Exploring factors that influence peer-relations among older adults living in residential homes

Wharfe, Zoe

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Doctor of Clinical Psychology

July 2021

ABSTRACT

Background:

An understanding of peer relationships whilst living in care homes, requires sensitivity to the complex breadth of factors that comprise the persons' experiential and social contexts. This is necessary to ensure that academic and public perspectives on older people in care homes are not subsumed under homogenising discourses that prioritise victimhood and biological impairment. Research generally on older people is relatively sparse and even less is known about co-resident relationships. The analytical focus for this study is on the perspectives of residents living in UK care homes and of the factors that inform their relationships with other residents. It is hoped that this, in turn, will inform clinical psychology and service delivery in supporting the lives of people in assisted living settings. In short, the paper seeks to inform an agenda of 'living well and dying well' (Kewell, 2019:20).

Method: Semi-structured interviews were conducted with seven older people living in a UK care home. Thematic analysis of transcripts was undertaken and was informed by a critical realist epistemology.

Results: Four main themes emerged from the analysis: 1. Belonging and Connection: an integral need, 2. Self-esteem and Validation: maintaining a unique presence, 3. Freedom and Control: negotiating authorship of life, and 4. Occupation and Growth: a search for meaning.

Conclusions:

The types of co-resident relationships found to exist within the care home are consistent with previous studies: no-contact (common), companion (common), confidante (rare) and antagonist (rare). Departing from existing studies, is the finding that social discourse and institutional context fundamentally inform peer relations. Participants were actively engaging with multiple losses: community, self-identity, autonomy and meaningful pursuit; all reinforced by institutionalised approaches to death, dying and assisted living. This negotiation of loss informed the behaviours of peer-avoidance, peer-selection, withdrawal, and a prioritisation of non-peer relations. The implications of the findings at research, service, clinical and policy levels are discussed.

CONTENTS

ACKNOWLEDGEMENTS

A heartfelt thanks to the seven participants who took part in this study. I will always be grateful to you for sharing with me, and others, your personal experiences, and for making this study possible.

I would also like to thank:

- Dr Maria Castro Romero (Senior Lecturer & Academic Tutor in Clinical Psychology at the University of East London) as my research supervisor for her thoughtful guidance and encouragement throughout the research process.
- Dr Ken Gannon and Claire Correia for their kind and behind-the-scenes administrative support at UEL.
- My UEL peers for their unwavering kindness, deep friendship and for seeing the funny side of things.
- Kathy Smith and Dr Natalie Read for their dedication and hours of proof reading and insightful comments.
- My parents for their love and devotion to supporting me and my children in any way that was needed, enabling me to complete this project.
- My husband and children for their love, patience, generosity and loyalty, and to my husband also for his constant faith, and emotional and practical support in seeing this process to fruition.

CHAPTER ONE: INTRODUCTION

1.1 Literature Search Strategy

A literature search was conducted across the following databases: CINHAL, PsycArticles, PsychInfo, ScienceDirect and SCOPUS. These databases are considered to be the most appropriate for psychological research.

Further literature searches were conducted using the reference sections of journal articles, and via ‘grey’ literature (e.g. Google scholar).

The specific search terms used were: ‘Older-age’, ‘ageing’, ‘care home’, ‘assisted living’, ‘peer-relationships’, ‘resident relationships’, ‘friendships’.

The inclusion criteria was non-stringent due to expectations that there would be relatively few contributions to this area in the literature. Searches were open-ended with date ranges and methodological approaches (e.g. qualitative and quantitative) all included and unspecified[1] (see Appendix A: Flowchart depicting selection of articles and Appendix B: Articles included in literature review).

1.2 Assisted Living: the UK contexts

Living in assisted care facilities outside of the family home is nothing new for many of those reaching older age and living in the UK. Groupings of poor and destitute people have been recorded over the centuries (Townsend, 1962). In the 1960s and 70s distinctions between health and social care were made – with residential care identified as primarily for those people failing to cope at home even with domiciliary care, yet not in need of continuous care by nursing staff (Peace, 2003). More recently, questions have been asked by those in more politically powerful positions about the life experiences of those living in care homes. Subsequent standards and reviews have been imposed, and alternative solutions to assisted living are being developed (e.g. The Eden Alternative).

---

[1] The literature search took place in 2016, prior to the interviews being conducted.

1.2.1 The Care Home: demographics and service delivery

Residential care homes in the UK provide short and long-term accommodation, food and basic personal care for older adults who can no longer live by themselves. Nursing Homes provide specialist care for those with more complex clinical needs such as those with Dementia and Parkinson's disease. The prevalence of severe levels of dependency requiring assistance is 70% in residential homes compared to 91% in nursing homes (Care Home Market Study, CMA, 2017). For the purposes of this study, the term Care Home will be used to encompass either or both nursing and residential homes.

It is estimated that there are around 400,000 people over the age of 65 living in UK care homes (Office for National Statistics, ONS, 2020). The sector is worth £16 billion a year with 5,500 different providers operating 11,300 care homes. The vast majority of the beds (95%) are provided by the independent sector (both for-profit and charitable providers), and the average cost for a self-funder in 2016 was £846 per week compared to Local Authorities which paid on average £621 per week (CMA, 2017). Care homes represent a significant context for many people in death and dying, with 22% of people who died over the age of 65, dying in care homes. This compares to 6% who died in hospices (Public Health England, 2018)[2].

As the UK population ages, the resident care home population also ages. The ONS predicted an increase of over a third (36%) of people aged 85 and over living in care homes between the years 2015 - 2025 (ONS, 2014)[3]. More women than men live in care homes with 2.8 women for each man of 65 years and over (ibid). The typical characteristic of someone living in the UK care home is White, 87years old, female, previously living alone, who requires assistance with approximately two functions of daily living, and who lives permanently in the home (ibid). However, older people in residential homes are from different backgrounds and have diverse identities and interests (Yamasaki & Sharf, 2011).

---

[2] Figures do not include deaths from COVID-19. During the COVID-19 pandemic (2020-2021), to date, an estimated additional 40, 000 deaths have occurred in care homes (ONS, 2021). This is almost a third of all fatalities from the pandemic.

[3] Figures do not include deaths from COVID-19.

1.2.2 Life in the care home: an historical and political context

Over the centuries, the experiences of those living in assisted facilities has been unknown and unrecorded inside and outside of the system. The voices of elderly residents have been hidden, silenced and obscured (Peace, 2003). It was not until the 1920s that the conditions of some of the homes were exposed, with common instances of neglect evident, including residents living with bed sores and exposed without protection to diseases. This paved the way for the beginning of independent reviews and the establishment of the 1926 Select Committee on Nursing Homes (Registration) (Samson-Katz & Peace, 2003). Decades later, Townsend carried out a seminal study of care homes, The Last Refuge (1962), which led to further recommendations for reform. Despite conditions being exposed, official concerns at this time focussed, not on the objectives of care, but on the development of new homes, the number of people accommodated, and costs (see Peace, 2003).

Subsequent political developments have taken place, with new codes of practice introduced - see especially, A Better Home Life: a code of practice for better residential and nursing home care (Centre for Policy on Ageing, 1996). Residential care homes are now legally required to adhere to a number of standards (e,g. consent) and are subject to inspections carried out by the Care Quality Commission (CQC), the Governmental body overseeing standards of recipients of health and social care services.

However, despite these advances and evidence of good practice and adherence to standards set, there is evidence that negative experiences of older people in care based institutional settings continue. A recent review of NHS hospitals concluded that elderly patients are not being treated with respect, are not involved in decisions relevant to their care, and are vulnerable to malnutrition and potential abuse (Care Quality Commission, 2013). The UK Government’s Care Homes Market Study (2017) concludes that “The protections of consumer law against potential exploitation and adverse outcomes are especially important in this market given the vulnerability of people...” (CMA, 2017).

Moving to a care home, even to the best of these institutions often signifies a sharp contrast between a life once lived and a life being lived (Yamasaki & Sharf, 2011). Often out of necessity rather than choice, people face dramatic changes in physical location, social networks, personal autonomy and daily routine. It is a time of intense stress, and multiple experiences of loss, including the loss of a partner and health (Kewell, 2019).

1.2.3 Societal influences: identity, institution and discourse

1.2.3.1 *Social Identity*

A meta-review of literature by Titman in 2003, identifies social identity as being a key determinant to older people's wellbeing and health (alongside relationships, flexibility and autonomy). For the oldest old, preserving self-identity is argued to be a central task (e.g. Tobin, 1991; Davis, 2004).

Identity can be described as the human capacity to know who's who, and hence, also, what's what. Jenkins (2014) in his review of theoretical contributions to social identity, argues that the process of identification is the basic cognitive mechanism that humans use to sort out themselves and their fellows, both individually and collectively.

According to Social identity theory (Tajfel & Turner, 1979) and self-categorisation theory (Turner, Oakes, Haslam & McGarty, 1994), social groups (e.g. community, family, profession) play a key role in providing meaning to the self (Knight, Haslam & Haslam, 2010). These groups (and the social identities which they provide) are incorporated and integrated into our sense of personal identity (i.e. the unique ways that individuals define themselves as individuals), and contribute to our understanding of who we are and of what we are able to do (e.g. as an older person and as a woman). Moreover, social identity is relational. 'Who we think we are, is intimately related to who we think others are, and vice versa' (Jenkins, 2014: 13), and it can matter enormously.

Identity is a process, not a thing, and it is rarely neutral. It is not something someone can have but is something that one does and is able to perform. As a political process, social identity has to be made to matter, through for example, the power of symbols and rituals (*ibid*). In older age, one's preferred and prior identities can be threatened by changes to roles in the family and society, and a loss of control over one's own environment, including facing poverty, physical disabilities and moving to a care home (Age Concern and Mental Health Foundation, 2006).

1.2.3.2 *Institution and Identity*

Institutions are established patterns of practice, recognised as such by actors, which have force as ‘the way things are done’’. (Jenkins, 2014: 47). Commentators argue that institutions, such as care homes, are among the more important contexts within which identification becomes consequential (see *ibid*). They are important vehicles of classification whereby individual and collective identities are systematically produced, reproduced and implicated in each other and allocated within power relations. Jenkins argues ‘the classification of populations as a practice of state and other agencies is powerfully constitutive both of institutions and of the *interactional experience* of individuals’ (P49). Institutionalised identities has implications therefore for how people relate to one another due to the influence on who they think others/themselves are, and are able to be (see further discussion under 1.6.2 Maintaining Social Identity).

Elders living in care homes, and other institutional settings, can become at best dependent, at worst irrelevant (Kewell, 2019). Kewell (2019) in her accounts of therapeutic work with older people quotes a resident as saying ‘there were times when the present felt so unimportant, so unnecessary. Just somewhere I had to dip into from time to time out of politeness’ (p 101*).*

Peace (2003) on an historical review of UK care homes, concludes that:

> ‘Living en masse has often led to a form of living managed for the organisation rather than the person and the pressures of institutionalisation. Consequently, ageism and neglect have had to be faced before acknowledging individual need…researchers over time have recognised the ‘social death’ of institutional care where residents have been seen as ‘less than whole persons’ and have sought to define accommodation and care that older people may value’ (p. 40).

1.3 Relationships as central to human experience

Identity only makes sense in relationships. The classification or identification of individuals, in relationship to one another, is imbued in power relations, and has real-life consequences for all (Jenkins, 2014).

Social Identity theory indicates that perceived similarity to others can promote solidarity. Increased identification increases its influence on people's own behaviours (Neighbours et al, 2013). However, if one is assigned to a sub-group that is perceived to entail a lack of respect from the larger group, such as those older adults living in residential homes, then strategies can be adopted to try and distance oneself from identification (*ibid*). For low status groups, research shows that the outcome of available group comparison is often negative for their self-esteem (Martinez et al, 2020). There are many examples of members of 'inferior' groups distancing themselves physically or psychologically from their groups. One reaction for members is to leave the group, if that is available to them. However, exiting ones assigned group might not be possible, especially if the group boundaries are relatively fixed and impermeable.

A key factor in generating social unrest among subordinate groups is a sense of relative deprivation, either in relation to their own group, or in relation to the dominant group (see Liebkind, Jasinskaja-Lahti & Solheim, 2004). However, if opportunities are so restricted and there are no real alternatives to resist, social identity theory suggests that subordinate groups are unlikely to openly challenge the existing order and attempt social change.

In a similar way, Systemic social constructionist theory posits that humans exist and come to be ourselves only in relation with others. Relationships are key. 'We cannot not respond' (Martin & Stott, 2010: 63). What we say and do, as well as what we do not say or do, will always have an effect on others and on ourselves (ibid).

Even in solitude, we are inescapably always in relation to each other (Satre, 1945/2003). A systemic review and meta-analysis involving more than 3.4 million participants has linked social isolation, living alone, and loneliness to premature death (Holt-Lunstad, Smith, Baker, Harris & Stephenson, 2015). Moreover, the body of literature for the societal origins of human distress is almost impossible to deny (See for example, Picket, Oliver & Wilkinson, 2006).

It represents a move towards what is happening between people – what meanings emerge when we interrelate, however subtly - and away from pathologising and individualising people. 'Relationships are our very existence and thus our interactions with each other must have the potential to heal' (Kewell, 2019: 81).

1.4 Research with Older People

Older people have a lower rate of participation in all health research (McKeown et al, 2020). Moreover, older adults with particular social characteristics are further underrepresented, including those with a diagnosis of dementia (Ries, Mansfield & Sanson-Fisher, 2019) and those from Black and Minority Ethnic communities (Harawa et al., 2017). Even in Community Psychology research - with specific aims to address and examine issues of social inequality and injustice - an international systemic review of journal articles found that the number of age-related articles represented between 0 - 4 % (Radermacher & Duckett, 2013).

Different factors are understood to contribute to low participation rates of older people in studies. Radermacher and Duckett (2013) argue that it is more broadly reflective of society where ageing issues, or funding for ageing-related issues, do not feature high on the agenda, and where older people may be deemed unworthy or uninteresting subjects for research. Moreover, disease-related research continues to receive greater interest and levels of funding in Western societies (see Rapley, Moncrieff & Dillon, 2011). In a meta review of research on older people, Liljas et al. (2017) identified barriers to participation that include: distrust or misunderstanding of research/researchers, poor health and a lack of motivation and lack of family support. Further factors identified by researchers include: a concern by older participants of over-excessive intrusion (Knechel, 2013), and of researcher exclusion criteria (Ries, Mansfield & Sanson-Fisher, 2019).

1.5 Understanding peer relationships

1.5.1 Resident-resident relationships

In line with an increasing recognition of the importance of relationships to emotional and physical health and wellbeing, and in response to a dearth of existing research, several papers have been published that look specifically at relations between residents living in care settings (see Appendix B).

However, this body of work remains limited with respect to the number of studies undertaken and to the majority of the work being conducted in the USA. Moreover, whilst valuable insight is provided into the nature and type of the relationships that exist between co-residents (based on sometimes large-scale observations of behaviours and interactions), a more in-depth discussion exploring experiential and contextual factors is less well established. With reference specifically to research with people with dementia, Tolhurst and Weicht (2017) argue: ‘if the complex range of factors that shape experience is underplayed, then dementia research is at risk of contributing to homogenising discourses that elevate neurodegeneration to the principal experiential basis of the condition’ (p30). It is with this critique in mind that the existing literature on co-resident relationships is reviewed.

1.5.1.1 *Types of resident-resident relationship*

There are consistent findings in existing co-resident studies of the emotional intensity, or ‘closeness’, and behavioural interactions of peers.

1.5.1.2 *‘Neighbouring’*

Powers (1991) undertook a study of 69 older people (with an equal ratio between the sexes) living in care homes in the United States to understand ‘the social networks’ and the ‘meaning of friendships’ (p. 43). Powers concluded that residents belonged to one of four types of peer-relationship network, that she called: Institution-centred; Kin-centred; Small cluster, and Balanced.

Small cluster networks which include ‘established cliques’ (p. 50) was the smallest network. Residents in this network provided the best examples of companionship, and, according to Powers, group identity was reinforced through established daily routines and small acts of kindness. The other networks focussed either on having predominantly family relationships (kin-centred); or having only ‘simple’ (p50) relationships with staff, residents and family, with an emphasis on self-sufficiency, but with a propensity too for avoidance of, and antagonism with, other residents (institution-centred); and of interacting with a wider range of contacts, enabling a flow of communication and support, and multiple types of resource exchange. This include ‘friendly’ and ‘unfriendly’ (p51) exchanges, with shared laughter, gossip, emotional release and conversely also quarrelling and disagreements (balanced networks). The latter was the largest network. Powers concluded that there was a difference in behavioural interactions between all residents within the care home to the ‘give and take’ (p45) in relationships outside of care homes, with fewer reciprocal exchanges of goods (e.g. reading material) and personal assistance (e.g. sewing).

The findings from a more recent study (Kemp, Ball, Hollingsworth & Perkins, 2012) undertaken over three years, across three homes in the USA and using mixed methods design, are consistent with Power's study. The authors, again, found that the most common relationships between residents was 'neighbouring' (p493). Neighbouring relationships were supportive and pleasant and often involved limited social support (e.g. pushing wheelchairs for others down the corridor). However, only the most proactive residents invited and welcomed new residents, kept their doors open to visitors, attended activities and sat in public spaces. A minority of residents had a fellow resident with whom they confided and with whom they enjoyed regular hobbies.

A consistent finding across the studies is that only a small minority of residents form emotionally close attachments with their peers, characterised by mutual trust and an ability to share confidences (Powers, 1991/1996; Mckee, Harrison & Lee, 1999; Hubbard, Tester & Downs, 2003; Kemp et al., 2012; Sandhu et al., 2013; Sefcik & Abbott, 2014; Casey et al., 2015; Roberts & Bowers, 2015). Instead, co-resident interactions tend to be kept at a more superficial level and conversations are limited for example, to pleasantries about the weather and updates about the activities of respective family members (ibid). The authors of one study noted that 'here a friendship is based on activities and things that you try to do together. It's not something that you do constantly' (Sefcik & Abbott, 2014: 22).

Also in the papers is a consistent finding that relationships between residents with those in their past life and/or those who live externally to the care home represent more emotionally supportive and valued connections and friendships (Powers, 1991/1996; Casey et al., 2015; Cook, Brown-Wilson & Forte 2006; Kemp et al., 2012; Sandhu et al., 2013; Sefcik & Abbott, 2014). Indeed, staff are described as being more like friends than are co-residents (Casey et al., 2015; Kemp et al., 2012; Sefcik & Abbott, 2014; Roberts & Bowers, 20015).

The studies lend support to arguments that state that a failure to recognise the problem of loneliness of residents in care homes, stems from a naïve assumption that being together with other people guarantees friendship (Wilkin & Hughes, 2003; Sefcik & Abbott, 2014).

1.5.1.3 *'Anti-Neighbouring'*

Powers (1991) found that residents showed successful avoidance of their peers and made explicit reference during interviews to members of networks who were not friends because of their annoying or upsetting behaviours. Similarly, Kemp et al. (2012) used the term 'anti-neighbouring' (p495) to describe the alternative type of peer relationships and included: bullying, gossiping and harassing, and 'cliques' that operated with exclusion and inclusion behaviours.

'Anti-neighbouring' behaviours were found consistently across the co-resident relationships (Sandhu, Kemp, Ball, Burgess & Perkins, 2013). Recent studies in the United States have explored 'anti-neighbouring' or 'aggressive' behaviours between residents in care homes, arguing that it is currently a rarely considered topic in research (Pillemer et al 2012; Trompeter, Scholte & Westerhof, 2011). Peer-aggression in these studies is defined as behaviours that are negative and involve aggressive physical, sexual or verbal interactions. Pillemer et al (2012) undertook a narrative reconstruction of 53 nursing homes in the USA, finding 122 events over a two-week period of behaviours including invasion of room privacy, arguments and teasing. Other studies suggest a prevalence rate for resident peer-aggression of between 10-20% (Trompetter, Scholte & Westerhof, 2011). A conference in the USA brought together professionals and made recommendations to address peer aggressions. Recommendations include: the identification of environmental factors triggering peer-aggressions, and the identification of 'perpetrator and victim' (p37) characteristics (McDonald et al., 2015).

1.5.2. Existing Literature: identifying influential factors

Several factors informing peer relationships are identified in the papers and some consensus exists. However, the provision of deeper analysis, sensitive to the person's socio-economic and political contexts, would arguably allow for more advanced understandings.

Authors identify residents as being socially withdrawn and suggest factors that inform this: depression (Casey et al., 2015), disability (Cook, Brown-Wilson & Forte, 2006; Jang et al., 2014; Casey et al., 2015), and old age attitudes (i.e. being selective or disinterested in forming new relationships) (Powers, 1996; Sefcik & Abbott, 2014; Roberts & Bowers, 2015). Sefcik and Abbott (2014) argue that there is caution in forming new peer relationships to avoid feelings of loss if the resident dies or is moved to another facility.

Disability is cited as one of the biggest barriers to a lack of verbal conversations taking place between residents (Sandhu et al., 2013; Hubbard, Tester & Downs, 2003). Cook, Brown-Wilson and Forte (2006) undertook a cross-study analysis on the narratives of two residents living in a care home, one with sight impairment and the other with hearing loss, to explore the influence that disability might have on peer relations in the care home. The researchers identified residents making conscious efforts to include the participants (e.g. ensuring that others in the home with disabilities received information about communal events), and other participants expressed feelings of isolation in the absence of other residents helping them. Sensory impairments also led to difficulties in recognising fellow residents which was perceived by the recipient as a breach of normal social conventions (e.g. failing to acknowledge others with a hello). The presence of disabilities is also linked in the papers to intolerance and exclusion of others, such as blaming those with lower Socio-Functional Status for inferior activity programmes (Hubbard et al., 2003; Sandhu et al., 2013; Jang et al, 2014).

Whilst social identity is not explicitly referred to in many papers, there are references made to participants not liking to see others go into decline for fear of what might happen to them (Sandhu et al., 2013), and to residents striving to be the same person and do the same things as in earlier life (Roberts & Bowers, 2015). Yamasaki and Sharf (2011) argue that people differentiate themselves from other residents on interpersonal levels of education and professional status. However, other authors highlight that having proximity (e.g. being in neighbouring rooms or table-mates) is enough to generate co-resident connections due to an increased familiarity and level of concern for one another (Kemp et al., 2012; Casey at al., 2015).

No longer being able to engage in shared interests (e.g. going to the theatre together) is mentioned in some studies as a barrier to friendships forming (Yamasaki & Sharf, 2011; Casey at al., 2015). Reference is also made to people engaging in formal activities with others as simply having something to do (Yamasaki & Sharf, 2011; Sefcik & Abbott, 2014; Roberts & Bowers, 2015). However, the contexts of the institution and of disability as limiting shared peer activities remains underexplored.

Yamasaki and Sharf (2011) refer to the importance of autonomy and control to people's experiences within the facility. Similarly, several authors raise the issues of peer support whereby co-residents value being able to assist others, but are largely unable to do so (Cook, Brown-Wilson & Forte, 2006; Kemp et al., 2012; Sandhu et al., 2013). Kemp et al. (2012) suggests that the policy of the home prevents assisting behaviours (e.g. pushing wheelchairs) of co-residents due to health and safety concerns. Powers (1996) concludes that aiding one another would be valuable to people 'having a job' (p52) and feeling independent, thus raising self-esteem.

The policy and management of the home is also implicated as a factor in peer relations with respect to withholding information from residents about co-residents in the name of confidentiality and protecting privacy. Participants in these studies state that this further prevents them from keeping in touch with one another once they transition into hospital or become unwell (Kemp et al., 2012; Sefcik & Abbott, 2014).

A prioritisation of prior-relationships is identified as a key finding in many studies and it is argued that these relations are emotionally deeper and more satisfying to residents (Powers, 1996; Hubbard, Tester & Downs, 2003; Sandhu et al., 2013; Sefcik & Abbott, 2014; Casey et al., 2015) (see also Cook et al., 2006). However, whilst it is mentioned that prior-relationships are 'outside of the institution' (Powers, 1996: 45), little exploration in the papers is made of the relevance of the institution and/or community contexts to a preference for external relationships. Instead, people's older age is given by authors as a reason for residents not desiring companionship and intimacy in the same way as younger people do (Yamasaki & Sharf, 2011), and that older people typically have smaller and family-centred networks compared to younger adults (Paye, 2012). Such arguments arguably feed into circular statements and offer little explanation of underlying reasons.

Shared experiences and backgrounds are found to inform closer connections (Casey et al., 2015). Kemp at al. (2012) suggest that 'race' (p 498) is unifying whilst Sefcik and Abbott (2014) argue that 'losing a spouse' (p16) is a meaningful experience that brings people together. Other authors suggest that gender (Paye, 2012; Sandhu et al., 2013), sexuality (Hubbard, Tester & Downs, 2003) and professional status

(Yamasaki & Sharf, 2011; Kemp et al., 2012) are relevant – for example, men being the ‘only two roosters in the hen house’ (Kemp et al., 2012: 325) and for residents forming sexual and romantic attachments with one another. These factors are also implicated as barriers to co-resident relations. Paye (2012) argues that interactions with sexual overtones may hinder relationships between male and female residents, and that being married and co-habiting in the care home with their spouse inhibits new relationships in the home. Class-based inferences are made by residents based on how people look, and this is concluded by authors as informing peer avoidant behaviours (Yamasaki & Sharf 2011; Kemp et al, 2012). Powers (1996) suggests gender differences as being relevant to dealing with hostile or unwanted behaviours, whereby women are more likely to avoid upsetting behaviours whilst men are more verbally aggressive than women in warding off unwanted attention.

The topics of loss and death are noticeably limited in the papers, though there is reference to residents forming closer connections to others in an absence of other relationships - “they’ve all I’ve got now” (Kemp et al., 2012: 498) and to the detrimental impact on bonds due to the transactional nature of being in the care home – moving out, dying, physical and cognitive decline (Sefcik & Abbott, 2014)

However, whilst many influencing factors are highlighted, further discussion, including an exploration of social discourses and of the institutional context, would help enrich an understanding of peer relations. Kemp at al. (2012) themselves acknowledge in their study that there is a lack of deeper analysis and explanation: ‘our effort to identify the multilevel factors affecting relationships mean that none was presented in detail’ (p 500).

