, and (in)formal segregation. Open to blackness and difference, the homeplace can be a site of empowerment and identity. Participants such as Ingrid remained rooted in the margin (hooks, 1990) even though these places had changed and disintegrated over time. Ingrid refused to consider leaving her decaying home due to an unwillingness to abandon long-cultivated insideness. She perceived that to abandon the home would be to give up her identity (Rowles, 1983). In fact, the physical decay of Ingrid's home precipitated even stronger emotional attachment to the home as she felt defensive of the house so tied to her self-identity (Proshansky, Fabian & Kaminoff, 1983). It was a site of resistance and empowerment where Ingrid felt safe from the harms of the outside world. She was determined to remain rooted 'in place' and uphold the structures of her life so carefully crafted over the years.

Stimulation

Participants cultivated well-honed routines in and around their homes and immediate neighborhood. Fulfilling and meaningful habits were vitally important to residential satisfaction and development of place attachment.

Home-Based Routines. Participants cultivated everyday habits and customs within the home. Small-scale activities such as reading, writing, knitting, cooking, gardening, watching television, talking on the phone, and receiving/providing care meaningfully filled the day. Participants often recounted daily migration through the home at uniform and regulated times – such as Warren (65y, Eden Prairie) who ate "breakfast at 7 o'clock in the kitchen, followed by reading the newspaper in the sunny

front room, 11 o'clock lunch, afternoon chores, and 3 o'clock tea in the shady back room." He felt immensely happy to enjoy his own space after successfully applying for a first-time homeowner's subsidy. He alluded to the importance of a familiar and comfortable environment with reliable spatial and temporal structure.

Participants honed rich micro-geographies around their homes. Nicola and Steve (both 85y, Eden Prairie) demonstrated their deep residential attachment during the mobile interview. Due to Steve's severe mobility limitation due to kyphosis (an abnormally curved spine), they provided an interior tour. Steve took frequent breaks in chairs strategically placed throughout the home. They spoke emotionally of treasured belongings, sentimental artwork, and family photos. Their accumulated lives were on display as Steve "do[es] more remembering than doing" these days. He expressed contentment to surround himself with pictures of grandchildren, friends, and departed loved ones. Autobiographical insideness (Rowles, 1983) reverberated through Nicola and Steve's mobile interview as they paused frequently to discuss the photographs and memories of the people and places that shaped their lives. Rich cognitive and affective ties to home instilled a sense of identity, purpose, and a meaningful life (Kyle & Chick, 2007; Scannell & Gifford, 2010).

Everyday Purpose. Participants found reasons 'to get up in the morning' through routines around their neighborhoods and broader communities. Sally (67y, North Minneapolis) went to great effort to keep busy despite a pinched nerve and diminished mobility. She began organizing regular trips on assisted transit to visit family, exercise at the YMCA, play bingo, socialize at the senior center, and gamble at the casino after her husband passed away: "It helps me keep going. I think now if I didn't do this, I would probably be crippled. Just sitting around doing nothing. I have to get out." These daily efforts helped her maintain a sense of connection and purpose in her local community. Sally and many others stated their reliance on affordable and free activities given limited resources. They particularly appreciated subsidized rates for public transit and recreational amenities, such as YMCA membership and bus trips organized through the senior center to cultural events (e.g., concerts, plays, art galleries, and museums).

Participants also mentioned a breadth of health conditions that frequently made getting 'out the door' difficult, including hearing impairment, blindness, intellectual disability, and chronic illness (e.g., arthritis, fibromyalgia). Less-able participants felt anxious when crossing streets or boarding the bus because of the physical dangers as well as the strangers that stared at them. They felt scrutinized during every move as a 'clunky old fogey'. Those with hearing impairments struggled to follow conversations, especially in crowded settings and urban environments where hearing aids amplify the cacophony of ambient voices and sounds. Not wanting to draw attention to their 'inadequacies' or feel embarrassed, participants might sit in a cone of silence unable to engage with those around them. As a result, participants might find it easier to simply stay home. As Klinenberg (2002, p. 60) observes: "Many seniors find that retreating into isolation and refusing support is the best means of saving face. Better to be alone… than to be disgraced." It is challenging to maintain one's self-worth and dignity in a society that denigrates people with visible needs. American culture thus inhibits the abilities of elderly people to 'get out the door' given the idealization and prioritization of independence and self-sufficiency.

Braving Hardship. Those without long-term or autonomous housing could cultivate meaningful routines, connections, and place attachment. Iris (68y, Downtown Minneapolis), for example, countered her lack of stable housing and unsafe homeless shelter by focusing on her positive connection to the downtown senior center. Iris travelled there daily to take advantage of the free snacks, socialize with peers, and enjoy a safe and supportive environment. She made friends and appreciated experiences of belonging. When she arrived each day, Iris entered into her community to belong, see, do, help, and be cared for (Cutchin, 2003). The senior center was a spatial metaphor for home: the enduring place in which Iris felt that she belonged (Imrie, 2004).

Denise (72y, Eden Prairie) was distressed that disability following a stroke and limited resources kept her cooped up inside:

> I wish I could get around. I wish I could walk over to [the lake]. I've always done a lot of hiking for vacations. It never dawned on me that I wouldn't be able to drive or walk. That's not fair.

As discussed in Chapter 3, Denise wanted to live in a building with more amenities, services, and entertainment; but lack of resources made this difficult or impossible to achieve. She felt unhappy with her current residential situation in a low-income subsidized apartment building but did not want to become overly anxious or distressed. Denise instead entertained herself with plants on the windowsill, knitting when her arthritis permitted, and mailed books from the local library. This qualitative account of her embodied experiences represents a means to challenge dominant narratives of disability as personal tragedy (Wilton & Evans, 2009). She deftly navigated around severe mobility and cognitive impairments (in addition to economic hardship) to resiliently cultivate meaningful activities and fulfilling routines. She did not let her embodied limitations spiral into a cycle of decline and despair.

Denise was a long-term renter with a history of frequent moves depending on variable finances and health status. She had a set of family photographs that carefully moved with her each time. Each environmental change involved a process of transference of being 'in place' (Rowles, 2017): Denise felt 'at home' in whatever space (e.g., hospital, nursing home, new apartment) as long as she had these significant objects. In creating place attachment and a sense of home, these cherished objects (and the memories and routines attached to them) were more important than the physical space itself or duration of residence (Aldwin & Igarashi, 2012; Wahl & Oswald, 2016). The personal artifacts enabled Denise to feel competent, in control of, and personally connected to her living environment despite economic and functional limitations (Golant, 2011; Cutchin, 2003). Denise determinedly developed 'at homeness' (Seamon, 1979) by seeking out comforting and familiar surroundings and objects. They were an essential part of her routine and identity.

Negotiated Place Attachment

This chapter aims to better understand how older adults make meaning out of and evaluate their residential environments. Understudied low-income aging individuals voiced their experiences, needs, and expectations of an ideal place to live. Their perspectives and the spaces that they inhabit represent a powerful vantage point from which to critique and rework conventional place attachment narratives. Seated and mobile interviews captured participant perspectives *in situ*, from sitting on the floor of a homeless shelter to witnessing a drug deal while walking along a downtrodden street. The empirical approach documented terrain that is often overlooked or marked as unimportant in geographical gerontology and made room for difference by recognizing diverse standpoints. Analyses illustrated unequal access to and potential risks of place attachment generated by underlying social, political, economic, and cultural contexts. Cultivating insideness in one's home and neighborhood was not uniformly possible given structural conditions of class, health status, race, and disability. Aging 'in place' in underserved and degraded contexts common to low-income and minority neighborhoods was hazardous to health and wellbeing.

Risk

Home traditionally incorporates ideas of permanence, ownership, privacy, refuge, comfort, autonomy, and identity (Rowles & Chaudhury, 2005). Scholars expect that one has increasing capability over the lifecourse to cultivate place attachment at home through well-honed routines, accumulated possessions, and meaningful events that transpire in this location (Rowles, 2017). Geographical gerontology tends to assume that most aging individuals have cultivated a strong sense of insideness; having lived in their homes a long time, the furniture, layout, and belongings represent treasured memories and contentment. This follows an idea of elective belonging (Phillipson, 2007), whereby people seek to inhabit places that mirror their identities and preferences. This chapter exposed how these theories of place attachment are predicated upon a privileged, white mainstream perspective. Findings demonstrated that not all individuals have the resources or even desire to be selective about their residential environments. Factors such as

socioeconomic status and race impacted the choice of living situation and ability to stay put. The abandonment of social services (Klinenberg, 2002) and commercial disinvestment (e.g., food deserts) in low-income and minority neighborhoods meaningfully impacted participant livelihoods and the shifting suitability of one's home and neighborhood over time. Prohibitive settings, including rules imposed in homeless shelters and subsidized housing, also limited the ability to intentionally construct a sense of home. Transitory lifestyles, voluntary moves, and forced mobility to geographically dispersed locations countered normative assumptions of lifelong familiarity and comfort within a locale (Rowles, 1983). Altogether, the findings problematize existing uncritical place attachment scholarship that assumes older adults have stable housing and secure economic resources. They concretely illustrate how place attachment is not inherently positive, nor necessarily attainable according to current uncritical conceptions.

Most of the participants described in this chapter had endured decades of living in deprived and disadvantaged areas. Soja (2009) notes that the socio-political organization of space is a particularly powerful source of spatial injustice, with examples including the gerrymandering of electoral districts, redlining of urban investments, effects of exclusionary zoning, and residential segregation. The accumulation of locational decisions in the capitalist economy generates spatial structures of privilege from local to global scales. Participants' everyday lives were influenced by spatially-fixed axes of inequality and injustice. This did not just occur through favoring of the rich over poor. Rather, the unevenness of opportunity to age well 'in place' was exacerbated by racism, ableism, and ageism. These participants represent a small and socio-politically marginal portion of city dwellers. This resulted in the underservice of marginalized older people as a structural certainty and reinforced everyday norm. Elderly outcasts were victims to fear, isolation, and harm. They suffered acutely from a lack of protection and support in their everyday contexts. Their daily crises and experiences of harm go largely unnoticed or ignored by policymakers, community service providers, and the broader public.

Durability and Adaptability

Despite grave challenges endured, my analyses also emphasize creative ways in which individuals navigated around structural barriers to cultivate belonging and envision 'a good place to grow old'. Individual resourcefulness enabled participants to cultivate localized meaning and belonging. Participants navigated material, socioeconomic, and cultural barriers to construct physical, social, and psychological dimensions of home and community. Limited budgets, for example, led participants to engineer low-cost modifications like a chair in the shower and furniture strategically placed around the house to prevent falls. Subsidized housing recipients navigated around restrictive rules to develop a comforting home environment through photographs, taped decorations, sentimental knickknacks, and family artwork. African American women developed spaces of love and care in their homes to welcome and support family members and the broader black community. This was a quest for counter-space (Lefebvre, 1991) through the appropriation of places and ability to invent new forms of space that generated enjoyment, comfort, and belonging. They re-appropriated spaces to suit their own needs. Participants resourcefully cultivated support networks through neighbors, friends, family, and professionals. They exercised agency through "reactive and proactive aspects of using, compensating, adapting, retrofitting, creating, and sustaining places" (Wahl, Iwarsson, & Oswald, 2012, p. 309). Participants navigated a complex geographical process of agency and belonging to resiliently achieve a sense of belonging, autonomy, independence, and safety. Generating insideness was an active and creative process (Rowles, 2017).

A resilient stance involved some trade-off's, such as Millie's (78y, North Minneapolis) prioritization of social connection and stimulation. She was firmly rooted in her home and felt that this was overall the best place for her despite poor safety and service access. The neighborhood had changed around her as it declined socioeconomically with transient renters, an influx of drug deals and petty crime, and abandoned lots. Millie's favorite stores down the block were permanently closed and the street was no longer a thriving site of families and mowed lawns. The neighborhood endured longstanding neglect from lack of municipal services and commercial

investment. Millie's memories of the neighborhood and emotional attachment to her longtime home prevented her from moving into safer and more accommodating settings. She was attached to a self-created place that was now a fictional remnant of the past (Rowles, 1983). Vivid memories of the neighborhood as prosperous and socially alive caused Millie to color her image of the present with a more positive hue. She identified with a vibrant multigenerational African American community that was no longer there. Her idiosyncratic sense of autobiographical insideness was so strong that it masked the growing risk of remaining 'in place'. In summary, the findings prompt critical re-evaluation of place attachment given the vulnerabilities that it can expose and exploit. More attention needs to be devoted to race, culture, ability, and age as they are engaged and negotiated in this production of space.

Conclusions and Next Steps

This chapter intervenes in geographical gerontology and human geography more broadly by focusing on a wider set of experiences and perceptions of place-making. Analyses revealed individualized geographies of aging and complex person-place negotiations framed by deeper intersectional axes of gender, race, ability, and age. By attending to overlooked older people and places, the chapter exposes experiences and terrains that are often hidden. Issues such as financial deprivation, transient housing, commercial disinvestment, and residential segregation came to the forefront. Diversity to date in the sub-field of geographical gerontology is primarily treated as inter-individual differences at the person level; little is known about the ways in which person-place interactions vary by cohort, culture, socioeconomic status, and other contextual variables (Wahl & Oswald, 2016; Scharlach & Diaz Moore, 2016). Human geography has yet to substantively engage with navigations of place attachment in old age, especially regarding the confluence of age with race, class, and disability.

There are deeply uneven opportunities to reside in a 'good place to grow old'. Deeper understanding of this phenomenon will involve unpacking the sociopolitical context of places: the histories, politics, exclusions, and cultural expectations integral to the present-day spaces in which older adults reside. As I will focus on in the next chapter,

American homes and neighborhoods are largely designed with illusionary 'Peter Pan' standards of *average residents* who are economically solvent, enjoy good health, and will not grow old (Antoninetti, 2008). They are organized to perpetuate a powerful gendered, raced, sexed, abled, and aged status quo, which prevents flexible adaptation of residential environments to suit the abilities and needs of an increasingly diverse aging population.

