OLDER MEN'S EXPERIENCE OF MOVING INTO RESIDENTIAL CARE

Simon Weighell

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Abstract:

Research examining the transition into residential aged care suggests that it can have a significant psychological and physiological impact upon older adults. There is a dearth of research examining the specific experiences of older men moving into and living in residential aged care. Older men may be at a significant disadvantage in managing the transition into care, particularly in context to; institutional living often characterised by increased dependency and a loss of control; physical disability and frailty; a feminised environment; and difficulties establishing supportive relationships. This study sought to explore the experiences of men who have moved into a 'residential care home'. This is paramount for understanding the needs of this group and attending to gaps in the literature.

Eight care home residents were interviewed with regards to their experiences of moving into a care home. A thematic analysis of these interviews was constructed. Four themes were found: 'Different roads same destination', 'The systems (at) work', 'Making it easier', and 'It's harder to connect'.

The analysis indicated that older men seek social support and intimacy in care but are prevented from meeting their needs because of individual and systemic barriers. Older men may use a distinct type of acceptance that is influenced by their cohort specific experiences to help them get used to institutional living. The thesis concludes with consideration of the wider professional and research implications.

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List of abbreviations

CH	–	Care home
NH	–	Nursing home
RC	–	Residential aged care
RCH	–	Residential care home

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CHAPTER ONE: INTRODUCTION

"Life is a voyage, in the process of which, we are perpetually changing our scenes" wrote Seneca (Cole, 1992, p.120).

Considerable demographic changes have taken place in the 21st Century. The population is ageing and many older people are living longer, often with life limiting illness or disability (Age UK, 2015). Those with higher support needs may be faced with the prospect of residential aged care. This research seeks to examine the experience of one particular cohort, older men, following their move into a residential care home. This group's experiences are routinely hidden from view and little is known about how they manage the move into care.

In order to provide a sound rationale for the study of older men in their transition into a residential care home, the introduction will be divided into six sections. The first section will visit 'older' adults: The concept of old age, theories of ageing and issues of health and care faced by those in the latter years of their life. In section two I will focus on residential aged care in the UK, from the past to the present. In section three and four I will examine the transition into care, reviewing the literature. In section five I will review older men and ageing in context to the male identity and masculinity. In section six, older men's experience of the transition and life in care will be reviewed, paying particular attention to coping. Finally, a rationale for this research will be presented.

1.1. Older Adults

1.1.1. Terminology

In everyday language and within the psychological literature the terms used to describe older people vary. In this thesis the term ‘older’ is used to describe men, women, adults and people. Many terms previously accepted as neutral are now considered to have negative connotations i.e. the ‘elderly’ (Britton & Woods, 1999). Alternative terms preferred by many older people are the ‘third’ and/or ‘fourth age’ (Hazan, 1996).

In this thesis (and throughout the UK) the terms ‘Residential aged care’ (RC) and ‘Care home’ (CH) describes an “establishment providing accommodation with nursing or personal care” for older people (Department of Health (DOH), 2003, p. 41). They offer services to individuals whom may not be able to live independently and traditionally encompass two distinct types of home; ‘Residential care homes’ (RCH) (providing personal care only); and ‘Nursing homes’ (NH) (providing nursing and personal care) (Froggatt, Davies, & Meyer, 2009).

1.1.2. Constructing Old Age

Definitions of age are constructed within historical, social and cultural contexts. In the UK, old age has typically commenced at 65 years, in line with retirement from work, though this is now being phased out (Calasanti & Slevin, 2001). Set by policy makers, chronological age can be used to define eligibility and allocation of resources. In this way old age can be administratively defined (Wilson, 2000).

It is widely accepted that human beings with the same chronological age can show, even from a biological point of view, very different ageing characteristics (Baars, 2007). Not only does chronological age lack synchrony with the ageing process it is also a poor predictor of any important dimension in later life, including physical health, psychological wellbeing, and quality of life (Bengston, Gans, & Putney, 2008).

Research suggests that the subjective experience of ageing is largely independent

from chronological age (Humphrey, Lee, & Green, 2011). People do not often begin describing themselves as 'older' until they have reached their mid-seventies (Kaufman & Elder, 2002).

The question of when old age begins is difficult to answer - does old age commence at 65, 75 or 85? Age demarcations between ‘older adults’ and others may be arbitrary given the significant differences within and between these groups (Baars, 2012). If old age begins at 65, this group may span 30, possibly even 40 years. There is little doubt that this broad range encompasses much diversity and difference.

Critical positions on old age and ageing assert that it is a discursive construction rather a discrete category (Woodward, 1999). Old age can be mapped onto particular bodies in a similar way to gender, sexuality, race and class (Dolan, 2010). Once old age is viewed as a product of discourse it forms part of a larger continuum - a system that includes infancy, childhood, adolescence and young adulthood (Woodward, 1999).

In western societies the social construction of older adults is largely based on ageist notions; older adults are seen as frail, dependent and decrepit (Talarsky, 1998). This construction assumes that 65 marks unavoidable bodily and mental decline and a consequent need for health and medical care (Talarsky, 1998). In this way the older persons body is constructed as a social problem, which society can resolve through medical, social and institutional management.

1.1.3. Theories of Ageing

Growing old is not an event but a process of gains and losses over time (Schumacher, Jones, & Meleis, 1999). Early theorising on these processes centralised on death, end of life and impossible quests for immortality (Gruman, 2003). Today, debates within gerontology remain on whether ageing is pathological - a disease, or physiological - a normal development (Bengston et al., 2008). These essentialist approaches often equate ageing with biological processes (Birren & Birren, 2001). Critics suggest that whilst this may lead to medical

advances, to view ageing as an exclusively medical or biological phenomenon is largely in the interest of profit rather than health (Estes & Binney, 1989).

A number of psychosocial theories focus on the social and psychological aspects related to 'successful ageing'. Continuity theory (Atchley, 1982) posits that experiential learning enables older adults to adapt to environmental changes, helping them preserve and maintain existing psychological structures. In this way, adaptation enables older adults to maintain a consistent view of the self to cope with the ageing process (Atchley, 1989).

To maintain late life satisfaction activity theory purports that the maintenance of relationships and valued pursuits is essential (Neugarten, 1964). This may prove increasingly challenging as we advance in age, particularly if physical disability impedes our contact and interaction with others in our social system. Disengagement theory (Cumming & Henry, 1961) suggests that this social withdrawal in later life is both inevitable and a natural part of ageing. However, neither end of the dualism captures the variation in the possibilities or limitations affecting both social bonds and meaningful endeavours in later life (Marshall, 2008).

Erikson's (1963) model of psychosocial development divided the lifespan into a series of 8 stages, each marked by a particular psychological task. The way in which a person masters any particular stage influences future success or lack of success in mastering subsequent stages of development (Erikson, 1982). Erikson proposed that in old age, the psychological task is the achievement of wisdom through the resolution of the conflict between ego-integrity and despair (Erikson, 1963). Successful resolution of this eighth stage arises when the individual accepts what has gone before as inevitable and satisfying, and without fear that death may occur in the not too distant future (Brown & Lowis, 2003). Evidence suggests that successful negotiation of this stage is correlated with life satisfaction (Lewis & Raubenheimer, 1997).

Subsequently, a ninth stage of psychosocial development was added that reflected the challenges faced by the very old: loss of autonomy (through declining physical independence) and loss of self-esteem (Erikson & Erikson, 1997). This drew heavily on Tornstram's (1989) theory of gero-transcendence, which assumes that facing the challenges of old age brings about a change in meta-perspective. This shift from a materialistic and rational view to one that is cosmic and transcendent is normally accompanied by an increase in life satisfaction (Tornstram, 1989). Whilst Erikson's theory has been a valuable conceptual framework for understanding human personality, critics contest the notion that development is always unidirectional and argue the work is based on white middle class men (Whitbourne, Zuschlag, Elliot, & Waterman, 1992).

Baltes (1987) proposed another model of lifespan development, selection, optimisation, and compensation (SOC). This model examined the adaptability of older people to age related changes and loses, those who according to Erikson have achieved ego integrity. In this model the selection of goals and subsequent investment in pursing and maintaining them in spite of losses (physical and material), contributes to wellbeing and 'successful ageing' (Baltes, 1997). Research suggests that SOC is positively associated with satisfaction with ageing, lack of agitation, and, the absence of emotional and social loneliness (Freund & Baltes, 1998). Though, there remains limited data as to how SOC is enacted differently by different age groups.

At its heart, 'successful ageing' is a value judgement, one that largely depends on the vantage point of the observer (Vaillant, 1994). Most theories of ageing seemingly ignore economic and health disparities that may reduce life chances and opportunities for older people (Wilson, 2000). Societal factors ranging from discrimination, to the consequences of policy decisions can adversely affect the identities of older people, marginalising them in the community and within the care system (Bengston et al., 2008).

1.1.4. An Ageing Population

The world population is changing and increasing numbers of people are living longer. For the first time since records began, there are 11 million people aged 65 or over in the UK (Office for National Statistics (ONS), 2014a). This age group is projected to increase by 50% in the next 20 years (ONS, 2013). The numbers of those in older age groups is also rising with over 3 million people in the UK aged 80 or over (ONS, 2014a). These population changes reflect significant improvements in our environment and advances in health and social care. Should this not be cause for celebration?

Advancing age represents a marker for several discernable processes within older peoples lives that include biological, psychological and social changes (Arber, Davidson, & Ginn, 2003). The physiological ageing process increases our chances of ill health, disability and dying. Despite significant investigation, we know little about the complex biological process of ageing, and what can be done to reverse this (Bengston et al., 2008).

It is estimated that 4 million older people in the UK have a life limiting longstanding illness (Age UK, 2015). For those aged 75 and over this equates to almost two thirds of the population (ONS, 2011). Adverse health and ongoing disability associated with advanced age mean some older adults have high support needs (Blood, 2010). As the group of the 'oldest old' grows, the proportion of that group with high support needs is likely to increase (Centre for Population Change, 2010). Advanced age and ill health are both predisposing factors for entry into RC (Shapiro & Tate, 1988).

The ageing population and increased prevalence of long term conditions is placing pressure on health and social care services in the UK (Age UK, 2015). Over the next few years it is projected that health and social services may require £5 billion additional expenditure to deal with demand (ONS, 2012a). Projections of future demand of CH places for older adults with dementia indicate that more than double the current number of places are required by 2043 to maintain the current ratio of

institutional to community services for dementia (Lievesley, Crosby, & Bowman, 2011).

Critics suggest that healthcare costs for older people are often exaggerated for political reasons (Wilson, 2000). In recent years political debates about older age are frequently restricted to the question of how to fund social care, with potentially unfortunate consequences (Centre for Social Justice (CSJ), 2010). This may lead older people to be portrayed as a problem that society has to pay for, limiting broader thinking on what kind of care system we want in the first place (CSJ, 2010).

The current health and social care system in the UK encompasses a range of services which support people to maintain their independence, helping them to live with disability or ill health (Blood, 2010). This includes personal care, practical help and social support that is provided across a range of venues: in a person's own home (domiciliary or home care), at community venues such as day centres, and institutionally, whether RCH's or NH's (CSJ, 2010). Despite a policy emphasis towards care in the community encoded in the NHS and Community Care Act 1990, RC remains the bedrock service which is provided in practice for the frailest and most disabled older people in our society (Peace, Kellaher, & Willcocks, 1997).