1.6 Understanding peer relationships: contributions from wider literature

1.6.1 Theoretical development: a person-centred and needs-based approach

An infinite number of factors are likely to inform the lives and relationships of older people living in UK care homes. To help identify potential factors, it is helpful to draw out key themes in the wider socio-psychological literature on older adults.

A conscious shift towards hearing the voices of those most marginalised, including of those living in older age in institutional settings and with a diagnosis of dementia, is being increasingly made, and is helping to give clarity and depth of understanding to older people's experiences and to advances in theory and clinical application (Kewell, 2019).

Kitwood (1997) has been highly influential in this regard and introduced the Person-Centred approach to care. The premise of Person-Centred Care (PCC) is that the person is understood and supported in terms of their 'needs', achieved in part through changes to the physical and social environments. In this context, Kitwood identified the following needs as essential to someone's wellbeing: Attachment, Inclusion, Occupation, Identity, and Comfort. PCC is acknowledged in The National Service Framework for Older People (DoH 2001b) as an essential standard. However, a critique of Kitwood's early work is that people were positioned as being passive recipients of a status bestowed on them. Advances have been made in recognition of a person's active role in shaping their own experiential circumstances and of their own personhood (Tolhurst & Weicht, 2017).

More recently, James and Reichelt (2019) have amalgamated existing needs-based models with other themes found in the literature and identify the following areas as crucial to the welling of those living with a diagnosis of dementia (adding also a relational dimension of the person's desires to meet the needs of 'others'):

1. Physical Comfort and Freedom from Pain (e.g. room temperature, shelter, freedom from pain and sleep)
2. Perception of safety (e.g. having a sense of security in terms of health and safety - not wishing to feel fearful, nor having worries about health).
3. Positive touch (e.g. gain pleasure from meaningful physical touch with another person)
4. Love and belonging (e.g. the need for relationships, social connections and interactions, to give and receive affection and to feel part of a group).
5. Esteem needs (e.g. feeling valued, treated with dignity and respect. To be recognised as competent, to be listened to and to have a sense of self-worth).
6. Control over environment and possessions (freedom) (e.g. the need to be free is the need for independence, autonomy, to have choices and to be able to take control of the direction of one's life).
7. Occupation and exploration (e.g. the need to be active, to exercise curiosity, exploration. The need to have meaning and predictability in our lives).

8. Fun (e.g. the need to find pleasure, to play and to laugh).

Corresponding themes emerge from a literature review undertaken by Help the Aged (2007) which is an amalgamation of age-based charities and universities in the UK, with a stated aim to ‘focus positively on care homes, sharing best practice and more inspirational stories of success’ (p1). According to their review, the most relevant contexts to people’s lives in UK care homes are: ‘working to help residents maintain their identity’ (p1), ‘creating community within care homes’ (including, ‘negotiating roles, rights and responsibilities’) (p2), ‘shared decision making in care homes’ (p3), ‘health and healthcare’ (p3), ‘end of life care’ (p3), ‘transitions into care’ (p2), and ‘keeping the workforce fit for purpose’ (p5).

1.6.2 Maintaining social identity

1.6.2.1 *Social identity and relationships*

The role of social identity in the formation and development of peer relationships has received most attention in the literature with respect to younger people, especially in the institutional contexts of school and university.

Commentators argue that there are two types of peer relationships: dyadic (i.e. friendship quality based on voluntary, intimate dynamics and that involves cooperation and trust) and group-level (i.e. relationships with looser interpersonal connections, but include a form of categorisation such as being class mates) (Douman & Goossens, 2012). Identification in both types of relationships can be consequential.

The process of identity development and the evolution of the self takes place in the context of important relationships and ongoing interactions (*ibid*). Close relationships in particular, provide a central context to the development of self-awareness and representation and open, active exploration of identity occurs more readily in more intimate peer relationships (*ibid*).

Social identity has been found to play a key role in peer relationships. People with whom others most strongly identify have the largest influence on one’s behaviour. Social identity has been found to moderate the influence of those, for example, who are in the same sports groups (see Bruner et al, 2017), and on behaviours around substance use (Neighbours et al. 2013). Young children’s favouritism for their own gender group has been documented as being remarkably robust, across different cultures and socio-economic groups, with reportedly higher preference and liking for members of their own gender over others (see Martinez 2020).

Minimal literature to date, however, exists on the role of social identity in older people's experiences and especially of those living in care homes.

Knight, Haslam and Haslam (2010) conducted a longitudinal experiment to test social identity theory with 27 older adults living in residential homes in the UK. Residents on one floor of a new facility were involved in decisions surrounding its décor, while those on another floor were not. The residents' various attitudes were monitored at three points over five months. Identification with residents was measured by a single item, 'I like my fellow residents' (p1401). The researchers argue that consistent with social identity literature (e.g. Turner et al.,1994; Tyler & Blader, 2003), the members of the 'empowered' group reported increased identification with fellow residents, displayed enhanced citizenship, reported improved wellbeing, and made more use of communal space. Care staff ratings supported the self-disclosure measures observing that residents were visibly more active and willing to engage with one another. The results suggested to the researchers that 'rather than simply being 'in a home' residents 'felt at home' (p1408).

The importance of autonomy as self-direction and control over our identity has been identified in the wider literature, given that identity is changing, multiple and something that we need to take control of over ourselves (Hague, 2011). A study by Anderson, Issel and McDaniel (2003), of 164 USA nursing homes - although not theorised in terms of social identity - reinforces the importance of autonomy in the home. The study found that more inclusive management practices led to increased wellbeing of those living in the homes, specifically to greater communication openness; defined as being able to say what you mean without fear of retribution. An increased participation in decision-making at the organisational level was also related to lower prevalence of aggressive/disruptive behaviour among residents.

1.6.2.2 *Social identity and peer-rejection/belonging*

The definition of Ageism was proposed by Butler in 1969 in which he stated that ‘Ageism can be seen as a systematic stereotyping of and discrimination against people because they are old … on both individual and institutional levels’ (p244). For people who have experienced an accumulation of social inequalities over a lifetime, such as those from working-class backgrounds, reaching older age can result in multiple forms of disadvantage (e.g. Martinsson et al, 2012). Social discourses have the power to shape who we are and who we become (Fredman, Anderson & Stott, 2010). Stories describing older people as weak and lacking abilities are often so powerful and prevalent that it may be difficult for them and those around them to construct alternative stories (Fredman, 2010).

Laidlaw (2015) who devised the Cognitive Behavioural Therapy model for working therapeutically with older people has argued from clinical experience that negative beliefs surrounding ageing is one of the most pressing challenges when working with older people, and goes as far as to suggest that older people are the only group who do not want to be associated with the ‘in-group’. Lund and Engelstrud (2008) in their study, observed older adults attending a senior centre in Norway, engaging in subtle ways of distancing themselves from other members, especially those who had physical frailties, with a participant remarking, for example, “..I feel we are younger in our group…not necessarily in age but in behaviour” (p685). However, the literature on older people’s own attitudes towards ageing is relatively sparse in contrast to younger people’s views (Allen & Ranger, 2013).

Levy (2003) carried out a literature review on self-stereotyping and found that environmental cues can activate the threat of being associated with a discriminated group. This, in turn, has effects on behavioural responses such as shifting attention and reduced effort and lower self-expectations. Similarly, Allen and Ranger (2013) based on their clinical work, argue that a realisation that growing older independent of, or in addition to, health related complications, can lead to: rumination and self-attacking beliefs (e.g. ‘I’m too old to be helped’ (p13)), withdrawal and avoidance of others (e.g. ‘I don’t want to be seen by my friends/relatives looking old’ (p13)), unhelpful behaviours associated with negative beliefs (e.g. I’m too old to continue with my hobbies and interests’ (p13)). Motivation can be low and older people can be stuck in cycles of negative automated thoughts linked to negative stereotypes about old age (e.g. ‘my life is over, I’m just waiting to die’ (p13)).

In contrast, a clinical therapeutic group for people living with a diagnosis of Dementia -the Forget me not game -, Slade, Bone and Razzel (2015) talk about the therapeutic impact on members through identifying with their group. Group participants described themselves as ‘a forget me not’ (p40) which was taken to suggest that they associated with, and valued, the group as part of their identity (Tajfel, 1978). Group therapeutic factors, based on the theory of Yalom (1995), were identified by the authors that included evidence of increased altruism with members helping one another both inside and outside of the group context, and of an induction process being undertaken by existing members for new members to the group.

1.6.3 Loss and trauma

In addition to a threat to social identity, there is evidence too that moving into a care home can contribute significantly to people’s ongoing experiences of loss and trauma. Davis (2013) argues that experiences of some older people in later life, such as the loss of agency, the influence over one’s life decisions, and the loss of physical and cognitive health, may mirror the helplessness of trauma and provoke an unexpected reaction. Trauma, he argues, may be hidden at an implicit level. However, this might be enhanced due to reduced opportunities in care homes to help manage feelings of loss, such as an inability to commemorate (e.g. attending funerals and visiting grave stones).

Hiskey and McPherson (2013) carried out interviews of older people about their experiences of loss and trauma. They argue that issues of trauma are interwoven with culture, historically determined stigma, and social constructions of mental health. Overarching themes included: Don’t Tell Anyone *(*e.g. ‘put your feelings in your pocket’ (p21) -with an underpinning fear that ‘they will put me away’ (p21) -in an institution); Whinging is Weak (e.g. there is a lack of dignity associated with the expression of emotion); and No Self-Indulgence (e.g. getting on with it is virtuous). The findings here suggest that cohort related perspectives might impede the communicating of shared experiences of loss and trauma and that further opportunities for collective responses could be lost as a result.

Worden's (2009) bereavement theory states that people can be isolated by loss and that we only need someone to visit and listen as a necessary part of the grieving process. Otherwise, some of those experiencing bereavements, dying and multiple losses withdraw into self and silence and quietness; a gentle and natural process of withdrawal from life (Kewell, 2019).

1.6.4 Disabilities

Studies in the wider literature explore physical and cognitive impairments and their impact on relations between older people. Accounts from people with a diagnosis of dementia have revealed some of the difficulties in communicating with others. Norris (2015) has provided a written account of his experiences of living with Fronto Temporal Dementia and says that in conversations with others,

> "..people don't seem to comprehend just what I believe I have clearly outlined or said….I have a conversation twice over. This can be very tiring and sometimes it is easiest to remain quiet and to retire from the conversation' . (p36)

His difficulties in taking part in conversations with others, and his subsequent withdrawal, is supported in literature elsewhere. Carter, Stuart and Gooding (2015) undertook grounded theory with two older aged people with a diagnosis of Dementia and found a master level theme of Stigma. They identified a process of internalisation of stigma or 'self-stigmatisation' (p56), linked to feelings of invisibility and of behaviourally withdrawing from social contact. One participant spoke of losing 70% of his friends following the onset of cognitive decline. Other authors have also argued that some of the benefits of friendship, such as enhanced self-esteem and well-being, may be lost in situations where, for example, reciprocity is compromised (DuPertuis et al. 2001).

However, societal discourses of older people are often stigmatising for example, as being a burden on the UK economy (see Rampell, 2011), and are often underpinned by reference to declining physical and cognitive abilities. Similarly, assumptions can be made about people with disabilities being unable to enter into meaningful communication with others (Fredman, Martin & Stott, 2010). This can lead to an under-exploration of older and disabled people's experiences, when instead, attending more closely to their perspectives, or joining with them, can reveal deeper and nuanced understandings of how people continue to relate to one another in the context of disabilities (Kewell, 2019).

1.6.5 Death and Dying

Townsend's research in the 1960s led him and colleagues to conclude that the ways in which the death and dying of residents was supported and responded to, was a fundamental representation of their quality of life and of their relationships within the home. He writes:

> '..generally, however, a death was hushed up and the body removed swiftly and silently…. The death of others disturbed them less than the concealment of it. And the way death was treated was perhaps a crucial test of the quality of the relationship between staff and residents. …Prompt removal of the body was not only, old people felt, the final indignity which a resident suffered but it gave no chance to those who were left of paying their last respects to someone who had lived amongst them, however remotely, and of thereby giving a little more strength, dignity and feeling to the slender relationships between those who continued to share the life of a ward. ..' (Townsend,1962: 96).

For Townsend, the psychological and social consequences of death were little understood, and it symbolised the fundamental failure of the post-war homes. The response to death, for Townsend, '..did not create a substitute community or a network of social relationships which could sustain a sense of individual purpose or pride' (p148).

The importance of death and dying to the experiences of older people per se is something that is gaining more attention in the literature, though remains underexplored (Missler et al, 2012). Fleming et al. (2016) undertook research in the US of men and women between the ages of 95-101 (almost half of whom were in long-term care) to shed light on very old people's preferences regarding care towards the end of life and on their attitudes towards dying, to help inform policy and practice. The authors concluded that death was now a part of life for these very old people and that they were ready to die. There was a sense of life ticking along and living one day at a time in the present moment, "It is only day-from-day when you get to ninety-seven" (p3101) and many felt that they had nothing purposeful to live for.

Crucially, they attached importance to being able to maintain a quality of life for themselves that they determine (e.g. being able to continue to read) and to ‘not being a nuisance’ (p20) or a burden to others.

Systemic theorists have been influential in seeking to move the experiences of death and dying away from a focus on the individual and on medicalised discourses, towards an approach that opens up opportunities to understand death and dying in the contexts of relationships (e.g. Klass, Silverman & Nickman, 1996; Hedtke, 2014). White’s (1988) paper, ‘Saying Hullo Again’, has been influential in thinking about the ongoing relationship that someone has with the person who is deceased; moving away from a normative model that focusses on ending bonds or ‘saying goodbye’, for example, by inviting the deceased person’s point of view into current conversations.

Similarly, Fredman (2010) highlights the importance of allowing opportunities to talk about death and dying to be away from a position of expertise held by professionals and away from an expectation about how one might grieve – as assumed in theoretical models of grief (e.g. the Grief Wheel of Goodhall, Drage and Bell, 1994).

Studies and practice have shown that when people who are close to death are actively encouraged to talk about it, including to devise end-of life-plans, and to explore what matters most to them, they live longer (e.g. Greer et al., 2013). If we do not allow people to talk about death, the opportunity to confront their own mortality is lost (e.g. Fredman, Martin & Stott, 2010; Kewell, 2019). The fear that older people have, is not necessarily about death itself, but is more often about the lack of agency over death (e.g. dying at home versus in hospital and dying before the onset of cognitive decline) (Flemming et al., 2016; Kewell, 2019). With the certainty of degeneration and death, agency and idiosyncrasies can be pushed aside (Kewell, 2019).

How we approach death, and our autonomy and choice about how we die, affects our ability to flourish and our ability to find meaning in our lives, and thus too of how we relate to others. There is a search for ongoing meaning because of death, not despite it (Miller, 2015).

1.7 Current Study

The current study aims to contribute to a limited body of literature looking at co-resident relationships in UK care homes. Moreover, without sensitivity and critique, the experiences of residents from their own perspectives, including as research participants, can be lost and subsumed under powerful and hidden discourse. Providing space for people to share, and to have acknowledged, their own perspectives, is a powerful way of them retaining their own unique presence and identities. This study seeks to shed light on how older people actively search for meaning within the changes that are imposed upon them, rather than of being their victim (Karpen, 2016). Ultimately, it is hoped that a contribution is made to ongoing debates about how to create a good and meaningful life, with and for older people, who are ultimately and increasingly dependent on the assistance of others.

1.8 Research Questions

The following research questions inform the study:

1. What relationships do older adults have with their peers in residential homes?
2. What experience do older adults in residential homes have of other residents?
3. What factors influence peer relationships in residential homes?

CHAPTER 2. METHODLOGY

2.1 Overview

This chapter provides the rationale for adopting a qualitative methodology and informs the reader of the epistemological position taken, to address the over-arching research questions. Further details are provided on the research procedure, including data analysis and ethics.

2.2 Qualitative methodology

Qualitative methodology was chosen as the most appropriate methodology for this study due to the underlying core principles, aims and research questions. The theoretical principles that underpin qualitative methodology also better reflect the personal position of the researcher with respect to pre-assumptions about the nature of knowledge (epistemology), what can be known and how this can be known (Willig, 2013).

Qualitative methodology allows for a more in-depth and rich exploration into participants' own understandings, meanings and realities (Snape & Spencer, 2003). This is important due to the limited literature on this topic and the evidence of disempowered voices and perspectives of older people (Age UK, 2018). In contrast, quantitative methodology arguably makes greater claims to objectivity and is primarily concerned with testing hypotheses that are generated from existing theories, and of establishing and quantifying causal relationships (Harper & Thompson, 2011).

2.3 Epistemology

Epistemology is the 'study of knowledge and methods of obtaining it' (Burr, 2003: 202). It is the investigation of what distinguishes between opinion and informed belief. Historically, the existence of two scientific paradigms have been a divisive force in Clinical Psychology. Positivism has been historically privileged and assumes that the study of humans is comparable to the natural sciences. It posits that there exist 'truths' that can be accessed and known by an objective, independent and value-free researcher (Miller, 1999). More recently, qualitative methodologies have gained support in the field of clinical psychology and have shifted the focus from assumptions of objectivity to subjectivity within research (Parker, 2004). Epistemological positions informing qualitative methodologies acknowledge that the researcher cannot be value-free nor independent from those being researched.

2.3.1 Critical Realism

The epistemological position in this study is critical realist. Critical realism lies between realism and social constructionism. Realism assumes that material reality can be directly observed and social constructionism theorises that knowledge is developed in a social context and is dependent on individual interpretation (Harper & Thompson, 2011). Critical Realism posits that reality is not socially constructed and yet we also cannot be directly aware of the material objects in the world, though we can gain some knowledge of them (Burr, 2003).

Both critical realism and social constructionism have in common the idea that scientific and technical concepts need to be examined in the context of the broader socio-historical contexts in which they emerge (Bentall & Pilgrim, 1999). However, critical realism argues that a critical analysis of socio-economic influences such as age, disability, race and gender, allows for the acceptance or rejection of claims about reality (ibid).

In taking a critical realist position, it is assumed in this study that the participants' accounts can tell us something about reality but that it is not a direct mirroring of reality. Instead, socially constructed discourses will influence older adults living in residential homes (e.g. Rogers & Pilgrim, 2003) and their accounts will be subjective perspectives and interpretations of the world (Harper & Thompson, 2011). Moreover, the critical realist position recognises researcher's own contexts as being as important as participants' contexts and, thus, the study is a product shaped by the participants, the researcher and of the relationship between the two (Willig, 2013).

2.4 Reflexivity

Due to the subjective and active involvement of the researcher throughout the research process - including on the collection, selection and interpretation of data- it is important to undertake a process of reflexivity. Reflexivity involves the 'process of examining how the researcher and intersubjective elements impact on and transform the research' (Finlay & Gough, 2003: 4). The researcher must engage in a process of critical self-reflection with regard to how their own socio-economic background, life experiences and related interpretations and behaviours might influence the research (ibid), and be transparent about their existing relationship to the topic area (Willig, 2013). Reflexivity is a crucial feature of critical realist research and of qualitative research more broadly (Parker, 2004) and helps to gain insight into how understandings and final analyses are reached in a research study.

2.4.1 Statement Positioning

It is important that the researcher is reflective and undertakes measures to reduce their own influence in the data collection and analysis, including any influences on what is or is not spoken of (Parker, 2004). As part of this reflexive process, it is appropriate to discuss several contexts of the researcher that might inform this study.

It is important that I seek to unpick any pre-understandings that I have gained from my interest in the topic area and remain curious to what is raised (Fredman, Anderson & Stott, 2010). My own interest in this topic partly comes from observing my grandmother living in a nursing home. I am also from a generation where older people being in residential homes is viewed as normal (Kewell, 2019), however, neither of these understandings may be shared by those currently living in care homes and with whom I might speak.

Being from a privileged (White) and professional background might help me gain consent to speak to those living in residential homes, as medical discourses might elevate my status as someone who is 'helpful' and worthy of engagement (Fredman, Anderson & Stott, 2010). This needs to be navigated carefully, ensuring that those I speak with do not feel obliged to take part due to our differences in social status (or indeed of any assumed similarities as being female and White), and that these influences are considered with regard to what might be comfortably brought up or not by someone living in receipt of care services (see ibid).

My experience of living at home without dependency on others, and of remaining in a privileged position of being able-bodied and in my younger adult years, is a stark difference that is likely to further influence what is raised and inform my ongoing understanding. My life is such that I have not lived in fear - however illusory or not -

of social isolation and ill-health. My personal and professional position is likely to differ markedly from those older adults living in residential homes. I also do not want to assume differences to the extent that I succumb to societal discourses and view those older adults that I speak with as a ‘different species’ (De Beauvoir, 1972:9).

A reflexive journal will help provide a space in which I can reflect on my own thoughts, pre-understandings and beliefs that might inform the research (see Appendix C, for an excerpt of my reflexive journal).

My position statement will not be able to capture the myriad of factors that will likely influence this research. I will endeavour to continue with a process of ongoing critical self-reflection and reflexivity throughout, and this will be addressed in the discussion.

2.5 Data Collection

There exist different types of methods for data collection within qualitative research and ongoing debates about what contributes to the best quality research (Potter & Hepburn, 2005). Some researchers favour ‘naturalistic’ style data collection above interviews due to the risk of ‘leading’ participants during the interviews. However, arguably, the preference for naturalistic data collection reinforces the idea of objectivity where researcher and researched can be separated and negates the processes of reflexivity.

Using semi-structured interviews, allows the acknowledgement of impact of the interviewer in the construction of the research and data collection and of the relationship between interviewee and interviewed in the co-construction of knowledge (Banister et al., 1994). In comparison to closed-interviews, semi-structured interviews allow for more participant-control and freedom over what is spoken about, which is deemed especially important for older populations where, more typically, life stories are woven into interviews and where power and coercion are heightened ethical considerations (Robertson & Hale, 2011). Focus groups were also considered for this study, however, due to the nature of the topic being about peer-relations of those currently living together, including potentially about problematic relations, it was considered to be too sensitive a topic to be explored initially in this way.

Jonathan Smith's (1995) guidelines on semi-structured interviews were used to help construct the questions and ensure that the interviews were well-paced and that the language was accessible to participants (see Appendix D Interview Schedule).

2.6 Participants

2.6.1 Inclusion criteria

- Older adults living in UK Residential Care Homes[4]
- Are able to communicate verbally
- Are able to give informed consent to participate

2.6.2 Exclusion criteria

- Those diagnosed with Dementia.

The reason for not including those with dementia in the study was because of concerns about informed consent (Cubit, 2010). Additional requirements would be required to assess capacity and informed consent that were deemed beyond the scope of this study.

2.6.3 Sample justification

Recent guidelines for thematic analysis (Braun & Clarke, 2012) recommend 6–10 participants for interviews to yield enough data in smaller projects to uncover all themes of interest and to meet criteria for data saturation.

2.7 Procedure

2.7.1 Recruitment

The recruitment of older people in care homes is claimed to be more straightforward as compared to recruiting those who are living in the community (Liljas et al., 2017), however, many factors remain relevant. Those living in residential homes are arguably some of the most socially disadvantaged older people in our society (Equality and Human Rights Commission, 2011, British Geriatrics Society, 2020).

---

[4] Residential care homes provide meals and 24-hour access to personal care to those with comparatively fewer mobility and dementia-related care needs.

This context lends itself particularly to requiring ethical sensitivity to recruitment and consent.

Particular ethical considerations are critical to enable an informed and empowered decision-making to take part. This is in a context where there may be particular expectations or concerns about access to ongoing advocacy and services, and of the need to attend to power dynamics; not least with regard to the potentially blurred boundaries between professional/personal role and between public/private spaces within the care home (Robertson & Hale, 2011).

2.7.1.1 *Engaging with care home management*

To maximise recruitment, and attain interest in the research, the managers of seven care homes in Hampshire were contacted initially via email. Building relationships with professionals in a care home is important, as they play an important role in safe-guarding (NICE, 2021) and can act as gate-keepers to potential participants (Knechel, 2013).

None of the homes responded via email. Follow-up phone calls were made to all seven care homes and messages were left for managers via colleagues. Out of the seven homes contacted, one responded and a meeting took place in August 2016 between the researcher and the manager of the home. Following this meeting, further email exchanges took place with the Head of Human Resources of the care home ownership company, who, alongside the manager, gave their consent for the research to take place in one of their residential homes (in line with the study's ethical requirements).

Between July and August 2016, two additional care homes in London were visited and relevant information was left with Reception staff, however, the manager of one site was unavailable to meet and at the second site, the interim-manager was covering sickness and was not in the position to agree to research taking place. The recruitment process of email and follow-up phone call in this study proved to be the most successful.

2.7.1.2 *Visiting residents in the residential home*

Visits were made to the care home that had agreed to take part. I attended two activities sessions in the lounge where residents were present. This allowed familiarity to be gained for both the residents and myself, and provided me with an opportunity to introduce myself and the research. Recruitment was further aided by the manager approaching residents first and passing on the details of those who had first given their consent for me to visit them in their rooms; repeated visits took place over four days. Overall, this recruitment method yielded the most participation, as the manager was onboard with the research, and it meant that the residents were more likely to trust the process and to participate (Robertson and Hale, 2011).

2.7.2 Description of the Sample

In total, seven participants took part in this study. The table below (Table 1.) provides demographic information on the participants.

Name*	**Gender**	**Age (years)**	**Ethnicity**	**Length of stay in Residential Home (years)**
Ethal	Female	93	White-British	15
Pam	Female	86	White-British	3
Joyce	Female	82	White-British	5.5
Lynn	Female	89	White-British	3
Ken	Male	87	White-British	1.5
Mabel	Female	91	White-British	5
Violet	Female	89	White-British	4

Table 1. Participant Demographics

*All participant names have been changed to ensure anonymity.