There is a rise of older populations who live alone and without proximate or reliable sources of support. The Pew Research Center (Stepler, 2016) reports that over 12 million Americans aged 65 and older live alone, which is a dramatic rise from 6 percent of the population in 1900 to 26 percent in 2014. Sixty-nine percent of older people living alone are women. One-third of those living alone are financially comfortable (in comparison to nearly half of those living with others), and 12 percent of those living alone report that they do not have enough money to meet basic expenses (in comparison to 5 percent of those who live with others). In the context of privatization, extreme inequalities, and concentrated zones of affluence and poverty, marginalized older adults face everyday harms. They endure invisible crises and unspoken indignities, such as Iris' inability to safely and privately shower in the homeless shelter. Soja's writings on spatial justice (2009) are again useful as a starting point to imagine a fairer and more equitable spatial distribution of resources and the opportunities to use them. While it is important to voice descriptive examples of spatial injustice, we need to go deeper to identify and understand the underlying historicized processes producing these unjust geographies. Enjoying spatial structures of privilege and advantage are predicated upon class, race, gender, disability, and age. There are no easy solutions to the present-day challenges and injustices endured by those aging in the margins. They require deep and structural changes, which I shall tackle next in Chapter 6.

Chapter 6. City of (In)Difference: Invigorating the Urban

Looking Backwards to Move Forwards

Knowing the ending of my dissertation eased the process of writing each preceding chapter. I first devoted my attention to investigating person-place strengths and challenges facing the older adults who participated in the study. My task was not to *supply* the ideas; but rather to be patient enough to *find* the ideas. I read and re-read hundreds of pages of transcripts and fieldnotes to find critical narratives and intervening arguments. I sent draft materials and publications to check in with participants who remained in contact. Grounded in participant voices throughout the writing process, I paid particular attention to those vulnerable and disadvantaged aging in the margins. My dissertation is not a narrative of victimization, deprivation, or decline. While recognizing the challenges of aging, I see creativity, resourcefulness, and resiliency coming to the forefront. Participants' messy perspectives interrogated how we understand aging in place and intervened in current theorizations on the body (Chapter 3), therapeutic landscapes (Chapter 4), and navigations of everyday spaces (Chapter 5).

Kate Derickson (2015) argues that the point of attending to the politics of ethnicity, race, citizenship, class, and gender is not to map how social axes are attached to particular bodies in urban spaces, but rather to illuminate how the material production of built environments *depends upon* parallel productions of complex inequalities and intersections of difference. She uses the example of Ferguson (Missouri) where the city's financial solvency depends upon racialized difference to make it politically feasible to exploit and terrorize black residents in order to raise municipal funds in times of financial crisis and austerity. City officials explicitly tasked the police department to use nuisance laws and traffic violations as a method to raise municipal revenues. This reveals the mutually constitutive relationship between neoliberalism, racialization, and urban governance in American cities (Derickson, 2016; see also Heynen et al., 2006; Hankins et al., 2012; Bonds, 2013; Brahinsky, 2014; Inwood, 2015). Social difference is crucial to the reproduction of capitalism.

This chapter speaks to changing socio-spatial manifestations of ageism in American cities and workings of the political economy. By connecting historical to present-day modes of housing older populations with broad economic arguments, this chapter crystallizes the role that old age plays in both culture and the political economy. I argue that age is an openly-stated and deeply important social relation shaping present-day urban development. The ageist production of space is contributing to the reconfiguration of Minneapolis' urban core. This chapter exposes how sociopolitical constructions of old age are integral to the everyday functioning and perpetuation of modern capitalist urbanization processes. Tackling and destabilizing aging is essential to deepening geography's interrogation of the political economy of cities in the present conjuncture.

Whose City Is It? Advocating for Spatial Justice through a Politics of Difference

I seek a fuller understanding of modern-day urban processes in order to lay the groundwork for future projects that expand human rights and socio-spatial equality across the entire life course. Derickson's (2015) work drew my attention to a 2002 article in the *Professional Geographer* by Clyde Woods entitled "Life after death". In this, Woods questions whether the social sciences (and geography more specifically) can truly hear the struggles and wishes of the disadvantaged through the theoretical noise. In describing the destruction of black communities across American cities, Woods (p. 63) expresses:

> My encounters have forced me to seriously question a social science literature that is, for the most part, seemingly incapable of hearing the cries emanating from the soul of this nation. The same tools that symbolize hope in the hands of the surgeon symbolize necrophilia in the hands of the coroner. Have we become academic coroners? Have the tools of theory, method, instruction, and social responsibility become so rusted that they can only be used for autopsies? Does our research in any way reflect the experiences, viewpoints, and needs of the residents of these dying communities? On the other hand, is the patient really dead? What role are scholars playing in this social triage?

Woods (2002) contends that scholars must attend to the textured plurality of struggles and desires in our work. This includes careful consideration of race, class, gender, sexuality, multiple ethnic identities, religions, places, and political positions. For Woods, the concept of black community represents dynamic complexities and intersections. Studies of informal and formal patterns of violence, discrimination, and bias are narrowly defined in social science literatures. Woods (2002, p. 64) elaborates that scholars need to further trace the violation of human rights through instances such as the denial of adequate housing, systematic destruction of low-income housing, homelessness, denial of access to subsistence programs, environmental racism, mass incarceration, industrial redlining, and so on. These 'bulwarks' of inequality may be hidden by disciplinary practices but are firmly embedded in the consciousness of repressed groups entangled in growing webs of inequality. Without a historically grounded multidisciplinary approach, studies can mask active oppressive practices enacted by the local state and investments of capital. Woods (2002) insists that we listen to black people and understand black lives otherwise we risk extending white privilege in our scholarship. In her reading of Woods, Derickson (2015, p. 828) poses a fundamental question: do our theoretical tools help us understand, or obscure, what is really at stake in social struggles?

My dissertation project began by listening directly to older people. I endeavored to be highly attuned to the complex situations and multi-scalar experiences of my participants. I followed their prioritizations for the topics that I pursued in writing up my dissertation fieldwork, such as embodied vulnerabilities exposed in wintertime and the structural exclusions built into urban form. When engaging with the Phase III policymakers and community service providers, I felt responsible to communicate findings from prior Phase I and II fieldwork. I shared my observations of urban patterns of inequality that endanger and harm vulnerable older adults. This process required recognizing my own privilege, as recorded in my dissertation journal during Phase III data collection:

> I am ever-conscious of my privilege – my positionality as a resourced, educated, white, youthful doctoral candidate. These overlapping markers give me the 'credibility' to enter into the exclusive professional domains of decisionmakers

with ease. I can engage with them as an equal, and they show every willingness to listen to my findings. Yet I feel guilty as I hear Christina's voice shine through my own, knowing that she cannot enter into this space to tell her own story.

In my dissertation fieldwork and writing practice, I committed to reflexively and consciously checking in with my production of knowledge. I repeatedly journaled about the uneven power dynamics between me and some of my older research participants. Donna Haraway's (1988) and Sandra Harding's (1991) writings on partial knowledges were often in-mind as I wove together observations and knew that my own perspective influenced the narratives that I told. As I discussed in Chapter 3, knowledge is always partial and situated. Scholars too-frequently inhabit a conquering "gaze from nowhere" (Haraway, 1988, p. 581) through an unmarked position of privilege. In *Whose Science? Whose Knowledge?* Harding (1991) envisions emancipatory knowledge-seeking, in which women's experiences provide unique vantage points to investigate masculine bias and question conventional claims about nature and social life. A feminist epistemology recognizes the situatedness of knowledge production and endeavors to make room for alternative ways of knowing. I therefore inhabited a view from somewhere in this process: the view from my body where I tackled my own positionality in the partiality of the knowledges that I produce.

A critical part of my personal growth during each step of the PhD has been to hone my voice in justifying and advocating for disadvantaged older persons. I increasingly recognize my position as both a scholar and advocate. I have emailed and called the Mayor's office regarding my findings, presented to and met with local policymakers and service organization employees, and passed along resources directly to older adults themselves. I have gained the confidence to take a bold stance on the age-friendly city movement.

While age-friendly initiatives on the surface seem laudable in intent and design to make cities more comfortable and supportive for elderly populations, my analyses reveal that they in fact perpetuate exclusions generated by previous modes of urban development and governance. Age-friendly developments are part of gentrification's fluid form based upon the impulses of capitalist production. To lay the groundwork for

these theoretical arguments, I will begin with a description of my Phase III dissertation fieldwork with policymakers and service providers.

Up to the 30th Floor: Engaging the Decisionmakers

After extensive fieldwork immersed in the lives and perspectives of older adults themselves, I was naturally curious about how policymakers and community services providers regard and act on the aging demographic. Phase I and II prompted critical questioning of to what extent municipal organizations address and accommodate the needs of aging citizens. How do policymaker perspectives compare to older adults themselves? In order to address these questions, I conducted semi-structured interviews with ten civic staff and community services providers (see Chapter 2 for details). Unlike the prolonged and consciously-personal interactions of Phase I and II, the set of Phase III interviews was brief and couched in the official language of policymakers. I entered into their workspaces for thirty to ninety minutes for 'easy' interviews. I no longer carried tissues with me to offer a crying participant and did not block off personal time afterwards in my calendar to decompress (as I did routinely in Phase I and sometimes in Phase II with emotionally-taxing sessions to preserve my own mental health). The Phase III policymakers and service providers largely discussed aging in terms of health care utilization, housing infrastructure, assisted living, nursing home models, and transportation networks. They applied a detached and often-clinical 'expert' lens. Aging was viewed from the outside as a pressing policy issue to be addressed.

These participants applied terminology from the age-friendly city movement to develop more accommodating urban communities for older citizens. The WHO (2007, p. 5) defines age-friendly as a community in which "policies, services, settings and structures support and enable people to age actively." As expressed in one interview by the state director of an aging organization (Participant E):

> How do you build communities that are supportive? The key thing with our age-friendly model is that it's not a certificate of achievement. It's a commitment to deliberately engage older adults… We have some research that shows that Boomers and Millennials have some of the exact same community preferences,

> especially when it comes to more urban settings: access to transit, parks and greenspace, all the things that people want in a community. The age-friendly community motto is building great places for people of all ages.

Interviewees were aware of widespread and deep impacts of the demographic change, including a range of housing, transportation, service, and care needs for aging residents. They were highly supportive of aging in place as a policy goal. In this, interviewees stated eagerness to support the autonomy of people to remain in their homes and communities for as long as possible. They generally felt that the Minneapolis metro area and state more broadly were supportive to older adults. When asked 'Do you think that the state of Minnesota is able to provide a high quality of life for its aging populations?', for example, the director of a state-level board on aging (Participant G) responded:

> Well, Minnesota is ranked number one by AARP on its score card, so it's doing it better. There's a couple states that are with us: New Hampshire and Massachusetts and Pennsylvania. But we're at the lead… This is the place you want to get long-term care or healthcare in the nation. Now, is it perfect here? No. But it's the best you'll get. We have very healthy seniors here. I think we're ranked number one now for that.

Participants tended to celebrate the Minneapolis metropolitan area as an age-friendly environment composed of healthy and active seniors. They discussed high rates of civic engagement, family caregiving, and opportunities to utilize the knowledge and resources of aging Baby Boomers.

Seeing Through the Cracks

It was rare to hear Phase III participants discuss the prevalence or needs of disadvantaged older adults. Any discussion that they initiated on challenges primarily focused on the lack of affordable one-story housing with access to necessary services, particularly for aging rural homeowners. One notable exception was my interview with the director of a senior center (Participant D). She described how essential it is to provide a safe and welcoming daytime space for older adults who are living in homeless shelters, group residential housing, or on the street. Her priorities for the center on its limited

budget included computer and cell phone tutoring to get a job, and health and wellness education. Securing funding was an ongoing struggle: "[The biggest challenge is] a lack of resources. I wish we had a social worker here who could work one-on-one with folks. That would be really helpful due to the population we serve." She worried about attendees' livelihoods given that "some people are really financially teetering on the edge, and there's a lot of mental health issues. There's chemical dependency issues. We deal with folks on a day-to-day basis who are really struggling." This interviewee was attuned to the multiple disadvantages marginalized older adults faced, including lack of inclusion in policymaking and decision-making:

> Really low-income and transient people, they don't vote, so they don't really connect with elected officials and policymakers. They're not on the radar as much. It's not a cause that has a lot of broad general public support. They can be voiceless.

While the director did not explicitly address race or ethnicity with me, it was visible that a number of senior center regulars were African American. As discussed in the preceding chapters, impoverished minority older adults navigate multiple oppressions through the confluence of racism, classism, and ageism. The daily barriers they face and crises they endure often go unnoticed by policymakers and the broader public.

On rare occasion, those in higher-level policymaking positions addressed these issues. The director of a local metro agency (Participant H), for example, recognized that those living in poverty could have worse health, and that immigrants or refugees could not navigate local systems set up in English. She expressed: "Marginalized communities, communities of color, GLBT communities – I think any diverse community has needs that the mainstream recognizes but can't meet in any real way; or [their] needs are just not being recognized or elevated." In a rare moment of candid conversation, this interviewee reflected on the failure of state agencies to accommodate and support the full spectrum of aging people. My interview sessions often ended on a somber note as I described some of my observations and findings from Phase I and II. I communicated the multiple barriers and challenges participants faced in navigating old age.

Opportunity to Intervene

While geography has challenged and contributed to examining innovative urban form in many ways, I observed that well-designed lifelong spaces remain exclusive and often-unattainable. The decisionmakers were not fully aware of the multiple ways in which older adults are explicitly and implicitly barred from full participation in civic life. In this chapter, I argue that while the age-friendly city model conceptually embraces old age, in actuality it perpetuates and extends the exclusion of many older adults. It does not adequately redress the harms generated by previous modes of urban development.

This chapter poses these theoretical interventions to urban geography in order to advocate for more just methods to recognize and celebrate diversity, sites of difference (Young, 1989), and the thrown togetherness of people in space and place (Massey, 2005). I critically unpack the popular age-friendly city movement to generate future opportunities for more meaningful places in old age. The culminating intention of my dissertation (discussed in Chapter 7) is to create more room for alternative ways of 'being in the world' based upon a richer understanding of people, place, and space across the life course. It represents a crescendo towards thicker, deeper understandings of the previously-unrecorded histories and geographies of older people's lives and socio-spatial experiences to invigorate the discourse of urban geography.

Ageism and the Built Environment: Longstanding Reciprocity

Just as geographic attention to race, gender, class, sexuality, illness, and disability has exposed how complex societal power relations are spatialized (Butler & Parr, 1998), so too does old age generate a deeper understanding of the city. The built environment is simultaneously a cause and effect of ageist attitudes and uneven power relations. Urban form separates generations across space, such as playgrounds for children and senior centers for retired non-workers. Spatialized age relations structure social and built geographies; and influence the form and function of cities traced by gender (England, 1991), class (Harvey, 1985), race (Ellison, 2018), and sexuality (Oswin, 2008).