1.2. Residential Aged Care

This section aims to provide a context to the setting of this study in RC. Firstly, a history of the CH system in the UK for older adults will be reviewed. Secondly, the current social, political and economic context to RC will be described. Finally, an overview of the residents, workforce, standards and abuses in care will be presented.

1.2.1. History of RC

RC is typically regarded as the contemporary expression of institutional living (Peace et al., 1997). Its roots can be traced back to the nineteenth century poor law and workhouses (Lievesley et al., 2011). Throughout the 19th century

workhouses became a place of refuge for the elderly, disabled and sick instead of the able-bodied poor (Peace et al., 1997). Workhouses were abolished and their responsibilities taken over by local authorities with the passing of the Local Government Act 1929. However, many continued under the new designation of Public Assistance Institutions (PAI's), accommodating the elderly, chronically sick, single unmarried mothers and vagrants (Higginbotham, 2015).

The birth of the National Health Service (NHS) and passing of the National Assistance Act in 1948 saw increased access and availability of free healthcare for all. The latter established local residential accommodation for older and disabled people on a statutory footing and abolished the poor laws (CSJ, 2010).

In the 1950's the success of deinstitutionalisation in the childcare field led to a growing consensus of the need for community rather than RC (Wanless, 2006). This consensus was enhanced by a national study of CH's by Peter Townsend, 'The Last Refuge' (1962), which examined the care of older people under the National Assistance Act 1948. It exposed many failings and a poor quality of life within the institutions that had become relegated to a status of 'last resort' (Johnson, Rolph, & Smith, 2012). Supporting older adults to live in their own homes for as long as possible became both cheaper for the state and more humanitarian (Wanless, 2006).

1.2.2. The Last 50 Years

Since 'The Last Refuge' (Townsend, 1962) there has been considerable change in the quality and landscape of RC. Despite drives to redirect development away from CH's in the 1980's, places in private homes have increased exponentially (CPA, 2012). Changes in funding saw placement in RC incentivised for families and local authorities as central government footed this bill (Wanless, 2006). The introduction of the NHS and Community Care Act in 1990 led to further revisions in funding and tightening of the eligibility criteria for state funded places. These changes have resulted in dramatic shifts in the numbers of publically and privately run homes. Now independent (whether charitable or for-profit) CH's provide 90% of the available placements in care (CSJ, 2010).

Despite considerable changes to form over the last 50 years, some authors question whether this is matched by a change in function (Froggart et al., 2009). On the face of it RC aims to promote ageing in place - extending the length of life and facilitating active life expectancy in the presence of age related disabilities (Hill, Thorn, Bowling, & Morrison, 2002). However, critical positions on the institutionalisation of CH's would argue that it has another purpose: to segregate and marginalise older people (Townsend, 1981) and to regulate and control (Foucault, 1977).

1.2.3. Current Social, Political and Economic Context

Recent social, economic and political changes have led to a focus on greater choice, involvement and control for service users (Owen et al., 2012). The personalisation agenda has enabled service users to have direct control over care planning (Owen et al., 2012). However, this may be an unrealistic expectation for the most frail and socially excluded older people in care (CSJ, 2010).

The current social care backdrop is at somewhat of a 'crisis point' (Kennedy, 2014). A lack of integration of health and social care teams has resulted in some older people falling through the cracks, and rationing of services has led to the thresholds of eligibility and need being raised (CSJ, 2010). This has meant that RC is only provided for those with the highest needs and lowest means.

These changes in eligibility and thresholds have led to the distinction between RCH's and NH's to become out dated. It fails to take into account the increasingly complex clinical profile of people in RCH's (CSJ, 2010). Critics argue that maintaining this distinction means structural differences in funding reduces the quality of care in RCH's and increases the likelihood of forced relocations into NH's, as care needs outweigh resources (Wild, Szczepura, & Nelson, 2010).

Over half of all CH residents (approximately 260,000 clients) receive long-term care services funded by their local authority (NHS Information Centre, 2011). Many

people remain self-funders with some having to face the harsh reality of exhausting savings and running down assets to pay for their care (CSJ, 2010).

1.2.4. CH's in The UK

In the UK there is an estimated 5,153 NH's and 12,525 RCH's (Laing Buisson, 2014). There are approximately 414,000 people aged 65 or over in care, accounting for 95% of all CH residents (Age UK, 2013). This equates to around 4% of the population of those aged 65 or over (ONS, 2014a).

1.2.4.1. *Residents*

The population in CH's is ageing; the average resident is aged over 80 and the number of those aged 85 years and over increased by 3% from 2001 to 2011 (CSJ, 2010; ONS, 2014b). Levels of need are rising and the population in RCH's now overlaps considerably with those living in NH's (Bowman, Whistler, & Ellerby, 2004). It is estimated that 75% of all residents in CH's are severely disabled and more than 50% of CH placements are related to dementia, stroke and other neurodegenerative diseases (Bowman et al., 2004). The drivers for placement in long-term care in all but a few cases are now clinical (CSJ, 2010).

1.2.4.2. *Workforce*

There is an absence of national data about the structure and size of the CH workforce (Oliver, Foot, & Humphries, 2014). Available data indicates that the workforce is largely from overseas and predominantly female (Lievesley et al., 2011). Many workers receive minimum wage and numerous homes are understaffed with no statutory agreement on minimal staffing in place (CSJ, 2010). It is not surprising then that high staff turnover exists with estimates of around 42% of the workforce leaving within 12 months of joining (Lievesley et al., 2011).

The quality of life which residents experience is largely dependent on the caliber of the staff caring for them (Centre for Policy on Ageing (CPA), 1996). Care workers are required to carry out personal and intimate services, requiring much sensitivity and tact. If staff are overburdened and engaged in increasingly task-oriented work the likelihood of resident's needs being neglected increases (CSJ, 2010).

A stressful and demanding working environment may lead staff to maintain a degree of separation to residents (Peace et al., 1997). Staff may focus on physical care rather than social interactions and some may objectify residents in order to defend against the harsh realities of death and dying (Menzies-Lyth, 1960). Unfortunately, the abuse of residents by staff does take place and is often associated with increased stress and burnout resulting from systemic failings (Drennen et al., 2012).

1.2.4.3. *Good practice and satisfaction in care*

Models of care need to be broad enough to allow for individual variation; no two residents will have precisely the same needs or definition of quality of life (Oliver et al., 2014). A project by the Joseph Rowntree Foundation, 'My Home Life', has become a leading blueprint to promoting quality of life in CH's (Owen et al., 2012). Its conceptual framework of best practice places relationship-centred care at its heart. This is a move away from 'person-centred care' because its focus on individual service users, promotion of independence and consumer choice is seen as less meaningful in long-term care than the positive relationships between the older people, relatives and staff (Owen et al., 2012).

Research indicates that four broad areas have consistently emerged in the literature on satisfaction in RC; spatial or physical environmental features (e.g., urban planning); social relationships; functional supports and services; and more transient contextual features such as lifestyle (Bonaiuto, 2004). Satisfaction of life in care is not only dependent on the immediate environment but also the local community and wider health and social care system (Owen et al., 2012).

1.2.4.4. *Ensuring standards of care*

The proliferation of private CH's in the 1980s led to the need for greater regulation and quality assurance by the state (CSJ, 2010). Today the independent body, Care Quality Commission (CQC), is responsible for monitoring, inspecting and regulating care services. Residential services for older people are assessed against the 'National Minimum Standards for Care Homes for Older People' (DOH, 2003).

These standards are used to determine whether CH's meet the needs, and secure the welfare and social inclusion of the people who live there. However, critics argue that the CQC's monitoring and inspection system is flawed; it has limited experience in the running of CH's and inspection data is provided by those who are being inspected (CSJ, 2010).

1.2.4.5. *Abuse in care*

Despite regulation and monitoring, abuse in care is common (Glendenning & Kingston, 1999). A report by Action on Elder Abuse (AEA) (2004) found that 23% of reported abuse against older adults in the UK occurred in CH's, where less than 4% of the older population lives. This disproportionate figure is disturbing given that elders reporting abuse needed to access a telephone in private, something that is not possible for all CH residents (AEA, 2004).

Whilst abuse against the individual may be alarmingly common, institutional abuse, where the environment, practices and rules in themselves become abusive, is more prevalent (Peace et al., 1997). Enquiries into abusive practices have highlighted the detrimental effect of providing limited choice and flexibility in routines, and of treating residents en masse (Clough, 1999).

1.3. Moving Into Care: Becoming a Resident

This section aims to introduce the experience of becoming a CH resident, which is often reported as a negative life event, potentially leading to feelings of loss and increased mortality (Aneshensel, Pearlin, Levy-Storms, & Schurler, 2000; Barredo & Dudley, 2008). For some individuals and their families it can be positive, enabling recovery and improving relationships (Wilcock, 2010). Lundh, Sandberg, and Nolan (2000) suggest that relocation into RC is a temporal process that consists of four overlapping phases: making the decision, making the move, adjusting to the move, and reorientation.

1.3.1. Transition Into RC

Bridges (2004) defines transition as a psychological reorientation with three distinct

phases: (a) endings that involve letting go and experiencing loss in some form, (b) a neutral zone that is an in-between phase, usually associated with uncertainty and, (c) the new beginning that may involve a new focus or new identity. The transition into RC is one of the biggest challenges older people and their families face in later life, inducing high levels of stress and requiring considerable psychological reorientation (Ellis, 2010).

The circumstances surrounding a placement in care are often unique (Lee, Woo, & McKenzie, 2002). Many older people who leave home permanently have the opportunity to make a planned and informed decision before relocating. However, some will be placed because of decisions made by relatives and/or professionals (Chenitz, 1983). Mostly, this will occur at a time of crisis, often following an acute illness or a period of hospitalisation (Wilson, 1997).

Common precipitants of moves into care include recurrent falls, illness, physical disability, behavioural symptoms of dementia, and death of a spouse (Lievesley et al., 2011; Lui & Tinker, 2001). Chiefly, these circumstances impede an older person's ability to look after themselves, signalling a loss of independence and control.

The impact of the move into RC is associated with a number of adverse effects. These include increased chances of anxiety, depression, loneliness, decline in cognitive abilities, and increased morbidity and mortality outcomes including falls, injury and death (Aneshensel et al., 2000; Friedman et al., 1995; Kirchbaum et al., 1999; Mikhail, 1992). Many older adults will also be managing illness or physical disability, both of which are consistently shown to increase the risk of mental health problems (Hill et al., 2002). Despite this, many cases of depression in care are not detected and remain untreated (Davison et al., 2007).

1.4. Literature Review

Four databases were searched for relevant literature: PsycINFO, PsychARTICLES, CINNAHL and MEDLINE. The search criteria were inclusive and only restricted to

research written in English (for a detailed account of the search see appendix A). A total of forty-eight studies were yielded and a summary of the key findings will be presented, which includes factors influencing adjustment to relocation, transition experiences, and transition frameworks.

Studies examining the move into CH's span some 30 years and have mostly been conducted outside the UK. Cultural and historical differences may influence the experiences, construction and meaning making of individuals, and, the physical environment, models of care, policy and regulation that makes up the homes they reside in. This may involve significant heterogeneity and limit generalisations across the literature.