2.7.3 Data Collection and Analysis

2.7.3.1 *Semi-Structured Interviews*

Seven individual semi-structured interviews lasting between 20 minutes and 67 minutes were conducted in one residential home. The interview schedule comprised of a list of predefined questions (See Appendix D). However, the interview remained flexible depending on what was discussed by the participant. All of the interviews were audio-recorded.

2.7.3.2 *Transcription*

The interviews were transcribed according to Malson's (1998) transcription convention (see Appendix E) and were transcribed verbatim. Due to the methodology selected for this study, detailed aspects of the recordings were not necessary (i.e. tone, non-verbal utterances and pauses).

2.7.4 Thematic Analysis

Thematic Analysis (TA) was selected as the method of choice for this study due to its suitability for a topic that is largely under-researched (Breakwell, Smith & Wright, 2012). Given the dearth of research on peer relations between those living in their older years in residential homes, TA allows for theoretical 'flexibility' (Joffe, 2011). A critical realist approach was adopted, and interpretation of the data involved exploring how participants made sense of their relationships with other residents living in the home, whilst also allowing for analysis of the boarder socio-economic contexts informing meanings (Braun & Clarke, 2006).

Any potential losses from choosing TA above alternative methods, such as Narrative Analysis, can help to be mitigated with a TA approach that carefully adopts similar principles - acknowledging social structures and discourses in shaping experience and how stories can be told; close listening and an awareness of what is 'absent but implicit'; valuing insider knowledge; and providing rich, nuanced and complex descriptions using 'rescued' words'. However, care is needed to ensure a fair representation of diversity, when TA leans towards making sense of commonalities rather than of idiosyncrasies, as in Narrative work.

Furthermore, TA is acknowledged to be a suitable method for informing service provision (Braun & Clark, 2006), which is of ethical importance given the prevalence of social inequalities amongst older people and of those living in care homes. It is also in line with the Clinical Psychology professional body's own acknowledgement of the need to improve psychological services for older people (British Psychological Society, 2006). TA enables the identification of themes through adopting either an inductive ('bottom up') or deductive ('top down') approach (Braun & Clarke, 2006). The present study adopted an inductive TA, with aims to understand themes as they are grounded in the data, rather than pre-prescribed by a theoretical framework (Willig, 2013). However, given that a literature review was conducted prior to the data collection, the approach also represents a deductive approach in so far as this knowledge will have influenced how the data was interpreted (Joffe, 2011).

A six phased approach as devised in Braun and Clarke's (2006) paper, was used to guide the process of analysis whilst also taking into consideration further discussions by the authors in subsequent papers (Braun & Clarke, 2019), namely about the importance of reflexivity, and the intersection of data, analytic process and subjectivity (rather than the assumption of waiting-to-be-discovered themes presiding in the data):

- Phase one involved immersion in the data in order to gain familiarisation and was undertaken through the processes of transcription and active reading and re-reading of the transcripts, including jotting down of ideas and observations as they arose.

- Phase two involved the generation of initial codes to help organise the data into meaningful groups or "buckets" (Braun & Clarke, 2019:12) (see Appendix F for a list of initial codes). Codes were noted in the margins of all of the transcripts (see Appendix G for an example of an annotated transcript).

- Phases three and four involved the process of generating, reviewing and revising themes. Initially, this involved collating codes and related material (see Appendix H for an example of a coded data extract). Subsequently, codes were printed, cut out and organised visually into meaningful clusters with central and unifying features (see Appendix I). The clusters of codes were then organised in proximity to one another where they were seen to be in relationship. This process fostered a sense of coherence across the data and allowed for decisions to be made with regard to boundaries between themes. An initial thematic map was produced (see Appendix J), which was then redefined to produce a final thematic map (see Appendix K). Phase five involved reviewing the coherence, quality and boundaries of themes and producing a defined and named theme. The process of reviewing involved comparing the themes with excerpts from the original transcript to ensure that the essence of what was said had been captured and not lost through the stages of analysis, and to help ensure the quality of the themes in relation to the research questions.

- Phase six was the final write-up of the analysis which seeks to provide a concise and coherent account of the data both within and across the themes.

2.8 Materials

A password-protected computer, transcription equipment, an interview schedule and a digital recorder were used to conduct this study.

2.8.1 Construction of Interview Schedule

The interview schedule was developed based on existing literature having identified both salient topics and under-explored areas. Open ended questions were devised to reflect these broad topic areas. The semi-structured interview was undertaken in a non-prescriptive way and the interview questions were used as a guide and brought in flexibly, in response to the participants' responses. Digression from the schedule from time to time was allowed when new ideas came in and to follow what was being said, however, the schedule was always returned to make sure the necessary information had an opportunity to be heard.

It was important to ensure that the questions were not leading in any way (Smith, 1995). A draft interview schedule was checked by my supervisor to help ascertain clarity and structure to the questions. A general last question was given inviting participants to share anything additional that they would like to talk about.

2.9 Ethics

2.9.1 Ethical Approval

The University of East London granted ethical approval for this research (see Appendix L). As the participants were recruited from a community sample, NHS ethical approval was not required.

2.9.2 Consent

An information sheet was provided to any potential participants (see Appendix M) with details of the aim of the study, the process involved and information about anonymity and withdrawal. Furthermore, staff were informed of exclusion criteria with regard to a diagnosis of dementia when providing names of those who were interested in taking part, and any suspected cognitive impairment/dementia during the process of gaining consent (or at any other time) would have led to the exclusion from the research. Those who agreed to take part were asked to read the information sheet again and to sign a consent form (see Appendix N).

Participants were monitored for signs of fatigue and distress, throughout the interview and were offered breaks or to terminate the interview as necessary. In the event of participants becoming distressed, they were informed that they would be signposted to the appropriate support services. At the end of the interviews, participants were debriefed and were provided with the opportunity to raise any concerns or questions.

2.9.3 Confidentiality

To ensure the anonymity of participants, pseudonyms were used and all identifiable information, such as location, was removed during transcription. Only the researcher and supervisor had access to the audio recordings. Audio recordings will be deleted at the end of the research and transcripts will be destroyed three years after the study has been successfully examined, in line with the Data Protection Act (1999).

CHAPTER THREE: ANALYSIS

This chapter examines in detail the themes that were derived from the data analysis and provides extracts from the participants' interviews.

In total, four themes were constructed, each with sub-themes (See Table 1. Themes and Sub-themes). The four themes are: Belonging and Connection: an integral need; Self-esteem and Validation: maintaining a unique presence; Freedom and Control: negotiating authorship of life, and Occupation and Growth: a search for meaning.

The themes reflect aspects of the participants' account to varying amounts. Descriptive terms such as 'all', 'most' and 'some' will be used as indication for the level of participant response.

In order to protect the anonymity of participants, pseudonyms have been used for each participant, and in place of people and place names the following is used e.g. [fellow resident]. The letter 'I' is used to refer to the interviewer and the name e.g. [Mabel] for each participant. Minor changes have been made to the interview excerpts to improve the readability. For the purposes of clarity, repetitions or filler words (e.g. 'like') and hesitations (e.g. 'errr') have been omitted from excerpts. The omission of words to shorten quotes is indicated by a dotted line in enclosed brackets (…). The addition of text to provide further explanation or to signify non-verbal responses to the reader, is denoted by square brackets [text].

Table 1. Themes and Sub-Themes

MAIN THEME	**SUB-THEMES**
Belonging and Connection: an integral need.	• Institution versus 'home' • Prior-life relationships
Self-esteem and Validation: maintaining a unique presence.	• A social and physical death • Seeking those who bolster Self
Freedom and Control: negotiating authorship of life.	• The institutional context • Barriers to bonding
Occupation and Growth: a search for meaning.	• An absence of shared interests • Withdrawal into Self

3.1. Belonging and Connection: an integral need

The first theme refers to a desire to have a sense of connection, closeness and belonging with other people that is of personal and/or social value. It includes opportunities to interact in settings that provide a sense of belonging.

The first theme sets the context for the proceeding themes as it explores the institutional setting in which they are all living and represents an underlying need to be in connection with others. This theme will be explored in relation to two sub-themes: ‘Institution versus ‘home’’ and ‘Prior-life relationships’.

3.1.1 Institution versus ‘home’

The participants all compared and contrasted the residential setting to the homes in which they lived prior, and it appeared to represent both a significant change and a meaningful loss to them; the residential home was not their ‘real’ home. Feelings were expressed in statements referring to life as a “new chapter” (Lynn, 227), and in descriptions that, on the face of it could appear mundane, but that instead seemed to refer to changes that have altered a way of life that they had previously enjoyed. Mabel remarks:

> (Mabel: 203-217) I brought some wool to do more crochet and I can’t be bothered to start. I used to do patchwork too. It’s difficult to do some things when you haven’t got things to hand and there’s no table in here for a start really is there (…) not got room to do the things in the way I used to do them.

The residential home, as a departure from ‘real’ home, is encompassed too in how co-residents relate to one another. There is a marked absence of conversation and reciprocal exchange, and most participants spoke of their peers as not being relatable to in a typical way. In the extracts below, Ken and Pam connect changes in social interactions to the experiences of loss and separation from community and home to now being in “a place like this”.

> (Ken: 114-116) Living at what we call home is completely different to living here, when you know everybody down the road, and they come and chatter to you. But you miss a lot of that in a place like this.

> (Pam: 400-469) Most people are very docile. They have their foibles; most people are very quiet. I think what I miss most is normal social interaction. (…) I miss the casual

> conversation between adults of one’s own age or younger. I mean, I’ve never, when I was working you never thought about. It was only when I stopped working that I began to realise that people I just dealt with were maybe 20 years younger. You know age difference and among my peers in terms of rank, some would be older, some would be younger. But you know age was never material. Come here and to be, that has been quite difficult. And it’s surprising because as I say I’m not a sociable person, it’s just the surround, the stage setting has not been stimulating (…) it’s sort of saying moving from a multiculture to a monoculture (…). So, when I say beached whales that sounds a bit horrid, but it is just that they’re lost to sight and lost to everyone else, are real people.

Pam describes a move from a “multi-culture”, which infers a diverse and intergenerational community that would happen naturally in society, to an artificial “monoculture”, whereby “age” (old age), is now instrumental. Moreover, Pam’s description of fellow residents as “beached whales” is a powerful image and is further suggestive of a place that is disconnected from real life. “Real” people have become so separated from others, from the community, that they are now stranded and left to die.

The care home is compared, by some participants, to the institutional settings of school and medical training living quarters. In a similar way to Pam, Joyce describes institutional life as being with a “crowd of people about your age”, and arguably infers too that the care home is an infantilised context, when she compares it to school; and is a medicalised context, when she brings in diagnosis. Such descriptions suggest an imposed labelling of people living in the care home that is not out of personal choice, and is unlikely also to hold personal value and create the desire to belong.

> **I** Can you tell me what it is like living with other residents here?
>
> **Joyce.** Well, I was at boarding school and then a nurses’ home, so it’s similar to that.
>
> **I** So, in what ways is it similar?
>
> **Joyce.** Well, living with a crowd of people about your age.
>
> **I** Okay, can you tell me what that’s like?

> **Joyce.** What do you mean what's that like? If you've been brought up with it you don't, it's not diagnosed, you don't consider it, it's just part of the scene, isn't it?
>
> **I** Okay, so it hasn't felt much different living here with other residents to how you've lived with others in your earlier life?
>
> **Joyce.** Well, obviously it's different than living in your own home with your children around you. (22-30).

As might be expected, some participants discuss their own and other resident's disabilities as a factor in the difficulties of conversing with their peers. However, notably, disability is not mentioned by all the participants, nor is it given as the exclusive reason by any of them for limited engagement with others. Ethal only mentions her difficulties with hearing as a possible factor at the end of the interview, almost as an after-thought.

> (Ethal: 300-316) there is not the number of people that I want to form a close relationship with (…) And I have to wear hearing aids, which is restricting.

Participants instead are speaking of factors, additional to disabilities, that inform co-resident relationships. Ethal, for example, describes a resident who she finds pleasant and who she is able to converse with (presumably who can engage in intelligent conversation as she "knows everything"), but who is still someone that she does not always want to "listen" to. Ken identifies that there is a "reluctance" in others to speaking to him.

> (Ethal: 276-278) Well, half the residents haven't got a conversation. The lady I am sitting with at the moment, she is a retired civil servant who knows everything, but I don't always listen. She is quite nice. But I don't know.
>
> (Ken: 1-2) you don't really make contact with other people too much, because either they're deaf or they're *reluctant* to talk.

There is an ongoing curiosity in Pam's account about possible unknown factors. Pam speaks of an effort by organisers to encourage people to talk about their life travels and experiences, by holding objects intended to stimulate people to reminisce. However, no one spoke to which she concludes:

> (Pam: 482-483) I think it was too much effort probably. I mean I can't say why, you'd have to ask them.

In the accounts of some participants, Men are observed to have even less contact than women do with fellow residents. Ken, as a male, reinforces this observation as he seems particularly unable to form closer connections despite his efforts to do, and despite his feelings of loneliness without this. Ken describes his attempts at getting to know others and to "have a bit of a laugh" (Ken, 9), but it is largely futile. This is also a comparison to the fact that all the female participants interviewed spoke of having at least one peer companion. It is possible here that gender and/or marital status are contributory factors within this non-community setting, that inform a particular 'reluctance' or otherwise, for residents to converse with one another. Ken also speaks of having his "other half" (Ken, 187) living in the care home with him, whereas most others in the home are widowed and are presumably managing and living with their grief. Providing a contrast to Ken's situation, Violet remarks:

> "I think most of them that are in here have lost their husbands, I think that's obvious" (51-52).

It is possible that those who are widowed are distancing themselves from the married couple as they are needing to protect themselves from further reminders of their loss.

There are descriptions of other residents that most of the participants make, that is suggestive of a setting in which they feel that they both do not belong to, nor want to belong to. Derogatory descriptions of others include others as not being "normal" (Lynn: 249), and not being "civilised" (Ethal: 61). This is indicative of a process of Othering being deployed by the participants in which a distance between 'us and them' is created, and in which the Other is of a lesser status.

3.1.2. Prior-life relationships

Nearly all the participants referred to the emotional importance of ongoing bonds with those that they have known in former years, and importantly too, who are external to the care home, whether they be alive or deceased. Families, old friends and even little-known neighbours, provide a significant source of connection and meaning. The death and dying of old friends and family is raised by several of the participants as a significant loss and concern to them, and for Lynn, her family are more important to her now as "they just really care about you" – presumably in contrast to experiences of 'care' undertaken in a professional capacity, by staff who might not. For Ethal, the identification with her (deceased) husband and of her former professional role, is an ongoing source of strength, connection and belonging to her. It is also the reason given by her for not missing deeper peer-relations in the home.

> (Lynn: 81 – 91) we lived in the same retirement block close to here and were neighbours there (…) *we already knew each other* (…) I really still miss her (…) because we used to get together apart from activities. Every Sunday morning we'd get together and have a good old chat and talk about things here that have irritated us and just have nice chats. She died just over a year ago.
>
> (Lynn: 111-114) I feel sorry for people who have no family because it is particularly when you are old, you realise that they're the most important people in your life, and they just really care for you. So, I've got a lot to be thankful for.
>
> (Ethal, 383-386) **I** those deeper friendships, is it something that you miss, not having here, or does it?
>
> **Ethal**. Not particularly, of course, because I had a husband. And I was very busy with the [War-time body]. I have got a long service [War-time body] medal presented to me by Lady Reading, if you have never heard of, when she retired. And I got her, I got the [War-time body] medal.

A desire for connection and belonging, nevertheless, remains important to all those interviewed, and regardless of the level of connection. Lynn suggests that making contact with others is vital to prevent the decline into a “vegetative” state – akin perhaps to the “beached whale” (Pam:468).

> (Lynn: 48-51) One thing I sometimes think, if elderly people who live on their own perhaps don't see anyone to talk to, I think then they just vegetate and it's so important to keep in touch with people, to keep your brain just going around a little bit.

A need to connect to other residents is evident in all the accounts. Nearly all of the participants identify one other resident who is a companion or “neighbour”. These peers are a valued source of company, including for example, as an exclusive dining companion at mealtimes. However, they do not appear to be intimate nor emotionally intense relationships, and is even inferred by Violet as being replaceable. In the extracts below, these identifiable residents are people with whom the participants are “friendly” with but do not have a deeper friendship with:

> (Violet: 147-149) Very friendly. We have a good laugh together, she's very nice. She talks about her family and that, you know? It's just like being at home with your neighbour.

> (Ethal, 285-289) I quite liked the lady next door, we had very little in common except sport, but she used to send me little notes when there was any tennis on or when there was any cricket or anything that might interest me. But we didn’t have a close – she kept very much to herself and probably I do.

> (Lynn: 67-77) So, I am friendly with a lady in the middle floor, but there again her memory has gone so much in decline she can't remember what happened yesterday or anything. So, that's a bit more difficult now, but I am friendly with her (…) we get together sometimes and we can chat. She's alright talking about things in the past, so we can discuss things like that. You know that whatever you say to her you might have to say, she'll ask the same sort of things the next time I see her, so it's not easy really, but she's a nice person, I like her.

Only Pam is seeking deeper peer-relations in the home. Pam has found herself needing to find a way to “live” this life, and as a way to achieve this seeks a level of intimacy to a peer. However, notably, she is consciously breaking with a life-time way of relating to others. It is living in the care home, trapped in a “cocoon” and alone, that has driven a substantial change for her. Such intimacy is found through both women disclosing personal information in a trusted space, and Pam is purposively talking “with” rather than “to” her confidante.

> (Pam, 65-68). I have said to her things that I wouldn’t normally say to anybody. Simply because they need, I need to express them. They’re things I’ve said to myself umpteen times and she said, well I told you what she said, and I said as we parted, I said ‘we can talk’.

> (Pam 155-163). she said something about I was the only person she could really talk to. I said the same back (…) Partly when I said it, I did mean it, but there was a definite element in my saying it because I thought it would be important to her to know that I appreciated talking to her, talking *with* her.

> (Pam: 170-182) But I'm not basically a people person. I've always avoided any sort of close commitment and I think of myself as an observer of life rather than a liver. I chose not to marry, not to have, chose to avoid all sorts of close contacts (…). Well, I never needed, really needed to conform because everybody was living such a busy, full life. And certainly, any sort of taking time out of work to do a bit of mutual therapy, would not have been encouraged. And while I was working I, it really was the focus of my life, and living alone, I didn't really need to. But I can't be here and I can't be here in a cocoon. I have to live it.

Pam is the only participant who has an intimate connection to a peer, which seems born out by her isolation, but is generated too, perhaps, by the absence of family members, and prior-known close contacts, in her life.

3.2 Self-Esteem and Validation: maintaining a unique presence

This theme refers to being valued and acknowledged by others for one's contributions and competencies, and to maintaining relations with others that are characterised by dignity, respect and a commitment to an equal voice. This theme will be explored in relation to two sub-themes: 'A social and physical death' and 'Seeking those who bolster self'.

3.2.1 A social and physical death

Death and dying appear to be omnipresent experiences. Although the participants speak of not knowing others well, nonetheless, they are emotionally moved enough to speak of their co-residents' deaths. In the extracts below, the deaths of others are described by Pam as a statistic with "an average death a month" which seems divorced from its significance of it and conjures up an image of a production line. Violet refers similarly to the dying and/or death of co-residents in a way that appears to be distant or restrained but is instead likely to be a highly significant experience. She refers to observing other residents going missing at the dinner table and who she anticipates will never return. The reality and proximity of death and of going "missing", represents a stark contrast to the daily routine of meal times.

> (Pam: 321-322) things do turn over, they tend to happen in bunches. But it works out about on average a death a month.

> (Violet: 38-44) you notice the same people often sit at the same table for a long time, and then you miss them because they're not there, and you think, 'Well where are

> they?'. So, you just ask the people that they've been sitting with, 'Oh, they're not well today, they're in their room'. But gradually you realise that they're not coming down for a meal and they must be quite poorly.

The way in which death is managed within the home comes under question and appears to ignite an emotional response of both upset and anger in the participants who raise it. In the extract below, Pam is reflecting on the death of a family member and is making a comparison to her own death and the death of other residents in the care home. Pam is speaking of a community death versus an institutional death. Her aunt was on a “widow’s cruise” (Pam: 530) and “surrounded by friends” (Pam: 531) and in contrast, Pam is facing a death which, enshrined in company policy, is purposely under-acknowledged and is not celebrated. The policy, which she goes on to successfully challenge, has been to simply place a sign of a dove on someone’s door when they die.

> (Pam: 539-563) [my aunt] would say “old people are so used to it (death) we aren’t affected by it” (…) I’m sharing [her philosophy] intellectually. But I mean my immediate neighbour died and it was still in the days of putting up that wretched thing. Well, I mean I’d known she hadn’t long (…). But I didn’t know and they put, it was still at the stage of nobody is to be told. Bloody confidentiality, it’s crazy. And I went out of the room at about half past eight, nine o’clock, and something made me, oh the door was shut, properly shut. Something made me look up, and there was this thing. And I did go down the next, to [the manager] had only just arrived, the new manager, and I just went down the next day and said ‘look it’s wrong’, she said she thought it. Don’t get the pigeon anymore.

However, this still seems unresolved to Pam, despite a change of policy, as she continues to grapple with the hushed-over sense of someone’s death. Despite the significance to her of someone’s death, Pam concedes that “life’s just carrying on normally” (Pam: 578).

Several participants are reflecting on those that they live with as representing something akin to a social death. They are alive but with little resemblance to their former identities. For some of the participants too, their own death and dying is spoken of with a fear of whom they might become and is tied up too with what other residents represent to them. Lynn speaks initially about other residents, however, soon reverts back to her own changes and cognitive decline which makes her "panicky".

> (Pam: 466-468) She said that [fellow resident] was Armenian in origin, and again, she must have a fascinating back story. But it's not something that you can ask her for.

> (Ethal: 60-74) we are getting people in that are different. They are not civilised (…) we didn't have such odd people in those days.

> (Lynn: 178-260) they're not particularly unhappy or anything, they smile and when I go in the lounge we always wave to each other. So, there is a kind of reaction there (…). I'll probably, my memory's not half as good as it was and I suddenly get, as I'm speaking to somebody, a word that I know so well but suddenly my brain just closes down and then I get a bit panicky because it makes it worse. So, I might get, maybe I've noticed the way that older people gradually go into a decline. I don't feel as well as I did even a couple of years ago.

However, there are hints in some of the participants' statements too that such negative judgments made of other residents might be too dismissive of their true selves and capabilities. In the extract below, Violet goes on to question her own pre-assumptions of others:

> (Violet: 35-37) Well, perhaps you think that they like their wine and that. You know, more. I can't explain it really. They know more than what you think they do, perhaps that's the best way, and we're all a bit of a mix up because everyone's different here.

Violet's judgment about alcoholism, the assumed shared understanding with the researcher in saying "you know", and her confusion over this, might all suggest an underlying assumption of others that she cannot quite decipher but that she ultimately deems to be inaccurate - a pre-judgement perhaps, informed by wider societal stereotypes and discourses.

Several of the participants refer to experiencing negative emotions when another resident acts in an unfriendly way towards them and to other residents. It appears to be a lack of acknowledgement of the other person that is so intolerable and seems to ignite feelings of inferiority and of widespread upset.

> (Violet: 94-99) Oh, she did look miserable! And in the end, I asked if I could be moved to another table, because she didn't say good morning, good afternoon or goodnight when she was at the table, she really did absolutely. I don't know.
>
> **I** Why do you think that was? Why do you think she was like that?
>
> **Violet.** I would put it down, she did think she was superior. I don't know.
>
> (Lynn, 188- 210) There's one lady who sits at my table at lunchtime and I've never known such a miserable, complaining (…). For instance, another lady who came, she came here and she was a very happy person and when she was introduced to, I won't say the name, I nearly did, she just said, 'Oh hello, nice to meet you, how are you?' or something, 'are you well?' or something, and she just barked back ‘I wouldn't be in here if I was’. It makes her very unpleasant. So, you get the odd resident who's like that, but that's unusual (…). In fact, when she's at the table, I notice that once she leaves, when she's finished her lunch, we're all in a happy environment. She makes you feel uncomfortable really.

In Ethal’s account, her prior professional identity is invoked as a response to an unwelcome judgment that she receives from another resident. It appears to be a defensive response under a perceived attack, and one that serves to reinforce and maintain her own sense of competency. She refers to having “quite a background” that is not necessarily one of privilege, and is a reminder to herself, that she is a resilient person.

> (Ethal: 63-68) And he said “well, you are all right, you have never gone without anything”. So I said I am not a doctor and my husband wasn’t a doctor, but there is a younger generation who are. But he mishears then says I have never gone short of anything. Well, I probably haven’t. I mean, I have never starved. But I was in the services during the War; that gives you quite a background.

Notably, the participants all refereed to their roles either in the Second World War or of other professional roles, namely, as a nurse, economist and telephone typist. These references indicate an ongoing identification with, and a need to be known and recognised as a professional and competent person, in this context of assisted living and old age.

3.2.2 Seeking those who bolster self

It was striking that the participants all seemed to share an attraction for particular characteristics in their chosen companion. Violet and Pam describe their chosen companions.

> (Violet: 19-23) I've been friendly with a young, she's not young but she looks young, for some time since I've been in here, and I thought she was perhaps forty, instead of that she's nearer my age! She doesn't look it you see, and she's a happy person and she's very nice, but she certainly doesn't look her age.
>
> (Pam: 79-86) I just can't be in this place that's got no life in it. And I found myself seeing [fellow resident] and she's physically, like [fellow resident] across the way, both of them are women of some degree of physical distinction, they've aged beautifully. And she looks very, looks intelligent and nicely dressed, and so I was immediately attracted to her as someone who stood out from the (crowd).

The characteristics of youth, beauty and intelligence might here represent an antidote and resistance to the stereotypical understandings that surround them of old and very old age being associated with, for example, victimhood and dependency.