Ageism manifests itself in urban structure. Ralph Waldo Emerson (1862) captured this notion early-on in the following (sexist) excerpt regarding the 'places of aging':

> Youth is everywhere in place. Age, like women, requires fit surroundings. Age is comely in coaches, churches, in chambers of State and ceremony, in council chambers, in courts of justice, and historical societies… But in the rush and uproar of Broadway… [f]ew envy the consideration enjoyed by the oldest inhabitant. We do not count a man's years, until he has nothing else to count… In short, the creed of the street is, Old Age is not disgraceful, but immensely disadvantageous" (Emerson, 1862, p. 135, cited in Achenbaum 1978, p. 36).

To better understand fundamental linkages between societal perspectives of old age and manifestations in the urban built environment, I draw upon Glenda Laws' (1993) seminal publication in the *Annals of the American Association of Geographers:* "The Land of Old Age". Laws read the urban landscape through three historical moments in the evolution of North American cities: (1) turn-of-the-century industrial city, (2) post-World War II suburbanization and inner-city developments, and (3) the emergence of gated suburban retirement communities. These historical developments form the basis for contemporary urban structure and deepen understanding of the co-constituted relationship between aging, culture, capitalism, and urban governance.

The changing urban form follows and extends Harvey's (1982) observations that capitalism works dialectically: its regimes are not sustainable over time. Capital builds an environment relevant to its own condition at that moment in time, only to later destroy it – usually given a crisis. The following sections explore how each successive wave of urban development reflects the political economy's treatment of older adults in that period. I build towards a fourth era, the age-friendly city, to deepen and extend the project of reading present-day American urban geographies.

From Industrialization to Urbanization

Up until the American Civil War, older people were generally respected and regarded positively. They were active producers and contributors in the colonial economy (Achenbaum, 1978). The transition from a rural agricultural economy to urban-industrial had profound effects on the type of labor required. Extended family farms were surpassed by urban-based labor markets. Workers increasingly distinguished and travelled between

sites of home and employment, in which they were admitted to their places of work during set hours and under certain terms of employment (Laws, 1993). Employers sought 'efficient' workers who could contribute to the mission of increased productivity and profits (Katz, 1986). Russell and Malhorta (2002, p. 213) note that this mode of production increasingly valued people's bodies for their "ability to function like machines." Employers pushed their workers to produce at ever-higher rates, which increasingly precluded the older worker.

Labor commodification in modernizing capitalist societies de-valued workers with impairments as they were thought to be unable to conform to the demands of the labor market (Abberley, 1987; Oliver, 1990; Barnes & Mercer, 2005). In standardized forms of industrial production, the factory space presupposed and required the normality of the able-bodied worker (Roulstone, 2002). This produced a disabling division of labor, which engendered enduring influences on the labor market for people with impairments and chronic illnesses. With precise mechanical movements required in the factory, the deaf, blind, and those with mobility impairments were seen as less 'fit' and thus excluded from paid employment (Russell & Malhorta, 2002). These labor expectations influenced aging individuals given that physical and cognitive impairments increasingly occur with old age. They, like disabled people, were excluded from occupational associations and paid employment in the modernizing economy (Gleeson, 1999; Barnes & Mercer, 2005). As a result, rising numbers of older adults in the industrial city were unable to find employment and lived in poverty.

An increasing number of older adults found themselves dependent upon their families and private charities. This contributed to changes in attitudes toward old age at the end of the nineteenth century as economic imperatives informed wider social attitudes (Roulstone, 2002). Older adults became associated with disability, disease, poverty, and troublesome burdens on society (Laws, 1993). Social values defined old age as unemployable and unproductive, and thus separated the elderly socioeconomically from mainstream life. This had spatial consequences given the subsequent relegation of old people to separate spaces in industrializing and urbanizing environments at the turn of the twentieth century (Achenbaum, 1978). The elderly poor who were previously cared for

primarily by family members now became dependent upon social models of housing given their families could not, or would not, support them. Laws (1993) explained that public almshouses, also referred to as poor houses, transformed into homes for the elderly. The age profile of poor houses during this period rose dramatically as care for children and a variety of 'special-needs' groups including the blind, deaf, and mentally ill were transferred into specialty facilities (Katz, 1986). The number of institutional, private charitable, and religious housing facilities operating exclusively for the elderly rose dramatically in the early twentieth century (Laws, 1993). Age-segregated housing became a prevalent feature of urban form.

Laws (1993) reported that criticisms of public institutional housing for the elderly gained momentum in the 1920s. Reports emerged that facilities were in disrepair, cheaply made, and poorly maintained. Private institutions were seen as highly preferable but recognized as often-unaffordable. Advocates for improving the care and housing of older Americans corresponded with significant developments in the welfare landscape. Social reformers argued that the new industrial society needed a pension system for those forced to retire from the manufacturing-based economy. In 1925, for example, John Lapp published an article on the "Growing Insistence upon Pensions Instead of Institutional Care for Aged Dependents." He argued:

> The latest recognition of the pension system as a social means to care for the aged makes an appeal to the heart of the public because of the unhappy situation in which worthy aged people have found themselves. It will stand for a long time as a blot upon our history that no better outlook has been afforded for the worthy aged than the associations provided in the county almshouses. The old-age pensions system will not take away the necessity for almshouses for those who are completely incapacitated, but it will take out of the almshouses the worthy aged and it will provide for thousands who now live an uncertain and unhappy existence outside (Lapp, 1925, p. 28).

By the 1930s, Americans generally recognized that assured income was a social requirement in old age. Organizations in charge of operating senior housing actively supported securing a regular income for their residents in order to stabilize their revenues.

The implementation of the Social Security Act in 1935 boosted age-segregated housing. State-guaranteed income encouraged the development of residential care for older adults, particularly nursing homes (Laws, 1993). The elderly and frail increasingly entered care-supportive housing models through their pension incomes. It is therefore evident that changing social expectations of old age given the political economy historically manipulated built form. Shifting societal views shaped – and were shaped by – concomitant shifts in housing and urban configurations.

Expansion of Suburbia

The demographic change of the baby boom drove suburbanization after World War II. Margaret Marsh's (1990) seminal study of suburbia identifies how the nuclear family was at the center of developing the American suburbs as urban form catered to young parents and their children. The distance between workers and their jobs in the central business district grew, in addition to the distance between generations (Laws, 1993). Nearby grandparents were rarely in the picture as suburbia promoted green yards, playgrounds, and schools (Antoninetti, 2007). Large yards and car dependence were designed in conformity with illusionary standards of mobile and affluent middle-class mainstream families. Fincher (1998) notes that suburban developments fixed life stage assumptions so that certain periods of our lives are associated with particular housing patterns, behaviors, and activities. A suburban child in the 1950s, for example, was set on a path to attend school and then seek employment (particularly for men) and marriage (especially for women). These normative expectations were reinforced by surrounding social institutions including schools, bureaucracies, the media, and workplaces.

The term 'segregation' is often applied to racial and ethnic segregation, but here age-related segregation also comes to the forefront. Vanderbeck (2007) observes that in contrast to vigorous debate regarding how best to measure, conceptualize, and understand racial and ethnic segregation, a paucity of attention has been devoted to the study of age segregation. This perhaps reflects the extent to which certain kinds of age segregation are viewed as natural, inevitable, and unproblematic (Hagestad & Uhlenberg, 2005). Suburbia generated multiple forms of age segregation. It placed children and youth in

schools, yards, and streets to play; women in the domestic homespace; and working-age men in workplaces. Suburbanization was ageist just as it was sexist and racist, and served to exclude and ignore older populations.

Seldom during the initial phase of post-World War II suburban development did advertisements attempt to lure older people from their existing residences (Laws, 1993). They were largely ignored in the rush to capitalize on young families moving to the suburbs. Many older adults continued to live in the inner city, which was increasingly characterized by deviance, joblessness, and community dysfunction. Older people and racial/ethnic minority communities were abandoned to the inner city as whites, enterprise, wealth (Fincher, 1998), and youth fled to the peripheral suburbs. Jakle and Wilson (1992) argue that suburbanization left a trail of decaying and abandoned neighborhoods, and a new urban underclass. The inner city became plagued by chronic underutilization, long-term disinvestment, widespread vacancy, and substantial demolitions. People literally disappeared from the streets, in which the downtown became a shell of its former self. The neglect of post-war industrial downtowns was reinforced by urban planners and social workers who helped to cultivate and promulgate a separationist ideology along racist and classist lines. Widespread negative imagery of deprived African American communities depicted the inner city as pathological, dangerous, and nefarious (Gotham, 2000).

Suburbanization resulted in the destruction of housing and community, in addition to the collapse of public health, in the inner city. Wallace and Wallace (1995), for example, study the process of urban decay in central cities. They detail 'hollowed out' centers of physically and socially devastated, politically and economically abandoned, high-density minority neighborhoods that were surrounded by rings of relatively affluent majority white suburban populations. In New York City, Wallace and Wallace (1989) find that the inner city was characterized by homelessness, the mentally ill, rapid diffusion of AIDS, crime, and violence. Fires broke out with regularity in the late 1960s to early 1980s, particularly in an epidemic of abandoned buildings and equally abandoned services like firefighting. This posed constant threats to the marginalized individuals abandoned to live in these deteriorating neighborhoods.

Older low-income individuals are particularly susceptible to violent and deteriorated urban areas. As Klinenberg (2002) notes, they suffer acutely from the dangerous ecology of abandoned buildings, commercial disinvestment, and degraded infrastructure. Broken sidewalks, for example, are more difficult to navigate with a cane, walker, or in a wheelchair. Age-associated declines in immune system function result in increased vulnerability to illness (Montecino-Rodriguez et al., 2013), particularly for those living in overcrowded homes and underserved by public health programs. The inner city 'ghetto' conditions thus imperiled older adults already oppressed by processes of racial exclusion, ageist disregard, and class-based segregation.

Age-Segregated and Gated Retirement Communities

Preoccupation with housing young white families post-World War II initially minimized attention on where to house older adults. Starting in the 1960s, marketing experts were beginning to note the potential for windfall profits from growing numbers of customers over the age of 65 (Laws, 1993). A shift ensued, in which expectations of structured dependency of old age transitioned to viewing older adults as potential consumers. Opportunities to commodify the senior lifestyle and extract 'value' from aging residents occurred in part because of improvements to income-maintenance programs and shifts in federal transfer payments (Laws, 1993). The incidence and rates of poverty sharply declined. Between 1959 and 1983, for example, the proportion of those aged 65 and older below the poverty line dropped from 35 percent to 15 percent (Ellwood & Summers, 1986). By 1989, 11.4 percent of those over the age of 65 lived below the official poverty line (Golant, 1992). As a result, large-scale, amenity-heavy private subdivision developments aimed exclusively at older adults became a profitable model.

Sun City Arizona opened on January 1, 1960 with five home models, a shopping center, recreation facility, and golf course. Built on the site of former ghost town Marinette, developer Del E. Web planned and built "The Retirement City: A New Way of Life for the Old" (TIME, 2018). Given its immense popularity, Sun City Arizona spawned into Sun City West in the late 1970s, Sun City Grand in the late 1990s, Sun City Anthem in 1999, and Sun City Festival in 2006 (Trolander, 2011). Marketed as "The

Original Fun City!", Sun City Arizona's website (2018) explains that the community was designed for "active adults" over the age of 55. It is dedicated to "a more leisurely lifestyle and unending choices of recreation for the retired, active adult" (n.p.). These housing developments proliferated from the 1960s to early twenty-first century as retirement communities became a sought-after form of suburbanization (Trolander, 2011). They derived a profit by housing older people in extremely expensive suburban campuses. Retirement thus became a commodity: an arena for policymakers, marketers and developers to exploit.

To extend Laws' (1993) observations, I see the rise of neoliberal dominance in social policy and the political economy as having a vested interested in these 'lifestyle' communities. Gated suburban retirement communities promulgate existential concepts such as self-responsibility, self-governance, and self-care. They advance the shift from structured dependency on institutional forms of housing and care to private models. It has become the responsibility of older people to take care of themselves, underpinned by minimal state intervention via a rolling program of privatization, deregulation, and contraction of welfare services (Powell, 2006). Market-oriented, consumer-based approaches to senior housing and the delivery of care have changed the imagery, expectations, and housing structures of later life. Sun City Arizona (2018, n.p.), for example, boasts eight golf courses to "play a different course every day of the week", seven recreation centers, state-of-the-art fitness centers and pools, and over 130 chartered clubs for "a constant stream of events and activities to fill your day with ways to be active." These sites are maintained by property taxes and assessment fees. Housing options range from small one-bedroom apartments and mobile homes to luxurious multi-bedroom houses. Sun City Arizona's (2018) website reports that housing prices vary between $35,000 and $350,000 depending on size and location, which coupled with low sales and property tax rates, make the community "even more affordable." They note that resident volunteers play a large part in the cleanliness, low crime rate, and successful operation of numerous programs. As the "City of Volunteers", costs to maintain the sprawling complex are significantly lower than other American communities comparable in size.

In this model, older adults are the target of marketing campaigns to lure them into lifestyle-oriented communities. These housing developments reject notions of 'age as decline' in favor of 'age as opportunity'. Individually, activity offers a lifestyle strategy to combat illness, reduce health issues, and sustain mobility and independence. At the societal level, it represents a tactic to minimize public health and social welfare costs for the aging population (Jolanki, 2008; Katz, 2000). Manicured golf courses, exercise classes, pools, and regular activities are predicated on the strong prevailing notion that 'if you rest, you rust' (Rudman, 2006, p. 191). For those who can afford it, there is ample senior-exclusive infrastructure available that supports active aging. It rests upon principles of health, independence, vitality, and consumption power.

Consumerist ideals conveniently ignore issues of poverty, racism, and social deprivation. These gated retirement communities enforce and perpetuate homogeneity in race and social class, along with age (Trolander, 2011). The marketing imagery largely surrounds heterosexual white couples socializing, being creative, and staying physically fit. A development executive for Arizona's Sun City told a reporter in 1964 that the sales management should explain to prospective African American buyers "what they are getting into, because, let's face it, a Negro would be miserable in Sun City" (cited in Freedman, 1999, p. 65). In 1974 Sun City California, outside realtors were handling resales and willing to show homes to prospective African American buyers. The residents, however, subjected minorities to hostile stares at the clubhouse and shopping center. Residents forcefully communicated that blacks "would be happier elsewhere" (Trolander, 2011, p. 964). This is an example of what sociologist Jerry Jacobs (1974, p. 50) termed 'genteel discrimination'.