1.4.1. Factors Influencing Adjustment to Relocation

The beginning period of the move is considered to be the most critical (Brandburg, 2007). This initial adjustment period has been labelled the 'one month syndrome' (Brooke, 1989) and the North American nursing diagnosis, 'relocation stress syndrome' (Walker, Curry, & Hogstel, 2007). This latter diagnosis is characterised by confusion, anxiety and depression (Manion & Rantz, 1995), and physical health problems such as coronary heart disease (Huppert, Brayne, Jagger, & Metz, 2000). One group of studies has examined the factors influencing adjustment to life in RC that includes the nature of admission, type of social support, gender, and culture.

1.4.1.1. Nature of admission

Wilson (1997) examined planned and unplanned moves into a NH and found that older adults who had a planned admission were found to be in the adjustment phase sooner than adults where the admission was unplanned. Studies of participation and choice in the move have shown an association between involvement in the decision and subsequent adjustment (Chao et al., 2008; Davidson & O'Connor, 1990). Forced relocations are understood to negatively influence the outcome of the move, increasing stress and anxiety, as measured by elevated cortisol levels (Hodgson, Freedman, Granger, & Erno, 2004).

1.4.1.2. Type of social support

Paterson (1995) interviewed twelve participants over a year period and found that different types of support were reported to be useful at different phases of adjustment. During the earliest phase (disorganisation) the participants reported that emotional support was most useful, with practical support useful across all phases of adjustment. Transition and adjustment can be facilitated by building social connections with residents, family and staff (Lee, Simpson, & Froggatt, 2012; Wilson, 1997).

A quantitative study by Lee (2010) examining adjustment in 156 NH residents found that emotional support from other residents and staff, along with self-efficacy and satisfaction with facilities, was significantly associated with adjustment. This was assessed using the 'Nursing Home Adjustment Scale' for elderly residents developed by Lee (2007), with established reliability and validity (Lee, 2007). However, this study used a cross sectional design with adjustment measured at one point after relocation. Thus, the influence of time in care and length of stay was not examined, limiting validity.

1.4.1.3. Gender

Two quantitative studies have examined the impact of gender upon adjustment in NH's. Joiner and Freudiger (1993) used staff ratings of 32 men and 82 women, observing men to have adjusted better to care on a 5-point scale. Claridge, Rowell, and Duffy (1995) examined 153 female and 47 male residents and found that men and women adjusted differently in care. Compared to women, length of stay for men significantly predicted positive self-concept, life satisfaction, and perception that NH staff were more responsive and reassuring. However, both studies failed to control for physical health, marital status, or social resources, all of which may influence adjustment.

Whilst many qualitative studies using mixed populations have examined the move into care, only one has reported a gender difference. Using a very small sample (two men and three women) Barredo and Dudley (2008) examined the experience of losses, and found that men expressed a marked sense of loss of meaningful

activity compared to women. Despite evidence suggesting that gender influences adjustment and experience of losses, there remains a paucity of studies examining this phenomenon.

1.4.1.4. Culture

Lee (2001) found in a study of eighteen elderly Chinese residents that sociocultural values influenced self-reported adjustment to the NH. Chinese elders reported little difficulty with rules and regulation and communal living - usually reported as problematic for adjustment. This was possibly because the Chinese culture values collectivism over individualism (Lee, 2001). Another study by Kahn (1999) on twenty-one Jewish NH residents, found they responded to their conflicted feelings about the NH as a 'home' and 'institution' by 'making the best of it'. This involved participants engaging in a continuous effort to reframe and reconstruct the meaning of their social environment: it was inferred that being with others with a similar cultural understanding and background aided this process.

1.4.2. Transition Experiences

This section will review some of the key transitional experiences described in the literature, including the decision to move, a new home, losses, relationships, and managing the move.

1.4.2.1. Decision to move

Residents may consider moving into care for many reasons, including increasing physical disability, fear of falling at home, changes in health, lack of outside help, and loneliness (Iwasiw, Goldenberg, MacMaster, McCutcheon, & Bol, 1996; Lee et al., 2012). A number of factors have been reported to influence a choice of home or organisation that includes prior experience of CH's, finances, proximity to family and previous residence, and the reputation of the facility (Iwasiw, Brandburg, Bol, McMaster, 2003; Lee, 1997; Lee et al., 2012).

A UK study by Reed, Cook, Sullivan, and Burridge (2003) of twelve residents, identified a typology of involvement and participation in the move into a NH. This included; preference relocations (moves in which residents exercised choice);

strategic relocations (planned moves pre-empting changes in circumstances); reluctant relocations (resisted or disagreed with); and passive relocations (arising from the decisions of others that are accepted and not questioned). The study identified that responses to the moves were highly individual and considered more positive when greater opportunities for choice and involvement were available.

Participating in the decision to move into care can influence reported satisfaction with CH living (Iwasiw et al., 1996). The extent to which residents are able to exercise a degree of control over the move is an important determinant of the experience of relocation (Chenitz, 1983; Iwasiw et al., 2003). Exclusion from a relocation decision can make it more difficult for residents to accept changes to living arrangements (Marshall & Mackenzie, 2008). When the decision to move falls to family members it may impact upon on-going relationships and lead to resentment (Iwasiw et al., 2003).

1.4.2.2. A new home

Where one lives has several functions. A CH is both fundamental to identity and connected to feelings of wellbeing (Riedl, Mantovan, & Them, 2013; Rioux & Werner, 2011). Moving from a place of familiarity to within an institution may lead to significant disorientation and feelings of displacement (Brooke, 1989).

A phenomenological study of ten newly admitted residents to a U.S. NH by Heliker and Scholler-Jaquish (2006) found that over a three month period residents moved through three phases of transition in their new home. This involved an initial experience of becoming homeless, to getting settled and learning the ropes (i.e. rules and routines), and finally, creating a place and home to live in. The latter phase was achieved by building new memories and relationships with other residents and members of the community.

Many new residents may strive to maintain a sense of normality and identity but this may prove challenging, particularly if they have lost valued and familiar possessions (Brandburg, 2007). One qualitative study in a Swedish assisted living facility found that new residents retained possessions that were linked to historical

events and a personal context, enabling continuity in self and others (Nord, 2013). These possessions included memorabilia, representational and mundane objects.

Privacy in a communal living environment is important, and a single room can become a symbol of control (Jilek, 2006). Indeed, when residents are able to make choices in their new home regarding activities and rules, they can experience power and control, enhancing feelings of wellbeing and adjustment (Anderson, Peterson, & Sidenvall, 2007; Wilson, 1997).

1.4.2.3. Losses

A recent literature review of nineteen studies examining the transition into care found that the admission and move is reported to lead to a loss of independence, autonomy, decision-making control, privacy, purpose, meaningful engagement and continuity of former roles (Brownie, Horstmanshof, & Garbutt, 2014). Moving into care can involve a loss of material and abstract possessions (lifestyle, role and freedom), leading to a loss of identity (Nay, 1995). Leaving home and being separated from loved ones and communities, may compound the experience of loss and feelings of isolation (Bland, 2005; Fraher & Coffey, 2011).

Barredo and Dudley (2008) identified three types of losses, including: (a) cohort loses of family relationships and lived experiences (i.e. World War II), (b) antecedent loses that mostly contributed to admission, including loss of physical capacity and control in relation to decision making, and (c) consequent losses experienced as a consequence of placement, such as a loss of independence, activities and relationships.

1.4.2.4. Relationships

However operationalised, social support is found to be important to health and wellbeing in later life (Jackson & Antonucci, 1992). The development of meaningful relationships with other residents and staff is a critical factor in the adjustment into RC (Chao et al., 2008). Relationship building, whereby residents attempt to make connections and emotional ties to others, is considered a distinct phase in the adjustment process (Brooke, 1989).

An Australian study by Marshal and Mackenzie (2008) found that 'fitting in' with others formed a significant part of becoming a resident. Furthermore, relationships with staff and residents were more valuable to those who had experienced loneliness, or a loss of social connectedness to family and friends prior to their admission. Indeed, maintaining family and friendship networks is important for new residents (Coughlan & Ward, 2007), contributing to feelings of connectedness and quality of life in care (Iwasiw et al., 2003).

1.4.2.5. Managing the move

A grounded theory study by Brandburg et al. (2013) identified twenty-one facilitative strategies helping residents with institutional life and in making the move into the NH. These include seeking out supportive relationships with staff, residents and family, letting things go, and learning the NH system and how to get what you need. Other reported strategies in the literature include reframing the perception that the CH is a bad place to live, and going along with what takes place there (Porter, 1992); and maintaining habits and routines from before placement (Riedl et al., 2013).

1.4.3. Theoretical Models of Transition Into Care

Most theoretical frameworks of transitions into care emphasise phases by which people move from an initial reaction through to adaptation (Brandburg, 2007; Brooke, 1989; Wilson, 1997). In reviewing thirteen studies of transition into NH's, Brandburg (2007) proposed a transition process framework which sets out four stages: (a) an initial reaction to the move (marked by emotional responses), (b) transitional influences (personal characteristics, values, history and admission circumstances), (c) adjustment (forming relationships, reflection, reframing, future orientation and a search for meaning), and (d) acceptance that occurs between 6-12 months post admission, leading to adaptation (stabilisation, feeling at home, meaning in life, helping others, and wellbeing) or maladaptation (depressive or forceful resistance).

A recent UK study by Lee et al. (2012) found that in contrast to Brandburg's (2007)

framework the transition process is not one that is time bound or linear. Instead, participants' experiences reflected key plots of 'control', 'power', 'identity', and 'uncertainty', interwoven throughout their narratives and some had difficulty incorporating this into their life stories (Lee et al., 2012). Clearly, there are a number of interpretations of the transition process within the research literature and one can be certain that it is a highly individual and complex process.

1.5. Older Men and Ageing

The previous section introduced the literature on the transition into RC. This section aims to introduce the group on which this study will focus - older men. It will review the issues older men face as they age with specific reference to masculinity and the male gender role.

At birth we are assigned a gender on the basis of external genitalia, to which a framework of socially constructed rules is applied (Harding & Palfrey, 1997). In western societies the traditional male gender role is characterised by attributes of emotional inexpressiveness, instrumentality, independence, strength and dominance (Courtenay, 2000). These characteristics are understood to be the basis of the dominant 'hegemonic' model of masculinity, one that largely remains the territory of young men (Thompson, 1994). The 'hegemonic' model refers to the traditional, patriarchal view of men and male behaviour as the most influential and culturally accepted notion of 'manliness' (Lee & Owens, 2002). The references of Thompson (1994) and Courtney (2000) are over 20 years and 15 years old respectively, yet, they remain widely cited and influential on their writing and depiction of masculinity and hegemony.

Masculine gender roles specific to one's age cohort are thought to remain stable throughout life (Soloman & Szabo, 1994). Many older men will have been socialised to accept traditional binary ideas about sex and gender issues (Marsiglio & Greer, 1994). One of the challenges facing men as they proceed into later life is the waning of physical or sociological means to complete tasks and roles that were valued when they were younger (Soloman & Szabo, 1994). Research on younger

men suggests the inability to enact the masculine gender role may lead to a gender role conflict (O'Neil, 1981).

In western societies success is often defined by the external products of actions (material and symbolic) and as men age they may be less able to demonstrate these (Segal, Qualls, & Smyer, 2010). This may lead older men to enter into a dilemma of 'generativity and stagnation' and limitations on dominance and success may lead to a major life crisis (Erikson, 1963).