Nevertheless, it appears that some staff and family members have a larger capacity than do co-residents of reinforcing someone's preferred sense of self. Several of the residents speak of particular staff members with whom they consider to be "friends". For Violet, it is the events organiser that she will "miss" when he is not around. Violet appears to be referring to herself and her peers being treated by him without denigration and with a fairness and validation of them as individuals regardless of any (undervalued) characteristics which they might otherwise be associated. The excerpt highlights though that for this resident, sadly, this is a rare find among staff.

> (Violet: 167-168) We've got a very good, [member of staff], but he's on holiday at the moment, a very good organiser and he's marvellous. He treats everybody the same, it doesn't matter whether they're this big or this big, you know? He's exceptional, and we do miss him when he's no here, all of us.
>
> **I** What's so important, do you think, about him treating you all the same?
>
> **Violet.** He knows everyone's name. He never leaves anybody out.

In the extract below, a member of staff appears to bolster Ethal's preferred earlier self, bringing to the fore her humour, and her prior-leadership skills and professional identity as leader in a women's wartime air force. This boost by a staff member provides a contrast to her descriptions elsewhere of her interactions with co-residents, and of other staff as "enemies" (Ethal:114), that are more commonly of a judgmental and adversary kind.

> (Ethal, 368-362) I am more friendly with the cleaners. I had a lovely girl from Nepal, one of the Ghurka wives (…) she has been posted to [English town] (…) And she said, but I don't want to go. And I said well, you have got to, [member of staff]. But with two kids at school, it is very hard on these Ghurkas, very hard (…). I have learnt a lot about the Ghurkas. I find they interest me (…) she waters my plants when my regular lady isn't here and I call her my assistant gardener. And she is tickled pink (…) but everything is dead over there, even my orchid. Well, not dead, it is not live, it is artificial (…). When she came to say goodbye, she brought her little girl, and I had a packet of Maltesers for her, but I forgot (…) and I should think this interview is just about to end.

Ethal finds a connection to the cleaner, who is in a similar position of limited autonomy to herself, and who probably also represents to her the women that she had led and supported during the war. Ethal is able to express her sympathy to this younger woman and is in a unique position now in her life of providing encouragement and direction to her. She teases this comrade as her "assistant gardener", and in doing so, shares too in the belittling of an artificial and constrained life. The depth of Ethal's upset at the cleaner's departure, and of her failure to provide a gift to the cleaner's daughter, seemed to be expressed in her momentarily wanting to terminate the interview.

3.3 Freedom and Control: negotiating authorship of life

The fourth theme refers to the autonomy to shape one's own life experiences. It includes the choices and decision-making opportunities that residents have over their living environment. The freedom and control that they have is inescapably linked to the residential setting. This theme will be explored in relation to two sub-themes: 'The institutional context' and 'Barriers to bonding'.

3.3.1 The institutional context

Most participants appear to be answering a question similar to 'why am I here'?, that was not asked by the researcher. Justifications were made for why they have had to move to the care home, and in doing so, a common factor of choice and autonomy is raised. Some justifications are made with respect to the benefits that being in the care home brings to one's health and safety. In the extract below, Lynn talks about the upsides of living in the care home, and notably does so in relation to her status of "vulnerability". A term that she might not herself identify with and has, instead, been given to her by a (younger) family member. Lynn also makes comparisons of her current setting to other residential homes, whereby she is grateful to be living free from abuse. However, it is a freedom from abuse that in her mind seems partly borne out of a need by staff to meet external sanctions than perhaps being driven by the needs of the residents themselves: staff are "very very keen to keep everything as nice as they can". These relative freedoms from the outcomes of "vulnerability" and from abuse, appear to account for her expressions of feeling "lucky" to be in the care home. Ken too, refers to the "biggest asset of being here" for all those who reside in the home as being "fed and watered".

> (Lynn: 31-32) it gives [family members] peace of mind knowing that I'm here being looked after, because I had several nasty falls before I came and I was told that I was very vulnerable.
>
> (Lynn: 121-132) I think we are exceptionally lucky here. I think it is one of the best places around (…). It's nothing like the cases that you read about in the paper. With it being a big company, they're one hundred percent careful that you couldn't sue anyone. And if you had a bruise that suddenly appears or something, somebody comes and takes a photograph of it. They make absolutely sure that you can't say that anyone's hurt you (…). I've noticed it much more since there's been all these reports in the papers about these dreadful homes where the staff are not very nice. They're very very keen to keep everything as nice as they can.
>
> (Ken: 23-26) I think they're happy to be here and to be fed and watered all the time. I mean, that's the biggest asset of being here, being looked after and knowing that there's help across the road if you want it.

However, in a momentary departure from Ken's justifications, he expresses his dismay at the knowledge of another resident who has lived in the home for many years. He says:

> The mind boggles (…) being here 15 years (169-170).

Ken seems unable to contemplate the prospect of a long-term life in the home.

Lynn states that she is approaching her new life consciously with an attitude of curiosity and with an intention to be happy. She is authoring this "new chapter" and is actively engaging in a process of acceptance by doing so.

> (Lynn: 224-229) To be happy, which I like to be happy, can't stand when I'm a bit depressed, to my mind you've got to, in life, adapt to the next stage and not think too much about hobbies, you have your memories, but not think too much about the past because it's a new life, a new chapter starting, and it's in a way quite interesting to move on. If you live in the past all the time, I don't know how they get by really.

However, other participants continue to fight for acceptable levels of autonomy, to the point at which they seem willing for an alternative option of death, should it deteriorate further. Ethal claims in the extract below that there has been an increase in the institutionalisation of the home over time and points to an example of her autonomy being removed over self-medication use. She reflects on this, and has no answer for it, other than it must be something to do with her "age". With an increased significance of age, and of loss over autonomy, is an increased departure from home and communal living, and her living environment no longer resembles a "domesticated old people's home".

> (Ethal, 15 - 23) there have been a vast number of changes since the time I have been here, when it was a happy, sort of, domesticated old people's home. It is different.
>
> **I** So what are the differences? What changes have been made?
>
> **Ethal.** Regulations from [care home company], I think. Rules and that sort of thing (…) the changes to the way medication is handled, because I came here with what I called 'self-medicating'. In fact, I had what I call every-day drugs to take myself. That has been taken away from me. Whether it is my age or what, I don't know.

Furthermore, a couple of participants use freedom-fighting descriptions when referring to the care home, that go beyond any comparison made by others elsewhere to school.

The descriptions are akin to warfare and to being in prison, and include, being "imprisoned in her room" (Pam: 16), "colonisation" (Pam, 18), having plenty of "enemies" (both staff and residents) (Ehtal, 114), and including a reference to some residents being seen to be more appropriately suited to a "mental home" (Ethal, 225) and to a "concentration camp" (Ethal, 227). Whether these descriptions are used in slight jest, anger or sympathy towards another resident, they are nevertheless made and point in some cases to extreme scenarios whereby autonomy and freedom is totally subjugated, and where too there is some social sanction of this.

Several participants conflate a living death to being fully incapacitated or dependent on others. Ethal uses the terms of "shooting" herself and others if they can no longer feed themselves or go down to the dining hall unaided. It is a fantasy of having control and authorship over how she wants to live her life and death. Pam too is toying over a preference for her death before a state of being fully dependent on others. This is perhaps, however, also part of a process of grappling with and reaching acceptance of their upcoming deaths. Joyce seems resigned to the loss of her physical abilities and death, hoping only for a pain-free death.

> Well, but I don't have to go (to the dining hall), but I can go, but there are people who can't. Those are the ones that I would *shoot* at ninety, and myself, if I couldn't get down to the dining room. I am going for the first time today, since last Thursday, since I had this fall. And I have said I would like a wheelchair, whether I will get one or not I don't know. But getting old is not amusing (Ethal, 260-264).
>
> (Pam, 680-685) I don't want to live if I can't be you know, me as I am. I don't know when that will be, at the moment I think 90 would be quite nice. By the end of 12 months I may be saying something quite different. But you know, [fellow resident] next door, she had her hundredth birthday and people say how lively you'd say she was. They'd mushed up a bit of birthday cake and were feeding it to her with a spoon.
>
> (Joyce: 54-64) I used to like walking, I used to walk about eight miles a day. Who here can walk eight miles a day, let alone me? (…) if your body is limited in what it can do, other people's bodies are limited in what they can do, their brainpower is going, obviously the whole thing is restricted, it's part of getting old.
>
> **I** Right. And how do you feel about that?

> **Joyce.** Well, I’m going to die one day, so I’m going to die. I’d rather it wasn’t painful but..

Ethal’s fight to remain as fully independent as possible is expressed in the following extract. She is determined not to be reduced or disempowered by a medicalised interpretation of her physical state, especially when there is so much at stake for her.

> (Ethal: 323-328) I have been in this room now eight years and I am not moving until I am dead (…). I was very poorly. And then my doctor stood at the end of that bed and said to me ‘you will never walk again’. And I said, well (…) ‘I bloody well will’. And I have. Because I do what I want to do. But there comes a time when I won’t be able to.

Ethal accepts that it is ultimately a losing battle – the body is ageing - but that she will not relinquish all control over herself in response to what is imposed on her by others, including, and especially perhaps, by a medicalised interpretation.

3.3.2 Barriers to bonding

Participants make references to restrictions placed on them and others in relation to rules and expectations within the home. There are remarks made about an absence of co-resident helping behaviours taking place. Joyce suggests that restrictions are in place due to concerns by those in management about “being sued” and that these concerns or anxieties are reified in health and safety policies. For Joyce, an inability to provide assistance to her peers goes against how she self-identifies (as a nurse) and how she would like to relate to others. There is a sense of disempowerment too when she refers to a punishment of getting “told off” and to her feelings of “frustration”.

> (Joyce: 178-183) we’re not allowed to (help anyone). Health and safety. Because if you do something wrong, they can get sued for letting us do things (…) it feels very frustrating but, you know, if somebody else is going to get told off because I’ve done it.
>
> **I** Yeah, so it sounds like it’s something that you’d like to do is help, be able to help each other.
>
> **Joyce.** Well, I’m a nurse.

Violet and Pam both reflect on inhibited interactions – even in the context of heightened emotions – that might be unique to the present setting. Violet appears to be holding back from going to see others in their rooms when she suspects that they are unwell or dying. She states: “but you don’t immediately say, ‘Shall I go up and see them’”, and this holding back is a conflict for her. Unlike a behaviour towards others that would, perhaps, be typically displayed by concerned neighbours in the community, here in the care home, she concedes that it is the domain of family, unless you get “closer” to people. She does not define what “closer” is, but it suggests again, that in the context of the care home, people would need to be closer (and are not closer) in order to be freed up to relate to one another in a more community-typical way.

> (Violet: 42-47) But gradually you realise that they're not coming down for a meal and they must be quite poorly, but you don't immediately say, 'Shall I go up and see them?' You don't unless you get closer to people. Some people don't have many visitors, others have a family round them, when they come in. There's family and they go.

In a rare example of residents uniting, Pam shares a situation that ignited enough “turmoil” to bring residents together. Pam is suggesting however, that nonetheless, they do not have a collective voice to be able to take their frustrations over their living situation further and, thus, the agency to be making a real difference. The turmoil is to do with the number of staff leaving (compounded further by a larger number of recent deaths of residents). She says that “those of us that utter opinions, were all saying there’s just too much turmoil, it’s just got to stop, settle down” (Pam: 366-367). However, despite their strong desires for the staffing situation to change, “nothing led to anything”.

> (Pam: 393-396) I mean those of us who are vocal were all grumbling, all sharing our grumbles but it, there was nothing very constructive about it. Nothing that led to anything, well just grumbles, grumbles there and no hot water

A lost opportunity is represented here for co-residents to converge, and take forward in discussion and group-based action, changes to their shared living environment.

In several of the accounts, there is reference made to territorial style disputes. There appears to be some competition over access to valued resources. Peer aggressions are rare in the accounts given by the participants, however, in the extracts below, Ethal speaks about threats to her privacy and autonomy posed by other residents when she is in her private room. There are disputes over TV-watching – an activity that she wants to do – but that is “restricted” by others. This is compounded by the “thin walls” of the care home or by (her own assessment of) the resident as not being “civilised”. Ethal describes a scenario of another resident entering her private room, when she is in bed, that results in her engaging in an aggressive way.

> (Ethal: 57-61) I didn’t touch him bodily, I held his tie and told him to ‘go away’. And the night before that, I have a weekly call with my sister, we have a chat. Quarter past seven, I was in bed, no television on, he still comes and moans. But that sort of thing, we are getting people in that are different. They are not civilised.

It is a frightening invasion at a time when she likely felt particularly in a private space and vulnerable. The description of civility and difference here also suggests a set of behaviours that go against her own chosen way of life. In response to a question about what impact these interactions are having on her, she describes it as making her “very depressed”. It is an invasion on her private life that she has limited defence over, perhaps mimicking her move to the care home in the first place.

> (Ethal: 92-95) Well, I haven’t – it has made me very depressed. And it has also, I have a little problem hearing next door, because she has her television on very softly and of course mine overrides hers. It is only cardboard walls, you know. It is a not a brick wall between us. And that restricts my television.

Several of the participants are managing where they are able to sit at the dining hall, as a way to control their distance or proximity to others, for example, by having food in their room or by asking to be on a table with one self-chosen resident. In Mabel’s interview where she is describing otherwise passive behaviours (e.g. blaming herself for not attending activities), she intends, in contrast, to be assertive if she finds someone else sat in her seat. She states that it is “my seat” and thinks too that it is “how we feel”, suggestive of this being a shared and natural feeling amongst the co-residents.

> (Mabel, 154-157) if someone was sitting in my seat, you notice. That is how we feel about them. I would feel justified in saying, ‘do you mind, I usually sit here’ or something like that.

In the extract below Ethal is defending her seat at the dining hall from a “newcomer”.

> (Ethal: 105-109) one day I went out to do something, went back and found that some newcomer had come and sat in my seat. And I told her ‘excuse me, that is my chair’. And she said ‘oh, well, I have been told I can sit anywhere’. I think they have stopped this because they said anybody could sit anywhere. Well, that is not fair on anybody. I disapprove of that very much.

The assertive responses and language used by the participants suggest something beyond a desire for routine. It appears that there is an element of protecting one’s territory. Other residents pose as a possible disruption or threat to this and it is further undermined by a policy on flexible seating. Ethal “disapproves” of this policy very much and Mabel is presumably also willing to override it.

However, interestingly, Ethal appears to insist on restricted flexibility for others to choose where they sit, yet in practice, exercises free movement for herself.

> (Ethal, 104-105) I have sat at this, that and the other table. A lot of different people.

> (Ethal, 281 – 285) I am not sure if I want to keep it (a missing resident’s seat) warm. There we are (…). I don’t know if I want to sit at that table.

This desire for freedom for herself but not for others, appears to be informed by an intention to manage distance and interactions between herself and others, combined by a need to have as much self-autonomy as possible.

3.4 Occupation and Growth: a search for meaning

The fourth theme represents the experiences of being fulfilled in life and includes activities and relationships that provide exploration, interest and self-growth. This theme will be explored in relation to two sub-themes: ‘An absence of shared interests’ and ‘Withdrawal into self’.

3.4.1 An absence of shared interests

There is a palpable sense of loss from a lack of meaningful pursuits in the participants’ new life in the care home. This is compounded not only by a lack of authentic and inspiring interests to access, but also by the presence of other residents. Other residents are largely unavailable to engage with in a fulfilling way.

Ethal and Ken both express the emotional impact that the loss of interests and “taking part in things” has on their enjoyment of their life now. In answer to the question about living with fellow residents in the home, Ethal responds that it is “horrid” (Ethal, 9) and gives a primary reason for this assessment as the loss that she has felt since losing her professional and personal activities and pursuits.

> (Ethal 10-11) When I came, I was full of, not joys of life, I had lost my husband and, well, I enjoyed life, taking part in things. I can’t do that now, so obviously it’s not so nice.

Similarly, Ken mentions that:

> (Ken, 218-219) not being able to garden is the thing that upset me most when I came.

Furthermore, an interface between the institution and to disabilities, appears to exacerbate the experiences of loss. Joyce is referring to a double-whammy and recognises it as a collective loss for the residents, impeding on their ability to undertake activities together.

> (Joyce: 70-72) But if we were allowed dogs and we did dog training or we could go for long walks, that would be wonderful, but if we’re not physically able to do it, there’s no point pining for it.

To illustrate this loss further, Mabel and Ken both remark about a sense of belonging that they got with others through a collective passion or hobby prior to living in the care home. In Ken’s account too, there is an expression of the potential for growth and of continued learning and contribution within him and his wife, that is untapped in this new context.

> (Mabel: 283-285) the other groups I have been in (…) patchwork and sewing, I am known to people, we’ve had a common cause, so to speak’.

> (Ken: 234-235) it sounds like we’ve got plenty of interests, and we have. Makes a difference, where you belong to.

The formal activities on offer in the home do not provide a meaningful replacement to the losses and any untapped potential in those who were interviewed. Whilst the staff “fall over backwards” (Mabel, 231) to provide something entertaining, none of the participants spoke about the formal activities in an exclusively positive light. Indeed, several refer to experiencing an infantilisation of them and speak about the activities in a way that is not only un-enticing but is unattractive to them. Co-residents appear to reinforce rather than help resolve feelings of boredom and a lack of stimulation.

> (Pam: 5-8) something like half the people I never have any contact with. I don't go to most of the planned activities in the downstairs lounge because they're not demanding enough for me.
>
> (Mabel: 33-41) I think mainly because I've been used to being alone all my life, or the greater part of my life, so I'm quite happy to be alone. If it was stimulating conversation, I would certainly go (…) and it's that sort of activities and work, I used to pride myself on being good at, is what you would give a four year old on a couple of occasions I have seen it.
>
> (Ethal: 259-260) some of them are very boring and the entertainers are dreadful. Well, but I don't have to go, but I can go, but there are people who can't.

The excerpts reveal too, a barrier with respect to their co-resident relationships because, in the most simplistic terms, they do not have contact with others by not attending communal activities.

In the excerpt below, Pam expresses the impact of other residents as being visible but unattainable to her. There is the potential for a fascinating engagement with others, but as with other accounts, co-residents do not represent a stimulating resource.

> (Pam, 427-429) Come here and to be, that has been quite difficult. And it's surprising because as I say I'm not a sociable person, it's just the surround, the stage setting has not been stimulating.

The use of the term "stage setting" again perhaps indicates an artificial and non-organic set up, devoid of spontaneity and interest.

3.4.2 Withdrawal into self

There is also a general lack of motivation, and conversely an active pursuit, in seeking something alternative to inspire them. The results of which both appear to inform a withdrawal into oneself and to further non-engagement with peers.

As Pam suggests elsewhere in her interview that "you have to catch people before they enter beached whale phase" (Pam, 677-678), she herself is finding ways to be alive, to fill the void that she now experiences and that represents such a contrast to her earlier life. Pam actively requests a new job from a member of staff.

> (Pam: 223-250) I’ve actually got, I’ve gained a little clerical, some clerical out of the receptionist which I do with great pleasure and pride (…) I was getting bored, I needed some activity

The clerical job is an activity that does not involve her fellow residents but is one that she undertakes on her own.

Some form of escapism from the present reality of the care home is, like Pam (above) and Lynn (below), also alluded to in Ken’s pursuit for something meaningful that exists outside of the care home. The “mini bus” takes Ken and his wife out of the home, which he greatly values, and appears to be less about an activity that is providing real interest to him per se but is about a desire for “getting out” of the home and of reigniting a deeper connection for him to their home where he was ‘born and bred’.

> (Ken: 263-265) we get out when we can, don't we? Done it all before probably, but that doesn't matter, you're getting out.

Lynn suggests too being “lost” without her IPad and of it being “vital” to communicate with family and staff who live outside of the home. A search for meaningful and stimulating engagement with others who are not resident in the care home, is an important pursuit for Lynn.

> (Lynn: 40-43) What is very important is that I have an iPad and so I'm able to keep in touch with people and receive and send photographs. I'd be absolutely lost without that

The social representations of those living in the home, and the assumptions by Lynn of co-residents having dementia, appears to be contributing to a lack of fulfilment for her, and in turn, to a further withdrawal from her peers. Lynn forms closer relationships to those who are living in the care home on respite-care rather than to those who are permanent occupants.

> **Lynn** Respite, yes, and I've made quite a number of friends that way (…)
>
> **I** Is there something different about them to the other residents here that's enabled you to have friendships with them?

> **Lynn.** Oh, there is in that they have, apart from getting over some operation or other, they're, I was going to say normal, but you know what I mean.
>
> **I** I can guess what you mean, but could you just tell me what you mean by normal, that they're normal?
>
> **Lynn.** Well they haven't got dementia (242-253)

These respite residents represent something “normal” to Lynn. It is not the case that all permanent residents have a diagnosis of dementia, and so it is arguably her perception based on where the people live, that is relevant to whom she deems to be worthy and fulfilling to engage with.

Mabel’s excerpt Illustrates a deeper and general lack of motivation and is suggestive of a lack of engagement with other residents indirectly through this.

> (Mabel: 182-218) When I was at home, there was quite a lot to do. I had a very big garden, which I loved working in (…). I could find plenty to do. I’ve just not got the incentive to get on and do it at the moment (…) I suppose I’m too lazy now to bother

Pam provides an example that is in stark contrast to residents being hidden or unknown to her. Pam observes the behaviour of her peers change radically to one of energy and engagement when children are brought into the home.

> (Pam: 201-209) it’s a great delight when a great grandchild visits, “oh it’s a baby!”. One of the helpers had twins, boys, she brought them in and there was (…) literally a queue. She brought them in lunchtime, and literally a queue of residents sitting in these two chairs. Just for pleasure of having. And if one of them, a great grandchild of one of them is brought in and is running round, there’s always delighted coos.

Here, “just for the pleasure of having” appears to be providing fellow residents with a stimulation that they need to become socially engaged and present for, and to move out of a state whereby they otherwise “just sit” (Pam: 39). It is suggestive too of an intergenerational contact, and of a contact with the youngest members of society, that would naturally happen in life in the community - a community life with purpose and meaning that bolsters engagement with, rather than withdrawal from, others.

CHAPTER 4: DISCUSSION

4.1 Reviewing Research Aims

In this section, the main themes derived from the analysis will be discussed in relation to both the research questions and to existing literature. The chapter provides a critical review and evaluation of the study and concludes by exploring the implications of the findings at research, service, clinical and policy levels.

4.1.1 What relationships do older adults have with their peers in residential homes?

There is close alignment in the findings to prior studies about the types of relationships that exist. Peer relationships are typically characterised by little verbal exchange, though closer relationships do exist. It is common for residents to be in a companion dynamic characterised by neighbourly interactions, such as exchanging newspaper clippings and sitting together at a dining table, (see Powers, 1996; Kemp et al., 2012; Paye, 2012; Casey et al., 2015). Also, in line with previous findings, is the identification of two more, and rarer, dynamics: 1) confidante, characterised by an intimate exchange of personal information, and 2) antagonist or enemy, characterised by verbal and/or physical aggression (ibid). The latter dynamic is one that participants were found to try and avoid, echoing previous studies (Powers, 1996; Sefcik & Abbott, 2014; Kemp et al., 2012).

4.1.2 What experience do older adults in residential homes have of other residents?

The overarching experience of the participants in this study was of their peers as hidden, unknown and out of reach. The lack of verbal exchange was experienced as abnormal and as a departure from social life before living in the care home. This is consistent with the findings in the co-resident literature (Powers, 1991/1996; Kemp et al., 2012; Sandhu et al., 2013; Jang et al., 2014; Casey et al., 2015). Powers (1991) concluded that the ‘give and take in relationships is often less symmetrical than commonly associated with the norms of reciprocity’ (p45).

However, as a departure from existing studies, this study also identifies that non-typical interactions between peers can be experienced as a profound loss of community and of social belonging, whereby interactions with others contrast to anything lived before. As one participant concludes: “I think what I miss most is normal social interaction” (Pam: 401). These peer interactions compound their experiences of institutionalisation and the associated loss of home and social identity.

Until more recently, Social Psychology literature has primarily focussed on interactions of people with their friends and family. However, in accordance with the finding of the present study, is recent research that reveals the importance of regular interactions with weak social ties or acquaintances (e.g. speaking with a waitress in a café), to levels of happiness and to feelings of social belonging (Sandstrom & Dunn, 2014). Further research examining experiences of ‘weak’ peer interactions as significant to experiences of loss, might help develop understandings.

Consistent with existing studies, was the experience of the companion relationship as ‘being friendly, but not friends’ (Powers, 1996: 46), and of the confidante relationship as being intimate and emotionally satisfying (e.g. Kemp et al, 2012). Unfriendly, or aggressive dynamics were experienced as significant and generated widespread feelings of upset, whereby “one person can irritate a whole collection” (Ethal, 322). Discussion on the experiences of peer relationships (no-contact, companion, confidante, and antagonist) will continue in the next section.

4.1.3 What factors influence peer relationships in residential homes?

The third research question seeks to go beyond a descriptive illustration of peer relations and explore influencing factors. It is addressed by all four themes.

4.1.3.1 *Theme one: Belonging and Connection: an integral need*

The experience of the care home was one of being in an institutional setting (Kewell, 2019). This was not ‘home’ to participants – it was not a place in which they felt that they truly belonged. The move to the care home marked a step change for participants and there was a clear distinction for them between prior life in the community and life now in the care home. Co-residents reinforced this distinction and sense of institutionalisation, especially through the limited presence of conversation (see discussion above under section 4.1.2).

Some of the authors of existing studies directly attribute the findings of a lack of verbal exchange between residents to the impact of disabilities (Sandhu et al., 2013;

Jang et al., 2014). However, whilst difficulties with hearing and memory were raised by participants as a barrier to verbal exchanges, unlike existing literature, in this study, difficulties with physical and/or cognitive abilities represented only part of the picture. Memory issues and difficulties with hearing did not, for example, prevent participants from having companions (though it made exchanges more difficult), and an ability to converse, that was unaffected by disabilities, did not automatically result in closer connections.