As a result of pervasive racism, Trolander (2011) reports that in 1980 less than one percent of Sun City Arizona's population of 47,000 was African American. Racial homogeneity continues to dominate these communities across the country. In 2000, Century Village in Florida was 95.6 percent white, and The Villages (also in Florida) was about 97 percent white. One Villages resident commented: "There are a lot of people just like us" (Blechman, 2008, p. 6). These sites reflect the perpetuation of widespread racism and racial segregation inherent to American society (Harris et al., 2012). Implicit and

explicit racial bias against minority populations, in addition to formal age-restriction zoning, prevent large segments of the population from residing in these gated communities. The hefty price tag to purchase units in many gated communities further excludes lower-income people.

The planning and perpetuation of these restrictive retirement communities overlooks the growing risk of hardship in old age. Neoliberal ideals have cut state finance and forced people to use their own private funds in the management of housing and welfare. Powell (2006, p. 54) notes that while neoliberalism at the surface level is equated with freedom and agency, the rollback of public services can leave the poor and marginalized in vulnerable, 'choiceless' positions. They are excluded from the neoliberal menu of rights, self-responsibility, and 'freedoms' equated with being a 'responsible' consumer. Given the increasing socioeconomic and spatial polarization between privileged and disadvantaged aging populations, a growing number of marginalized older adults are overlooked, ignored, and underserved.

According to the Organization for Economic Cooperation and Development's ([OECD], 2017) *Preventing Ageing Unequally* report, inequality among current retirees in the US is higher than all other OECD countries except Chile and Mexico. In 2014, over 25 million Americans over the age of 60 were economically insecure living at or below 250 percent of the federal poverty level ($29,425 per year for a single person) (National Council on Aging, 2016). Under the supplemental poverty measure, 7.1 million older adults (14.5 percent of those over the age of 65) lived in poverty in 2016, and these rates were notably higher for women, blacks, Hispanics, and people in relatively poor health (Cubanski et al., 2018). Older women receive, on average, $4,500 less than older men in Social Security benefits due in-part to lower lifetime earnings, sexism, and/or time taken off work for caregiving. Older minority workers are more at risk for unemployment, with older African American men twice as likely to be unemployed as older white men. One-third of senior households have no money left over or are in debt after covering essential expenses, and in 2013 61.3 percent of households headed by an adult over the age of 60 had some form of debt, with a median value of $40,900 (National Council on Aging, 2016). The gated retirement model distinguishes between senior

citizens who can contribute to wealth and power, and those who cannot. Poor and ethnic minority elders are largely excluded from the apparatus of active aging.

The Age-Friendly City

With the 'tidal wave' of aging Baby Boomers, a new socio-spatial configuration of aging is emerging. Instead of seeking large-scale suburban retirement communities, older adults now increasingly express desires to remain nested within their existing homes and neighborhoods (Golant, 2011). One example of this aging in place is the Villages movement, which emerged in 2001 when a group of residents in Boston's affluent Beacon Hill neighborhood formed a nonprofit to support access to services. Members paid an annual fee in exchange for services such as transportation, yardwork, and accounting (Thomas, 2011). The Village serves as a liaison – a concierge – between aging homeowners in need of help and able-bodied Village members, younger neighbors, and community service groups. The Village also provides lists of vetted home maintenance contractors, many of whom offer discounts to members. There are now approximately 220 Villages across the United States (Thompson, 2017). Primarily found in affluent urban areas, the Villages are united by a common goal: "a determination to age in place" (Thomas, 2011, n.p.).

Aging in place is a mainstay of the age-friendly movement, which is employed by global organizations (e.g., WHO, 2007), national entities (e.g., AARP, 2014), and local municipalities (e.g., City of Minneapolis, 2017) to redevelop and "modernize" cities. The AARP (2014, n.p.) guide to age-friendly communities advises: "As the US population ages and people stay healthy and active longer, communities must adapt. Well-designed, livable communities promote health and sustain economic growth, and they make for happier, healthier residents – of all ages." There are 231 communities currently listed in the AARP (2018) Network of Age-Friendly Communities. This geographic model has shifted from suburban gated retirement communities to the development of age-friendly infrastructure within existing urban areas. It applies the WHO's (2002) active aging policy framework to optimize opportunities for health, participation, and security through built and social environmental interventions. The age-friendly city planning guide (WHO,

2007, p. 9) encompasses eight categories: (1) housing, (2) social participation, (3) respect and social inclusion, (4) civic participation and employment, (5) communication and information, (6) community support and health services, (7) outdoor spaces and buildings, and (8) transportation. The guide provides checklists in each category of core features (with accompanying technical documentation to help implement urban changes) to achieve the universal standard of an age-friendly city.

Crisis Management

Why the shift in urban governance of old age? There is now a growing crisis with pools of unutilized and long-lived Baby Boomers finding limited 'productive uses' in the capitalist system. Fears of employment shortfalls, overtaxed healthcare systems, and the depletion of Social Security abound in popular culture and economic forecasts. As the World Economic Forum (2011) stressed, the 'tidal wave' of global population aging poses immense peril and comprises "one of the most significant risks to global prosperity." (p. 2). In the report, the founder and executive chairman states: "If policy-makers and leaders fail to plan adequately for the changes ahead, they will be inundated by the effects of global ageing, such as a dearth of workers, strained pension systems, and overburdened health care systems" (p. 2). Given widespread fears of an economic crisis, there is mounting pressure to "act now, in a creative and productive manner" (p. 2). The age-friendly cities movement has become a highly-sought after model of development to "fix the problem" (p. 10).

In *The Limits to Capital* (1982a, 1999), Harvey traces the circulation of capital in various urban and economic formations, and the successive waves of investment and accumulation. This can include splurges of investment in buildings, roads, and other infrastructure. While the initial investment may be expensive to build, the return on this investment over a number of years can far outweigh initial costs. A multi-million-dollar convention center or sports arena, for example, can be profitable long-term by attracting conference goers and sports fans, in addition to associated local spending. With the crisis of the 'silver tsunami' in the minds of policymakers, there is a strong push to remake the urban environment. They see urban infrastructure modifications as an opportunity to

advance economic growth and minimize public expenditure on healthcare and services for the aging demographic. The growing number of affluent older adults also provides new opportunities for profit given the demand for age-friendly, upscale urban design. Maximizing access to pleasant and clean environments, such as Rio de Janeiro's beaches or proximity to the river in Melville and London (as cited in the WHO's [2007] *Age-Friendly Cities Guide*), attracts people to live in and visit these idealized spaces. Older adults are expected to buy or rent homes here to 'age in place'. They can become more active as a result with nearby desirable amenities and smooth paving, and therefore become healthier through the pursuit of active aging practices. Age-friendly residential buildings with elevators, ramps, wide doorways and passages, nonslip flooring, rest areas with comfortable seating, and adequate signage (WHO, 2007), can be highly marketed and drive up housing prices (as I will discuss regarding the Minneapolis context in the following section). These investments can stave off an economic crisis – what Harvey (2001) famously termed a 'spatial fix' for capitalism's contradictions – by catering to affluent Baby Boomers' desires and needs.

On the surface, the age-friendly model is a generous model to reform cities to become more convenient and comfortable for older populations. Critical investigation, however, reveals economic motives that are primarily designed to benefit the state, not older citizens. Age-friendly developments minimize expenditures on health care and social services while generating new forms of capital investment and growth. They are the newest form of exclusionary gated communities. Rather than walled suburban communities, urban highrises employ locked entryways, surveillance tactics, security guards, and concierge staff to become new enclaves of the rich.

The Next Generation of Gentrification

Age-friendly is a new tool through which to revamp central and inner cities. Neil Smith (1996) observes in *The New Urban Frontier* that gentrification overhauled many urban areas in Europe, North America, and Australia. He positions gentrification as part of a shift in the political economy and culture of the late twentieth century. It is not a simple outcome of newfound tastes and demands for urban living. Rather, it expresses the

impulses of capitalist production. Smith (2002) traces the history of gentrification through three waves, with the first beginning in the 1950s. Sociologist Ruth Glass (1964, p. xviii) originally described gentrification as a discrete process:

> One by one, many of the working-class quarters of London have been invaded by the middle classes… Shabby, modest mews and cottages – two rooms up and two down – have been taken over, when their leases have expired, and have become elegant, expensive residences.

The new urban 'gentry' transformed previous working-class quarters. Smith (2002) argues that a second wave followed in the 1970s and 1980s as gentrification partnered with broader process of urban and economic restructuring. Following political economic crises in the 1970s, conservative national administrations coming to power in the 1980s dismantled liberal urban policy. Public policy barriers to gentrification were replaced by subsidized private-market urban transformation. The third wave emerged in the 1990s as gentrification generalized and expanded globally. Smith (2002, p. 427) observes: "The process of gentrification, which initially emerged as a sporadic, quaint, and local anomaly in the housing markets of some *command-center* cities, is now thoroughly generalized as an urban strategy that takes over from liberal urban policy." Gentrification represents a global urban tactic that is ambitiously and scrupulously planned.

I regard the age-friendly city movement as part of gentrification's evolving form. It expands demand for trendy chic by making urban areas attractive to late middle-aged individuals beginning to look ahead to retirement and later life. As mentioned by Phase III's Participant E earlier, the prevailing notion is that Millennial yuppies and Baby Boomers are both seeking the same amenities: upscale highrise living, nearby services, and proximity to entertainment and employment, which, for older adults, can transition into sites of flexible retirement and volunteering. In the Minnesota context, the removal and restoration of older buildings in Minneapolis' core has catered to both young professionals and early retirees. Affluent Phase I participants residing in downtown condos, for example, often explained at-length about how their buildings were age-friendly designs. This included widened doorways to accommodate a wheelchair, disability-friendly toilets, reinforced shower walls to enable future installations of grab

bars, and no-lip elevators and doorways. Walking around the downtown together during Phase I and II, participants and I on occasion paused to read the residential retail flyers posted. Advertisements marketed the joys of downsizing to the comfort and excitement of downtown living with ample opportunities to age in place in a one-story condo or apartment.

The age-friendly city movement represents a next wave of gentrification with relatively rapid physical and social regeneration. It does not simply reflect the sociocultural preferences and material needs of older adults for city-center living. Rather, it is a highly profitable form of reinvestment. As Smith (1991) observes in *Uneven Development*, expensive private property investment is typically favored by property developers, local planners, and credit institutions like banks given the potential for high profit margins. In the catchment area for one of Minneapolis' urban Villages (a membership organization for local residents aged 55 and older), the median household sales price ranged from $290,500 to $545,000 in 2017 (Trulia, 2018). Jim Buchta (2018) reports that developers have built nearly 24,000 apartments in the Twin Cities since 2010 – and by the end of 2019 will have completed another 13,000 units. These are chiefly market-rate and luxury apartments in the metro area. The Baby Boomers and empty nesters are credited as a major factor in this apartment and condo boom as they flock to upscale urban living. Developers are capitalizing on the wealth and desires of affluent retirees.

Age-friendly developments largely cater to the 'healthy and wealthy' – early-stage retirees whose bodily capabilities enable them to move around the city physically and socially with ease. They retain power in the form of wealth and decision-making, such as sitting on civic boards and voicing concerns directly to policymakers concerned about getting the 'senior vote'. Given the generally-high prices of the urban core, economic exclusion overlooks and ignores the housing needs of low-income older adults. Harvey (2008, p. 33) describes waves of capitalist development as a cycle of 'creative destruction', which "nearly always has a class dimension since it is the poor, the underprivileged, and those marginalized from political power that suffer first and foremost from this process." In this instance, urban redevelopment efforts catering to the

privileged exclude the needs and experiences of low-income older adults, a majority of whom are people of color. It subtly perpetuates racism through residential segregation perpetrated by economic exclusion. There are likely also covert social mechanisms of racial exclusion. The bottom line of capital investments and financial returns often obviate the need for the latter, however, by welcoming only the privileged – the white few who can afford upscale age-friendly housing occupy exclusive membership – while claiming objectives of racial harmony and equality (Matsuda et al., 1993).

Uneven Development

Celebratory attention regarding age-friendly efforts mask stark urban realities, including the severe lack of affordable housing available. The Section 202 Supportive Housing for the Elderly Program (U.S. Department of Housing and Urban Development [HUD], 2018b) was established under the Housing Act of 1959. It provides direct loans and capital advances from the federal government to support nonprofit entities to build housing for very low-income elderly (defined as 62 and older and earning less than 50 percent of the local median income). The capital advance does not have to be repaid as long as the project serves very low-income elderly people for 40 years. HUD's (2015) *Worst Case Housing Needs* report to Congress notes that the number of elderly very low-income renters increased by 21 percent from 2003 to 2013. A report from the National Low Income Housing Coalition (Couch, 2016) states that there are more than 400,000 Section 202 units serving very low-income seniors. Thirty-eight percent of tenants are frail or near-frail but continue to access community-based services and supports "to keep living independently and age in place in their community" (p. 28). The report also notes that only 36 percent of income-eligible seniors receive the rental assistance for which they qualify (Couch, 2016).

Despite widespread needs for affordable housing, HUD's (2018b) website states that no new funding has been available for Section 202 capital advances since 2012. In other words, no new Section 202 rental properties have been built in a period when demand is rising and far outstrips supply. The program was cut back to maintenance levels when the waiting list for each Section 202 unit was 10 people (Ramnarace, 2011).

The 2019 Presidential Budget Request for Section 202 housing allotted $601 million to the program: $508 million to fund staff assistant contracts, $90 million to renew existing senior coordinator grants, and $3 million for property inspections and related administrative costs (HUD, 2018a). This ignores the fact that new construction and rental assistance are desperately needed to address the insufficient supply of affordable housing for very low-income seniors (Couch, 2016). There is no other program to meet the needs of America's poorest older adults. In addition, HUD Secretary Ben Carson recently proposed raising the rent for low-income Americans receiving federal housing subsidies, and imposing work requirements to qualify for aid (Jan et al., 2018). This threatens the livelihoods of millions of vulnerable individuals.