Declining physical strength and increased disability may inhibit the ability to express the task-orientated aspects of the traditional male role (Segal et al., 2010). Research on masculinity in later life has shown a potential shift of men's interests and roles from 'generating income' into 'being useful' such as the role of grandfather or carer (Mann, 2007). This change in role does not mean men necessarily resist traditional 'hegemonic' norms but rather men strategically negotiate caring within conventional masculine constructions (Ribeiro, Paúl, & Nogueira, 2007). For example, a grandfather's notion of masculinity may be underpinned by his role as an elder patriarch of the family, and the dispenser of advice and instrumental help (Davidson, 2004).

Older men can face unique challenges to maintaining and renegotiating a masculine identity. This is particularly salient in western societies where they are often represented as genderless and frail beings (Smith, Braunack-Mayer, Wittert, & Warin, 2007). Older men's masculinity has been couched as an invisible part of the dynamics of 'hegemony' or, more simply it is ignored (Thompson, 1994). Theories of masculinity are primarily constructed in relation to younger men and little is understood about how older men and those in RC comprehend and enact being male (Moss & Moss, 2007).

Whilst some beliefs and behaviours may be seen to be typically male, we should not assume that individuals hold the same beliefs or behave the same way throughout their life (Addis & Malik, 2003). Significant diversity and difference (i.e. age cohort, race, culture and sexuality) across older adults and in later life gives

rise to the possibility of multiple masculinities, and yet, these rarely rise to a threshold of public consciousness (Thompson, 1994). If we fail to pay attention to the cohort specific, gendered social lives of older men, we may further serve to homogenize and de-gender them.

1.6. Older Men in Care: From Transition to Resident

This section will examine the literature on older men's experiences of the transition and life in RC. The CH environment and moving process, characterised by a loss of control and independence, may pose a unique challenge to men and their male identity.

The numbers of older men in the UK are rising (ONS, 2012b). As more men are living longer and later in life, the gender gap in CH's is also narrowing. In 2011 there were around 2.8 women for each man aged 65 and over (ONS, 2014a). Men still remain a minority in care, making up around 30% of the population (CPA, 2012). For older men in care their status as a minority is likely to be a more salient aspect of their day-to-day living than in the general community, because the majority of care workers and residents are female (Gleibs et al., 2011).

1.6.1. Transition Experiences of Older Men in Care

On the whole, there remains a dearth of research examining the experiences of older men in care (Jilek, 2006). This is surprising given that gender differences have been found in the adjustment to care (Claridge, Rowell, & Duffy, 1995) and in the experiences of losses (Barredo & Dudley, 2008).

Only two studies specifically examining the transition experiences of men have been identified. The first, a thematic case study on George in a New Zealand NH found; circumstances around his placement impacted upon the meanings he ascribed to his new home; intrusive experiences of other residents with dementia; a feeling of homelessness; and a loss of meaning, control and safety (Bland, 2005).

Another Australian study by Rodney Jilek (2006) examined the experience of fourteen males entering ten different NH's. This phenomenological research identified four key themes: (a) the struggles for control, (b) institutionalisation and the fight for privacy and dignity, (c) the black hole of social isolation and the need for mate-ship, and (d) the need for meaning. The results are summarised below with reference to the research literature. Of interest, both studies identified constructs salient to the masculine gender role i.e. control and aggression, however, neither referenced the notion of masculinity or the masculine gender role.

1.6.1.1. *The struggle for control*

The men reported that the struggle for control commenced before admission, particularly when family members made placement decisions. This struggle was found to continue throughout placement, leading to resistance, enacted through aggression or depression. These findings are consistent with studies on mixed populations (Chenitz, 1983; Wilson, 1997).

1.6.1.2. *Institutionalisation and the fight for privacy and dignity*

Privacy and dignity was impaired by the physical environment (i.e. shared bathrooms and lack of acceptable social and recreational areas), culture, policy and practice of the staff. Participants described the problems with the environment and privacy as demeaning, degrading, belittling, depressing and controlling. Of interest, given the choice the men reported they would prefer to share a room with another male (as long as they could converse) rather than having a single room, sacrificing a level of privacy for the sake of companionship.

1.6.1.3. *Social isolation and the need for mate-ship*

Consistent with the transition literature social contact was identified as an important factor for quality of life (Iwasiw et al., 2003). A lack of gender-appropriate activity was identified and participation in such activity was reported to be a key driver of satisfaction. It was understood that the activity programs in the NH's were overly feminine and restricted in their content, variety and delivery, with an almost complete absence of male-specific activity.

1.6.1.4. *The need for meaning*

Prior to entering the NH's, participants described a rich life - most men had served in the armed forces and they described a significant level of satisfaction with their achievements. However, post admission they described life as futile, demeaning, directionless and boring. A universal need for meaning was described and attempts were made to preserve meaning from their past and present lives, a finding shared by the case study of George (Bland, 2005).

1.6.2. Older Men in RC

An Australian study by Moss and Moss (2007) examined the life of twenty-one older men in RC, and found that losses of work status, control and function (associated with disability), independence, and the ability to contribute to meaningful activity, challenged participants self-esteem and positive perceptions of a masculine identity. Men were found to utilise coping mechanisms that fit within the masculine model, enlisting action, problem solving and containment of feelings (Moss & Moss, 2007). However, given the nature of institutional living (characterised by routine and dependency) and increased frailty, it may prove challenging for these men to execute these strategies successfully.

Research suggests that men in care are less likely than women to be engaged socially with people (Park, Knapp, Jung-Shin, & Kinslow, 2009). Typically, men in care have difficulty developing social networks and as a minority they may have limited opportunities for male companionship (Moss & Moss, 2007). A lack of socially desirable relationships available to men potentially deters them from building connections with other residents (Tesch & Whitbourne, 1981).

Hill and Donatelle (2005) found that restrictive emotionality consistent with a masculine gender role was associated with costs to social intimacy in older men. The findings suggested that a gender role conflict limited the perceived availability of social support, restricting older men's ability to appreciate the beneficial effects of supporting relationships (Hill & Donatelle, 2005). House, Landis, and Umberson (1988) argue that men have less experience with social relationships and this may further contribute to a reduced effectiveness in drawing on social support when

under stress, potentially impeding on adjustment and coping in RC.

Social contact and intimacy in care is considered important for older men's wellbeing and quality of life (Bullard-Poe, Powell, & Mulligan, 1994; Jilek, 2006). Indeed, positive interactions and engagement with others is a foundation for the development of a sense of social identification, from which favorable effects on health, social functioning and wellbeing may emerge (Blader & Tyler, 2009).

Research into gender based social groups (i.e. a gentleman's club) found that men who engage in these groups report higher levels of social identification with other members of their residential community (Gleibs et al., 2011). This may be important in helping male residents maintain a sense of identity and meaning, and provide opportunities for recreating a sense of masculinity in older age (Milligan et al., 2013).

On the whole, engagement in gender based social groups lead men to report higher levels of life satisfaction, and reduced depression and anxiety symptoms (Gleibs et al., 2011). Engagement in meaningful groups can prove especially beneficial for men, providing them with the social and psychological resources to meet and overcome the challenges faced as they begin their life in RC (Jones & Jetten, 2010).

1.7. Justification of the Research

The limited evidence examining the specific experiences of older men both moving and living in RC has direct implications for their wellbeing and welfare. Those entering care are often the most vulnerable in society. Supporting them at a critical point in their life may have considerable implications for physical and mental health outcomes.

Researching the specific experiences of older men tackles marginalisation and ageism within the academic literature (Thompson, 1994). Without knowledge of

older men's experiences of the transition into RC, services may be susceptible to discriminatory practices, potentially leading to unmet needs.

Increasing our understanding of the specific experiences of older men may help professionals and organisations to meet policy and guidance. For example, this knowledge can support organisations to meet the 'National Service Framework for Older People's' (DOH, 2001) standards of person-centred care and enhance models of 'personhood' (Kitwood, 1997), all of which may benefit from more fine-grained information on the experiences of individuals.

1.7.1. Research Considerations

Writing about and researching old age may itself run the risk of being ageist, intensifying disadvantage (Wilson, 2000). That this thesis writes about old age does not mean that it exists in a fixed or generalizable form. One may also argue that in researching male experiences, gendered assumptions could be reified and prevalent ideas about 'innate' differing characteristics of men and women reinforced. However, it is my position that whilst gender is a social and psychological construct, the accounts of older men may tell us more about how this group manages the move into care. This could be important for personalising care packages and meeting the needs of a group whom make up a minority in RC. My position/s influencing the research process will be considered further in the method and discussion section.

1.8. Research Questions

In light of the literature reviewed and the gaps that have been identified, this research will adopt a qualitative approach to exploring the accounts of older men in RCH's. The research questions within this study aim to pay particular attention to the experience of men moving into care, which largely remains unexamined in the UK and international literature. Examining the experiences of this group may tell us more about how older men manage this move, a move which men may find particularly challenging in the context of institutional living, increased physical

frailty, a predominantly female population and feminised environment, and difficulties establishing supportive relationships. The research questions include:

1) What are the experiences of older men moving into RC?

2) How do these older men manage this move?

CHAPTER TWO: METHODOLOGY

This chapter begins with an outline of the epistemological position and rationale for the methodology of this study. Following this a description of the research design, recruitment, ethical issues, participant sample and data collection will be presented. The process of analysis will then be outlined, and the positioning of the researcher within the context of the study discussed.

2.1. Epistemology

Epistemology is a branch of philosophy concerned with the study of knowledge (Martin, 2014). In research an epistemological stance refers to the extent to which data produced can be seen to reflect reality (Harper, 2012). Each epistemological stance enables us to access different facets of our world. Therefore, in research our choice of stance is determined by the context of what we want to know and study (Willig, 2012).

This research adopts a critical realist stance, one that assumes that whilst data can tell us more about the real world (i.e. psychological, social and material), it must be interpreted for us to access the underlying structures that generate it (Willig, 2008). Thus, critical realism acknowledges an inherent subjectivity in the creation of knowledge (Madill, Jordan, & Shirley, 2000). This position is suited to identifying and contextualising the material reality of moving into RC. This transition may have specific consequences for the individual, which are likely shaped by particular contexts and understandings relating to, for example, gender.

2.2. Methodology

The current research aims to explore the experiences of older men moving into RC and how they manage this move. Qualitative researchers are interested in how individual research participants make sense of specific experiences that occur within particular contexts (Willig, 2012). The qualitative concern is with meaning and interpretation rather than finding numerical properties as in quantitative

research (Smith, 2008). The qualitative approach to data analysis allows for the in-depth study of phenomena not readily quantifiable, enabling the emergence of unanticipated findings (Barker, Pistrang, & Elliott, 2002).

2.2.1. Method

This qualitative study utilises a Thematic Analysis (TA), a method of "systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set" (Braun & Clarke, 2012, p.57). The method and the epistemological position adopted in this research have a conceptual fit, in that a TA can be a method that works both to reflect reality, and to unpick the surface of reality (Braun & Clarke, 2006). Thus, a qualitative approach can pay attention to context and supports the exploration of subjectivity and the role of interpretation in the research process.

2.2.1.1. *Why not another method of qualitative analysis?*

When considering the most suitable approach to data analysis, both Interpretative Phenomenological Analysis (IPA) and Grounded Theory (GT) were considered. All three approaches aim to represent a view of reality by identifying and representing features of data. However, variations exist in their epistemological approach to data and in the analytic process (Smith, 2008). The methods of discourse and narrative analysis were excluded because of the primacy of their epistemological position in social constructionism. These approaches theorize that language creates reality rather than mirrors it (Braun & Clarke, 2012).