There was a reluctance to engage with peers, and the participants themselves showed a curiosity about this lack in desire to engage. A process of Othering of those living in the care home was taking place, influenced, in part, by medical discourse. Participants referred to their age as being instrumental to their experiences now, including, to their experiences of medication use and of medical interpretations of frailty and vulnerability, whereas, before, “age was never material” (Pam: 429-430). The accounts also revealed experiences of infantilisation and invalidation (with an “exceptional” (Violet:165) member of staff treating them as individuals). An undermining of individuality for older people, due to societal discourses, and especially of those in institutional settings, is well acknowledged in the wider literature (e.g. Fredman, Anderson & Stott, 2010; Kewell, 2019).

Othering of peers by the participants themselves was also evident, with the judging and devaluing of others. This process of Othering between peers in this study suggests that participants were rejecting a prescribed social identity, based on the devalued group, to which they had been assigned and were actively seeking belonging elsewhere in the community. Again, the distancing of people from others with whom they do not want to be associated with, or belong with, is well theorised in the social identity literature on social groups (see Turner, Oakes, Haslam & McGarty, 1994).

Although co-resident studies have not specifically explored ‘non-belonging’ as a factor in peer relations, references are made to residents seeking to distance themselves from one another and suggestions are made that differences in age, gender, disability, race and class inform this (see Powers, 1996; Yamaski & Sharf, 2011; Kemp et al., 2012; Paye, 2012). Kemp (2012) concludes that men ‘look like they don’t belong’ (p498) in the care home, and that they seek fewer interinstitutional relations than women do. However, further expansion would be helpful and only Yamasaki & Sharf (2011) makes a reference to the experience of 'institutional life' (p17) as being informed by the presence of co-residents having disabilities. Beyond this, to my knowledge, the link between enhanced feelings of institutionalisation to the experiences of peer relations - and specifically to social group identity, (Othering and non-engagement) - has not been explored in existing studies.

In this study, the need to connect to others was evident, and there were incidences of participants forming valued relationships with co-residents. However, these relationships were limited in emotional intensity and closeness, and contrasted with prior-life relationships on which participants placed more importance and value. In a rarer example, a close (confidante) co-resident relationship was based on a pre-dated friendship between two residents who had lived near each other in the community. This supports findings in existing co-resident studies, whereby a prioritisation of prior-life relationships is adopted by residents (Powers, 1996; Yamasaki & Sharf, 2011; Paye, 2012; Sefcik & Abbott, 2014; Casey et al., 2015). Residents have lost their friendships and have been unable to replace these more emotionally supportive and meaningful bonds (ibid). Prior-life relationships, and a need to connect and belong with them, for one participant in this study at least, holds greater significance since living in the care home.

Research shows that as people age, and/or are closer to death, perspective changes and there is a renewed focus on emotionally significant relationships, including family, and a de-prioritisation of less emotionally significant relationships, including newly acquired contacts or friends (Fredrickson & Cartensen, 1990). Research also shows that social identity support (i.e. to support the achievement of a preferred and higher perceived status in the community), may be a unique form of social support that contributes to the development and longevity of close-friend and 'best friend' status (in younger adults studies, and in comparison to mere 'friendship' status) (Weisz & Wood, 2005). It is possible in this current study that the absence of both family members and of pre-institutional friendships was a driving factor in a participant's more intimate bond with a co-resident; these were residents who were also previously unknown to one another.

This study supports wider needs-based theory (e.g. James & Reichelt, 2019) and social identity theory (e.g. Tajfel & Turner, 1979), in arguing that there is an integral need to connect to and to belong to others – whether this be via weak or strong emotional ties. However, socio-economic factors combine, and in an institutionalised setting, older people engage in the push and pull dynamic of belonging and non-belonging with others. A lack of typical exchange between peers reinforces experiences of institutionalisation and cannot be explained by disabilities alone. Belonging is sought away from an ageist monoculture and within a community whereby prior-life relationships (dead or alive) are prioritised. An inspection of these contributory factors is an argument to go beyond more simplistic and age-based conclusions elsewhere, that older people simply do not desire companionship and intimacy with others in the way that they did before (Yamasaki & Sharf, 2011).

4.1.3.2 *Theme two: Self-esteem and Validation: maintaining a unique presence*

Participants in this study spoke about death and dying both directly and indirectly. Death was an omni-present and institutionalised (rather than community) experience for those living and dying in the care home. Participants referred to dying alone and of witnessing the death and dying of other residents at a distance, the latter included the observing but not visiting of poorly co-residents and of seeing a neighbour in laboured breathing but being informed of their death indirectly by a notice on the door. The institutional death, without celebration and acknowledgement is detrimental to providing 'strength' to the relationships of those still living in a facilitated care home (Townsend, 1996: 96) and provides an additional threat to one's social identity. As Gawande (2015) argues, the only way that death is not meaningless is to see yourself as part of something greater: a family, a community, a society. 'If you don't, mortality is only a horror' (p127). There is a notable absence of discussion about death in the existing co-resident literature beyond an acknowledgement of emotional pain (Sefcik & Abbott, 2014).

In this study, there was also a depiction of something akin to a living-death, or social death, whereby co-residents no longer represented, nor could defend or recount their prior-life identities. This generated fear, and Sandhu et al. (2013), similarly, found that participants did not like seeing others decline, as it represented a reminder of what could happen to them.

The current study identified strategies adopted by participants to defend and maintain one’s sense of self in the institutionalised context of death, dying and social death, that included a reiteration of prior-professional status, but utilised too, relations with co-residents. Peers were effectively ‘cherry-picked’ from the crowd based on valued characteristics associated with youth and intelligence. Similar references are made to preferences for co-residents based on health status (Casey et al., 2015) professional status (Yamasaki & Sharf, 2011; Kemp et al., 2012) gender (Sandhu et al., 2013) and cheerful appearance - “I look for happy people” (Sefcik & Abbott, 2014: 17). However, the connection between choice of companion to self-esteem, validation and social identity is otherwise largely unexplored in the studies.

Seeking those with socially valued characteristics (or high social status), including those based on age, is explored in the wider literature. Social status is an important component in the formation of friendships amongst people in a peer group, whereby choosing someone of a valued or higher social status can help to reinforce one’s own preferred social identity (Ball & Newman, 2013).

Powers (1996) found that participants selected others based on ‘trust’ (p51) and the need to ‘avoid gossip’ (p51), however, this seemed to be secondary in this current study to preferences for social group characteristics. However, the avoidance of gossip might have a gendered component and is perhaps reflected in the male participant’s experiences of others who seemed reluctant to talk to him. As part of this, age-based gendered cohort norms might be dictating who it is appropriate to speak to (as found in the study by Paye 2012).

Staff and family in this study represented a greater resource than co-residents for bolstering a preferred self-identity, which meant that more effort was made by participants in strengthening and prioritising these non-peer relationships. Staff and family are recognised elsewhere in the literature as a critical resource in helping to witness, share and re-tell prior life experiences and identities of an older person (Wilson, Davies & Nolan, 2009). Moreover, there was some evidence that a greater intolerance of co-residents who behaved in an unfriendly or dismissive way towards participants, as reinforcing feelings of invalidation and of a lack of acknowledgement of their selves. This might be something unique to, or strengthened by, the context of the shared institutional setting, whereby being dismissed by someone in the same subjugated position represents a final afront (see Frankl (1946) for reflections at a concentration camp of fellow prisoners engaging in peer subjugation, as being some of the hardest experiences to endure). Further research exploring the experiences of unfriendly behaviours between care home residents with respect to an invalidation of self and social standing, would advance understandings.

Social discourses of older age can undermine someone's preferred self and render older people invisible in society (e.g. Fredman, Martin & Stott, 2010). Gawande (2015) argues that: 'The battle of being mortal is the battle to maintain the integrity of one's life – to avoid becoming so diminished or dissipated or subjugated that who you are becomes disconnected from who you were or who you want to be' (p141). There is evidence too that when residents in care homes feel more valued and recognised as individuals – when social identity is enhanced – that the attraction and interactions between co-residents is also enhanced (Knight et al, 2010). In this study, it is concluded that the relationships between residents, within this institutionalised context, can act as both a promotion (to a limited extent), and as a threat, to one's preferred and unique social presence.

4.1.3.3 *Theme three: Freedom and Control: negotiating authorship of life*

In this study, the care home was compared and contrasted to other institutional settings. The comparisons included discussions about relative freedoms and choices gained or lost within these settings, such as being 'lucky' due to a freedom from abuse or, conversely, of no longer being able to self-medicate. Justifications were made by participants too for finding themselves living in the home, which now provided them with having some of their needs met with respect to improved physical health (in comparison to independent living). However, justifications were not put forward by all participants, and issues around constrained and restricted freedom and choices permeated the accounts. The institutionalisation of older people, including a necessary loss of autonomy, is arguably something that is socially accepted and seen as an inevitable part of an accumulation of losses that comes with old age (Kewell, 2019). People face the dilemma of the necessity of moving out of their own home into a care home, and the reluctance to relinquish their independence. With the loss of their homes goes the loss of control, and staff who reinforce this divide, represent both a benign and authoritative presence (Gawande, 2015).

Addressing barriers and enhancing support for people to maintain autonomy is identified as a fundamental requirement to be accounted for and achieved in residential homes if people living there are to experience a higher quality of life (James & Reichelt, 2019). An experience of institutional living with restricted choices and self-autonomy over life decisions, appeared in this study to represent barriers to enhanced peer-relations. Participants were prevented from offering help and assistance to others due to restrictions with respect to health and safety policies. This was despite participants wanting to do so. Kemp et al. (2012) similarly identified that there were policies in place around health and safety restricting peer helping behaviours. Several studies discuss the opportunities (or otherwise) to help co-residents as being of significance to physical and emotional health (Powers, 1996; Kemp, 2012 et al.; Sandhu et al., 2013).

Research on the effects of volunteering shows that older adults who engage in volunteering regularly and frequently, and with the intention of helping others, are at a greatly reduced risk of mortality four years later (Konrath, Fuhrel-Forbis, Lou & Brown, 2012). Volunteering has been shown to play a role in maintaining and enhancing social identity, including for older adults. Volunteering can help strengthen one's preferred identity by enabling the expression of one's core values, and of reaching achievement, for example, of being a 'good citizen'; demonstrating one's talents through action, and of sustaining prior professional identities (see for example, Chen, Ye & Wu, 2020). Moreover, the motivation to help others can help provide strength to the values of belonging and community and thereby enhance in-group membership identification with other volunteers (Gray & Stevenson, 2019).

Those existing peer-relations studies where participants were able to assist others, said that they enjoyed being needed by someone else, such as accompanying someone who is visually impaired (Powers, 1996; Kemp et al., 2012; Sandhu et al., 2013). However, it is not concluded in this study, nor in existing studies, that assisting others is a strategy used by residents to necessarily form closer bonds. It is instead used, in part, as a way of enhancing one's own well-being through a strengthening of self-identity (e.g. as a nurse) and of reinforcing someone's sense of social purpose (as in the findings of: Powers, 1996; Yamasaki & Sharf, 2011). Whatever the intention, the autonomy to help others was restricted in this setting and was arguably because of a dehumanising trade off with a prioritised focus on health and safety (Peace, 2003).

Further restrictions were evident in the study around peers being unable to have an empowered and collective voice. Opportunities seemed to be lost for residents in coming together constructively to make changes to their living environment- something that has been found in other studies to enhance co-resident relations via the process of an enhanced identification with the group (Knight et al., 2010) and reduce peer aggressions (Anderson, Issel & McDaniel, 2003). Further research could help explore the impact on peer relations with respect to empowerment within a care home setting.

Competition for resources between co-residents was evident, and in this present study resulted in aggressive behaviours such as defending one's seating and TV-watching preferences, and was perhaps a defence of self and territory (see Forsyth, 2014). Several studies report conflict or negotiations between residents around seating preferences in the dining hall (Powers, 1996; Kemp et al., 2012, Sefcik & Abbott, 2014). Competition for resources as affecting group dynamics, and leading to interpersonal tensions, are examined in wider sociological and psychological literature (see for example, Karl Marx's conflict theory, 1847). Wider contextual factors have been identified in bullying (e.g. a culture of competition, a scarcity of resources, and at a time when new groups are forming and are in transition, Rodkin, 2011; Volk, Dane & Marini, 2014). Streib and Metsch (2002) found that residents in UK retirement villages will generally attempt to avoid conflict with others unless their economic interests or style of life (e.g. recreational pursuits) are severely threatened. Future peer-relations work could help develop an understanding of tensions as informed by competing needs and demands, including those that threaten one's social identity and desired way of life.

4.1.3.4 *Theme four: Occupation and Growth: a search for meaning*

A separation from community played a key role for participants in their experiences of loss around having a purpose in life and of engaging in meaningful pursuits. Those in older aged groups can be more vulnerable to barriers to opportunities for self-growth and learning due to the interplay between disability, societal discourse and societal restrictions (Kewell, 2019). A need for meaningful occupation (e.g. gardening and clerical work) and ongoing-learning throughout life is well theorised in the wider literature as being paramount to one's psychological and physical well-being (e.g. Kitwood, 1997; Kewell, 2019) and is incorporated into clinical initiatives (e.g. a toolkit for improving the quality of life for those living in residential homes, College of Occupational Therapists, 2015).

In the current study, a lack of purpose and of meaningful pursuits informed peer-dynamics in nuanced ways. A combination of ailing physical abilities, and restricted and 'infantilised' activities in the home, all fed into a no contact scenario between residents. Furthermore, a lack of being able to take part in shared hobbies was contrasted to previous life experiences whereby people felt a sense of belonging and identification to others in a hobby group.

The distancing between peers was further impacted by a withdrawal into self, informed by feelings of boredom, and of attempts to 'escape' the current living situation and to find meaning elsewhere. The latter, for example, was shown in participants' descriptions of leaving the care home via mini-bus "to get out" (Ken: 68), and of the "vital" (Lynn: 61) time spent on the Ipad. Further attempts to find meaningful pursuit, and to resolve a seeming lack of purpose, were found in a participant pursuing clerical work. None of these responses to boredom involved other residents but appeared inadvertently to reinforce non-contact with others. Moreover, a lack of conversation and of typical interactions between peers contributed to feelings of boredom in participants and blame was attributed to other residents for the formal activities being targeted at a cognitively (and emotionally) inferior level – that of a young child - an antithesis, presumably, to the participants own personal growth and to their preferred personal and social identities.

There is limited discussion in the literature on resident-resident relationships about a loss of occupation by coming into the care home and of any potential impact of this on peer relations. However, there are themes in line with the findings here. Some of this overlap appears to be captured in the studies that link depression to the withdrawing of oneself (Jang et al., 2014; Casey et al., 2015). Depression here might be capturing this sense of a loss of interest or pleasure (see Diagnosis of

Depression, DSM-5). There is also discussion about an association between depression and Functional Status/disabilities and to peer-avoidance (Jang et al., 2014; Casey et al., 2015).

There is wider recognition of the need to address shortfalls of meeting people's desires for growth and stimulation within residential homes. One such intervention that is gaining attention in the media is that of bringing children into contact with older people (see Channel 4's Old People's Home for 4 Year Olds). Gawande (2015) describes a care home experiment that brought children (and pets) in a care home, and concludes that amongst other things, it brought spontaneity in the place of 'boredom' (p116), and stimulated people into conversation. This aligns with a participant's account in this study about the difference in behaviours that she observed in other residents when children are brought into the home. These animated behaviours compare to an otherwise sense of "no life" (Pam: 83) in the care home, living with people whose lives have "shrunk" (Pam: 200).

The importance of bolstering someone's life by enabling a life of meaning as defined by that person, includes the support of continued learning and opportunities for growth at any age. Further work on how this interacts with peer dynamics, including via a process of social identity, would contribute to these early findings.

4.2 Critical review

This section provides a critical review of this study.

4.2.1 Limitations

The limitations of this study will be outlined with regard to the method, sample, recruitment, and the researcher.

4.2.1.1 *Sample*

The findings might not be representative of those living in either the residential home in which the study was undertaken nor of residential homes in other parts of the country. The participants came from one residential home in the UK, it is a small study and there are likely to be additional biases within the sample (discussed below).

There can be no claims made to the generalisability of the study, though this is also not the purpose of the study. Qualitative methodology seeks instead to explore a deeper and enriched understanding of participants' experiences (Snape & Spence, 2003).

The homogeneity of the sample was compromised due to the inclusion of a male participant and, thus, any benefits that might have been able to be reached for limited generalisability to a sub-group were further impeded. However, given the proportions of female to male ratios of residents within UK residential homes of 2.8:1 (ONS, 2014)), the current sample might reflect more closely the gendered characteristics of a significant proportion of residents living in care homes in the UK.

Whilst the sample was varied with respect to age and length of residence in the home, it can be argued that the perspectives of others have not been included here and, thus, the sample does not equate to an heterogenous nor truly representative sample. The sample was all White-British which is likely to have created a potential bias in the way the group experienced factors as relevant to the relating of other residents, such as to acculturation to Western medical discourses (Furnham & Malik, 1994), understandings of grief and death (Gross, 2018), and in their relating to members of staff who were from similar or different ethnic backgrounds – the latter of which might have influenced a preference (or otherwise) for friendships with staff members above those of other residents (Keirns & Goold, 2009). In order to ascertain whether there is variation in the factors informing peer relations, it would have been useful to recruit residents from different backgrounds into the study. However, difficulties in recruitment due to proximity and accessibility meant that it was not possible in the current study, but it would be important to consider in future research. This also applies to other socioeconomic differences, such as sexual orientation which remains poorly investigated in this population (Simpson, Bown-Wilson, Brown, Dickinson & Horne, 2017).

Furthermore, the study only included those without known or suspected cognitive impairment. This is likely to have influenced the study by incorporating the views of a significant proportion of the residential-home population. This is an important limitation of the current study as it is possible that there will be important differences in how individuals with (or presumed to have) cognitive impairments experience and relate to their peers. Further research would be beneficial here.

Moreover, those who were deemed by staff to lack an interest in, or ability to form peer companionship, might have been less likely to be included in the study due to the involvement of staff in recruitment (see 4.5.1.2 Recruitment section below). However, this was partly negated by the inclusion of different staff members assisting with the introduction of the researcher to different residents and by the researcher attending communal sessions and thus, also making some direct introductions.

The study sample is small, though it remains in line with Thematic Analysis (TA) criteria (see Clarke & Braun, 2013). However, the length of the interviews are also shorter than were planned for given the aim to reach saturation in TA (see Ando, Cousins and Young, 2014). There were several factors that are believed to have contributed to this, including interruptions by visitors and staff, a keen attention by the researcher to any signs of over-tiredness, and of limitations in creating a context – that is not therapeutic in intent - in which participants felt able to speak at length about their experiences in one single session and within an institutional setting (see discussion below under Reflexivity). Nevertheless, a richness of meaning was still revealed in the shorter sentences spoken by participants, and comparability across the interviews, as well as comparability to the wider literature, are factors that have all served to strengthen confidence in the validity of the findings.

4.2.1.2 *Recruitment*

Finding management staff of residential homes who were willing to take part was a difficult task. Being able to meet with staff was difficult in the first place and might be reflective of a workplace that is often emotionally and physically demanding and time poor (Shah, 2017). At least three homes that were approached had a temporary management team in place. Although it was made clear that this was not an appraisal of the care home itself, nevertheless, it might have contributed to wariness about assessment and evaluation and/or the potential reality of a need to raise formal safeguarding concerns. The study participants all raised some criticisms of the way in which the residential home is run and of the quality of services on offer. The residential home that agreed to take part had a manager who told me that she had a personal interest in the emotional well-being of her residents and had herself recently taken part on a training course. The residential home also appeared to have a good ethical framework in place for research to take place. They ensured that I liaised directly with the company head of Human Relations and that this director had agreed to the research taking place. These are factors that might not be present in other residential homes approached, despite recruitment targeting only those care homes with a ‘good’ or ‘outstanding’ rating from the Care Quality Commission inspection (See Parkin, 2020).

The seven participants who were willing to take part had all had a discussion with the manager about the study prior to consenting to the research. This might reflect pre-understandings from both parties about existing relations that they have with other residents and might reflect feelings of compliance as a ‘good resident’. However, there were others who declined to take part in the research despite having had discussions with and introductions from staff. Also, the participants seemed able to speak in a nuanced way about their experiences of services. It is important to give consideration to those who declined to participate and whether this reflected the voices of those who experience greater barriers to connection and to interpersonal relating with others. One woman who declined was registered as blind, for example. Further familiarisation of the researcher such as attending the dining hall, might have increased levels of trust and might have encouraged some of those who did not participate to otherwise take part.

4.2.2 Reflexivity: The Role of the Researcher

My personal and professional position differs markedly from older adults living in residential homes and from whom I interviewed for the study. Without a process of ongoing critical self-reflection, my own experiences could continue to mask alternative and subordinate perspectives, by privileging my own knowledge and of ultimately and potentially, feeding into age-related social inequalities (Fredman, Martin & Stott, 2010).

I am from a privileged background and remain privileged (see Statement Positioning in Methodology chapter). I enjoy opportunities and have choices to live my life according to my own set of values. I also have further opportunities to reflect on, and act on, my preferences through awareness-raising discussions with close confidantes whom I trust, and via skills developed during the experience of clinical psychology training.

These factors, and more, will have fed into the entire process of this study.
I was consciously fearful, exacerbated by our differences in age and life-circumstances, of challenging someone too much through the process of asking questions about them, and of it feeling potentially threatening to them. I was interviewing after recent abuse scandals in hospitals and in care homes, and this, coupled with concerns about over-tiring participants, and being mindful of discussions in training about the ethical credentials of undertaking research per se (especially in comparison to therapy, which has a more direct intent of supporting the person in question), might have inadvertently reinforced at times, a ‘non-listening’ stance (see Fredman, Martin & Stott, 2010). For example, I found myself not enquiring further about the death of family members for fear of entering into a sensitive subject when, a participant might feel obliged to answer. One participant commented on the “one-sided” experience of speaking in the interview as she received only confirmations and further questions. This seemed to contrast to normal conversations for her, in which I would have been expected to give detailed and/or personal reflections in response to hers.

A more curious position might have enabled those less able or willing to speak freely in the interviews to have felt heard at a deeper level and to have explored more with me. A pre-understanding of a person’s weaknesses and frailties, informed by wider societal discourses, is something that needs to be understood and navigated carefully to enable appropriate curiosity and challenge (Kewell, 2019). However, I do believe too that attention to these concerns, such as checking in about ongoing consent and ensuring that I was welcome to be in the private space of their rooms, also enabled trust and comfort to develop with those I interviewed. For example, participants invited me to come back again if I wanted to and continued to welcome me to stay in their rooms after the interview, sometimes sharing with me objects and memories from earlier life experiences.

Another factor during the interviews that I and the participants found ourselves needing to accommodate, were regular interruptions. There were sometimes quite lengthy interruptions of, for example, on one occasion someone changing light bulbs and there were regular interruptions for tea and biscuits. I endeavoured to return to the subject that the person had been speaking about, without trying to steer them, but was conscious that some discussion and focus was lost by this break. This seemed to lead to an early termination of one interview, as the participant became concerned about the time-table for that day and getting ready to attend lunch.

Despite the differences, I was also conscious of some participants speaking on an assumption of 'shared understandings' between us, which might have been influenced by shared ethnicity, gender, class or indeed as assumed identity as a member of 'staff' or of holding similar characteristics to a family member. For example, one participant thought that perhaps I had already met their son, and another said to me in the de-brief afterwards that it was good to talk because we are 'similar people', which I took as her possibly referring to a shared education and professional status. Any perceived similarities between us might have had benefits and enabled more discussion due to trust and ease, whilst also potentially making assumptions between us unexplored. In these ways, I held both an 'insider' and 'outsider' relationship to the participants (Dwyer & Buckle, 2009).

4.3 Evaluation of Research

It is important that a process of evaluation takes place in order to assess the quality of qualitative research. How 'true' or 'valid' and how 'reliable' research is applies as much to qualitative research as it does to quantitative research. Elliott, Fischer and Rennie (1999) outline a set of guidelines for evaluating qualitative research, the steps of which have been followed and are described below.

4.3.1 Owning one's own perspective

Several steps have been taken to help explore and make transparent my own values, interests and assumptions, to aid the process of my own analysis and understanding, to enable the reader to assess understandings reached, and to provide alternative perspectives.

I have provided a statement on my position in the research process (see Methodology section 2.4.1) to help orientate the reader and have attended to issues of reflexivity (see section 4.5.2) to further explore how my professional and personal contexts may have influenced the research. Moreover, I kept a reflexive journal (see extract in Appendix C) to note down my thoughts as I progressed with the research. This helped reveal any preconceptions and assumptions that I had whilst I conducted the interviews and engaged with the data. The reflexive journal is commonly used in qualitative research to maintain rigour and to provide transparency to the reader (Etherington, 2004).

4.3.2 Situating the sample

In order to assist the reader to consider the contexts of the findings and judge the wider relevance of the findings, I have situated the sample in sufficient detail by providing a description of the participant demographics that are deemed pertinent (i.e. age, gender and length of stay in the residential home). A description of the methods of recruitment has also been provided.

4.3.3 Grounding in examples

Extracts and quotations have been used throughout the Analysis chapter to make transparent the process of analysis and interpretation. The quotations provide the reader with the opportunity to consider the interpretations reached and invite the reader to provide possible alternative meanings and interpretations as ascribed to in my epistemological position.

4.3.4 Providing credibility checks

My supervisor and a peer were both asked to check through the process of analysis, including the main themes and sub-themes, and samples of the analysis are provided in the appendices. In addition, anonymised extracts of the data were discussed early on in a TA peer-group which provided an opportunity to help verify initial codes. Importantly, credibility checks were carried out with participants themselves during the interviews to help monitor my understandings.