The age-friendly city movement thus parallels the implementation of neoliberal policies that scale back the welfare state and related public investments (Phillipson, 2013). As the private sector provides increasing facilities and services for higher-income aging populations, governments de-fund affordable senior housing programs for low-income older people. Buffel and Philippson (2016) observe that many cities under the umbrella of the WHO's Age-Friendly list reduced services that directly benefit older people. This includes the closure of libraries, cuts to adult education, leisure sites, senior centers, and home- and community-based care. Austerity policies have blocked well-intentioned plans for age-friendly development and undermined local efforts to improve the built and social environment for older citizens (Tinker & Ginn, 2015). Older individuals are expected to inhabit the role of active consumers of public goods and smart shoppers of market-based services made available to them instead of being citizens entitled to social protection. Klinenberg (2002, p. 232-233) notes: "This market model of governance creates a systemic service mismatch, whereby people with the weakest capabilities and greatest needs are least likely to get them." Policymakers risk losing contact with isolated and outcast elderly populations. State agencies best positioned to redress inequities and protect the most vulnerable have done little to help. There is a continuing lack of political will to provide basic material needs such as food, energy, and health care. The state abandons those most vulnerable to largely fend for themselves.

Age-Friendly Minneapolis

Minneapolis is no exception to this trend. While touted as a prominent age-friendly city in the US (City of Minneapolis, 2017), spaces and resources vital to marginalized seniors have diminished in response to budget cuts. One staggering moment for me personally was learning that a senior center I repeatedly visited had closed. I knew this site as a literal lifeline for homeless and disadvantaged older adults. In this moment, the uneven distribution of resources and scale-back of public support became painfully apparent.

Many high-level policymakers and service providers in Phase III pointed to ample funds available to support aging initiatives during their interviews. Yet the senior center could not secure private donations or public funds to cover its roughly $200,000 annual operating budget to remain open. The City of Minneapolis (2018b) adopted a $1.54 billion operating budget for 2018, an $86.3 million increase from the 2017 Adopted Budget. In searching the 620-page full budget document (City of Minneapolis, 2018a), I found 'aging' written 55 times. In all but one instance, this was captured through "managing" funds, "encouraging public input", "engaging" the community, and "repairing aging" infrastructure and facilities. In just one sentence was the aging population specifically mentioned: "The highest need populations include juveniles, non-English speaking residents, low income and our aging populations" (p. 352). In my reading of the distribution of resources recorded in the document, I observed that the spending on the other three high-need populations overwhelmingly outweighed funds devoted specifically to older adults. However, I do recognize that many older adults are also non-English speaking and low-income.

Regarding 'seniors' specifically, the Mayor recommended a one-time contribution of $20,000 to Senior Support Services, which was increased by the City Council to $40,000. A further $70,000 was given to the Minnesota Visiting Nurse Agency to provide home health care and therapeutic services for eligible high-risk and low-income seniors aged 60 and older who lack medical reimbursement (City of Minneapolis, 2018a). I astoundingly could not find any other instances of investment in senior-specific budgetary items. This is hopelessly inadequate. While older adults certainly benefit from

general municipal services (e.g., affordable housing programs, public safety initiatives, parks, libraries), there is a dire need to fund senior-specific programs. For an officially-designated age-friendly community (City of Minneapolis, 2017), Minneapolis devotes scant resources to support the old. Neoliberal ideals and pervasive ageism are widespread within the municipal realm. There is little concern for North Minneapolis seniors, for example, being priced out of their homes. The City celebrates the introduction of new parks and re-population of the city with young families, yet ignores the older adults being pushed out by rising taxes, uncomfortable multi-story houses, and unsupportive urban design.

Low-income and minority Phase I participants felt increasingly unwelcome in trendy and upscale urban neighborhoods. They felt policed in public (but increasingly privately-owned) urban spaces, such as courtyards, street fronts, and malls. The city has become privatized to the point that space is not freely available. This parallels Mike Davis' (1993) earlier work on Los Angeles: "The city bristles with malice… Downtown, a publicly subsidized 'urban renaissance' has raised forbidding neighborhoods by battlements and moats" (p. 154). Davis provides a vivid description of the 'public' spaces of new megastructures and super-malls that supplanted traditional streets and open gathering spaces. He documents offensive municipal policies that cater to the middle- and upper-class demand for increased spatial and social insulation, and the celebratory language used to enforce racial and class polarization. Gun-toting private police, state-of-the-art electronic systems, and fenced shopping malls enforce this separation. Davis notes that some poor neighborhoods – predominantly black or Hispanic – are even sealed off by the police with barricades and checkpoints. The defense of urban luxury generates an arsenal of security systems and policing tactics.

Minneapolis' model of age-friendly urban governance is also predicated on the spatial exclusion of visible poverty and undesirable inhabitants. As in other American cities (e.g., Stuart, 2013), homeless and other 'undesirables' can be forcibly relocated to marginal spaces in order to revitalize and gentrify prime spaces in the urban core. Shopping malls, office buildings, cultural complexes, and leisure facilities are highly compartmentalized by activity under the watchful eye of private security forces. The

Minneapolis skyways are policed by security guards given that each section of pathway is owned and operated by the highrise looming above. Homeless and transient downtown participants mentioned being yelled at, threatened, and forced to leave parts of the skyways as guards enforced 'no loitering' rules. Some minority participants described these instances, in which racism continually impacted their everyday lives (Delgado, 1988; Tate, 1997). Through an intersectional framework (Crenshaw, 1993), we can again see how class, race, and age intersect to bear violence upon subordinated groups. The age-friendly city of Minneapolis 'bristles with malice' towards them.

Persistence of Ableism

Regardless of gender, race, or socioeconomic standing, aging is still expected to be done in private. The age-friendly city does not accommodate extreme disability or infirmity. It is age-friendly only up to a certain embodied ability level. City inhabitants, for example, are embarrassed to see and deal with public exposures of incontinence or dementia-related confusion and hallucination. Those whose bodies and minds betray them in old age are expected to be in tertiary nursing homes. The age-friendly city (WHO, 2007, p. 6) is explicitly designed towards "maintaining the independence" of 'normal', 'healthy', and 'able' bodies, and "preventing disability". As described in the preceding chapters, opportunities for older people with physical and cognitive impairments to navigate Minneapolis' urban environment is extremely challenging. It is not only physically inaccessible, but socially exclusionary as well when frail, slow, and immobile old bodies are routinely subjected to stares, whispers, rude remarks, and even violence.

These observations resonate in-part with the disability literature, in which scholars critically unpack the experiences of individuals who deviate from the 'norm' (Davis, 2016; Goodley, 2017). The able and mobile body continues to occupy a position of privilege, even in an age-friendly city. Physical inaccessibility and socio-spatial exclusion remain pervasive forms of urban oppression. Cities are rife with barriers to movement including broken surfaces, inadequate curb cuts, hand-open doors, and signage that assumes a high level of visual and cognitive ability. Even transportation modes

designed to accommodate impaired passengers are generally inadequate to accommodate those with acute mobility handicaps. Disability-friendly buses, for example, help those with lowered mobility through reserved seating, hydraulics that lower the bus entrance, and even an unfolding ramp for those in wheelchairs. Yet the snow mounds and icy puddles are nearly-impossible to navigate while entering and exiting the bus (even for those highly-mobile). In peak travel times, maneuvering in a crowded bus can be extremely difficult for those with a cane, walker, or wheelchair – particularly on slick surfaces and when laden with groceries. Phase I participants mentioned fears and anxieties generated by the re-routing of buses for construction and inadequate signage that did not accommodate their (often invisible) cognitive disabilities. Further challenges include extra charges to order a taxi with handicap accessibility and rideshare programs with limited accessibility options. Most accessible Lyft vehicles, for example, have to be booked at least 24 hours in advance according to their website (Lyft, 2018). The drivers are not properly trained to accommodate passengers with disabilities. The assisted mobility transit system in the Minneapolis metropolitan area is overtaxed: Phase I participants frequently mentioned waiting up to two to three hours for their ride pickup. The unpredictable and lengthy wait times generated embodied struggles, such as anxiety for those with urinary incontinence and joint pain for those standing for extended periods. An Eden Prairie participant recounted reading entire books while sitting on her walker waiting for the mobility transit, which generated frequent stares from passersby. This is just one example of many regarding the oppressive character of social and built environments that prevent or limit opportunities for people with disabilities to participate fully in everyday urban life (Wilton & Evans, 2009). Reminiscent of Emerson cited earlier (Achenbaum, 1978), youth and ability continue to be everywhere ‘in place’ while deep old age (marked by embodied physical and/or cognitive limitations) is compartmentalized and relegated to senior centers, orchestra halls, retirement communities, nursing homes, and other ‘appropriate’ peripheral spaces. The age-friendly city thus does not adequately recognize or accommodate the oldest old or less physically able older adults in its current urban form.

Moving Forwards

The uncritically-celebrated age-friendly city movement is only accelerating in popularity and implementation from local to global scales. Underlying political economic motivations and resulting socio-spatial exclusions remain problematically unexamined in both policymaking and academic spheres. In the following chapter, I outline the steps necessary to break down and re-orientate the age-friendly city through a critical urban geographical lens. My final chapter suggests novel academic and political possibilities working towards a more just, inclusive, equitable, and representational model of urbanity.

Chapter 7. Critical Geographies of Aging

Opening Up the Age-Friendly City

The age-friendly city needs to be critically unpacked and re-positioned given exclusions and harms produced by the current model. Here I suggest five methods to address underlying sociopolitical processes of age-friendly cities and train geography's focus on the in-between spaces of everyday later life. Engaging these steps will deepen and extend geography in the present-day context of cities and expand the discipline's address of socio-spatial injustice.

I. Theoretically- and Empirically-Engaged Geographies of Aging

First, we need a stronger and more coherent link between research and policies on urban aging. Though scholarship in environmental and geographical gerontology is beginning to amass an impressive literature, it remains largely detached from critical analyses of the deep impacts of global and local political-economic forces that transform social and physical contexts (Buffel & Phillipson, 2016). Addressing this will require close collaboration and dialogue between a range of disciplines including urban sociology, political economy, urban and regional planning, and human geography. Critical urban geographers have yet to substantively engage with the topic of old age but are well-positioned to do so given their analytical toolsets. This includes much-needed critical analyses of contemporary gentrification under the guise of age-friendly development, the experiences of older adults pushed out to 'new ghettoes' in peripheral suburbs, and devastating funding cuts to Section 202 subsidized housing. Deepening efforts to examine the representations and differences of older citizens in cities will require studying the changing dynamics of urban poverty, consequences of urban renewal and regeneration, informal and formal racial segregation, and the growing transnational mobilities of aging populations. It involves attention to Baby Boomers across the entire socioeconomic spectrum to grasp distinctions between groups of older populations, as opposed to one homogenous view of aging. Careful intersectional consideration (Crenshaw, 1993) of race, class, gender, sexuality, religion, culture and other social

categories of difference that overlap with old age will enhance our understanding of the urban.

Iris Marion Young argues that reformulating justice and democracy must be undertaken using *situated* analyses. In *Justice and the Politics of Difference*, Young (1990, p. 3) contends that conceptions of justice should begin with the concepts of domination and oppression. As a starting point, urban geographers need to examine the oppressions that immobilize or diminish particular groups of older adults. Young's heuristic device would be useful to situate the lived experiences of marginalized older adults within broader structural frameworks of exploitation, marginalization, powerlessness, cultural imperialism, and violence. Combining Young's historically and socially contextualized approach with geography's nuanced approaches to space and place would enable deeper theorizing on the highly entangled production of urban space and injustices endured by oppressed elders.

From an applied standpoint, this dissertation demonstrated the inappropriateness of 'one size fits all' approaches to aging in place and the age-friendly city. Scholarly attention that voices the particularities and differences of old age could develop new calls for justice and more just models of urban development. There are deep structural issues to be addressed in the implementation of any age-friendly city, including enduring racial and colonial injustices. Policymakers need to distinguish between distinct groups of older adults instead of assimilating them all together. This includes particular attention to racial and ethnic minorities, the LGBTQ community, disabled, poor, and very old. Oppressions vary by group, so specific aims and strategies will too. Engaging with feminist, disability, and critical race scholarships in these endeavors will extend and deepen calls for socio-spatial justice in our group-differentiated society. As Young (1997) notes in *Intersecting Voices*, we cannot put ourselves in others' places, but we can communicate across difference: "A condition of our communication is that we acknowledge the difference, interval, that others drag behind them, shadows and histories, scars and traces, that do not become present in our communication" (p. 53). Older adults embody an accumulation of life experiences that produces highly uneven experiences of 'being old'. They occupy a

fruitful vantage point from which to better understand the complexities of urban life across space and time.

II. Urban Complexity

Second, scholars must approach age-friendly in a manner that better distinguishes the complexity of urban environments. Jane Jacobs (1961) observed that cities are a problem of organized complexity. Unlike simple two-variable or disorganized-complexity problems of statistical randomness, urban issues consist of numerous interrelated factors. Aging further adds to the sociocultural, political, and economic complexity. Aging in place is neither possible for nor necessarily desired by those in transient living situations, underserved low-income and minority neighborhoods, and the homeless. Place attachment motivations to remain in a longtime home can generate risks and minimize wellbeing when aging in the face of longstanding neglect. There is a need to put forward new models of intervention that reflect and respond to the highly unequal contexts of older adults and the built environments they inhabit.

A focus on aging interventions need not preclude attention to younger populations. More-nuanced approaches to age-friendly efforts should focus on both current and future cohorts of older residents in working towards long-term urban change. This moves away from intergenerational clashes over limited resources towards a more unified approach in setting out distinct and general needs and concerns and identifies priorities to facilitate action and change. Meaningful intergenerational exposure and engagement can happen in the most unassuming of places, such as the grocery store and elevator. Jacobs (1961, p. 59) writing on the 'sidewalk ballet' stated:

> A good city street neighborhood achieves a marvel of balance between its people's determination to have essential privacy and their simultaneous wishes for differing degrees of contact, enjoyment, or help from the people around.

Jacobs later continued: "Lowly, unpurposeful and random as they may appear, sidewalk contacts are the small change from which a city's wealth of public life may grow" (p. 72). Localized experiences in the between spaces of urban life can be pivotal sites to thwart age segregation. Regular differential contact within and among generations can

destabilize ageism more effectively than empathy from afar. Laurier and colleagues (2002, p. 353) note: “the massively apparent fact is that people in cities do talk to one another as customers and shopkeepers, passengers and cabdrivers, members of a bus queue, regulars at cafes and bars, tourists and locals, beggars and by-passers, Celtic fans, smokers looking for a light, and of course... as neighbors.” Ash Amin (2006, p. 1012) refers to these civil exchanges as ‘small achievements in the good city’. The age-friendly needs to build upon mundane friendliness inherent to many urban public encounters (Thrift, 2005).