IPA stems from the epistemological position of phenomenology, and it aspires to gain 'insider knowledge' of a particular phenomenon through the experiences of participants (Willig, 2012). Thus, it aims to examine how people make sense of their personal and social world by studying the meanings that experience, events, and states hold (Smith & Osborn, 2008).

GT is an inductive approach that aims to construct a theory grounded within the data (Charmaz, 2008). The collection and analysis of data runs concurrently, with analysis informing and shaping subsequent data collection decisions (Birks & Mills,

2011). Whilst this method shares features with phenomenology, at its core it assumes the analysis will generate one over-arching and encompassing theory (Biggerstaff, 2012).

All three approaches of IPA, GT and TA aim to find patterns within the collected data. However, TA differs in that its method is independent of theory and epistemology, thus it can traverse a range of theoretical and epistemological approaches (Braun & Clarke, 2006). Rather than being an approach to conducting qualitative research, TA is a flexible method of analysis, one that can provide both a rich and complex account of data (Braun & Clarke, 2012).

It is TA's flexibility and accessibility that makes it a suitable approach for this study. As older adults are not a homogeneous group I can pay attention to multiple accounts and phenomenon (semantic and latent features) within the data. TA's epistemological and methodological flexibility affords me the opportunity to examine the varied experiences of moving and managing a life in RC, without developing a theoretical account of the process (as in GT) or focusing solely on the experiential aspects of the move (as in IPA).

2.2.2. Data Analysis

The majority of qualitative research aspires to follow an inductive model of knowledge generation (Willig, 2012). However, the proposed use of TA in this study aims to adopt both an inductive (a bottom-up approach that is driven by the content of the data) and a deductive (a top-down approach, that uses concepts, ideas or topics brought by the researcher to interpret the data) approach to analysis (Braun & Clarke, 2012). Adopting both approaches acknowledges the limitations of a purely inductive method, in that it is "an impossibility given the role of the researcher in the research process and that without some kind of theoretical lens, data collection and analysis cannot take place" (Willig, 2012, p.7).

Specific to this study, an inductive approach may be suited to the novelty of the population under research, particularly as the specific views of older men have not been examined within RCH's in the UK. Adopting a deductive approach is to

acknowledge that much research has been conducted on mixed populations of older adults moving into CH's and a number of theoretical models of transition exist (i.e. Brandburg, 2007). Furthermore, much research exists on gender and coping in later life.

Another level at which themes are identified within the data is either at a semantic (the explicit or surface meanings of the data) or latent level (within underlying assumptions that shape or inform the semantic content of the data) (Braun & Clarke, 2006). Primarily, data will be examined and interpreted at the latent level in order to interrogate the meanings that lie behind what has been explicitly stated by participants. However, some semantic analysis will be undertaken in order to describe the experiences of the group under study, serving as a foundation for the latent examination.

2.3. Research Design

A qualitative research design was employed for this study. The study aimed to recruit between six and ten participants in line with guidance on professional doctorate research (Smith, Flowers, & Larkin, 2009). This is within the range of existing qualitative research examining the experience of transition into RC (Cheek et al., 2006; Heliker & Scholler-Jaquish, 2006). The participants were invited to talk about their experiences in a semi-structured interview. The delineating features of semi-structured interviews are that they have a fluid and flexible framework, which is usually organised around an interview schedule (Given, 2008). This affords the interviewer to be both guided by the interviewees responses and their own interests, allowing for unexpected data to emerge (Given, 2008).

2.3.1. Inclusion/Exclusion Criteria

Participants were required to be male and aged 65 years or over. Those taking part were required to have been in a RCH for at least 6 months in order to have experienced a transition. As interviews could be quite demanding all participants were required to have the cognitive and physical ability to communicate during an interview. Residents with a formal diagnosis of dementia were excluded.

2.3.2. Ethical Considerations

Ethical considerations for this study were guided by the British Psychological Societies (BPS) professional codes of ethics (2009), BPS guidance on research (2010), and BPS guidance on conducting research with people not having the capacity to consent to their participation (2008).

2.3.2.1. *Approval*

Prior to recruitment, the University of East London (UEL) ethics committee granted ethical approval for the study (see appendix C). All sites taking part in the study requested and accepted the confirmation of registration and approval from the UEL's ethics committee. As the participant group was not derived from a clinical population, NHS ethical approval was unnecessary.

2.3.2.2. *Consent*

Older adults moving into care are often in a vulnerable state during the early phases of transition (Brooke, 1989). Therefore, retrospective interviews after 6 months allow residents a period of stability and the opportunity to reflect back on their move. All prospective participants were provided with information sheets outlining the fundamentals of the study (i.e. purpose, confidentiality and data management). Participants that agreed to take part were asked to sign a consent form (see appendix F) at the interview meeting. One resident refused to take part at this point and he withdrew from the study. A debrief at the end of the interview helped the researcher and participants to consider together whether any additional psychological support was required. No further support was deemed necessary and there were no risk or safety issues identified throughout the research process.

2.3.2.3. *Capacity assessment*

A high proportion of CH residents live with a diagnosis of dementia. Some estimates suggest that between 48% (CPA, 2012) and up to 80% (Alzheimer's Society, 2015) of residents have some form of dementia or significant memory complaint. Excluding those with a diagnosis of dementia and those with significant cognitive and physical disability may pose challenges to the external validity of the

study. However, as this study is based on the recall of the transition experience, excluding this population is required in order to gather valid data and to meet guidelines on consent and capacity (BPS, 2008).

Assessing capacity to consent to participate in the study was an on-going process. The BPS (2008) recommends that in order to have sufficient capacity to participate in research a participant must be able to understand information, retain information, use or weigh up the information and communicate their decision. At the interview meeting it was important to see what information had been retained.

At interview, one of the ten participants selected was unable to recall the introductory meeting and he was unable to orientate himself to time and date. Upon further questioning he could not tell me where he was, why he was in care or how long he had been in the CH. This led me to conclude that at that time he did not have the capacity to consent to the research interview or cognitive ability to reflect back on his experiences. I debriefed the participant, advising him that the study was not right for him, particularly as it focused on remembering the move into care and the events surrounding relocation, and he was withdrawn from the study. Contact was made with the management of the home to explain the events and to reiterate the importance of the inclusion and exclusion criteria. The management team shared with me that this resident had a diagnosis of dementia that unfortunately was not communicated to me at the recruitment phase.

2.3.2.4. *Confidentiality and anonymity*

All data has been annonymised and pseudonyms have been given to participants, people (friends, family and staff), CH's, organisations and places. This was agreed with participants prior to the interview.

2.3.2.5. *Data management*

All data was managed in accordance with the UEL Code of Practice for Research (2013). Consent forms and transcripts were held securely and identifying features were altered to protect anonymity. Electronic data was held on a password-protected computer, and within password-protected files.

2.3.3. Selection and Recruitment of Participants

This study sought to speak with older men in RCH's from sites across North London. CH's were identified from Google searches, local authority websites and the CQC database. A total of twenty RCH's were contacted across seven inner and outer London boroughs. Contact was made by telephone and a standardised email was sent that introduced the researcher and explained the purpose of the study.

A total of five RCH's agreed to share the participant information sheet (see appendix E) with residents that met the inclusion criteria. From this a total of ten residents were contacted and met for an introductory meeting to explain the purpose of the study and to agree practical arrangements for the interview. The interviews were completed within a few weeks of the introductory meeting, helping to form part of an on-going capacity and consent to research assessment process. In total eight participants took part in the study with two participants lost at the interview phase. One participant withdrew from the study and one was assessed to not have capacity to consent and the cognitive ability to reflect on his experience of moving into care.

2.3.3.1. *Summary of sites: Table of site information*

A total of eight participants from five sites across north London took part in the study.

Table 1: Site summary

Site Number	Funding: Independent or Local Authority (LA)	Type of home (RCH or mixed RCH and NH)	Number of participants
1	Independent and LA	RCH	2
2	Independent and LA	Mixed	2
3	LA	Mixed	2
4	Independent	RCH	1
5	Independent	Mixed	1

2.3.3.2. *Participant sample: Table of participant information*

Table 2: Participant sample

Pseudonym	Age at interview	Ethnicity	Length of Time in care at interview	Reason for relocation	Planned or unplanned relocation	Moved from
Tom	83	White/British	1 year 6 months	Unable to look after self	Planned	Home
Pat	84	White/British	2 years	Ill health and physical disability	Planned	Hospital
Allan	71	White/British	8 months	Relationship problems	Planned	Home
David	92	White/British	8 months	Physical disability	Unplanned	Hospital
Bob	83	White/British	1 year 4 months	Ill health and physical disability	Planned	Hospital
Fred	72	White/Irish	6 years	Unable to look after self	Planned	CH
Charles	94	White/British	2 years	Ill health and physical disability	Planned	Home
Stan	92	White/British	4 years 6 months	Physical disability	Unplanned	CH

2.3.4. Data Collection

Eight semi-structured interviews took place between November 2014 and February 2015. In line with Guest, Bunce and Johnson (2006), eight to twelve interview's is understood to be sufficient to reach theoretical saturation within the data. The interviews were held on site in a private space agreed with the resident at their CH.

An interview schedule was devised in line with the research questions (see appendix G). The schedule was discussed with my director of studies and with two clinical psychologists working in an older adult service. The interviews lasted between 31 minutes and 65 minutes.

2.4. Data Analysis

A six-phase approach to data analysis as outlined by Braun and Clarke (2006) has

been followed. Whilst this section outlines a stepped guide to data analysis, it is understood this process is recursive rather than linear (Braun & Clarke, 2006). Primarily an inductive approach to analysis was taken, one that means codes and themes are derived from the content of the data themselves (Braun & Clarke, 2012). As the research process has involved the development of a proposal, one that provides a summary of the literature on RC, deductive elements will be present. As with all qualitative research and with this study, the interviews, coding and analysis are inextricably influenced by the research questions and the assumptions and contexts of the researcher (Willig, 2008).

Following data collection the audio information was transcribed using an adapted transcription scheme (see appendix H) from Banister, Burman, Parker, Taylor, & Tindall (1994). Interviews were transcribed only at a semantic level, emphasising what was said rather than the way in which it was said (e.g., tone, intonation etc). The transcription process forms part of the initial data analysis, enabling the researcher to become more familiar with the data set. All audio recordings were listened to at least twice to check for accuracy and errors in the transcription process.

2.4.1. Phase One: Familiarity With the Data

All qualitative analysis involves a period of familiarising and immersing oneself in the data by reading and re-reading transcripts or other textual data (Braun & Clarke, 2012). Noticing and looking for patterns of meaning and areas of potential interest that relate to the research question/s should begin early during the process of data collection (Braun & Clarke, 2006).

In this study, becoming familiar with the data began during transcription and continued through reading and re-readings of the typed transcripts. From here notes were made about each interview, identifying a list of what was interesting in the data. Transcripts were then read with notes made that initially focussed on the semantic elements of the data but later on moved towards developing an emerging account of the latent information.

2.4.2. Phase Two: Generating Initial Codes

The process of coding aims to start organising the collected data into meaningful groups (Tuckett, 2005). A code refers to the "most basic segment of element of the raw data or meaningful way of assessing phenomenon" (Braun & Clarke, 2006, p.19). Data was coded for both semantic and latent content, primarily using an inductive approach. A list of codes (see appendix I) was generated from the entire data set and collated into a codebook (see appendix K).