4.3.5 Coherence

I have attempted to provide a coherent account of the findings in answering the research questions, and have mapped out the themes and the relationships between the themes in Appendices J and K. Where relevant, I have highlighted and discussed overlaps and the connections between the themes.

4.3.6 Resonating with readers

I was interested in conducting this research, based on my training and work in mental health with older adults, and personal experiences, because I wanted to contribute to an underexplored area of research and of mental health work that is increasingly taking place with those living and working in residential home settings. I hope, therefore, that this study will encourage interest in others too. I hope that it will resonate with a broad audience through the dissemination of this work to mental health services, residential home companies and residents, and to participants who took part in the study, through publication.

4.4 Implications

In this section, I will outline the implications of this study across three areas: research, service, clinical and policy.

4.4.1 Research Implications

Given the limited research that exists on peer relations in residential homes, similar exploratory studies would provide opportunities for theory development. As part of this, studies should seek the perspectives of residents who are men, and who are from different backgrounds, as it would allow for a broader and more inclusive understanding of peer relations. This study highlights potential gender differences with indications that there is increased isolation amongst men, and that marital status and sexuality might influence peer reciprocity. Moreover, it would be beneficial to understand more about how socio-economic differences and/or additional factors inform experiences of death and dying, and of maintaining self-hood.

Certain issues were identified as pertinent in this study and are areas of consideration for future research:

- Exploration of how ‘weak’ interactions between residents inform experiences of loss.
- Comparisons to the hospice model might provide insight into more person-centred and community-based approaches to death and dying.
- A consideration of the role of self-esteem, and of social identity, in the formation of companions/confidantes.
- An exploration of peer-hostilities and experiences of invalidation and competing needs.
- Further research on empowerment/increased autonomy and its influence on social identity and peer relations.
- Experiences of ongoing growth and learning and peer dynamics.
- Staff perspectives on staff relationships with residents, and any perceptions of similarities/differences between these and co-resident relationships, might reveal additional factors informing peer relations.

Following COVID-19, new studies on the impact of those in care homes might incorporate an analysis of peer relations, during a time of further restrictions to freedoms, increased levels of death and dying amongst peers, and of increased fear through government and media communication.

4.4.2 Service Implications

It is imperative that services connect with the community and break down the separation to wider society. This study reinforces the importance of this to enhanced relationships within the care home. Endeavours in many care homes are already taking place, and examples of this include residents attending clubs that they did so prior to entering the home.

Participants spoke of finding it difficult to have meaningful contact with other residents; this was compounded by a lack of stimulation. Moreover, existing initiatives (i.e. formal activities, group sessions and excursions), might inadvertently inhibit connections and bonding due to the threat it can pose to someone’s sense of self-worth. Formal activities should be devised in accordance with residents to mitigate experiences of infantilisation and ensure, instead, a provision of meaningful and growth-related experiences.

Activities, rituals, and symbolic events that offer opportunities to celebrate people entering and exiting the home (including in death) will help build relations and provide validation of being human, and enhance one's social identity - all crucially feeding into social connectedness. It also acknowledges ongoing relationships with those who have died and could help provide and endorse a valued, safe and connected space to grieve.

Participants spoke of their willingness to be assertive and involved in management decisions when it was important for them to do so. It is important that residential homes continue to seek to go beyond resident representation on a committee, and actively and genuinely involve residents in the decisions that affect them. For example, a recent UK initiative - Super Carers, London - provides 'Carer's Profiles' for older people to choose the carer that they see as being of a 'good match' for them.

There should be assessment and encouragement by staff (and reflected in policy) of increased 'risk'-taking by residents, including, but not limited to, residents being able to help one another in ways that they choose.

4.4.3 Clinical Implications

Clinical Psychologists have skills in consultancy, supervision and teaching/training and can work with staff in and across care homes, to exchange expertise and develop understandings about the impact of institutionalisation on people's relationships. As part of this, Clinical Psychologists could work with staff to help address any staff emotional regulation/avoidance of anxiety about death and dying, and work to challenge the 'safety' and risk-free discourses that might be constraining residents' social engagement.

Clinicians should find alternative therapeutic and consultancy approaches that attend to factors seen as important to older people. Systemic, Narrative and Community Psychology, and Cognitive Analytic Therapy based approaches may all be suitable, collaborative, relational and resilience-building ways of working with staff and with older people in care homes- taking time, for example, to ask questions such as: W*hat do you need and want? -* and reflexive training on: *How can someone be as individual as possible?'* (Fredman, Anderson & Stott, 2010). Group based sessions with both staff and residents might help enhance communication and shared decision making between all those in the home, generating feelings of inclusion, communication and autonomy.

The following is a list of recommendations that Clinical Psychologists and others working with older people in care homes could include in their work:

- Support awareness raising and deconstruction of limiting societal stereotypes and self-beliefs (e.g. ‘I make no contribution to society’).
- Ask questions such as: How can I *be* with you? What would you like to be different? What is and could be? (and to challenge ‘what isn’t and can’t be’).
- Accompany people through distress and into experiences of hope – especially in the contexts of multiple loss, death and dying.
- Help people to continue to find a place in the world.
- Understand that sometimes just talking and listening is enough to help someone with their daily concerns, to die in peace, and to feel in control of a situation (Gawande, 2015, Kewell, 2019).

4.4.4 Policy Implications

The Care Quality Commission (CQC) performs a range of functions to ensure that care homes in the UK meet legal requirements (Health and Social Care Act 2008) and adopt good practice – the latter of which includes the CQC regulations for registration. The CQC’s core functions are: 1. Registration, 2. Monitor, Inspection and Rating (leading to a public publication)., 3. Enforcement and 4. Independent voice (events, articles and reports). The existing standards and legal requirements incorporate Person-Centred-Care and include the key principles of consent, dignity and the involvement of service users in care-based decision-making (CQC, 2015). A human rights approach is also adopted and includes the right of service users to a private and family life (CQC, 2019).

The findings from this report should feed into discussions, events and reports undertaken by the CQC, highlighting the significance of peer-relations to people’s experiences of living in the home. In doing so, it would help encourage greater awareness and understanding about the importance of a relational approach and, importantly, one that extends beyond a limited focus on relations with family and staff to one that includes co-resident relations. The aim of incorporating a resident-resident relationship focus too would be to attend to power differentials and help move debates and practices beyond 'care-focussed' narratives that are imbued in medical, health and safety discourses (Kewell, 2019).

For example, the CQC regulations (that are monitored, reviewed, and enforced) – includes Regulation 16: Notification of the death of a service user. The findings from this study highlighted the significance of how the deaths of service users are managed, as informing experiences of an institutional life versus being at home in the community, and of influencing avoidance and inhibition between service users. Incorporating an understanding into policy would help extend current regulations beyond an administration process about notifying authorities of the circumstances of one's death and go further in meeting CQC aims of integrating a person-centred approach (see CQC, 2015). This might include guidance on the celebration of someone's life, and involvement of others, when they die.

The CQC should undertake impact assessments and evaluation of their own policies to ensure that the standards by which they are requesting care homes to comply with extend beyond mere legal compliance. The premise of evaluation is to judge, according to evidence, the extent to which work is meeting objectives, and based on this, make recommendations for improvement (Rampell, 2011). A critical evaluation would move beyond questions such as*: To what extent are care homes meeting existing standards?* to questions such as: *To what extent are services addressing a need for community belonging in care homes?* Such a shift in perspective allows for a renewed scrutiny of what represents a meaningful life for those living in care homes. The incentives of those running care homes otherwise are to demonstrate compliance with legislation (a Western-Liberal and individualistic discourse) and to acquire funding based on this; both of which are essential for the long-term survival of the organisation. As part of this process, having residents involved in evaluation is fundamental in providing alternative and non-dominant perspectives.

Initiatives in the care homes following review, might extend, for example, current initiatives on bringing children and pets into the care home, to residents taking responsibility for the care of living things, including of animals, plants and other residents.

The CQC should form partnership with other non-care-home based initiatives to inform discussions and to exchange innovative and good practice ideas, in line with their adherence to equalities, human rights and person-centred-work.

4.5 Concluding remarks

Consistent with existing studies is the finding that peers have little contact with one another, though most have one named companion. Fewer still are in a confidante or antagonistic dynamic with others. This study also found that all co-resident relations, regardless of ‘closeness’, is emotionally significant for participants.

Also departing from existing studies, is the finding that social discourse, identity and institutional context fundamentally inform peer relations. A separation from community is a profound loss, and when socio-economic factors combine, in an institutionalised setting, older people engage in the push and pull dynamic of belonging and non-belonging with others. Peers (in life and death) were found to act as both a promotion (to a limited extent), and as a threat, to one’s preferred and unique social presence. This informed seeking/rejecting behaviours, and a prioritisation of non-peer relationships. Restrictions to autonomy impeded both helping behaviours and opportunities for collective voice and identification, and exacerbated tensions due to competing needs. The ‘no-contact’ experience of peers and a withdrawal into self, was further informed by feelings of boredom and a lack of purpose and of meaningful pursuits. Institutional life was found to be inseparable from the way in which people relate to one another, and recommendations align with initiatives that are collaborative, relational and resilience-building.

REFERENCES

Abel-Smith. (1964). The Hospitals 1800-1948. In Samson- Katz, J, S. and Peace, S. (2003). *End of Life In Care Homes. A Palliative Care Approach*. USA: Oxford University Press.

Age Concern and Mental Health Foundation. (2006). *Promoting mental health and well-being in later life. A first report from the UK Inquiry into Mental Health and Well-Being in Later Life.* London: Age Concern. https://www.mentalhealth.org.uk/publications/promoting-mental-health-and-well-being-later-life (accessed on 27 July 2021).

Age UK. (2018). *Policy Position Paper Ageism and Age Equality (Great Britain)* https://www.scribbr.com/methodology/qualitative-research/ (accessed on 27 July 2021).

Allen, C., & Ranger, G. (2013). Ageist beliefs among older people and adapting CBT to challenge this in the therapeutic setting. *Clinical Psychology Forum* No 250, October

Anderson, R, Issel, M & McDaniel, R. (2003) Nursing Homes as Complex Adaptive Systems. Management Practice and Resident Outcomes. *Nursing Research*, 52(1)

Ando, H., Cousins, R., & Young, C. (2014). Achieving Saturation in Thematic Analysis: Development and Refinement of a Codebook. *Comprehensive Psychology.* 3(5),

Ball, B. & Newman, M. (2013). Friendship networks and social status. *Network Science,* 1(1)

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative Methods in Psychology: A Research Guide.* Buckingham: Open University Press.

Bentall, D. & Pilgrim. R. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of mental health*, 8(3), 261-274.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

Braun, V., & Clarke, V. (2012). Thematic analysis. In Cooper, H (Ed.). APA

Handbook of Research Methods in Psychology Volume 2. Washington: APA.

Braun, V. & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health.* Vol 11 (4), 589-597

Breakwell, G, M., Smith, J, A., & Wright, D, B. (2012). *Research methods in psychology*: Fourth Edition. London: Sage.

British Geriatrics Society. (2020). *COVID-19: Managing the COVID-19 pandemic in care homes for older people*. https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes (accessed on 27 July 2021)

British Psychological Society. (2006). Good Practice Guidelines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to Older People. https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Faculties/Older%20People/PSIGE%20BPS%20Nov%202006%20Good%20Practice%20Guidelines%20Training%20Providers.pdf (accessed on 27 July 2021)

Bruner, M., Balish, S., Forrest, C., Brown, S., Webber, K., Gray, E., McGuckin, M,. Keats, M,. Rehman, L. and Shields, C. (2017). Ties That Bon: Youth Sport as a Vehicle for Social Identity ad Positive Youth Development. Research Quarterly for Exercise and Sport.

Bodner, E., Bergman, Y. S. & Cohen-Fridel, S. (2012). Different dimensions of ageist attitudes among men and women: a multigenerational perspective. *International Psychogeriatrics*, 24, 895–901

Burr, V. (2003). *Social constructivism*. London and New York: Routledge.

Butler, R. N. (1969). “Age-ism: Another Form of Bigotry.” *The Gerontologist*, 9(4), Part 1, 243–6.

Care Quality Commission, (2013). *Dignity and Nutrition Inspection Programme*. Review of Compliance: London.

Care Quality Commission. (2019). *Our human rights approach for how we regulate health and social care services*: London

https://www.cqc.org.uk/sites/default/files/20200922_Our_human_rights_approach_post_consultation_document_FINAL_WEB_accessible.pdf (accessed on 27 July 2021).

Carter, H., Stuart, K., and Gooding, H. (2015). Experiencing recently diagnosed dementia: The influence of stigma. *Faculty for the Psychology for Older People: No* 132. *October*.

Casey, A, N., Low, L-F., Jeon, Y-H., & Brodaty, H. (2016). Residents Perceptions of Friendship and Positive Social Networks Within a Nursing Home. *Gerontologist,* 56(5), 855-67

Centre for Policy on Ageing. (1996). *A Better Home Life*. Centre for Policy on Ageing. London

Chen, L., Ye, M., and Wu, Y. (2020). Shaping Identity. Older Adults' Perceived Community Volunteering Experiences in Shanghai. *Nonprofit and Voluntary Sector Quarterly* 49 (6), 1259-1275

Channel 4. Old People's Home for 4 Year Olds https://www.channel4.com/programmes/old-peoples-home-for-4-year-olds (accessed on 27 July 2021)

Competition and Markets Authority. (2017). *Care Home Market Study into residential and nursing care homes for older people*. GovUK

https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report (accessed on 27 July 2021).

Cook, G. (2006). The risk to enduring relationships following the move to a care home. *Journal compilation*. Blackwell Publishing ltd.

Cook, G, Brown-Wilson, C & Forte, D. (2006). The impact on sensory impairment on social interaction between residents in care homes. *International Journal of Older People in Nursing*, 1, 216-224

Clarke, V., & Braun, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*. London: Sage.

College of Occupational Therapists. (2015). *Living Well Through Activity in Care Homes: Tool kit.* PKC Gov.UK

https://www.pkc.gov.uk/media/42488/Living-Well-Through-Activity-in-Care-Homes/pdf/Unit2-Care-home-staff-resources-2015 (accessed on 27 July 2021).

Cook, G. (2006). *The risk to enduring relationships following the move to a care home*. London*:* Blackwell Publishing

Cubit, K. (2010). Informed consent for research involving people with dementia: a grey area. *Journal of Bioethical Inquiry*. 14(3), 359-374

Davis, D.H.J. (2004). Dementia; sociological and philosophical constructions. *Social Sciences and Medicine*, 58, 369-378.

Davis, S. (2013). Stones in the pond: Late life effects of psychological trauma, *Clinical Psychology Forum* No 250, October 46-48

De Beauvoir, S (1972). *Old Age*. London: Harper Collins

Department of Health (DoH). (2001b). *National Service Framework for Older people.* Department of Health and Social Care, England. https://www.gov.uk/government/publications/quality-standards-for-care-services-forolder-people (accessed on 27 July 2021).

Douman, S. and Goossens, L. (2012). Identity and perceived peer relationship quality in emerging adulthood: The mediating role of attachment-related emotions. *Journal of Adolescence*, Vol (35), 6: 1417-1425

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International journal of qualitative methods*, *8*(1), 54-63.

Elliott, R., Fischer, C. & Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology,* 38, 215-229.

Etherington, K. (2004). *Becoming a reflexive researcher: Using ourselves in research*. Jessica Kingsley Publishers.

Equality and Human Rights Commission. (2011). *Close to home An inquiry into older people and human rights in home care* https://www.equalityhumanrights.com/en/publication-download/close-home-inquiry-older-people-and-human-rights-home-care

Finlay, L & Gough, B. (2003). *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*. Wiley-Blackwell.

Flemming, J., Farquhar, M., Brayne, C., & Barclay, S., (2016). Death and the Oldest Old: Attitudes and Preferences for End-of-Life Care - Qualitative Research within a Population-Based Cohort Study. *PLOS One*

Foucault, M. (1988a). On Power. In Kritzman, L. (Ed.). *Politics, philosophy, culture. Interviews and other writings 1977–1984.* (p96-109). New York: Routledge.

Frankl, V. (1946). *Man's Search for Meaning: The classic tribute of hope from the Holocaust.* London: Rider Books

Fredman, G. (2010). Introduction: being with older people – a systemic approach. In G. Fredman, E. Anderson and J. Scott (Eds.). *Being with older people: A systemic approach* (pp 1-30). London: Karnac.

Fredman, G., Martin, E. & Stott, J. (2010). *Being with older people: A systemic approach*. London: Karnac.

Fredrickson, B. & Carstensen, L. (1990). Choosing social partners: how old age and anticipated endings make people more selective. Psychological Aging. 5(3), 335-47

Froggatt, K. (2004). *Palliative Care in Care Homes for Older People*. The National Council for Palliative Care. London

Furnham, A., & Malik, R. (1994). Cross-Cultural Beliefs About “Depression". *International Journal of Social Psychiatry*, 40(2), 106-123.

Gawande, A. (2015). *Being Mortal*. Illness, Medicine, and What Matters in the End. London: Profile Book

Godhall, A, Drage, T & Bell, G. (1994). *The Bereavement and Loss Training Manual*. NY. Routledge

Golant, S, M. (2003). Conceptualizing time and space in environmental gerontology: A pair of old issues deserving new thought. In Yamasaki & Sharf (Eds) Opting out while fitting in: How residents make sense of assisted living and cope with community life. *Journal of Aging Studies*, 25, 13-21.

Gray, D. and Stevenson, C. (2019). How can ‘we’ help? Exploring the role of shared social identity in the experiences and benefits of volunteering. *Journal of Community & Applied Social Psychology*. Vol. 30 (4). 341-353

Greer, J., Jackson, V., Meier, D., & Temel, J. (2013). Early integration of palliative care services with standard oncology care for patients with advanced cancer. *A Cancer Journal for Clinicians*. 63, 5

Gross, R. (2018). *The Psychology of Grief (The Psychology of Everything)*. London: Routledge

Guse, L, W., & Masesar, M.A. (1999). Quality of life and successful aging in long-term care: Perceptions of residents. In Yamasaki & Sharf (Eds) Opting out while fitting in: How residents make sense of assisted living and cope with community life. *Journal of Aging Studies*, 25, 13-21.

Hague, R. (2011). Autonomy and Identity. The politics of who we are. London: Routledge.

Harawa, N., Manson, S., Mangione, C., Penner, L., Norris, K., DeCarli, C., Scarinci, I., Zissimopoulos, J,. Buchwald, D., Hinton, L., & Pérez-Stable, E. (2017). Strategies for enhancing research in aging health disparities by mentoring diverse investigators. *Journal of Clinical and Translational Science*. 1(3), 167-175

Harper, D., & Thompson, A. R. (Eds.). (2011). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. John Wiley & Sons.

Hedtke, L. (2014). Creating Stories of Hope: A Narrative Approach to Illness, Death and Grief. *Australian and New Zealand Journal of Family Therapy*. 35(1)

Help The Aged (2007). *My Home Life: A Review of the Literature.* http://myhomelife.org.uk/wp-content/uploads/2014/11/mhl_review.pdf (accessed on 27 July 2021)

Hiskey, S & McPherson, S. (2013). That's Just Life: Older constructs of trauma. *Faculty for the Psychology for Older People*, No 124, October, 19-24

Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review Perspectives on Psychological Science. *A journal of the Association for Psychological Science*. 10(2), 227-37

Hubbard, G., Tester, S., & Downs, M. (2003). Meaningful social interactions between older people in institutional care settings. *Ageing & Society*, 23, 99-114

Jang, Y., Park, N., Dominguez, D. & Molinari, V. (2014). Social engagement in older residents of assisted living facilities. *Aging & Mental Health*. 18(5), 642-647.

James, I, A. & Reichelt, K. (2019). Understanding people's needs: The 8-needs framework for the treatment of behaviours that challenge**.** *Faculty for the Psychology for Older People* No 147, July.

Jenkins, R. (2014). Social Identity (Fourth Edition). London: Routledge

Joffe, H. (2011). Thematic analysis. In Harper, D., & Thompson, A. R. (Eds.).*Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 200-223). John Wiley & Sons.

Keirns, C. & Goold, S. (2009). Patient-Centered Care and Preference-Sensitive Decision Making. *JAMA*, 302(16), 1805-1806

Karpen, R. R., (2016). Coming to care. In Wyatt-Brown, A, M., Karpen, R, R., Kivnick, H, Q., The Big Move: life between turning points. Bloomington: Indiana University Press (p29-39).

Kemp, C., Ball, M., Hollingsworth, C. & Perkins, M. (2012). Stranger and Friends: Residents' Social Careers in Assisted Living. *The Journals of Gerontology, Series B. Psychological Sciences and Social Sciences*, 67(4). 491-502

Kewell, H. (2019). Living Well and Dying Well. Tales of counselling older people. Monmouth: PCC Books

Kitwood, T. (1997). Dementia Reconsidered: The Person Comes First (Rethinking Ageing). Open University Press.

Klass, Silverman & Nickman. (1996). *Continuing Bonds: New Understandings of Grief* 1st Edition. NY: Routledge

Knechel, N.A (2013). The challenges of enrolling older adults into intervention studies. *Yale Journal of Biological Medicine*. 86(1):41–7.

Knight, C., Haslam, A., & Haslam, C. (2010). In home or at home? How collective decision making in a new care facility enhances social interaction and wellbeing amongst older adults. *Ageing and Society*. 30(8)

Konrath, S., Fuhrel-Forbis, A., Lou, A., & Brown, S. (2012). Motives for volunteering are associated with mortality risk in older adults. *Health Psychology, 31*(1), 87–96.

Laidlaw, K. (2015). *Cognitive Behaviour Therapy for Older People: An Introduction*. London: SAGE Publications.

Liebkind, K., Jasminka-Lahti, I and Solheim, E. (2004). Cultural Identity, Perceived Discrimination, and Parental Support as Determinants of Immigrants' School Adjustments: Vietnamese Youth in Finland. *Journal of Adolescent Research*. Vol 19 (6): 635-656

Liljas, A., Walters, K., Jovicic, A., Iliffe, S., Manthorpe, J., Goodman, C. & Kharicha, K. (2017). Strategies to improve engagement of 'hard to reach' older people in research on health promotion: a systemic review. *BmC Public JHealth*. 17, 349

Lund, A. & Engelstrud, G. (2008). 'I am not *that* old': inter-personal experiences of thriving and threats at a senior centre. *Ageing & Society*, 28, 675-692

Malson, H. (1998). *The Thin Woman. Feminism, Post-Structuralism and the Social Psychology of Anorexia Nervosa.* London: Routledge.

Martin, E and Stott, J. (2010). Using ourselves in work with older people. In G. Fredman, E. Anderson and J. Scott (Eds.). *Being with older people: A systemic approach* (p 31-59). London: Karnac.

Martinez, M., Osornio, A., Halim, M., Zosuls, K. (2019). Gender: Awareness, Identity and Stereotyping in Encyclopaedia of Infant and Early Childhood Development (Second Edition).

Martinsson G, Fagerberg I, Lindholm C, & Wiklund-Gustin L.(2012). Struggling for existence-Life situation experiences of older persons with mental disorders. *International Journal of Qualitative Studies on Health and Well-being*., 7(10)

Marx, K. (1847). *The Poverty of Philosophy*. Paris: Progress Publishers.

Mckee, K., Harrison, G., & Lee, K. (1999). Activity, friendships and wellbeing in residential settings for older people. Aging and Mental Health. 3(2)

McKeown A, Turner A, Angehrn Z, Gove D, Ly A, Nordon C, Nelson M, Tochel C, Mittelstadt B, Keenan A, Smith M, Singh I. (2020). Health Outcome Prioritization in Alzheimer's Disease: Understanding the Ethical Landscape. *Journal of Alzheimers Disease*, 77(1), 339-353

Miller, B.J. (2015). *What Really matters at the End of Life*? Ted2015. https://www.ted.com/talks/bj_miller_what_really_matters_at_the_end_of_life/up-next (accessed on 27 July 2021).

Miller, E. (1999). Positivism and Clinical Psychology. *Clinical Psychology & Psychotherapy*, *6*(1), 1-6.

Missler, M., Stroebe, M., Geurtsen, L,. Mastenbroek, M., Chmoun, S., Van Der & Houwen, K. (2012). Exploring Death Anxiety Among Elderly People: A literature Review and

Empirical Investigation. *The International Journal of Management Science*. A, 64(4), 357-379

Morgan-Williams, S. (2002). All real living is meeting. In du Plock, S. (ed). *Further Existential Challenges to the psychotherapeutic Theory and Practice: papers from Existential Analysis*. London: Society for Existential Practice

Neighbours, C., Foster, D., Fossos, N. (2013). Peer Influences on Addiction. *Principles of Addiction*. 323-331

Norris, C. (2015). Living well with fronto-temporal dementia. *Faculty for the Psychology for Older People* No 132, July. *34-37*.

NICE. (2001). Safeguarding adults in care homes. NICE guideline.

https://www.nice.org.uk/guidance/ng189/resources/safeguarding-adults-in-care-homes-pdf-66142030079941 (accessed 27 July 2021)

Office for National Statistics. (2014). *Changes in the Older Resident Care Home Population between 2001 and 2011.* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/changesintheolderresidentcarehomepopulationbetween2001and2011/2014-08-01 (accessed on 27 July 2021)

Office for National Statistics (2020). *Impact of coronavirus in care homes in England: 26 May to 19 June 2021.* https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/impactofcoronavirusincarehomesinenglandvivaldi/26mayto19june2020 (accessed on 27 July 2021)

Office of Fair Trading (2005). *Care Homes for Older People in the UK. A market study*. Office of Fair Trading. London

O'Keefe, M. Hills, A., Doyle, M,.McCreadie, C.Scholes, S.,Constantine, R,.Tinker, A,.Manthorpe, J,.Biggs, S. & Erens, B. (2007). *UK Study of Neglect and Abuse of Older People, Prevalence Survey Report for Department of Health and Comic Relief*. National Centre for Social Research and Kings College London.

http://www.natcen.ac.uk/media/308684/p2512-uk-elder-abuse-final-for-circulation.pdf (accessed on 27 July 2021)

Parker, I. (2004). *Qualitative Psychology: Introducing Radical Research*. McGraw-Hill Education (UK)

Parkin, E (2020). The Care Quality Commission. *House of Commons Briefing Paper*. Number 08754 https://researchbriefings.files.parliament.uk/documents/CBP-8754/CBP-8754.pdf (accessed on 27 July 2021)

Paye, Y. (2012). *"Men Don't Talk": Examining the Dynamics of Men's Co-resident Relationships in Assisted Living.* Gerontology Institute. Georgia State University.