To do so, age-friendly ideologies and policies need to move away from broad scales and grandiose visions to these mundane everyday sites of urban life. Focus instead on common (and much-needed) basic projects of urban transformation that enable older adults to ‘get out the door’, such as better-designed curb cuts that do not become clogged with puddles, ice, and snow. An age-friendly city is one that has home maintenance and care services readily and affordably available, an adequate supply of subsidized housing, senior-specific homeless accommodations and housing rehabilitation programs, centrally-located grocery stores and fresh-food corner stores with wide aisles and bright lighting, frequent sheltered benches, and barrier-free sidewalks. Shorter block lengths and cut-through paths would increase mobility options between destinations. Mixed-use spaces could bring together different people in shared purposes to facilitate organic contact, such as a mix of retail, residential, and recreational sites. This will blend boundaries between districts as opposed to massive single-use spaces (e.g., light industrial zones, homogenized suburban developments, and even large-scale forested parks) that do not accommodate a diversity of uses. The blending of spaces may generate opportunities to think of and imagine local sites as contributing to broader environments of expression and diversity that depend upon the political and cultural projects of speaking and listening to one another (Gieseking et al., 2014).

One qualification is that I do not want to over-romanticize the urban encounter. As Valentine (2008) demonstrates, differential contact can leave attitudes and values unmoved, even hardened. We need an urban politics that addresses both real and perceived inequalities and diversity. Urban geography can help to recognize inclusions

and exclusions that occur. The field can push the age-friendly city movement into contemporary debates regarding prejudice, discrimination, socioeconomic inequality, the violences of capitalist priorities, and political power. Through this, we can begin to develop meaningful contact and further build the capacities of those frequently marginalized and overlooked.

Rather than seeking one common value or unity at the city level, age-friendly should instead enable micro opportunities to celebrate differences in identity, activity, and belief. As discussed in the disability movement, a universal approach to urban form is inadequate. To achieve an enabling geography, Gleeson (1998) argues, we must "pursue a geography with disabled people that seeks an inclusive, but not homogenous, ideal of social justice" (p. 113). Universal design is not adequate given the high variability among disabled populations (Davis, 2013), just as one format of an age-friendly city cannot universally accommodate all segments of the diverse aging population. Instead, as inspired by Young (1989), age-friendly cities should encourage people to cluster according to their affinities in addition to regular contact with people of differing approaches and attitudes. Attach senior centers to preschools, for example, where older adults can engage with both peers and toddlers. Invite school groups into senior buildings. Welcome seniors to sit in IKEA cafeterias and McDonald's where they can purchase a cheap cup of coffee and interact with different groups gathering in and passing through those spaces. Convert old houses into communal housing models for older adults to rent a room, and have affordable, well-kept apartments available in their longtime neighborhoods. Train grocery store clerks to recognize signs and symptoms of dementia in order to better engage, help, and connect to elderly customers. Modifying our existing socio-spatial configurations can build much-needed respect for and contact with old age instead of pushing it to the literal and figurative periphery.

III. Elderly Voices

Third, any implementation of age-friendly initiatives necessitates close engagement with older people themselves. Buffel and Phillipson (2016) observe that in numerous studies older adults are invisible or excluded from urban regeneration policy

efforts. Not only is the absence of older adults problematic, but also the pervasive ageism through which older people are seen as merely victims of neighborhood change. Urban practices could benefit from the experiences of older adults, their histories with landscapes, and involvements in informal networks. This is especially important for marginalized people who are often negotiated out of the planning process. They suffer from a utilitarian planning perspective where the 'general public interest' is approved (Fang et al., 2016). In this, minority and othered perspectives (be it age, gender, race, sexuality, class) are ignored. This statement is not meant to create the grounds for tokenistic inclusion of marginalized voices in insincere attempts to claim broad community engagement. 'One-size-fits-all' efforts ignore the heterogeneity of older adults. Sustained engagements with diverse older populations are essential, including awareness of the unique issues faced by different ethnic groups, those with physical and mental health needs, and those living in areas with high socioeconomic deprivation and disadvantage. In my own research, I asked older adults to evaluate their residential environments with basic prompts such as: Do you like living here? What do you think is good about your home and neighborhood for older residents? What concerns do you have about your home and neighborhood for older residents? What, if anything, could be improved in your home and neighborhood to better meet your needs now and in the future? Participants described their ideal ("dream") place to live as they age and articulated what constitutes 'a good place to grow old'. Their ideas at times diverged from mainstream policymaking and existing infrastructures (see Chapter 5).

Effective planning and redevelopment should attend to the psychosocial realities of old age. As Fang and colleagues (2016) note, simply altering the built environment is insufficient to generate more inclusive and supportive spaces for older adults. Meaningful places of old age require psychosocial and cultural considerations that go beyond issues of physical space. Place-making with older adults needs to be made from the inside out (Relph, 1993; Hubbard et al., 2008). Qualitative research approaches, storytelling, and visual methods can capture hidden practices and social processes (Andrews et al., 2007). One example is participatory community mapping workshops. Fang and colleagues (2016) utilized this method to access personal experiences of place, identify cultural and

emotional facilitators and barriers to access, and co-create affordable housing units through dialogue between older adults and service providers. Age-friendly efforts need to go beyond issues of universal accessibility (i.e., environmental adaptations predicated upon progressive disability in old age) to models that focus on environments as positive and fulfilling spaces for later life.

Engagement with these issues can in turn advance theories and applications of urban geography. Derickson (2015) argues that most critical urban theory has inadequately engaged with how its own theories and knowledge production practices are implicated in and potentially reproducing cultural marginalization and misrecognition. She introduces "a different temporality of emancipatory change – not one in which knowledge precedes change but wherein the production of knowledge is the simultaneous site of change" (p. 826). This is part of a project to produce knowledge with and for those most in need to benefit from social change. Visions for more just futures must be generated in conversation with historically marginalized communities (Derickson & MacKinnon, 2015). Urban geography needs to engage underrepresented and vulnerable elders including the impoverished, racial minorities, disabled, transient, and unwell. Using an approach grounded in everyday urban experience, marginalized older adults can then share a platform with knowledge-makers and decision-makers to discuss ways of facilitating positive change (Fang et al., 2016). This could counter age-friendly initiatives that assume older adults have good health, significant free time, and secure financial resources. The AARP *HomeFit Guide* (2015), for example, is not relevant or appropriate to those without the financial resources and/or autonomy to install home modifications, those over-burdened with more urgent commitments (e.g., caregiving, employment, healthcare), and those who would prefer to move to a new home entirely. Homeless and transient Phase I participants were in desperate need of senior-specific services, housing, and information. They mentioned caseworkers and social workers that had "no clue" how to help them secure a better living situation. Interventions that meaningfully involve these populations could develop more specific and appropriate age-friendly policies that reflect the 'on the ground' conditions of our cities.

IV. Emancipatory Possibilities

Fourth, academia needs to ensure that older adults themselves are at the center of the research process. They are best-positioned to identify areas of need, prioritize urban issues, and guide appropriate implementation (Menec et al., 2011). This echoes a call from disability scholars who advocate for participatory and emancipatory research. In this paradigm, individuals with disabilities and chronic illnesses figure not just as respondents. They take on active roles as stakeholders with influence over the research questions, kinds of knowledge produced, and ways to which study results are marshalled (Wilton, & Evans, 2009). Derickson and Routledge (2014, p. 2) provide three useful prompts to triangulate research questions for scholar-activist emancipatory aims: What are the current theoretical debates or intellectual questions? What do non-academic collaborators want to know? What publics and institutional projects are served by knowing? This involves recognizing the value of intellectual and academic inquiry closely aligned with community-based methods of questioning and knowing.

Applied methods drawing from participatory research can actualize deeper engagement in knowledge production. The mobile interview in my dissertation fieldwork, for example, attempted to democratize participate-researcher power dynamics (Finlay & Bowman, 2017). Participants shaped the literal and metaphorical direction of the mobile interview (Holton & Riley, 2014). No one is better suited than older adults themselves to articulate their own experiences, needs, and desires. In pushing feminist projects of knowledge production, scholars need to become more responsible in generating knowledge about old age. Involving older adults as co-researchers, leaders, and visionaries will challenge underlying biases and ageism in academia. Maximizing opportunities for meaningful input from older adults needs to also respect any embodied constraints and social barriers to participation. Participatory projects, for example, may assume that people have the time and energy to be involved in the entire research process (Wilton & Evans, 2009; Davis, 2016). It is critical to find innovative ways to train and compensate older adults as researchers to minimize harms and foster greater inclusion. There is an opportunity to mobilize their expertise, skills, and understandings to stimulate co-productions of knowledge and urban space. In other words, involving older adults can

advance opportunities for more just and inclusive ways of knowing, and generate greater equality in the urban experience.

V. In Pursuit of Justice

Fifth and finally, old age needs to be incorporated within contemporary debates over critical urban scholarship and social justice. This will contribute to what Soja (2010, p. 19) terms the 'new spatial consciousness': an awareness that "the geographies in which we live can intensify and sustain our exploitation as workers, support oppressive forms of cultural and political domination based on race, gender, and nationality, and aggravate all forms of discrimination and injustice." Cities can be disabling and threatening at any age, but even more so for older adults given embodied vulnerabilities. Older people may feel an even greater sense of entrapment, harm, or disadvantage produced by urban decay and abandonment. Critical studies on topics such as poverty, loneliness, vulnerability to crime, heteronormative nursing care models, formal and informal residential segregation, and elder abuse can stimulate important discussions and new imaginations of more sustainable and inclusive urban environments.

Gieseking and colleagues (2014) note that it is often easier to grasp the abuses of justice in faraway places but fail to contemplate similar injustices closer to home. Aging operates in a similar manner given widespread discomfort to examine our own aging and confront perhaps deeply-engrained ageism. With the rapidly expanding aging population, geography's lack of critical attention to old age is noticeable. This reluctance to tackle old age may reflect unconsciously systematic gerontophobia in geography. Aging is not a comfortable or sexy topic. At times it can feel hopeless, particularly in contrast to working with young populations who hopefully have many years ahead to benefit from interventions and change. Aging can force us to confront uncomfortable personal realities, such as the plight of a severely isolated elderly family member who we forget to call. Despite any discomforts, old age deserves a mainstream presence in geography beyond the small sub-field of geographical gerontology. The overwhelming response to my Phase I recruitment materials is testament to the many older individuals who desire to engage in these conversations. Nuanced and sustained attention to old age can critically

rethink traditional values and norms in our own scholarship, and expose the implications of shifting cultural, political, and economic values of old age in our daily lives. These often-hidden and sparsely-discussed ideologies shape our cities and structure our everyday lives.

Revealing the multiple ways in which we perceive and experience place in old age offers more hopeful narratives and emancipatory possibilities. Urban geographers have demonstrated that cities are malleable, flexible, and constantly in flux. Given that space is socially produced and pliable, it can therefore be socially changed (Soja, 2009). Changing attitudes toward aging and old age can re-shape the built environment, and vice versa (Laws, 1993). By accepting that social and built environments can be deconstructed and reconstructed, a critical urban geography focused on aging makes it possible to envision and endorse alternative forms of space. We might apply Harvey's (1973) notion of the 'geographical imagination'. His concept builds upon sociologist Mills' (1961) concept of the 'sociological imagination', a tool that places individual personal biographies within broader social situations and histories. Harvey brought geography into the mix of biography and history to consider the literal and metaphorical ways in which people conceptualize and render space. Imagination recognizes gaps between what is thought or said, and what actually exists (Gieseking et al., 2014). Approaching old age as a spatial process shaped by local to global axes creates opportunity for deeper and more-sustained empathy in geography. The geographical imagination can aid researchers in addressing and redressing the unequal spatialities of old age.

Conclusions and Next Steps

Aging is one of the most significant social transformations of the twenty-first century. Geography risks becoming out of touch with our present-day world if it continues to overlook and exclude old age from much of the disciplinary cannon. My dissertation intervenes in this critical lacuna by situating aging as a fluid socio-spatial phenomenon and dynamic lens to investigate urban life. I demonstrate that aging should not remain siloed into one peripheral sub-discipline. The chapters articulate starting points to deepen and extend theories within and across feminist geography, health

geography, human geography, and urban geography. These cross-disciplinary investigations of aging invigorate our discipline from the scale of the aging body to global age-friendly city networks. I illustrate how the discipline is poised to engage with the implications of aging in nearly all sectors of society including demand for goods and services, provision of healthcare, modes of labor, financial markets, family restructuring, and urban regeneration.

The situated analyses of my dissertation investigated aging in a harsh continental climate with a focus on underrepresented low-income and racially diverse older adults. I concentrated on the intersections of age, class, and race that structure experiences of aging in place. One important axis that I was not able to substantively engage with was sexuality. Of the 125 older adults in my study, two self-identified as gay. One woman was upfront from the beginning and openly discussed the challenges of being in a mixed-race, same-sex relationship over 40 years ago. The other subtly referred to past partners as 'friends' and 'roommates' and was closeted about his sexuality to his children, ex-wife, and friends. I am aware that much of the policymaking and care infrastructures regarding old age are built around heteronormative expectations. In the documentary *Gen Silent* (Maddux, 2010), for example, six LGBTQ older adults residing in the Boston area faced difficult decisions regarding whether and how to hide their sexuality in order to survive in the long-term health care system. In the film, one gay man searches extensively for a nursing home where he and his partner can be open about their relationship and still receive high-quality care. A transgender woman seeks people to provide home-based care and emotional support because she is estranged from her family. A lesbian couple debates whether or not to disclose their sexuality to health care providers if it diminishes their ability to receive adequate care. The final two older individuals followed, a gay couple, are grateful to find a welcoming community care agency where they feel comfortable and safe enough to speak openly about their sexuality and 39-year relationship together for the first time.