2.4.3. Phase Three: Search for Themes

This phase is concerned with the interpretative analysis of the data and begins to outline the researchers argument about the phenomenon under study (Boyatzis, 1998). This argument is represented by a theme; an important feature of the data that relates to the research question, typifying a level of patterned meaning within the data set (Braun & Clarke, 2006).

The codes generated in phase two were collated and sorted into potential themes. This was done by writing down each code and a brief description below it on separate pieces of paper. This enabled a flexible approach to theme generation, testing out potential themes within the data set.

2.4.4. Phase Four: Review the Initial Thematic Map

Once a provisional set of themes were established I then set about refining them. The initial steps in this process involved ensuring themes were heterogeneous and that the codes within these themes were homogenous (Patton, 1990). This is important in determining whether themes cohere together meaningfully and have clear and identifiable distinctions between them (Braun & Clarke, 2006).

I reviewed the thematic map at two levels; firstly, at the coded data extracts to check whether they formed a coherent pattern; and secondly, using the entire data set I checked the validity of the themes and also if the themes reflected the meanings as a whole (Braun & Clarke, 2006).

2.4.5. Phase Five: Defining and Naming Themes

After reviewing the thematic map at both levels described above themes were further defined and refined (see appendix L). Braun and Clarke (2006) propose that by defining and refining, the researcher identifies the "essence of what each theme is about (as well as the themes overall), and determines what aspect of the data each theme captures" (p. 22). This involved identifying within each theme captured, what was of interest about them and why? It was critical to consider what narrative was being told by the themes and to what extent each theme related to the research question and overall aims of the study, ensuring there was no overlap (Braun & Clarke, 2006).

2.4.6. Phase Six: Producing the Report

The final sets of themes are presented in Chapter Three. This aims to provide a coherent and precise summary of the analysed data across and within themes (Braun & Clarke, 2006). To support this, data extracts are presented to provide evidence for the analysis and an opportunity for the reader to evaluate whether the themes and quotes reflect the story told about the data. Extracts are presented as evidence for the arguments of the researcher and are in annonymised form, with the researcher referred to as 'Simon'.

2.5. Evaluating the Quality of the Research

As qualitative research is concerned with meaning, quantitative criteria traditionally used to evaluate research (i.e. reliability, generalisability, representativeness, objectivity and validity) are not applicable to this qualitative study (Willig, 2012). Therefore, Spencer and Ritchie's (2012) three-principle framework of assessing quality in qualitative research will be followed. This involves an assessment of contribution, credibility, and rigour (comprising of reflexivity, audibility and defensibility). To support this, a generic 15-point framework for a good thematic analysis by Braun and Clarke (2006) will be used (see appendix M). However, it is noted that simply following criteria may not be sufficient, particularly as qualitative research is not a descriptive science but instead relies on generating imaginative

experience and the revealing of new meanings (Eisner, 2003). Thus, critics argue that this core feature may not be readily captured using a checklist or quality framework (Yardley, 2008).

2.6. Reflexivity

As qualitative research is largely inductive and concerned with interpretation and meaning, it is critical that researchers pay attention to the ways in which their beliefs, assumptions and experiences shape the reading of the data (Willig, 2012). Reflexivity can enable a researcher to identify and bracket off their assumptions and contributions in the collection and analysis of data (Willig, 2008). Thus, the process of reflexivity can protect against claims that qualitative research lacks validity or credibility (Coolican, 2004). The quality of this reflexivity is understood to depend upon its compatibility with the epistemological orientation of the study, and whether its use within the outlined method has met its objectives (Willig, 2012).

Spencer and Ritchie's (2012) guidelines on quality in qualitative research require the researcher to reflect on his/her role in the research process. Willig (2008) suggests that two types of reflexivity should be considered; personal (i.e. how our values, assumptions, experiences shape the research); and epistemological (i.e. the impact of the research question, design and method on the findings). To support this process I have maintained a journal throughout data collection and analysis (see appendix N). In this I have thought about my position/s in relation to the participants accounts and the experiences under study.

I am a thirty three year old heterosexual white British male and I have lived in England all my life. I am a Trainee Clinical Psychologist at UEL in the final year of clinical psychology training. I have worked in the field of clinical psychology for the last 7 years and within this period I have worked with older adults on placement for 6 months and I have no personal experience of RC. As a UEL trainee we are actively encouraged to think about how power and inequality are enacted and experienced within our society. One population at risk of significant social and structural inequality are older adults in RC. Older men make up a minority in care

and their experiences within the research literature have had limited attention. Thus as a UEL trainee I felt well placed to examine the experiences of this population.

By virtue of being a younger male, my beliefs, lens and positioning on masculinity will be different to that of the research participants. I was born and brought up in a different time leading to differences in cohort specific gender roles and gender socialisation. As a younger heterosexual male I may be considered to enact and embody a 'hegemonic' model of masculinity. This may influence my ability to identify and acknowledge the presence of non-hegemonic masculinities enacted in older adulthood, masculinities that are rarely raised to public consciousness (Thompson, 1994).

I consider my theoretical orientation to be integrative and my views influenced by the critical psychology and social constructionist teaching at UEL. This teaching has helped me consider my epistemological stance, which I would describe as underpinned by critical realist ideas. I believe adopting this position supports the identification and understanding of multiple interacting causal tendencies, from biological (i.e. in the causes of old age) to discourse (i.e. the way we talk about old age), providing a foundation for eclecticism and integration (Pocock, 2013). In taking this stance I aim to avoid both cultural and biological reductionism.

CHAPTER THREE: RESULTS

This chapter aims to present the findings of the current study. The themes generated from the analysis of data (from eight participant interviews) are presented below (see table 3). From the analysis, initial codes were grouped into four super-ordinate themes, and three have sub-ordinate themes. The individual themes will be outlined and their meaning and content will be reviewed. Extracts of the data will be presented to illustrate aspects of each theme. Further interpretation of the data, the relevance to existing literature and the assumptions held by the researcher will be reviewed in the following chapter.

Table 3: Super Themes and Sub-Ordinate Themes

Super-ordinate Themes	**Sub-ordinate Themes**
Different roads same destination	
The systems (at) work	"They really have looked after me"
	Control vs. Autonomy
Making it easier	Family and friends
	Activities and roles
	"I got used to it"
It's harder to connect	To other residents
	To me and my needs

Transcription conventions used in this study were adapted from Banister et al. (1994). When presenting extracts from the interviews minor adaptations have been made to improve presentation and readability. Where words have been omitted in order to shorten quotes, this is indicated by dotted lines within rounded brackets (….). Repeated 'filler' words such as 'er' and 'erm' have been removed to improve the readability. In some cases text has been added to help provide explanation and these are held within square brackets [text]. Pauses in speech, are indicated by dashes, whereby -- represents a brief pause and ---- represents an extended pause. In all extracts identifying information and names of participants, family members, professionals, organisations and places have been altered to protect

anonymity. The initials ‘SW’ indicate the interviewer’s speech.

3.1. Different Roads Same Destination

The use of this label represents the myriad of experiences involved in the move from home, hospital or care placement into RC. This theme includes the many reasons and decisions that form the foundation of becoming a CH resident. This begins with an identification of need, mostly underpinned by physical changes, but also includes self-neglect, loneliness and relationship problems preceding placements. When a need was identified, participants were supported by family, friends or professionals to make a decision to move and in the moving process. Participation in the move appears to fall on a continuum, with some fully involved and others excluded, impacting upon placement experience.

Many participants faced increasing disability and changes to health associated with advancing age. For some participants these changes meant living on their own was becoming increasingly difficult, occurring gradually and overtime.

> SW: So let me ask you the first question, which is what led you to come into residential care?
>
> It is because of my inability to stay at home for medical reasons. I used to look after myself and I managed to look after myself, but I couldn’t look after myself on my own anymore -- disability means I can’t do things at home as I used to. (David: 1-7)

All but one participant moving from home had a period of living on their own because their spouse had passed away or been placed in RC. Living alone increased participants' social isolation and many felt lonely.

> My wife died in 2006 and for four years I lived in my house, er -- and I, I don’t think my daughters thought I could do it but I did, and I found it very lonely. (Charles: 5-8)

Participants living alone at home had either extra support from family, or adaptations made to their home by social services, extending their independence and life in the community. However, the demands of physical change eventually outstripped the resources available.

> I carried on living alone and then I reached a stage where I found that er, -- despite the help I was getting from my son and daughter in law with regards to shopping and so forth I found that the question of cooking and looking after myself was getting a bit beyond me and I couldn't cope. (Tom: 7-12)

For two participants their diminishing ability to look after themselves was highlighted by an acute crisis, where the emergency services had to intervene:

> One day I fell over and I couldn't get up, so they came, my neighbours, came in and phoned up the ambulance, because I was in a bad state anyway without realising. (Bob: 110-112)

For Bob his health changes had come about 'without realising'. This inability to acknowledge the severity of his health difficulties led him to become seriously unwell:

> I was in hospital for 2 months because of, um, basically for neglect on my part, which led to me having my leg amputated and I had other things -- I had sores all over my body. (Bob: 5-7)

This suggests Bob has difficulties with health help seeking, which may be enhanced by his social isolation from living alone and separately from his wife. For some participants, physical changes and subsequent problems managing in their home environment led to a conscious reappraisal of their living situation and the consideration of extra support:

> SW: At what time did you think you might need extra support? You might need to move?
>
> Oh when I found it was a bit much to, to do the cooking everyday, and it's alright, it wasn't a question of cleaning the flat, cos I used to have a cleaner come in every week -- I used to occasionally get a visit from the heart, heart failure nurse, and that issue was making it harder and harder here and I realised I couldn't do this anymore. (Tom: 135-143)

For other participants an acute illness or health problem meant a rapid decline in their ability to look after themselves. Two participants experienced a significant brain trauma due to a stroke and tumour, leading to permanent physical changes:

> I was disabled for the first time. I was dealing with my MS ok up to that point, but I never walked after my operation. They put me in the chair immediately, and I have stayed there ever since. (Pat: 44-47)

These illnesses led to a loss of independence, underpinning their need for a placement in RC. However, one participant identified a marital problem as precipitating his move:

> I told her I'm 71 and I don't want to spend the next 10 or 20 years arguing on a daily basis (….) You stay in the house and I stay in Markus House. (Alan: 11-29)

Unlike other participants, Alan does not have a physical disability limiting his independence, instead he identifies he is unable to complete domestic tasks required for living on his own:

> SW: So (….) what led you to choose residential care over moving to another flat, privately rented on your own?

> What could I do? Where could I go? -- I wouldn't know where to go -- and in any case I'm not the kind of person who can, I can't look after my self, I don't know how to cook -- if you give me a kitchen, I wouldn't know what to do. So it wouldn't pay to do this, going somewhere else is not the answer, whereas Markus House seems ideal. (Alan: 58-67)

It appears Alan was dependent on his wife, potentially providing some clues about their daily arguments. This may also suggest the presence of rigid gender roles within his family system, possibly associated with his cultural background and representative of his age cohort.

Considerable variation existed in the participant's accounts of the decisions made that underpinned their placement, including who was involved, who made the decision, and the response of the support network to the decision. The process of deciding to move from home to RC after many years is a challenging one.

> The hardest part is making the decision to move, to weigh things up, to whether things should stay as they are, or whether things will improve by moving. (Tom: 466-468)

Participants with gradual physical changes were mostly afforded greater opportunities for control in the decision making process. This took place with or without the support of family members, using prior or researched knowledge of the home, the organisation, or reputation within the community.