Palacios-Cena, D, . Martinex-Piedola, R, M., Perez-de-Heredia, M,. Huertas-Hoyas, E,. Carrasco-Garrido, P,. & Fernandez-de-las-Penas, C,. (2016). Expressing sexuality in nursing homes. The experience of older women: A qualitative study. *Geriatric Nursing,* Vol 5, p1-8.

Peace, S. (2003). The development of Residential and Nursing Home Care in the UK. In Samson Katz, J. and Peace, S. (2003). *End of Life In Care Homes. A Palliative Care Approach*. USA: Oxford University Press.

Pearce**,** W. B., & Cronen**,** V. E. (1980). *Communication, Action, and Meaning: The Creation of Social Realities*. New York: Praeger

Percival, J. (2000). Gossip in sheltered housing: its cultural importance and social implications. *Aging and Society*. 20(3).

Picket K, Oliver J, & Wilkinson R. (2006) Income inequality and the prevalence of

mental illness: a preliminary international analysis. *Journal of Epidemiology and Community Health,* 60, 646-647

Pillemer, K., Chen, E. K., Haitsma, Van, , K. S., Teresi, J., Ramirez, M., & Silver, S., (2012). Resident-to-resident aggression in nursing homes: Results from a qualitative event reconstruction study. *The Gerontologist*, 52(1), 24–33

Potter, J. & Hepburn, A. (2005). *Qualitative interviews in psychology: problems and possibilities. Qualitative Research in Psychology*, 2, pp.281- 307.

Powers, A. (1991). The meaning of nursing home friendships. *Advanced Nursing Science*. 14(2), 42-58

Powers, A. (1996). Relationships Among Older Women Living in a Nursing Home. *Journal of Women & Aging*. Routledge

Prilleltensky, I. (2003). Understanding, Resisting, and Overcoming Oppression: Toward Psychopolitical Validity. *American Journal of Community Psychology*, 31(1/2)

Public Health England. (2018). *Statistical commentary: End of Life Care Profiles, February 2018 update.*

https://www.gov.uk/government/statistics/end-of-life-care-profiles-february-2018-update/statistical-commentary-end-of-life-care-profiles-february-2018-update (accessed on 27 July 2021).

Radermacher, H & Duckett, P. (2013). Ageing research in community psychology: Where are our elders? *The Australian Community Psychologist*, 25(1)

Rampell, C. (2011). The Burden of Supporting the Elderly. New York Times.

Rapley,M., Moncrieff, J., & Dillon, J. (2011) Carving Nature at its Joints? DSM and the Medicalization of Everyday Life. In Rapley, M. Moncrieff, & J., Dillon (Eds.), *De-Medicalizing Misery: Psychiatry, psychology and the human condition.* (pp. 27-42). Hampshire: Palgrave Macmillan.

Ries N, Mansfield E, & Sanson-Fisher R.J. (2019). Planning Ahead for Dementia Research Participation: Insights from a Survey of Older Australians and Implications for Ethics, Law and Practice. *The Journal of Bioethical Inquiry*. 16(3), 415-429

Roberts, T. & Bowers, B. (2015). How nursing home residents develop relationships with peers and staff: A grounded theory study. *International Journal of Nursing Studies.* 52, 57-67.

Robertson, L & Hale, B. (2011). Interviewing Older People; Relationships in Qualitative Research. The Internet Journal of Allied Health Sciences and Practice. 9(3)

Rodkin, P. (2011). White House Report/ Bullying – and the Power of Peers. *Promoting Respectful Schools*. 69(1)

Rogers, A. & Pilgrim, D. (2003) *Mental health and inequality*. Basingstoke: Palgrave Macmillan

Satre, J-P. (1943/2003). *Being and Nothingness: an essay on Phenomenological ontology.* Abingdon: Routledge.

Samson- Katz, J, S. & Peace, S. (2003). *End of Life In Care Homes. A Palliative Care Approach*. USA: Oxford University Press.

Sandhu, N., Kemp, C., Ball, M., Burgess, E. & Perkins, M. (2013). Coming together and pulling apart: Exploring the functional status on co-resident relationships in assisted living. *Journal of Aging Studies*, 27, 317-329.

Sandstrom, G & Dunn, E. (2014). Social Interactions and Well-Being: The Surprising Power of Weak Ties. *Personality and Social Psychology Bulletin*. 40(7), 910-922

Sefcik, J. & Abbott, K., (2014). “Right Back to Square One Again”: The Experience of Freindship Among Assisted Living Residents. *Activities, Adaptation & Aging*. 38(1), 11-28

Shah, H. B. (2017). Understaffed and Overworked: Poor Working Conditions and Quality of Care in Residential Care Facilities for the Elderly. *Publications 788*

Simpson, P., Horne, M., Brown, L., Brown Wilson, C., Dickinson, T., & Torkington, K. (2017). Old(er) care home residents and sexual/intimate citizenship. *Ageing Society*. 37(2), 243-265

Slade, L, Bone, A & Razzel, S. (2015). A psychologically informed model for supporting meaningful involvement of people living with dementia facilitated by undergraduate psychology students**.** *Faculty for the Psychology for Older People* No 131, July

Slater, R. (1995). The Psychology of Growing Old: Looking forward. Buckingham: Open University Press.

Smail, D. (2006). Implications for Practice. *Clinical Psychology Forum 162, 17-20*

Smith, J. (1995). Semi-structured interviewing and qualitative analysis. In J. Smith, R. Harre, & L.V. Van Langenhove (Eds.) *Rethinking Methods in Psychology* (pp.9-26). London: Sage.

Snape, D., & Spencer, L. (2003). The foundations of qualitative research. *Qualitative research practice: A guide for social science students and researchers*, *11*.

Streib, G. & Metsch, L. (2002) Conflict in Retirement Communities: Applying an Analytical Framework. *Research on Ageing*. Vol 24, 1

Super Carers, UK. https://supercarers.com/about-us/ (accessed 27 July 2021)

Tajfel, H. (1978). Social Categorization, Social Identity and Social Comparison. In H. Tajfel (Ed.), *Differentiation between Social Groups: Studies in the Social Psychology of Intergroup Relations*. London: Academic Pres p. 61-76.

Tajfel, H. & Turner, J, C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (eds), *The social psychology of intergroup relations* (p33-47). Monterey, CA: Brooks/Cole.

The Eden Alternative. (2021). *The Eden Alternative: it can be different*. UK

https://www.edenalt.org/about-the-eden-alternative/ (accessed on 27 July 2021).

Titman, A. (2003). The homeliness in care homes. *Working with Older People,* 7(2)

Tobin, S, S. (1991). *Personhood in Advanced Old Age*. New York: Springer

Tolhurst, E., & Weicht, B. (2017). Preserving personhood: The strategies of men negotiating the experience of dementia. *Journal of Aging Studies,* 39(2), 212-226

Townsend, P. (1962). *The Last Refuge*. London: Routledge and Kegan Paul

Trompetter, H., Scholte, R., & Westerhof, G. (2011). Resident-to-resident relational aggression and subjective well-being in assisted living facilities. *Aging & Mental Health*, 15, 59-67.

Turner, J. C., Oakes, P. J., Haslam, S, A., & McGarty, C, A. (1994). Self and collective: Cognition and social context. *Personality and Social Psychology Bulletin*. 20, 454-463.

Tyler, T. R., & Blader, S. L. (2003). the Group Engagement Model Procedural Justice, Social Identity, And Cooperative Behavior. *Personality and Social Psychology Review*. 7(4), 349-361

Viney, L. (1993). *Life Stories*. Chichester: Wiley

Volk, A., Dane, A, & Marini, Z. (2014). What is bullying? A theoretical redefinition, *Developmental Review.*

Weisz, C. and Wood, L. (2005). Social Identity Support and Friendship Outcomes: A Longitudinal Study Predicting who will be Friends and Best Friends 4 Years Later. *Journal of Social and Personal Relationships.* Vol 22 (3): 416-432

White, M. (1988). Saying hullo again: The incorporation of the lost relationship in the resolution of grief. In C. White & D. Denborough (Eds.) *Introducing Narrative Therapy: A collection of practice based writings*. Adelaide, South Australia Dulwich Centre Publications.

Willig, C. (2013). *Introducing Qualitative Research in Psychology (third edition).* Berkshire: Open University Press.

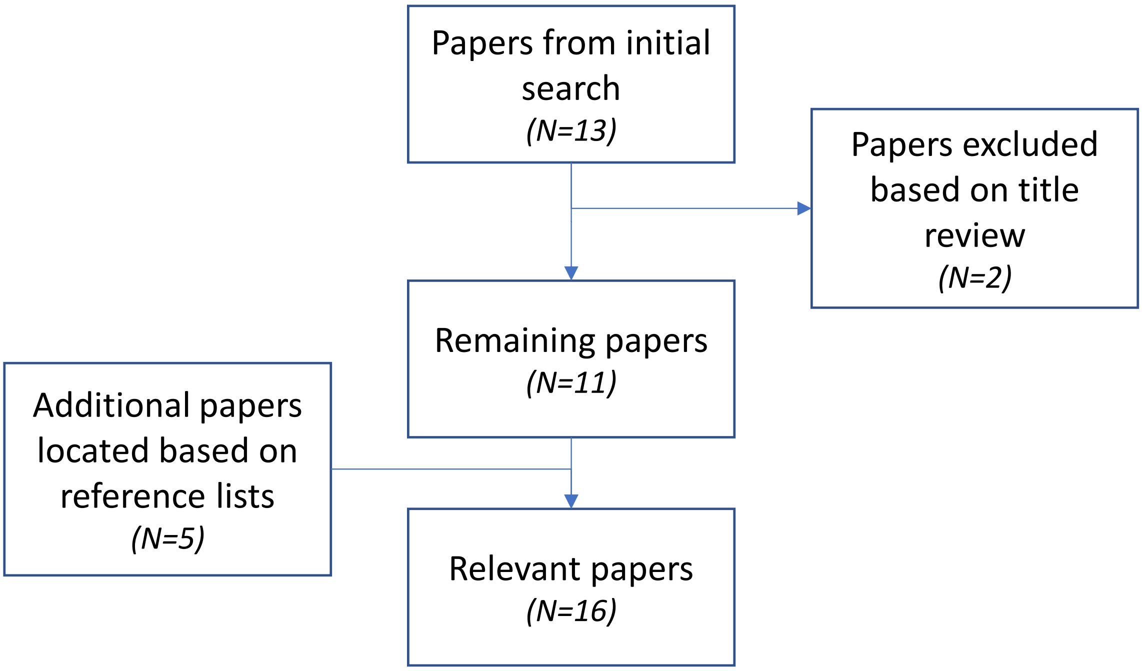
Wilson, C-B., Davies, S., & Nolan, M. (2009). Developing personal relationships in care homes: realising the contributions of staff, residents and family members. *Ageing and Society*. 29(7),1041-1063

Worden, W. (2009). *Grief Counselling and Grief Therapy: a handbook for the mental health practitioner (4th ed)*. Hove: Routledge

Yalom, I, D. (1995). *The theory and practice of group psychotherapy*. New York: Harper Collins Publishers.

Yamasaki & Sharf. (2011). Opting out while fitting in: How residents make sense of assisted living and cope with community life. *Journal of Aging Studies*, 25,13-21.

APPENDIX A: Flowchart depicting process of selecting articles



APPENDIX B: Articles included in literature review

Author (Date) and Country	Design	Sample	Title/Aim of Study
Casey, Low, Jeon & Brodaty (2015) Australia	Cross-sectional interviews, standardized assessments, and observational data. Residents answered open-ended questions about friendship, identified friendship ties, and completed measures of nonfamily social support.	36 residents Gender: male (n= 14), female (n =22) Age range: 63-94 years Facility: 3 care units Includes 1Dementia Specific Unit (DSU), of a 94-bed nursing home	Residents Perceptions of Friendship and Positive Social Networks Within a Nursing Home
Mckee, Harrison & Lee (1999) Australia	Observational assessment of activity and brief structured interviews assessing self-reports of friendships and psychological wellbeing	64 residents Gender: male (n= 11), female (n =53) Age range: Facility: 3 care units	An investigation into whether friendships influence the psychological wellbeing of residents in long-stay care settings for older people.
Powers (1991). USA	Network profile interview to elicit objective data (extend and behavioural aspects of social networks) and subjective data (importance to participant of network ties)	96 residents Gender: male (n= 32), female (n =37) Age range: 55-95years (mean: 73years) Facility: 1 care setting	The meaning of nursing home freindships. Aim is to consider the role of negative interaction in personal relationships, the meaning of intimacy and reciprocity in the nursing home context, and issues of age and gender.

Powers (1996). USA	Re-analysis of data from 1991 study (see above)	(as above)	Relationships Among Older Women Living in a Nursing Home.
Sandhu, Kemp, Ball, Burgess, & Perkins (2013). USA	Participant observation, informal interviews, and formal in-depth interviews with staff, residents, administrators and visitors, and surveys with residents. Grounded theory methods guided data collection and analysis.	12 residents (interviews) 27 residents (survey) 8 staff (interviews) one-year period Facility; 2 Assisted Living Facilities (ALF)	Exploring the influence of functional status on co-resident relationships in assisted living (AL)
Jang, Park, Dominguez & Molinari (2014). USA	Questionnaires: Depression and Activities of Functional Living	150 residents Gender: female = 78% Mean age: 82.8 years Facility: 1 ALF	Social engagement in older residents of ALF Hypothesis: The positive impact of social engagement within the facility would be greater among residents with higher levels of functional disability.
Kemp, Ball, Hollingsworth, Perkins (2012). USA	Participant observation, and informal and formal, in-depth interviews with residents, administrators, and AL staff. Grounded theory method.	27 residents (interviews) 66 residents (surveys) 13 staff Mixed gender Facility:3 AL units	This study examines coresident relationships in ALF and identifies factors influencing relationships.
Paye (2012). USA	Participant observation, and informal and formal, in-depth interviews with residents and staff	251 residents 42 staff Mixed gender Facility: ALF	""Men Don't Talk": Examining the Dynamics of Men's Co-resident Relationships in Assisted Living.
Roberts & Bowers (2015). USA	Unstructured interviews and field observations were conducted.	15 residents Facility: 2 AL facilities	How nursing home residents develop relationships with peers and staff: A grounded theory study

Sefcik & Abbott (2014). USA	4 focus groups. Content analysis	13 participants Gender: Female = 9, male = 4 Age range: 66-99years Facility: ALF facility	The purpose of this study is to describe the experience of friendship among ALF residents
Yamasaki & Sharf (2011). USA	In-depth Interviews. Narrative Analysis	2 residents Both female Both 91 years old	This paper examines how linkages between past experiences and present conditions enable residents to make sense of assisted living and cope with membership in a community comprised of diverse interests, backgrounds, and impairments.
Trompetter, Scholte and Westerhof (2011). USA	Participants completed questionnaires assessing personal experiences as victims of relational aggression and subjective well-being. Nurses reported on victimization of relational aggression for every participant. Linear regression models were used to examine the association between both reports of relational aggression and subjective well-being.	121 residents Age range: 60-93years Gender: 77% female Facility: 6 ALF	Resident-to-resident relational aggression and subjective well-being in assisted living facilities
Pillemer, Chen, Haitsma, Teresi, Ramirez, Silver,	Narrative reconstructions were created for each event based on information from residents and	Facility: 53 Nursing Home units.	Resident-to-resident aggression in nursing homes: results from a qualitative event reconstruction study

Sukha, Lachs (2012). USA	staff who were involved as well as other sources. Qualitative method analysis to identify common features of RRA events.		
Brown-Wilson, Davies & Nolan (2009). England, UK	combined methods including participant observation, interviews and focus groups.	Facility: 3 care homes	Developing personal relationships in care homes: realising the contributions of staff, residents and family members the nature and types of relationships between residents, staff and family members were explored.
Cook, Brown-Wilson & Forte (2006). UK	Two research studies, first, a hermeneutic inquiry examining the meaning ascribed to living in a care home, the second, a constructivist study, exploring relationships between residents, families and staff. Both studies drew on older people's narrative accounts to explore their experiences of living in a care home.	10 residents Mixed gender Facility: 1 care home	The impact of sensory impairment on social interaction between residents in care homes
Hubbard, Tester & Downs (2003). Scotland, UK	Ethnographic observations conducted. Symbolic interactionist perspective.	Facility: 4 Care Settings	Meaningful social interactions between older people in institutional care settings It focuses on two areas that have been neglected in research: the reasons for and types of social interaction in institutional settings, and the ways in which the context of people's lives shapes social interaction.

APPENDIX C: Excerpt from Reflexive Journal

Below is a small extract from the reflexive journal that I kept throughout the research process:

I've just finished my interview with Ken and at one stage it felt as though he might be seeing me more as a friend or visitor. He suggested that I could 'come and visit again any time' and how he and his wife 'enjoyed having visitors'. More than the other interviews, it has made me think about how I might be seen to them in comparison to other professionals and people in the community who drop in to see them. I wondered about leaving the comment unanswered and a part of me felt drawn into wanting to reassure him that I would like to visit again. I checked in with their understanding again about my role and they were fine and understanding about this and took an interest in who else I might be speaking to. It made me wonder about whether he felt lonely, and also whether he was keen to speak in a way that might not put off future visits? Or perhaps even affect his living environment?

APPENDIX D: Interview Schedule

Demographics

- Age
- Length of time living in the residential home.

Introduction:

Introduce myself as a researcher, a reminder about confidentiality/consent/withdrawal, no right or wrong answers, ability to take breaks and finish the interview at any time.

Questions

The interviewer will be guided by the participant's responses and will not be limited to the interview schedule.

The type of peer-relationships that exist

- What is it like to live with others here?
- What are others like towards each other?
- What sorts of things do residents do with each other?
- Is there anything that you would like to do (or see others do) more of/less of with each other here?

The experience of peer-relationships

- How do other residents make you feel?
- How do you/others respond to each other?

Factors that influence peer-relationships

- Why is it like this here (in the residential home) do you think?
- Is this similar or different to groups that you have experienced living in before? (e.g. community groups, or in the work place or in family).
- How? Or in what ways is it different/similar?

Ending

- Is there anything else that we haven't spoken about that you would like to share?

Debrief

- How did you feel taking part in the interview?
- Is there anything that concerned you?
- Provide details to contact if needed.

Probes/Prompts will be used:

- Tell me more about 'x'
- Explain what you mean about 'x'
- Can you give me any examples of 'x'?

APPENDIX E: Malson’s (1998) Transcription System

I	Interviewer
P3	Participant number to ensure anonymity.
( )	Inaudible or muffled sound/utterance.
xx	Identifiable information removed to ensure anonymity.
/	Overlapping conversation or interruption.
[Laughing]	Indicates a non-verbal activity.

Punctuation used to aid reading.

APPENDIX F: List of Initial Codes

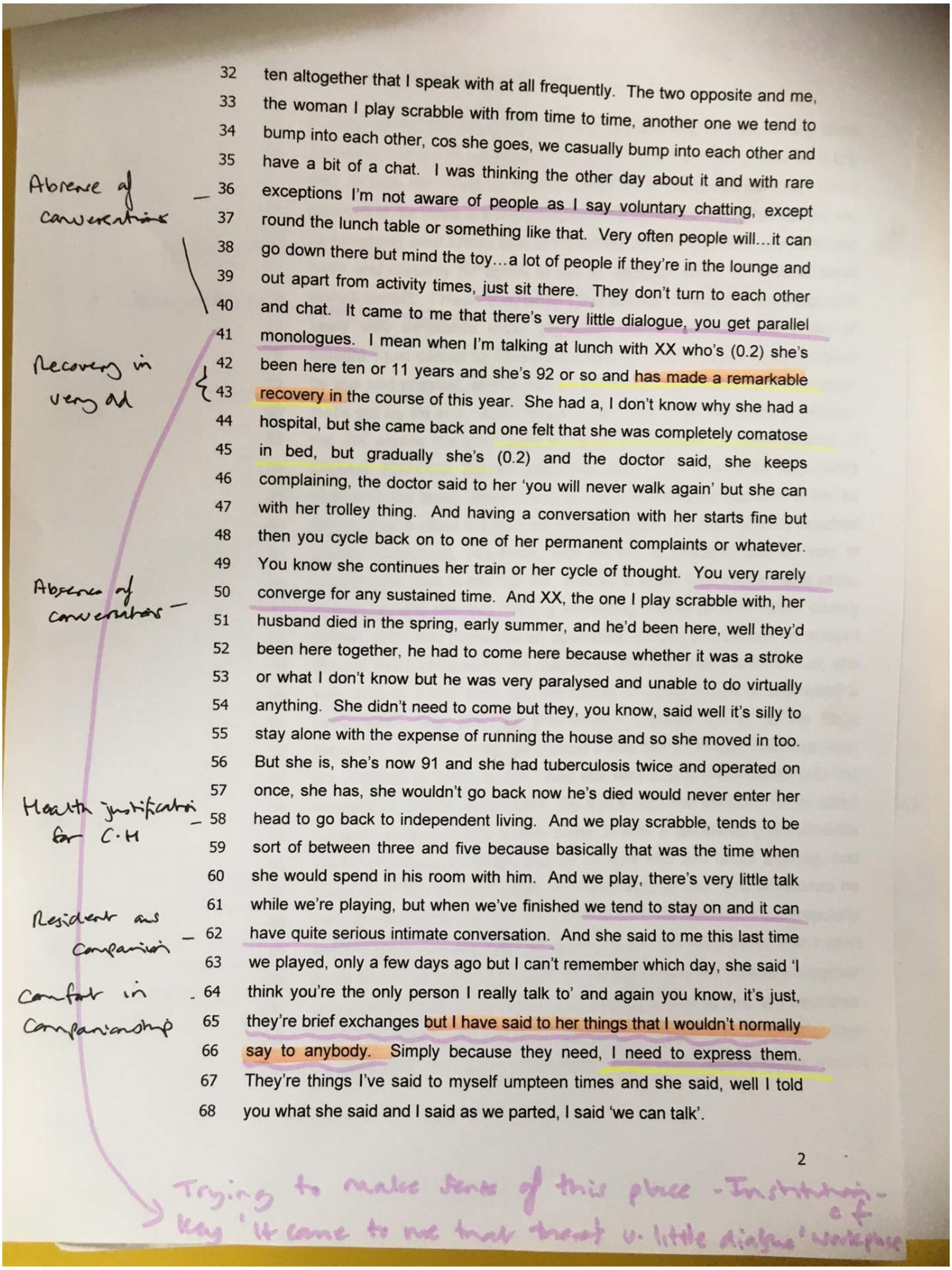
1. Residents are different to the norm
2. Residents are hidden to one-another
3. Residents have different backgrounds
4. Residents have nothing in common
5. Family as a key topic of conversation
6. Absence of conversations
7. Deafness inhibits communication
8. Ageing body
9. Decline in cognition
10. Physical disability as a barrier to shared-interests
11. Physical disability as a barrier to attending activities
12. Desire to be alone
13. Effortful communication
14. Loneliness in the absence of communication
15. Absence of communication as a main source of loss
16. Comfort in companionship
17. Family as main source of connection
18. Resident as companion
19. Resident as confidante
20. Trusted confidante
21. Mutual therapy sought via resident friendship
22. Death pact with peer
23. Death is harder for staff
24. Preference for dining hall companion
25. Staff as closer friends
26. Staff as ‘enemy’
27. Escape via external relationships
28. Physical escape from the home
29. Escape via memory of loved ones
30. Spouse as closest companion
31. Grief and bereavement
32. Suffering loss of a previous life

33. Fear of loss of a preferred self
34. Fear of the future-self
35. Fear of death
36. Disability and room confinement
37. Lack of acknowledgment of death
38. Community death is surrounded by friends
39. A preference for death over full dependency
40. Activities for a child
41. Activities infantilise
42. Activities do not provide stimulation
43. Constructions of age
44. Institution versus community
45. Lack of freedom in institutional setting
46. Autonomy restricts decision-making
47. Stimulation is not provided by residents
48. Freedom in diversity
49. Segregation of men and women
50. Judgements made about residents
51. Importance of privacy
52. Importance of autonomy and choice
53. Acceptance of a new life
54. A previous life is over
55. Reflections on a good life lived
56. Reflections of personal/professional life choices
57. Refrain from visiting dying residents
58. Caring for resident is the domain of staff and family
59. Lack of family support
60. Funeral for well-known/high status resident
61. Policy inhibiting peer help and assistance
62. Reflections on professional identity
63. Professional life was a full-life
64. Hobbies provided interest
65. Hobbies as a source of belonging
66. Institutional living

67. Residential home as a business
68. Prioritisation of health and safety
69. Comparison to boarding school
70. Comparison to nursing
71. Transition from multi-culture to mono-culture
72. Transitioning time needed on move to care home
73. Health justification for move to care home
74. A decline in ability
75. Remarkable recovery in the very old
76. Resident dispute over dining place
77. Residents seek familiarity
78. Residents' lives have shrunk
79. Stimulation achieved through children
80. Seeking a purpose
81. Lack of small pleasures
82. Absence of 'mini'-activity
83. Upset in staff leaving
84. Unrequited needs
85. Disappointment in the social life here
86. Lack of hope for the future
87. Grief in the loss of a happier life
88. Deeper friendship amongst those prior-known
89. Grief from the death of a friend
90. Residents are widowed
91. Reluctance in seeking-help
92. Medicine as prolonging life
93. Regular death of fellow residents
94. Turmoil from death of residents
95. Dying pact amongst residents
96. Witnessing others dying
97. Preference for circumstances of death
98. Intimacy in marriage
99. Acknowledged as individuals
100. Reaching acceptance of death

101. Prior known people as closer friends

APPENDIX G: Annotated Transcript



ten altogether that I speak with at all frequently. The two opposite and me, the woman I play scrabble with from time to time, another one we tend to bump into each other, cos she goes, we casually bump into each other and have a bit of a chat. I was thinking the other day about it and with rare exceptions I'm not aware of people as I say voluntary chatting, except round the lunch table or something like that. Very often people will…it can go down there but mind the toy…a lot of people if they're in the lounge and out apart from activity times, just sit there. They don't turn to each other and chat. It came to me that there's very little dialogue, you get parallel monologues. I mean when I'm talking at lunch with XX who's (0.2) she's been here ten or 11 years and she's 92 or so and has made a remarkable recovery in the course of this year. She had a, I don't know why she had a hospital, but she came back and one felt that she was completely comatose in bed, but gradually she's (0.2) and the doctor said, she keeps complaining, the doctor said to her 'you will never walk again' but she can with her trolley thing. And having a conversation with her starts fine but then you cycle back on to one of her permanent complaints or whatever. You know she continues her train or her cycle of thought. You very rarely converge for any sustained time. And XX, the one I play scrabble with, her husband died in the spring, early summer, and he'd been here, well they'd been here together, he had to come here because whether it was a stroke or what I don't know but he was very paralysed and unable to do virtually anything. She didn't need to come but they, you know, said well it's silly to stay alone with the expense of running the house and so she moved in too. But she is, she's now 91 and she had tuberculosis twice and operated on once, she has, she wouldn't go back now he's died would never enter her head to go back to independent living. And we play scrabble, tends to be sort of between three and five because basically that was the time when she would spend in his room with him. And we play, there's very little talk while we're playing, but when we've finished we tend to stay on and it can have quite serious intimate conversation. And she said to me this last time we played, only a few days ago but I can't remember which day, she said 'I think you're the only person I really talk to' and again you know, it's just, they're brief exchanges but I have said to her things that I wouldn't normally say to anybody. Simply because they need, I need to express them. They're things I've said to myself umpteen times and she said, well I told you what she said and I said as we parted, I said 'we can talk'.