Navigations of gender, sex, sexuality, desire, relationships, physical intimacy, and sexual practices in old age represent a rich domain for geographic inquiry. A critical stance could confront harmful normalizations and explore taken-for-granted assumptions

in Western and non-Western contexts. Geography could challenge sexual politics and the sociocultural structures shaping the ways that people live in and interact with the spaces and places of old age. For example: how do sexual practices in nursing homes potentially break down traditional normative understandings of sex and institutions of later life? This sort of questioning challenges the heteronormativity of old age institutions that render other forms of sexuality (as well as other ways of performing heterosexuality) as deviant and Other. It destabilizes categories of sexed bodies, identities, desires, and behaviors.

Applying a critical geographic lens can therefore interrogate the active production of old age spaces as heterosexualized, and powerfully critique the implicit heterosexual bias of much old age theorizing (Oswin, 2008). This creates not only conditions for more inclusive and insightful scholarship, but also alternative theories advocating for progressive action and social justice. Numerous retirement homes, for example, do not allow 'unrelated adults' to live together and perpetuate harmful assumptions that all residents are heterosexual. Hospitals often have policies in place that allow only 'immediate' family members to visit seriously ill patients and help make decisions for them (Powell, 2006).

The dissertation also did not engage extensively with health care environments or institutional care. There are robust avenues of investigation to examine experiences in hospitals and clinics, and older adults' interactions with physicians, nurses, and home-based care providers. These elements are frequently a central part of later life and can impact meaningfully on embodiments and navigations of old age. Additional communities for my future work include undocumented and immigrant communities. Older people in these communities often face enormous stresses on top of physical aging. This includes political precarity and daily anxieties regarding whether immigration officers will show up at the door, or whether their children will be arrested while at work and deported with no further word to the family. The increasing volatility of American politics, draconian policing, resurgence of discriminatory sub-cultures, and drastic budget cuts can devastate older people. The current political economy threatens the nation's health care system and dramatically curtails access to affordable housing, nutrition, and safety. Many policymakers in power pose distinct threats to older adults, in addition to

people with disabilities, veterans, members of LGBTQ communities, women, minorities, and rural dwellers (Schultz et al., 2018).

Geography can help us break free from prevailing social norms and spatial configurations that serve to alienate and oppress older people. I see the discipline as poised to tackle structural inequalities fixed 'in place' through ageism's intersections with sexism, classism, racism, heterosexism, and ableism. Through situated and multi-scalar analyses, geography can draw attention to the freedoms and constrictions, the beauty and blemishes, and the joys and sorrows of old age (Rowles, 1978).

It will be many years until I occupy an aged body and experience what it is like to be elderly firsthand. Until then, I will continue to place older adults' voices and experiences at the center of my research. I will attune my consciousness and methods to be highly sensitive to the complexity and subtle nuances of their geographic experiences. My career will involve interdisciplinary collaborations with scholars across geography, gerontology, public health, nursing, and urban and regional planning. Research efforts will focus on vulnerable groups of older adults aging 'in the margins'. I intend to engage policymakers, developers, service providers, and community stakeholders in order to develop and apply better practices for more inclusive configurations of urban form that accommodate people throughout the entire life course. I anticipate extending my optic to the families and caregivers of older people. These individuals can provide a wealth of information about older adults, in addition to describing how experiences such as caring for aged parents have changed their own lives, perspectives on later life, and thoughts on the self. Most importantly, I will continue to work directly with the real experts, older people themselves, in order to better understand and advance complex geographies of old age.

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Appendix

Neighborhood Design Characteristics Checklist

To spatially ground the qualitative Phase I fieldwork, I applied the Neighborhood Design Characteristics Checklist (NeDeCC). This provided a fine-grained geographic information sciences (GIS) analysis of participants' home locations and surrounding neighborhoods, as there was too much geographic variation within each case study area to examine by municipally-defined case site alone. Burton et al. (2011) developed this measurement tool for relevancy specifically to older adults. I applied it to evaluate the built environment at three levels:

(1) *dwelling:* type, form, height, and approximate age;

(2) *street:* type, shape, topography, pedestrian/traffic segregation, variety of built form, block size, motorized traffic levels, extent of 'eyes on the street', buildings setback from the street;

(3) *neighborhood within a 300-meter radius:* residential location, predominant block size, street pattern, number of junctions, total amount of open space, mix of land use, density of built-up area, general extent of natural surveillance, general level of legibility, general amount of greenery, and general amount of traffic.

The detailed geospatial information provided an opportunity to compare participant perceptions to quantitatively-measured environmental features. For example, how did participants talk about street greenery such as landscaping, yards, trees, and open space given what we measured? How did perceptions of nearby open space vary, such as a nearby 'pocket park' versus a vacant or abandoned lot? I could also look for patterns across residential areas, including participant commentary from those residing in older housing stock, multi-story dwellings, high-traffic streets, and dense mixed-use (residential/commercial) areas.

Select dwelling and street-level factors were measured on-site in-person (e.g., motorized traffic count), with the remaining factors analyzed through ArcGIS. In order to protect the privacy of participants, I aggregated home addresses to the census block level. Home point locations were randomly generated in a new feature class within the original

address' census block boundary using the ArcGIS "create random points" data management tool. I used in-person observations and ArcGIS mapping software to calculate the NeDeCC for every unique participant home location (n=81). Participants had the same scoring as one or more other participants if they resided in the same household or multi-dwelling building as another participant (n=63). One participant declined to provide a specific home address due to privacy concerns.

I worked with an undergraduate RA to evaluate neighborhood variables and demographic statistics at the census tract level, including age, race/ethnicity, life expectancy, poverty, employment rates, and incidence of crime. We evaluated distance-based proximity and access to the types of local services identified as important by participants (e.g., grocery stores, public transit nodes, medical centers). We obtained geospatial data from the latest U.S. Census Bureau and other publicly available sources including the City of Minneapolis, Metropolitan Council, Hennepin County, and state/federal-level organizations (e.g., Department of Transportation, Department of Natural Resources).

These measurements provided a detailed context into the spatial environments of participants. I referred back to this data on an ad hoc basis when developing narratives and analyses for my dissertation chapters. I have yet to fully 'dig in' to this data given my dissertation's focus on the qualitative material. For one mixed-methods side project (Finlay & Kobayashi, 2018, 2017), I partnered with an epidemiologist colleague to investigate individual and environmental influences on social isolation and loneliness among my Phase I participants. We applied a convergent mixed-methods design, whereby quantitative and qualitative approaches were used in parallel to gain simultaneous insights into statistical associations and in-depth individual perspectives. Logistic regression models predicted self-reported social isolation and loneliness, adjusted for age, gender, past occupation, race/ethnicity, living alone, street type, residential location, and residential density. Qualitative thematic analyses of interview transcripts probed individual experiences with social isolation and loneliness. The quantitative results suggested that African American adults, those with a higher socioeconomic status, those who did not live alone, and those who lived closer to the city

center were less likely to report feeling socially isolated or lonely. The qualitative results identified and explained variation in outcomes within each of these factors. They provided insight on those who lived alone but did not report feeling lonely, finding that solitude was sought after and enjoyed by a portion of participants. Poor physical and mental health often resulted in reporting social isolation, particularly when coupled with poor weather or low-density neighborhoods. At the same time, poor health sometimes provided opportunities for valued social engagement with caregivers, family, and friends. The quantitative data provided breadth in allowing examination of trends at the group-level; while the qualitative data enabled insight into variation within the trends, and also allowed the study participants to identify meaningful risk and protective factors for themselves. In the future, I plan to work further with the NeDeCC data for additional mixed-methods analyses.

While a useful and different vantage point, there were limitations to the NeDeCC. The tool was designed to be relevant to older adults (and their wellbeing more specifically). It was developed in an English (United Kingdom) context, which limited some usability to my US fieldwork. The housing terms “general private housing”, “general social housing”, “sheltered private housing”, and “sheltered social housing”, for example, did not map well onto the American context of market-rate and subsidized housing. Some of the terminology was different, such as roads being classed as a “high street” or “gated mews”. To address these cross-cultural differences, the RA and I had to be very clear regarding what each term meant in my specific research context.

There were limitations to the NeDeCC’s ability to capture space. I found the motorized traffic level count, for example, to be a crude estimate of moving traffic. It was one sample point that could not necessarily be generalized to the street’s overall amount of congestion (observations at 11am, for example, varied highly from observations at 5:30pm). Defining neighborhood as everything within a 300-meter radius of each participant’s home seemed arbitrary. As a result of these limitations, I have relied more upon direct participant observations of their home and neighborhood instead of the NeDeCC for analyses to date.

Semi-Structured Phase I Interview Protocol

"Aging in the Right Place" Semi-Structured Phase I Interview Protocol (Developed by Jessica M. Finlay, 2015)	
Section A: Demographics and Living Situation	A1. What year were you born? _____ A2. Were you born in the United States? ☐ Yes ☐ No If no, how many years have you lived in the United States? _____ Where did you move from? _____ A3. What race(s)/ethnicity(ies) do you identify with? ☐ White ☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian ☐ Hispanic or Latin American ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____ A4. Is English your first language? ☐ Yes ☐ No – what is? _____ A5. What is the highest education level you have achieved? ☐ No schooling ☐ Completed trade/technical diploma ☐ Primary school ☐ Some university ☐ Some secondary school ☐ Completed university degree ☐ Completed secondary school ☐ Some graduate education ☐ Some trade / technical school ☐ Completed graduate degree A6. Are you currently working or retired? ☐ Working ☐ Retired What is your job(s)? _____ What was your career? _____ A7. Do you currently have a valid drivers' license? ☐ Yes ☐ No If no, have you ever had a valid drivers' license? ☐ Yes ☐ No A8. Do you live with anyone? ☐ Alone ☐ With a spouse or partner ☐ With another family member(s) ☐ With a friend or roommate(s) ☐ Other: _____

	A9. What is your marital status? ☐ Single (never married) ☐ Separated ☐ Married (or common law) ☐ Widowed ☐ Divorced A10. Do you rent or own your home? _____ A11. How long have you lived in your current residence? _____ A12. How did you come to live here? What brought you to this home?
Section B: Physical Environment	B1. How do you describe your neighborhood to other people? B2. What do you think of / define as your neighborhood? What are the boundaries? B3. Do you like to do things in your neighborhood? B4. Aside from [mentioned in Section A], do you work or volunteer outside of the home? B5. How happy are you living in this neighborhood? B6. Are all of the services [places like grocery stores, banks, shops, the doctor's office] that you need nearby? B7. Are there services missing from your neighborhood? Do you have difficulties accessing any necessary services? B8. How do you get around your neighborhood? B9. If you were not able to [participant's main method of transportation] anymore, what would you do? B10. Are there places in your neighborhood that you avoid? B11. Do you feel safe in your home? B12. Do you have any fears or concerns about leaving your home? B13. Have you fallen in the past 10 years? B14. What, if anything, would add to your feeling of safety in your neighborhood? B15. Do you plan to stay in this home and neighborhood as you get older? Why or why not? B16. What do you think is good about your home and neighborhood for older residents? B17. What concerns do you have about getting older in your home and neighborhood? B18. When do you think you'll decide to move out? Where would you go? B19. What, if anything, could be improved in your home and neighborhood to better meet your needs now, and in the future? B20. Can you describe your ideal ("dream") place to live as you get older?

Section C: Neighborhood and Social Connections	C1. What do you do on a typical day? Who do you see or talk to? C2. Do you get to see your family often enough? C3. Do you get to see your friends enough as you would like? C4. Do you feel lonely? Do you feel socially isolated? C5. Do you generally know your neighbors? C6. If you had an emergency, would you feel comfortable asking any of your neighbors for help? C7. Do you feel like you're a part of your neighborhood community? Why or why not? C8. Do you feel your community is welcoming to people of different ages? Why or why not? C9. As you get older, do you feel like you're treated any differently by people?
Section D: Health and Quality of Life	D1. Do you feel happy about your everyday life? D2. Are you as happy now as when you were younger? Happier? Less happy? About the same? D3. Does anything bother you more now than when you were younger? D4. Do you feel sad about anything? D5. In general, how do you feel about your age and getting older? D6. Are you satisfied with how things are going? D7. On a scale of 1 to 5 (1 being very poor, 5 being very good), how would you rate your health? Do you think you have good health for your age? D8. Do you feel independent?
E. Conclusion	E1. Thank you for your time and insights. Is there anything else that you would like to come back to or add to our discussion today?

Table 10. "Aging in the Right Place" Semi-Structured Phase I Interview Protocol

Semi-Structured Phase III Interview Protocol

"Aging in the Right Place" Semi-Structured Phase III Interview Protocol (Developed by Jessica M. Finlay, 2016)	
Section A. Introduction	1. State official job title. 2. How long have you held this position? (Years/months) 3. What education, training, and past experiences led you to this position? 4. Could you briefly describe what you do in your role here at [department/organization]?
Section B. Issues and General Approaches	5. What are the primary issues that your department/organization is concerned with regarding older adults and aging more broadly? Please explain. 6. How does your department/organization address these issues? Do you have direct and/or indirect interactions with seniors? Please describe the planning and implementation of specific policies/programs/initiatives. 7. Have these initiatives been successful? 8. Have you faced any challenges or setbacks?
Section C. Aging in Place	9. Are you familiar with the term 'aging in place'? If so, how do you define it? 9a. How did you come to be familiar with this term? 9b. Has your department/organization undertaken specific initiatives to support 'aging in place'? If so, please describe. 10. Given the huge diversity of those 'aging in place', does [department/organization] strive to accommodate a wide breadth of needs and preferences? How do you reach vulnerable and isolated older adults?
Section D. Looking Forward	11. Overall, do you think that [interviewee's jurisdiction] is able to provide a high quality of life for its resident aging populations? Why or why not? 11a. Are particular areas / regions more welcoming or supportive than others? Explain. 12. What, if anything, could be improved in [interviewee's jurisdiction] to serve the current and future needs of aging populations? 13. Does your department/organization have strategic plans to address future needs of older residents? If so, please describe. 14. If anything were possible (i.e., no time, staff, or budget restrictions), what strategies and initiatives would you implement to support aging populations?
Section E. Wrapping Up	15. Is there anything that we did not cover today that you would like to discuss?