> Markus House is known in the Orthodox Jewish community for being particularly protective, warm, loving, and it has got everything. (Alan: 46-48)

Alan, along with others who had time to make a decision, was able to research RC within his community. When available, family networks had a supportive role in the decision to move, helping to plan and choose the home:

> My daughter who lives in Barrister Close, which is just over there, she said 'I think we will have to look round for a home', and she and her husband looked round and said this was by far and away the best place. (Charles: 18-21)

When the support of family and friends was unavailable, professionals were involved in a decision: from raising the issue of RC, making the decision to move or even in the closure and move between placements.

> SW: So someone, a doctor, decided that you would come into residential care you said?
>
> Yes they told me I had to, as I can no longer look after myself.
>
> SW: What was that like -- told you cannot look after yourself?
>
> Oh terrible, I left everything at home -- I left home on the assumption I would be in hospital for a day or two and after they did the investigation things deteriorated and I am stuck here. I have got all my things at home and I miss a lot of my things and I can't go home. (David: 80-92)

A decision by a professional here illustrates a problem of an unplanned or forced placement. On a practical level, David is without his possessions and is unable to go home. This 'stuck' position negates his potential instrumentality in making the choice for himself and limits his independence. Indeed, for another participant being moved between placements, exclusion from the decision to move highlights his role as passive recipient of the care system, 'being done to' rather than at the very least 'being done with':

> SW: Were you involved in that decision?
>
> No I was not -- they have now shut it down and we have been made to leave (….)

SW: Were you consulted about the closure?

No they didn't tell us. I didn't like that they did this at all. They should have told us, we weren't consulted. People have just been doing things for me. (Stan: 70-80)

For some with an available support network the decision to place participants in particular homes was challenged by friends or family:

Fortunately I had vehement friends who said that this will not do for this guy (….) so after much fighting with toing and froing and crossed everything these influential friends who I have still got, managed to say this man belongs in the centre of town, near his two remaining people he has known from his past career. (Pat: 43-51)

Finding a CH and navigating the care system can be done with the help of the support network. In this study, families consulted and involved participants in the move, helping them to retain a level of control. Without an available support network participants became susceptible to becoming passengers on the road into RC. When participants were not consulted or involved in the decision to move, this led to a total loss of control, resulting in a negative experience, potentially leaving participants feeling 'stuck' or disliking the home.

3.2. The Systems (at) Work

The theme above highlighted the many systems involved in the participants move into RC. The super-ordinate theme 'systems (at) work' refers to the functioning CH and social care system. At its heart the system aims to care for people with high support needs later in life. However in doing so, participant's independence and autonomy, which may be already severely compromised, can be further impaired, and the needs of the staff and organisation prioritised over the needs of residents.

This encompasses two sub-ordinate themes; “They really have looked after me” refers to the RC home meeting its purpose, caring for residents and supporting some to recover from illness, though, with limited resources levels of care are not easily maintained; ‘Control vs. Autonomy’ illustrates the functions of the home that potentially have a negative impact upon the life of residents.

3.2.1. “They Really Have Looked After Me”

Many of the participants chose or were placed into RC because of physical changes and some were critically unwell upon arrival. On the whole, the care provided by the home met the care needs and expectations of participants.

> I was in such a state that some time later, the, the manager that I spoke to at the hospital, came to me and said, you know when you first came here we didn’t think you would have a fortnight to live. I was that bad. If you had seen me when I had first arrived here I was all skin and bone and sores over my body, but since then I have filled out a little bit. From that point of view it has frankly been very good -- they really have looked after me. (Bob: 176-183)

Care provided in the home supported the physical recovery of participants like Bob, who were initially dependent on staff to move about the home:

> I had to be pushed around where I needed to be, you know, whereas now I don’t have that problem -- so that was, well I wouldn’t say a problem exactly, but it was irritating, having to not be independent. I had to be taken from A to B whenever I needed to be. (Bob: 554-558)

Bob’s account demonstrates an interdependency of autonomy (going where he wants in the home) and dependence (relying on staff to get there). This ‘irritating’ experience of dependency appeared to spur a drive for independence and recovery. Physical recovery largely enabled participants to enhance their autonomy and begin walking or using wheelchairs or tricycles on their own. Thus, care and

support from the staff helped participants gain increasing access to the home and local environment:

> After I had been here for a year, I started to get better, take an interest, and I started to go out -- I have an electric tricycle, you know I went out I went out to the park. (Pat: 59-61)

Here independence is contingent on the availability of aids and adaptations. This type of care enabled many physically disabled participants to increase their independence and autonomy. For many, the care and support provided was a relief, enhancing feelings of security:

> SW: You said that coming into care was a relief, how would you put this relief into words?
>
> Well, I, security I suppose in a way. I mean I never gave it much thought. Living by myself as a widower, I couldn't go on forever, er --well I, no I, wouldn't have been able to -- somebody would have had to come and care for me eventually. (Bob: 228-231)

Other participants reported feeling relieved that they did not have to climb stairs at home, as leaving or returning to their flat had become increasingly difficult. The specialist equipment available in RC also enabled participants to feel more comfortable:

> I felt a bit safer being given this bed, I had my own bed, it is an electric bed. I felt safer because people were attending to the bed, the chair, to my needs, to give me grab rails. I hadn't got the worry that I was going to fall over and break my hip like other people do. So I did definitely start to feel a bit safer. (Pat: 631-636)

The purposefully designed and adapted environment supported some participants to remain independent and explore the home:

> They had this easy thing where you follow the black line. You know you are always gonna end up in your room because I lost myself a few times before. (Fred: 625-627)

The staff team and the care they provided was reported to be a positive experience by all but one of the participants. This support involved; the provision of resources and services i.e. physical aids, bringing food to participants rooms or driving them to hospital appointments; the manner in which care was provided i.e. with kindness and sensitivity; and relatedly, in providing social and emotional intimacy. This support helped three participants to feel settled in RC:

> SW: So if I was to ask you about the kind of things you thought helped you settle -- what, what kind of things was it that was important to help you feel settled?
>
> I think it was the, erm, the behaviour of the staff really, who made me feel welcome, you know, and they went out of their way if I wanted anything. I felt very looked after, even by management. (Bob: 701-708)

Beyond the physical care provided, two participants reported the staff team meeting their emotional care needs:

> SW: What do you think helped you settle?
>
> I think it was the carers ---- cos I used to get upset, you know, I was very depressed, even suicidal, I was thinking of all the ways I could kill myself. They helped by talking to me and they said how silly it was. I have been married to my wife for 50 years and they kept fetching her up. Then I realised that I didn't want to. (Fred: 367-374)

The staff team helped Fred with significant distress and with the support of his wife helped reduce his suicidal ideation. The experience of the care and support

received in RC was compared favourably to that of hospital. Participants identified that the time spent by staff was different and valued:

> I found that here they were far more caring than in the hospital -- you know the hospital just gave me a quick wash and that was it, and go on to the next, next patient but here they had more time if you like, to spend with you and -- er, so I found that reassuring if you like, and satisfying. (Bob: 542-547)

Further to the physical and emotional care provided by staff, they were also a source of friendship and intimacy:

> I was on more intimate footing with one or two others. One gentleman was here for about 5 years and he was nice. I managed to have more intimate conversation with him for a time and he was good at it, a guy from Nigeria, I liked him. (Pat: 420-424)

Many participants reported developing relationships with members of the staff team. Those without available family support placed greater emphasis on relationships with staff. For one participant a close friendship with a female care worker gave life in RC meaning:

> She has been a god send in a way because it is something that I think I needed in a sense that er, because she took an interest in me, and I took an interest in her if you follow me, it managed to develop into a proper friendship and it is something that I look forward to when I know she is coming back on again, you know, it sort of kept me going. (Bob: 586-592)

The relationship described above appears to exceed the usual 'professional' support others described. This may be linked to the different nature of relationships in this setting compared to hospitals - they are likely longer-term and more pervasive. However, whilst much of the support was experienced as positive, a number of participants highlighted the one-sided aspect of the relationship and the

limits of staff resourcing. Most participants with higher support needs (i.e. greater physical disability) were more dependent upon staff and reported more problems with accessing their support.

> Sometimes as I'm disabled I can't get them to come quick enough. For instance when I need the toilet or things like that I can't always get them, I can't walk out of the bed and go to the toilet it's a big handicap (….) you get stuck on the toilet and can't get up or can't get anybody to come because they are too busy with the others and I'm stuck there for half an hour or three quarters of an hour. (David: 303-314)

Participants also reported that systems designed to make staff aware of the resident's immediate needs were not always effective.

> If I was out there [in the grounds of the RC home] getting back in again might have been a problem. A lot of people have call bells, you know, if you got a problem but they don't always respond to you. (Bob: 349-353)

One participant with a wife in RC reported finding it difficult to organise the staff team, whom he is dependent on, to help visit her:

> I wanted to see her today and I couldn't manage it because I depend on others to organise things and they come to me too late and I can't go there and come back in time. (David: 112-115)

For David, limits to the availability of the staff team, has a direct impact upon his ability to care for his wife. As David does not have other family or a readily available support network, he relies on staff to help him visit and contact his wife and resolve financial and practical issues of her care. One participant reported that time spent with residents is linked to a staff typology. Here there is an acknowledgement that members of staff are different and those who spend more time with residents are viewed more positively:

> I like the ones who have time to spare, who come in to say good morning, talk about the weather, (….) The other ones feel like that they are just doing it for money and in the wrong job. They have a family and they come in the door and I'm asleep and they come in for 1,2,3,4,5,6,7,8,9,10,11, they are in the room for 20 seconds. I am against that and I dislike it. (Pat: 407-415)

3.2.2. Control vs. Autonomy

This sub-theme refers to the negative impact the RC system and institutional living (i.e. being cared for, regimes, and closures) has upon residents. Participants reported that whilst the home can meet the care needs of residents, in doing so, it leads to a loss of autonomy and control and increased dependency.

> When you come into a home a lot gets done for you. You don't have to do so much for yourself, it all get's done and is there on a plate and life is consequently a bit more boring. I don't do the shopping, I don't have to make my own bed, make my own food, I don't have to do anything really. Yeah, I rather feel like a parcel, an object, you know, a piece of furniture who they just come and do things for. We should be grateful, I should be grateful. But it doesn't suit me somehow. So I'm still in the process of trying to do as much as I can for myself. (Pat: 493-500)

Pat illustrates how in meeting his needs he is left with little to do for himself. Like Bob (in 3.2.1. 554-558), dependence on staff may also provide an incentive for recovery. The process of being cared for leads Pat to feel objectified, like 'a piece of furniture'. In being cared for he feels a tension between being grateful but also uncomfortable that his autonomy is being taken from him. Stan shares Pat's discomfort with people coming and doing things for him, particularly in relation to intimate care and being showered:

> They were trying to give me a wash every day -- I don't like it, why would I need one every day, I don't need this (….) they tried to make me shower every day. They were making the decision for me why would I need it? (Stan: 113-119)

For Stan this loss of independence is potentially made more difficult by his belief that he cannot control or change the care he receives, as staff would not respond to his requests.

> SW: What did you do about this?
>
> I couldn't tell them. It would be like talking to a wall and they wouldn't take any notice of me (….) I feel like I got used to it, I had to. It took about a couple of month's maybe. (Stan: 123-129)

Over time Stan gets used to being showered every day. Other participants noted that coming into care meant they were supported in ways they had not experienced before, particularly with intimate care.