2

Absence of conversation

Recovery in very old

Absence of conversation

Health justification for C.H

Resident as Companion

Comfort in Companionship

Trying to make sense of this place - Institution - of workplace

Key 'It came to me that there's v. little dialogue'

APPENDIX H: Excerpt from List of Codes and Data Extracts

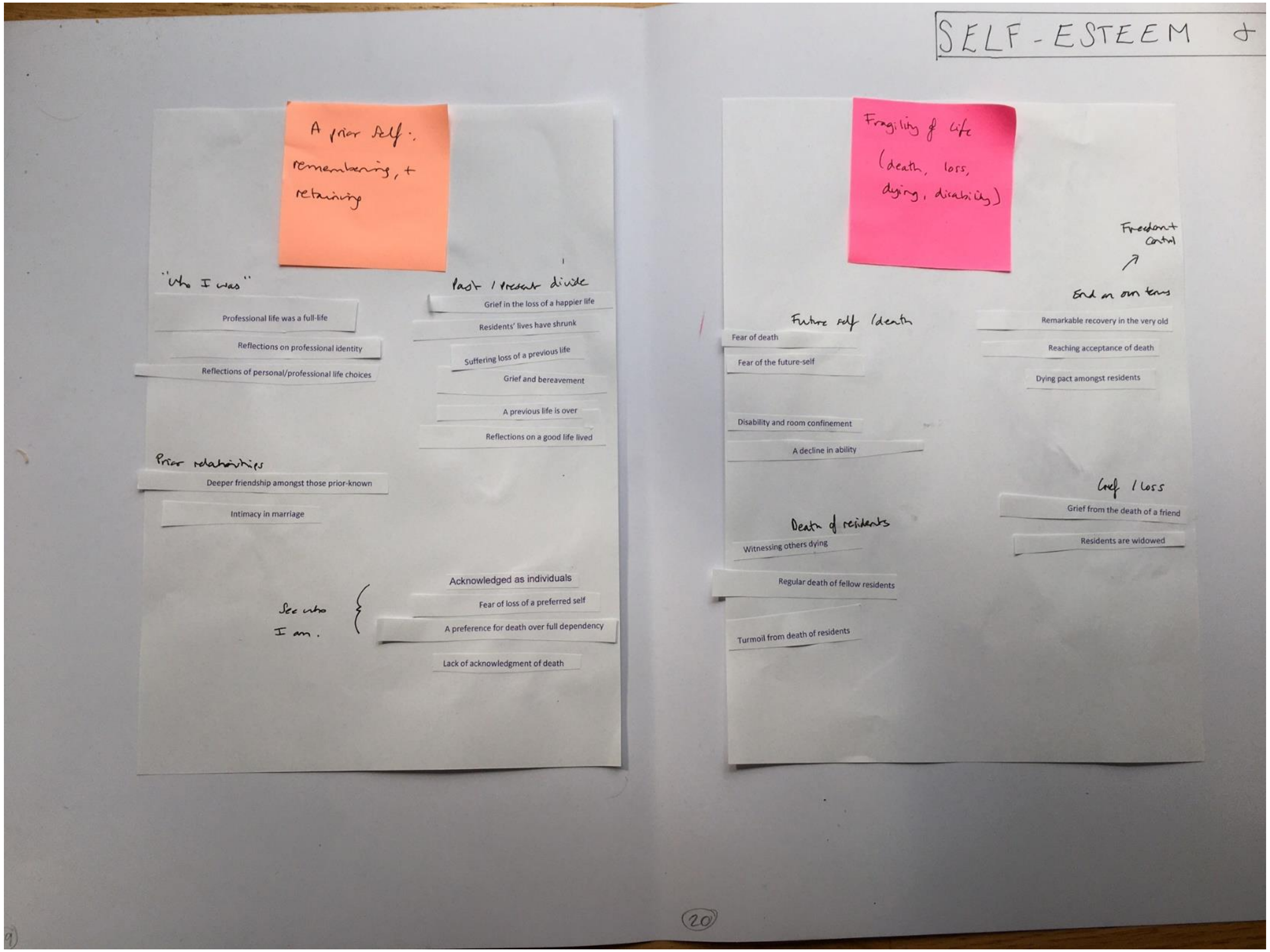
Code	Definition	Example extracts
Absence of conversation	**The experience of co-residents as being unable or unwilling to engage in verbal conversation.**	Well, half of the residents haven't got a conversation (**Ethal**: 276) I don't think there's anyone here now that I can really have a conversation with (**Lynn**: 59-60) We try, but it doesn't get beyond good morning really, that's as far as it gets (**Ken**: 82-83) I think, if we get together at a mealtime, which we do on just one meal a week, which we have upstairs, about eight of us on a table. The idea is to get a bit of this going [mimics talking action with hands], but it doesn't really get going. (**Ken**: 120-123) Short light conversation. You can't have a lot of conversation when you're eating a meal, except when we wait for a long time to be served or anything like that, then you can observe how people react (**Mabel**: 172-174) there's very little casual interaction (…) I'm not aware of people as I say voluntarily chatting, except around the lunch table or something like that (…) a lot of people if they're in the lounge and out, apart from activity times, just sit there. They don't turn to each other and chat. It came to me that there's very little dialogue, you get parallel monologues (…). You very rarely converge for a sustained time (**Pam**: 30-50). Most people are very docile. They have their foibles and their, well yes, most people are very quiet, I think what I miss most is normal social interaction. And mixed (**Pam**: 400-402). there is a little organisation that is supposed, it aims to bring things for people to handle, be stimulated by and encourage them to talk (…) but hardly anybody spoke up (**Pam**: 472-480).
Prior-known people as	**Closer relationships exist with those people**	Not close. I had a lot of friends before I came here and I had a lot of visitors. They have gone, one by one. That is one problem. I have one person in xx who still comes and visits me, we

closer friends	**(residents or non-residents) who are known prior to living in the care home.**	met playing Bridge about 25 years ago. But her husband died here (**Ethal**: 82-84). I don't think many people get individual friends, unless they come in with a local person (**Ethal**: 133-134). I'd say friendly rather than friends (**Joyce**: 35). It's not a close friendship (**Joyce**: 47). when you get older your friendships are made due to the children's friends, you know, you make friends with their mothers. And as we moved ten times in the first thirteen years we were married, you don't get much chance to form deep friendships, do you? I mean the friendships I go back to when I was nursing, because my school friends have all died now, very few people left alive (**Joyce**: 92-98). So, when I came here, of course, we already knew each other (…). I really still miss her (…) We knew that whatever we said to each other wouldn't get spread around at all (**Lynn**: 85 - 99) I think if the other people are XX people and they knew where I worked and all that sort of thing, that's when the chatter goes on. You've got common friendships in the town and we know XX and XX's where I was born and bred and I've more or less lived there all my life (**Ken**: 45-48). It was a big funeral, quite a lot, well several people went here, because he'd been here quite a long time and was very special to those who knew him before he got quite so profoundly deaf (…) his father was a vicar, he was a lay preacher at the big church in xx, and several residents here had been in the congregation of that church. So there was a big, a strong church connection with several residents and him. And he sat at the end of one of the tables (…) I mean everybody respected him and liked him (…) well those who had known, who are still here, who had known him (**Pam**: 578-599).
Residents are different from the norm	**Residents do not meet the typical behavioural**	We are getting people in that are different. They are not civilised.(**Ethal**: 60-61) But he has quiet – they are moving him today – he must have – he can't concentrate if television is

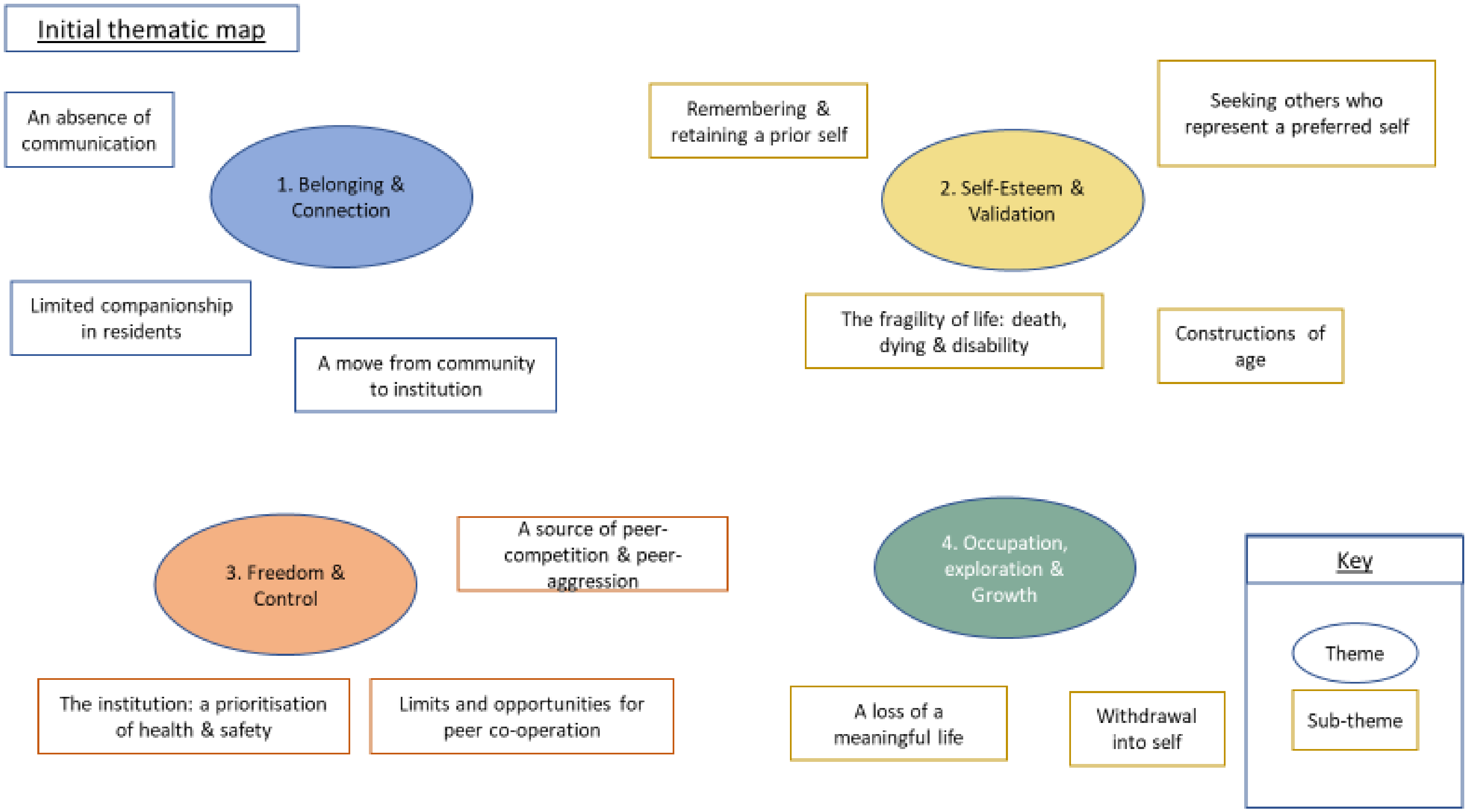
	expectations of other people	room in any one room. Well, we didn't have such odd people in those days (**Ethal**: 72-74). Again, she ought to be in a mental home, like this chap they are moving. Must have quiet in the evening, for concentration. Well, a concentration camp might be a good idea. I mean, you don't come – you expect, if you are in a home, a certain amount of noise, televisions, people talking, staff working (**Ethal**: 225-228). apart from getting over some operation or other, they're (respite residents), I was going to say normal, but you know what I mean (**Lynn**: 248-249). I was immediately attracted to her as someone who stood out from the (crowd). I tend to think, my description is beached whales, something, you know, with life but is stranded and no way of helping back to any real life (**Pam**: 83-86). Well, before it was all chattering, it was back chat you know? Have a bit of a laugh about things, but things are taken quite seriously, but we're happy aren't we? (**Ken**: 9-10).
Staff as closer friends	**Closer emotional connections exist in the staff/resident relationship versus resident/resident relationships**	I don't think there's anyone here now that I can really have a conversation with, so that's why it's so vital to have the carers to talk to and they're so friendly. In fact, I made my son laugh, I said this would be a lovely place if we didn't have residents (**Lynn**: 60-62). Oh, it's very important. After being here for three years, they're not just carers, they're friends. Some of them you send emails to each other and exchange, you begin to get to know all about them and their families and their troubles and joys. So, they're absolutely vital (**Lynn**: 118-121). the turmoil was essentially in the turnover of staff. You build up a little bit of a relationship with a carer and they've gone (**Pam**: 376-377). I am more friendly with the cleaners. I had a lovely girl from Nepal, one of the Ghurka wives, and she, a cleaner, and we were great friends and she has been posted to xx (**Ethal**: 338-340).
Health justification for move to care home	**Justifications for a move to the care home are weighed up in**	I think they're happy to be here and to be fed and watered all the time. I mean, that's the biggest asset of being here, being looked after and

	relation to health benefits.	knowing that there's help across the road if you want it (**Ken**: 23-26). But we're looked after, and that's the main thing (**Ken**: 117). the staff are very good and we get fed and watered and what else do you want? (**Ken**: 248-250) I think we're very lucky here really. It's very expensive, but it's, my family, because I have a son and a daughter and their families they're all in America, it gives them peace of mind knowing that I'm here being looked after, because I had several nasty falls before I came and I was told that I was very vulnerable (**Lynn**: 28-32). Well, I knew the – we used to call them a matron in those days. She was a friend of mine, went to my church. She suggested, after my husband died, because I had been a bit depressed, and I came for a month. Then I went away again and then I was a bit unsteady, I am not quite sure why, but I came for Christmas and she said do you want to stay? And as I say, I got friendly with one or two of the staff and I stayed. I am here still (**Ethal**: 185:189). when I first arrived, 13 months ago I was in a really very exhausted state, physically and emotionally (**Pam**: 76-77). but you see once you give up housekeeping with all its, I mean it takes a lot of time, even just for me. I'd reached the point where doing some shopping, doing a bit of cooking, doing a clothes washing, taking the sheets to the launderette, and that was about all I was doing (…). And now here I'm so much fitter (**Pam**: 210-223). Well, it's difficult because somehow you've got to catch people before they have moved into the beached whale phase, so that you delay them getting into it. But given modern medicine and all the rest of it, an awful lot of people are living too long (**Pam**: 677-680)

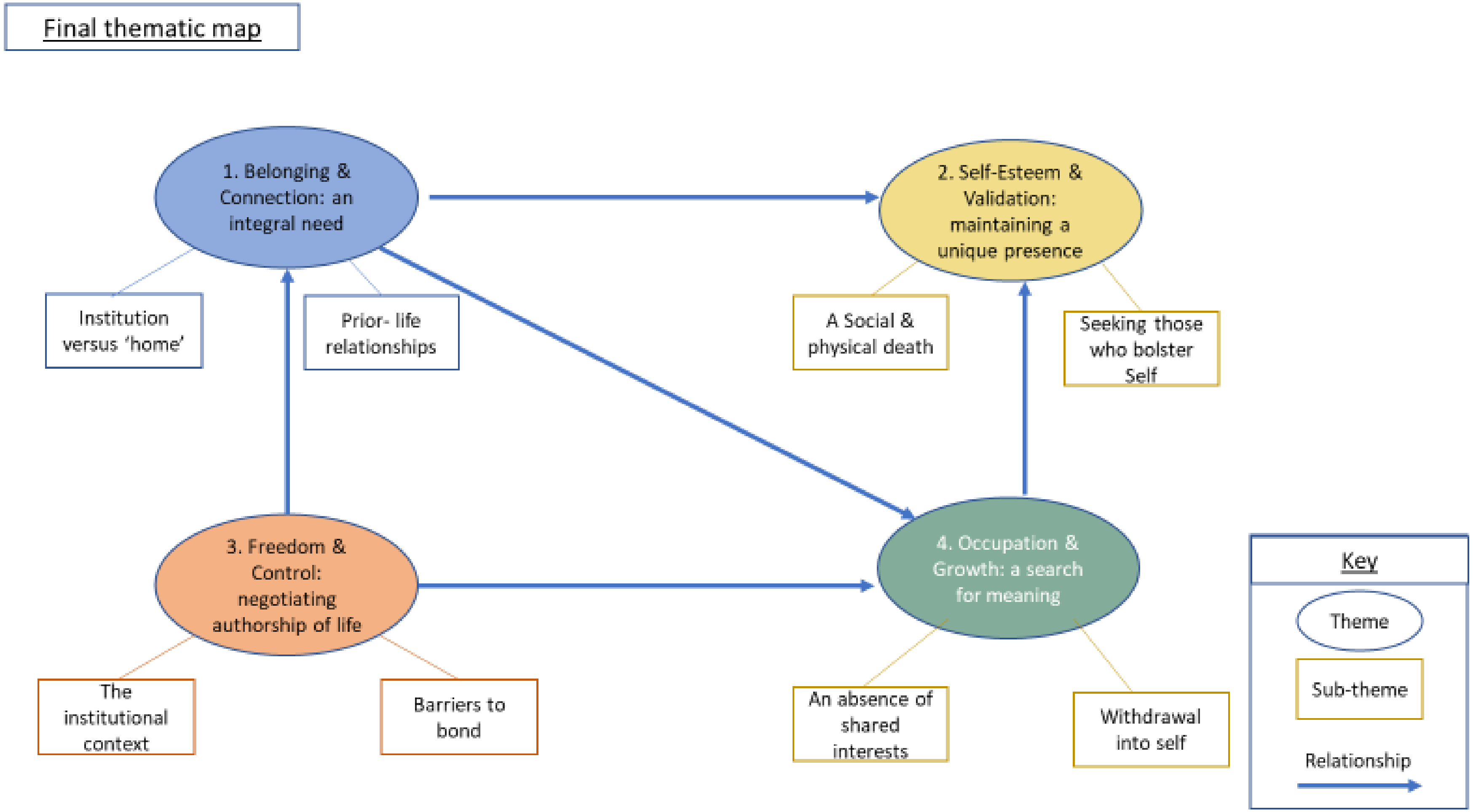
APPENDIX I: Organisation of Codes into Meaningful Categories



APPENDIX J: Initial Thematic Map



APPENDIX K: Final Thematic Map



APPENDIX L: Ethical Approval Confirmation

ResearchUEL

Dear Zoe
Change project title - Ms Zoe Wharfe
The Psychology Research Degrees Sub-Committee on behalf of the University Quality and Standards Committee has considered your request. The decision is:
Approved
Your new thesis title is confirmed as follows:
Old thesis title: How do older adults understand and cope with hostile peer behaviours
New thesis title: Exploring factors that influence peer-relations among older adults living in residential homes
Your registration period remains unchanged.

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Maria Castro **REVIEWER: Melanie Vitkovich**

STUDENT: Zoe Wharfe

Title of proposed study: How Do Older Adults Understand and Cope with Hostile Peer-Behaviours

Course: Professional Doctorate in Clinical Psychology

DECISION *(Delete as necessary)*

***APPROVED, BUT MINOR CONDITIONS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required *(for reviewer)*:

Consider further with supervisor the offer of compassion/friendship workshop afterwards – is this appropriate? Right training?

Would it not be better to check (rather than assume) that participant has capacity to give consent (i.e. has not been diagnosed with dementia, or another diagnosis that might affect capacity to give consent)? Discuss with supervisor.

If, during consent, you decide that an individual may not have capacity – perhaps mild dementia – consider an appropriate, non-obvious, and polite way to terminate. Also, if you suspect mild impairment etc,, discuss with supervisor whether there is any need to inform anybody.

Avoid asking why someone wishes to withdraw – make clear on Information they can withdraw at any point without giving a reason.

Unclear why any names etc need to be on a computer. It is usual to keep consent forms separately, and in locked cabinet, and never alongside data, nor able to be linked with it.

Consider using a code for the participant e.g., for audiofile (e.g., on a card, with contact details, and date by which they can withdraw if they want). Perhaps codes and their link to names could be stored at residential home rather than with you? At any rate, make clear on Information that they can withdraw after the interview, up to certain specific date, and how to do so. e.g., via residential manager, who could give you code?

Make clear on Information that any information given to them will be anonymised, and also kept confidential i.e. will not be discussed with any other resident during your visits (as the nature of what they tell you may quite likely involve other people you may interview).

Make clear on Information what will happen to audio files, and when.

Suggest discuss with supervisor whether to give example on Information sheet, of breach of law

Suggest make clear any debriefing of results will be in general terms (not refer to specific individuals).

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*

Student number:

Date:

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

☐

MEDIUM

☐ LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature)*:

Date:

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

APPENDIX M: Participant Information Sheet

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

Information Sheet

Hello, my name is Zoe and I am a Trainee Psychologist.

I am undertaking a research study for my Doctorate. I am really interested in finding out about how friendships and social relationships between residents develop.

What is it like living with other residents here?

By talking to you, I hope I can help those who live or work in residential homes, understand how people cope with challenging times and what helps people to have kind and supportive relationships with other residents.

Perhaps you have had some really positive experiences? ☺

- *making new friendships,*
- *sharing interests with others,*
- *being a shoulder to cry on*
- *....that have helped you feel happier, cope with difficult times.*

Perhaps you have had some difficult experiences? ☹

- *wanting to keep yourself to yourself,*
- *others being unfriendly,*
- *finding it hard to talk*
- *...that might have made you feel sad or worried.*

When we come together with other people, including living together for the first time, it is normal to have both happy and challenging relationships with others.

Would it be OK for me to talk to you?

- We would meet together for between 60-90 minutes.
- We could meet in your room, or meet in another room in your building.
- A tape-recorder will be used so that I can record our conversation.
- I will write up (or transcribe) our conversation, and I will not include any personal details such as your name or your residential home – our conversation will be kept strictly anonymous **and kept confidential i.e. nothing that you say to me will be discussed with any other resident during my visits**.
- The recordings and transcripts will be kept safe on a password-protected disc
- You will not be paid for talking to me.
- It is important that people are safe, and if you told me that you or someone else was in danger, then I would need to inform a support worker or social worker. I would let you know about this before I contacted anyone else
- I will write a report about some of what you and others have told me that other people will read. However, the information that I give will be given in general terms and will not be based on what an individual has told me.
- I will not write your name nor the name of others nor any other identifying details, such as location, in the report. **It will all be anonymous.**
- I will keep the transcript of our conversation for 3 years to allow for publication of the research. After this period, the transcripts will be permanently erased.
- The audio of the recording will be permanently erased as soon as the transcript has been written.
- Due to the sensitive nature of this topic, it is possible that you might experience some distress in talking about your experiences, but we will have time at the end of the meeting to talk about any distress or difficult emotions and I would point you to a service or person who can continue supporting you.
- **It is OK if you do not want to talk to me**, **if you want to take a break or if you would like to withdraw from being in the study at any time until the analysis begins in March 2017**. Taking part in the study, or not, will not impact on your living arrangements or the service that you receive.

Opt-in card

I am interested in taking part in the study on how friendships and social relationships between residents develop.

My name is ______________________________________

Zoe Wharfe will contact you as soon to talk to you about the study

Thank you

You can call me on xx at any time. Or email me at xx@gmail.com or xx@uel.ac.uk You can also contact my supervisor to discuss this research: Dr xx

APPENDIX N: Consent Form

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

Consent Form

- I have read the information
- It is OK for Zoe Wharfe to talk to me about my friendships and what it is like to interact with other residents here
- It is OK for Zoe to record what I am saying
- It is OK for Zoe to write down what I am saying
- It is OK for Zoe to write a report
- I understand the report will not have my name in it
- I understand the report that is written may be published so that other people can read it but it will **not be possible to identify me.**
- **I understand it is OK to stop talking to Zoe,** take a break or withdraw from the study at any point until March 2017 and without any impact on my care

Name

Signature

Date