Table 11. "Aging in the Right Place" Semi-Structured Phase III Interview Protocol

Thematic Analysis Framework

Code Name	Description of the Code	Examples of When to Use the Code
01. Built Environment	*The human-built spaces in which we live, work and play. The built environment encompasses urban design, land use, buildings and infrastructure. For the purposes of this project, services and amenities are differentiated as "Service Environment". The "natural environment" is also separated. I further differentiate the built environment by scale (household, common space, street, neighborhood, municipality)*	
01.01. Household	Micro features of the home	Housing condition, home repair, stairs/steps, roof, windows, bathrooms, bedrooms, deck/porch, building courtyard, driveways, private parking, belongings, modifications made in the home (single home)
01.02. Common Space	Shared spaces of multi-unit dwellings	Elevator, common area, pool, locked entry way, building itself, heritage park
01.03. Street	Micro-scale elements	Sidewalks, street crossings, garbage, lighting, curb cuts, timing of lights, traffic, walkways, graffiti, fences, broken features, skyway, green way
01.04. Neighborhood	Macro-scale elements according to definition of participant (participants had different definitions of the neighborhood)	Destinations, local street networks, land use mix, what participants consider their neighborhood, dominant type of housing in that area
01.05. Municipality	City-wide elements and physical infrastructure	Highways, waiting lists for housing in a certain area

02. Service Environment	*Availability of, access to, and use of man-made services and amenities. Services are defined as spaces and locations that are essential for daily life and civic functioning. Amenities are defined as public and private spaces / locations that are intended to make life more pleasant and comfortable.*	
02.01. Recreational	Public amenities	Swimming pool, community center, senior center, YMCA, library, Disneyland, casinos, stadium
02.02. Retail	Amenities for customers	Clothing store, bookstore, gas station, bank, post office, waste disposal, laundromat services, health plan/insurance, Disney Land, Stadium
02.03. Art and Leisure	Cultural amenities	Art galleries, theatres, plays, musical shows, casinos
02.04. Restaurants and Fast Food	Restaurants and fast food outlets	Fast food, coffee shops, bars, restaurants, cafes, strip clubs (type of bar), pedal pub
02.05. Groceries and Meals	Groceries and meal services	Grocery stores, home-grocery delivery, Meals on Wheels, home/building meals, bakery
02.06. Medical	Medical and health-related facilities	E.g. hospitals, clinics, pharmacies, dentist, specialist(s), health plan/insurance, caretaker
02.07. Emergency	Emergency services	Police, fire department, ambulance (911), jail
02.08. Education	Provision of school(s) and continuing education	Elementary schools, high schools, universities, colleges, trade schools
02.09. In-home	In-home services	Professional cleaning services, utilities (gas, water, electric), internet, home-based care, home maintenance

		(seasonal), building management, caretaker
02.10. Transportation	Transportation services	Public transit; senior-specific transit; subsidized transit; bus service; rail service; rapid transit, skyway, green way
02.11. Institutional Care	Institutional care	Nursing homes
03. Natural Environment	*For this project I define the natural environment as natural spaces in which we live, work, play and preserve. Nature often refers to untouched forests and lakes in the wilderness; but it can also refer to potted plants in a home, trees along a street, and a courtyard fountain (Finlay et al., 2015). The natural environment thus encompasses pristine wilderness, flora, fauna and climate; as well as natural areas with human intervention, such as gardens and parks.*	
03.01. Green Space	Natural areas and elements in wildness and urban settings	Forests, trees, gardens, parks, trails, street greenspace landscaping, mountains, wild animals, yard, golf course, green way, cemetery
03.02. Blue Space	Aquatic environments in natural and urban areas with standing or running water	Oceans, lakes, rivers, beaches, fountains, streams
03.03. White Space	Snow and ice	Blizzards, icy sidewalks, snow plowing
03.04. Outdoor Climate	Daily weather	Seasons, sunlight, darkness, heat, cold, wind, clouds, day/night, rain
03.05. Pollution	Air, noise, water, ground contamination	If living next to a factory or train tracks

04. Psychosocial Environment	*Sociocultural relationships and cultural milieus within which defined groups of people function and interact. Key elements of the psychosocial environment include social support / networks, social cohesion, ways of gathering (e.g. age, faith, culture, interest), and neighborhood safety.*	
04.01. Social Cohesion. Informal Social Opportunities	Level of informal social interaction and engagement	Watching children play, drinking coffee in a crowded shop, other drivers on the road, other people on the sidewalk
04.02. Ageism	Level of age integration/separation	Interaction on the basis of age such as: holding open doors, seeing kids play in street/playground, young people in bars
04.03. Faith	Social connection through shared beliefs (a faith-based community that exists outside the participant)	Religious community, church, mosque, synagogue, salvation army
04.04. Culture	Social connection through shared culture	Immigrant community, ethnic group
04.05. Interests and Hobby	Social connection through shared interest	Athletics, YMCA, book club, art, politics, woodworking, volunteering, gay parades
04.06. Workplace	Social connection through shared place of work	Interactions with co-workers, clients
04.07. Neighbors	How participants interact and perceive their past and present neighbors	Interactions with people living in close proximity to participant's household/ in the same building/neighborhood/street
04.08. Crime	Incidence and perception of crime	Break-ins, drugs, arson, vandalism, muggings, jail, prostitution
04.09. Safety	Expressed level of safety due to environment, why participants feel safe or unsafe	Crime, unfamiliar, racism, police presence, security cameras, heavy

		traffic, scary people, dark areas, urban warfare exercises
04.10. Comfort (Discomfort)	Expressed level of comfort or discomfort (non-life threatening), not a source of fear but comfort/discomfort	Temperature, heated garages, management (in-building), traffic
04.11. Socioeconomic or Status	Perception of socioeconomic status and cultural expectations for both people and places	Class, wealth, race/ethnicity
05. Individual Characteristics		
05.01. Attitude and Perception	A settled way of thinking or feeling about someone or something, typically one that is reflected in a person's behavior/action	How participant views the world, what they like and don't like about it
05.02. Preference	Psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor	"I prefer X" (alone time, clean surroundings, quiet places, smoke-free places, being different ages, wholesome people)
05.03. Internal Faith and Belief	Trust, faith or confidence in something or someone/acceptance that statement is true or that something exists	Belief in God, belief in Buddhism, sense of Heaven, internal spirituality, pray for guidance
05.04. Habit and Routine	How a person typically spends his/her time (semi-regularly/regularly) that they become automatic	Read the morning newspaper, drink coffee in a coffee shop, go to the pool/YMCA for exercise, talk to friends in person or on the phone, see grandchildren, weekly dinners
05.05. Self-Control and Self-Awareness	The ability to self-monitor of internal events including thoughts, feelings, and sensations, to prevent interference with function or task performance	Reflect on how participant feels and how they react afterwards, self-reflection, awareness of personality traits, self-monitoring
05.06. Resourcefulness	The ability to take initiative to employ problem-solving strategies	Not going out at night, avoid busy roads, home modifications, avoid

	when faced with stressful situation or conditions	certain areas, preventing cognitive ability decline, quitting smoking, eating better, exercise more
05.07. Resiliency	The ability to cope with difficulties and adverse situations; quality of self-efficacy to cope when faced with adversity; adapt or recover from adverse circumstances; enduring	Having a positive outlook on life, accepting and dealing with mental or physical health decline,
05.08. Fear	Perceptions and causes of fear and distress	Fear of falling, fear of cognitive ability decline, fear of other people
05.09. Vulnerability	Expression of being physically and/or emotionally wounded, being taken advantage of	Elder scams, victim of crime (robbery or mugging), feeling weak
05.10. Personal Interests and Hobbies	Favorable pastime; regular hobbies	Painting, reading, watching T.V., sewing, cooking, woodworking, going to the park, walking, exercising
05.11. Self-Reliance	Reliance on self	Complete tasks independently instead of relying on others
06. Friends		
06.01. Interaction and Engagement	How participant interacts, engages and communicates with friends	Frequency of talking on the phone
06.02. Proximity and Access	Feeling of closeness and distance to friends	Ability to see friends in-person
06.03. Care and Support	Ways the participant provide care and support for or are cared for/supported by friends	Help out after surgery
06.04. Best friend(s)	Explicit mention of closest friend(s)	Close friend(s), oldest friend(s), best friend(s)
06.05. Stories and Accounts of Friends	When statements do not fit into 06.01 to 06.04 regarding friends, often accounts of the past	Non-specific stories of friends in the past
07. Family		
07.01. Interaction and Engagement and Communication	How participant interacts, engages and communicates with family	Family gatherings and parties, mutual support

07.02. Proximity and Access	Feeling of closeness and distance to family members	Level of contact with family members
07.03. Care and Support	Ways that participant provide care and support for or are cared for/supported by family members	Family provides support after a health crisis
07.04. Spouse or Partner or Significant Other	Person(s) of interaction- spouse/partner/significant other	Past or present interactions
07.05. Children	Person(s) of interaction- children	Past or present interactions
07.06. Grandchildren	Person(s) of interaction- grandchildren	Past or present interactions
07.07. Siblings	Person(s) of interaction- siblings	Past or present interactions
07.08. Parents	Person(s) of interaction- parents, in-laws	Past or present interactions
07.09. Other Relatives	Person(s) of interaction- cousin, aunt, uncle, extended family network, does not have to be blood-related	Past or present interactions
07.10. Pets	Person(s) of interaction- pets	Past or present interactions
08. Financial and Career Situation		
08.01. Past and Present Career or Formal Employment and Income	Career and jobs (past and present) that provide(d) income	Work, part-time/full-time
08.02. Unpaid Labor	Explicit discussion of labor provided at no cost	Caregiving (spouse, grandchildren, neighbor, friend, etc.)
08.03. Financial Security	Discussion of their financial situation/level of security	Savings, sense of independence from financial situation, running out of money
08.04. Expenses	Past and present things people have paid for	Medications, transportation, furniture/home décor, fitness, dining, rent
08.05. Affordability	Perception about cost	Subsidized housing and services, being unable to afford groceries, health

		services, entertainment, travel, looking for bargains/good deals, seeking the best price
08.06. Personal Education	Education that participant has pursued; degree/non-degree seeking education	Training, university courses, high school diploma, trade school, continuing education
08.07. Informal Income	Post-career and/or side jobs	Sell woodworking at craft shows, sew/knit items for sale, paid child care
09. Mobility and Activity		
09.01. Self-powered Individual Mobility (e.g. walk)	Independent/unassisted self-powered travel	Self-powered activities such as walking, climbing stairs, running
09.02. Assisted self-powered Individual Mobility (e.g. cane and walker, bike)	Independent object-based travel	Wheeling a wheelchair, using a walker, using a cane, leaning on others/objects, biking
09.03. Exterior-powered Individual Mobility (e.g. car)	Independent motorized travel	Driving a car, using an electric wheelchair/scooter
09.04. Assisted Mobility (e.g. bus)	Assisted travel	Using public transportation, taxi, hired vehicle, receiving rides from family and friends
09.05. Mobility Inside the Home	Explicit discussion of moving around inside the home (purpose unspecified)	Activities performed such as cleaning, cooking, caregiving, hobbies, activities of daily living (bathing)
09.06. Utilitarian Mobility Outside the Home	Explicit discussion of moving around outside the home for functional purposes	Travel for errands, appointments, caregiving, commuting, employment
09.07. Leisure Mobility Outside the Home	Explicit discussion of moving around outside the home for recreational purposes.	Travel for vacation, organize activities, religious events, socializing, volunteering, hobbies, arts and culture
09.08. Falls	Reference to/experience of history of falls, reasons for falls, concerns/fears of falling	When participant mentions falling, or fears of falling

10. Physical Health and Wellbeing		
10.01. Physical Health Conditions	Reference to or experience of bodily health (past and present), physical illness	Blood pressure, cholesterol, stroke, cardiovascular disease, breathing problems, gastric reflux, physical experiences of aging (eyesight, hearing, smell, taste)
10.02. Medications	Explicit mention of medication and therapies	Cholesterol medication, blood pressure medication, pills, acupuncture)
10.03. Physical (In)Activity and Fitness	Reference to/experience of general fitness and physical activity; or lack thereof	Doing aerobics, exercise classes, strength training, walking for exercise, swimming, or lack thereof
11. Mental health and Wellbeing		
11.01. Happiness and Contentment	Reference to/experience of internal happiness and contentment in life, or lack thereof; situation in life	Level of happiness/unhappiness living in home/neighborhood, general satisfaction with everyday life
11.02. Sense of Purpose	Reference to/experience of having purpose or meaning, or lack thereof. Level of activity	Keeping busy vs. idleness, boredom
11.03. Sadness	Reference to/experience of sadness	When participant mentions explicitly about sadness or feeling sad
11.04. Cognitive Ability	Reference to/experience of cognitive decline and ability	Dementia, Alzheimer's, Parkinson's
11.05. Mental illness	Reference to/experience of mental illness	Researcher field notes mention mental illness, Schizophrenia, hoarding, compulsion
11.06. Depression	Reference to/experience of clinical depression	When participant mentions feeling depressed, seeking therapy for depression, medication for depression, can be talking about others, not just themselves
11.07. Stress	Expression of feeling stressed and anxious, sources of anxiety and	Stressed about finances, concern for children/grandchildren, health concerns; not as stressed because

	stress when older (past or present); noted lack of stress or anxiety	participant is financially more secure in retirement
11.08. Irritation and Anger	Expression of irritation and anger ranging from minor to major issues/experiences.	Noise sensitivity, traffic, bothered by other people or situations
11.09. Abuse	Reference to/experience of physical, verbal, emotional and psychological, chemical/substance, sexual abuse. Can be self-inflicted or inflicted by others.	Victim of domestic abuse, alcoholism, drug addiction, PTSD
11.10. Death and Loss	Reference to/experiences of death/loss/ missing people, a way of life/abilities and belongings.	Talking about loved ones who have passed away, loss of close connection with friend, being widowed or divorced, missing an old home/lifestyle, talking about suicide
12. Social health and Wellbeing		
12.01. Sense of Belonging	Expression and experiences of fitting in or not fitting in socially.	Not fitting in socially
12.02. Loneliness and Isolation	Expression or behavior of being lonely and/or isolated.	Reflects on being alone or not having anyone. When participants discuss isolating behavior.
12.03. Racism/Diversity	Experiences and perceptions of prejudice based upon race/ethnicity. Expressions of racism.	Can happen in workplace, community, friends. When participants display racist views and behaviors. Comments regarding gay parades and LGBTQ celebrations
12.04. Happiness and Satisfaction	Expression of happiness and satisfaction related to social connections with other people, or lack thereof (unhappy and unsatisfied).	Enjoy spending time with grandchildren/friends. Enjoy social interaction with others or want to spend more time with family/friends.

Table 12. Framework for Thematic Analysis