> Every morning I get a shower from one of them now. Five o' clock in the morning he comes here, he wakes me up, gives me a shower, helps me dress, gets me breakfast (….)
>
> SW: But am I right in thinking it is something you wouldn't have had before you came here?
>
> That's correct, I used to bath myself but they want to help with this, and my wife agrees one bath a week is insufficient. (Alan: 482-496)

Unlike Stan and Pat, Alan does not express discomfort with this experience, suggesting he may have become institutionalised to this practice. However, the time at which Alan is made to shower seems unusually early and may highlight a lack of control over the regime, one that suits the system and not the residents. Alan reports that some practices in the home, often relating to risk and safety are frustrating:

> There was a time, a short period umm -- when I felt there was an element of overkill here. I said to them and I still say it even now but I'm used to it, why do you feel you need to check on me every hour, why? 'Oh that's the rule' -- I said 'pardon and what peculiar rule is that?' 'Oh we have got to keep an eye on you, in, in case' (.) I said 'pardon in case what?' 'In case something happens to you in the middle of night' -- 'oh I see' I said, 'what you think I might commit suicide in the middle of the night?' 'No, no, but we've seen cases where we have found somebody on the floor and dead in bed', I thought I'm alive and will be around for many years to come, I don't want to be watched every hour, 'no we have to' they say -- so you have got that strange checking procedure. (Alan: 550-564)

Alan's account indicates checking practices are implemented for all residents in his home, further evidence of the needs of the system being served above the needs of residents, signalling a loss of control. Another participant experienced similar checking which began during his treatment in hospital:

> What annoyed me more than anything else was that during the night they would check my blood pressure every hour. I got really annoyed about that, but they could see I was alive, don't need to check my blood pressure all the time. Anyway -- I knew they were going to do it here, even at night time to check I was alright, you know. It wasn't a problem for me as I got used to it being in hospital. (Bob: 363-370)

Bob reports that these practices are maintained from one institution (hospital) to another (RC). He describes how this procedure becomes less of a problem as he get's used to it. One reported problem of regular checking on participants was of limited privacy:

> Well I think I remember being upset by having no privacy at all, people would drift in and out all the time, 15 strange people all day (.) it didn't matter whether you were here, there, naked, in bed, sitting in the bath or on

> the toilet, they would just walk about like it was Piccadilly Circus. (Pat: 607-612)

Whilst Pat finds this regular interruption upsetting, not all participants shared this view, and some saw the important nature of being checked upon.

> SW: I guess that -- that is an illustration [a member of the staff team had just knocked on the door to Bob's room and immediately walked into the room to see if he wanted anything] of what I meant by privacy -- is this a problem?
>
> No, no, that doesn't happen too often now, it's important too, to see if I'm ok or need something. (Bob: 643-647)

Bob reports that the checking has reduced, possibly because his dependency and support needs have decreased following physical recovery. His view that the checking is important, and something that he has got used to (see above - Bob: 363-370), may suggest he has become institutionalised to this practice. Whilst the staff could be intrusive, a number of participants identified that other residents compromised their privacy, particularly those with a diagnosis of dementia:

> One of the men is just down here and he is bonkers and he does a lot of screaming and he walks about (….) he used to wonder in here and he would come in when I wasn't here and take my clothes, and be seen walking about in them (….) you get used to it, but it makes you feel rather helpless. (Pat: 318-331)

This intrusion was reported by a number of participants and highlights the helplessness associated with communal living. Participants also highlighted how RC homes have their own lifecycle, independent of residents. Changes to form and function of the home can occur because of management decisions and business needs, or systemic changes in the organisation and care system. These changes can have a direct impact upon resident's lives:

> I was told at the time because it was being transferred as a dementia home, basically that I couldn't stay here, so I was told to get on my bike and go somewhere else. This was about 9 months or 10 months after I had been here, and then common sense prevails and they said no you can stay (….) it makes such a difference having to up sticks and go somewhere else and start all over again. (Bob: 31-40)

This institutional bureaucracy can make life in care less stable and highlights the lack of control residents have in their home. Furthermore, placements are not always permanent and both Pat and Stan had to move because of closures. This can have a significant impact upon the participants and residents they share the home with:

> The house closed itself and it had managed to rehouse all the other people, usually into unsuitable things and most of them died. You know how people do, older people have decided to live somewhere -- if they are moved it's rather like animals, they die out. (Pat: 29-33)

Pat compares the impact of closures upon residents to the treatment of animals. For Stan a forced relocation means he is further away from his local community, impacting upon his experience of RC:

> SW: So, er, they closed the last place you were in down, what was that like?
>
> It was better than this place it was. It was down near Brookes way, I felt settled down there -- then I did my own thing. I don't really like this place at all it is too far to go the shops. (Stan: 9-15)

The experiences described above highlight that whilst a functioning institution succeeds in caring for participants, it reduces autonomy and increases dependency, serving to control residents. Furthermore, residents have no control over organisational and wider system changes, all of which can have a direct impact upon their lives.

3.3. Making it Easier

The super-ordinate theme, ‘making it easier’ explores what can help participants to settle into RC. This comprises of three sub-ordinate themes; ‘Family and friends’ refers to their support and the benefits enabled by this network; ‘Activities and roles’ illustrates the importance of meaningful activity and a role in the home; “I got used to it” highlights a turn of phrase all participants used to describe coping with new and uncomfortable experiences.

3.3.1. Family and Friends

Whilst participants reported family and friends helped in the decision to move and choice of CH, they also helped with the practical arrangements of moving (organising possessions) and funding care. Once in placement, family and friends enabled participants to engage in social interaction, meaningful activity, a connection to life outside and, to an extent, the past, helping them to settle.

> SW: So you said it didn’t take you too long to settle, what do you think helped you?
>
> Well I think my daughters they kept in touch. Well I mean when I was a widower they were always ringing me up and I am now here my daughter this afternoon is coming to see me. I think I am very lucky in that. (Charles: 298-304)

Continued contact with family provides a bridge between Charles’s life before and after the move. His family relationships provide opportunities to engage in meaningful social contact, for which he feels lucky. For participants without family support, social networks helped provide both practical and financial support, and social contact. For Bob, the nature of his placement, coming direct from hospital, meant that he had difficulties financing care:

> SW: Was it important [contact with friends] when you first came here?

> Yes it was, it was I think, to get a little bit of my previous life shall we say, yeah it was important -- and also the fact that you know when I first came here I was a bit, how can I put it -- financially insecure so I needed to sort that out and I was helped out, by various sorts of friends and neighbours and they helped me out on that. Finally when I sorted it out it didn't matter, but I still saw them anyway and they used to come and see me and my neighbour used to bring me my post that went to my home address and he still does it now, even if I am not there anymore. It also gives me info and keeps me up to date with who goes to the pub you know -- so I get updates on my drinking mates. (Bob: 903-917)

Bob's social network provides him with financial security, enabling him to remain in placement. Contact with friends enable Bob to remain connected with his life before RC, and provide a bridge to his past. This may enable Bob to retain his social identity and sense of self, enhancing his adjustment and wellbeing. Another participant also reported that support from friends helped him settle into RC:

> SW: Was it important when you first came here to settle in to have contact with friends?
>
> Yes I think it was. They were here all the time and they did a lot for me, they painted my wall Moroccan red. My best friend the attentive friend, Paul, he used to come a lot and do a lot. He gave me things, good gracious he never stopped giving me things (….) he takes me swimming and I will see him tomorrow, he will take me to a film. I feel good today because I have things to do, you, swimming and the film. (Pat: 450-464)

For Pat, his friends do a lot for him and enable him to create a nicer home environment. They also provide regular social contact and enable him to engage in meaningful activities. This support leads to positive emotions, likely enhancing his wellbeing.

3.3.2. Activities and Roles

This sub-theme illustrates the importance that participants placed on engaging in meaningful activities and establishing a role in the home.

> SW: Are there any other things that were useful for you to help you settle and feel more comfortable here?
>
> At first I want to say no but it's not quite true (….) I gather up the remains of the musical talents as such as they were. I go down stairs and people sing the old golden oldie songs and I play for them (….) I tell myself strongly that at least I am doing something for somebody and this is the only thing that I do for anybody at any time, it's the only thing I can do, so I will do it. (Pat: 242-253)

For Pat this activity provides an opportunity to do something worthwhile, leading him to feel good about himself. This also helps him connect to his interests and identity before his illness and physical disability, and enables him to take control. One participant even established a role in the RC organisation:

> Management as well like me being here, cos I am also a member of the resident's scrutiny panel which is like a link between us residents and head office. So we can, so it's like we have regular meetings during the year to discuss what head office is thinking of doing or has done and we can make comments to them, or criticise them if we don't like what they are up to. (Bob: 48-54)

This unique role enabled Bob to access the organisation in ways other residents could not, for which he felt valued. This afforded him a chance to have a say and some control in the running of the home. Both Bob and Charles also felt valued for their identity and role as residents without dementia:

> I think they don't have many people who are really compos mentis, so they are relieved we can talk and they don't have to bother about me too much. (Charles: 342-345)

They felt this helped staff, and it defined a difference to other residents, potentially giving them an identity that was not grounded in their dependence. Most participants tried to maintain their routines from before placement, which included wellbeing activities (exercise and puzzles), religious practices and smoking.

> I mean I go out when I want to -- thank god I can just walk and I go up to the Green Road then to the bus stop and it takes with a rest about twenty minutes and I do it every day. If I didn't I wouldn't be able to walk. (Charles: 372-376)

This activity helps Charles remain active and maintain his physical independence and autonomy. Stan also valued being able to leave the home and maintain his routine:

> It's alright because I can use the 92 bus here, I can get to the shops and the bank. That is where I need to go, I go get my money every week, I stick to my routine. (Stan: 107-109)

Being able to leave the home was important for participants, but this was largely dependent on their physical ability and available support networks. Participants with physical disability were less able to maintain the routines they had in place before RC.

> The only thing is that I am disabled. I would like to walk, work a little more, and write as I used to, but I can't sit down and write. I wanted to write a letter to the newspaper and I can't get to get grips with it. (David: 489-492)

3.3.3. "I Got Used To It"

This sub-theme represents a phrase that all participants used to refer to managing and coping with something new or difficult about their experiences in RC. This included coping with intimate care, limited privacy, residents with dementia, and checking procedures. The process of 'getting used to it' appeared to involve a willingness to accept and accommodate the demands of the system and give up certain accepted rights (i.e. privacy). This acceptance may be based partly on a fear of the consequences of challenging the system, possibly grounded in past experiences or membership of such systems. The latter may suggest a potential cohort effect, as these older men may be the last to have experienced national service in the UK.

> SW: And then you mentioned that also one of the first experiences here you were bathed by a member of staff as well, what was that like?
>
> Well I got used to it. I had a man and I might have had a woman to bath me I suppose. I insisted that Martin who works on the floor below to come and give me a bath and he does so twice a week. (Charles: 235-242).

For Charles the choice of carer gender for intimate care was important, making him feel more comfortable and in control, potentially helping him get used to the process more quickly. However for Fred, who also got used to being showered, being washed by women was challenging at first.

> I don't suppose for one minute they were looking at me but you just felt that you didn't want to stand there naked with two women. I know it is an old joke from years ago, to have two nurses showering you was lovely, but its not. (Fred: 49-53)

Here Fred suggests that the reality of being washed by women is different to a male fantasy, and not how other (possibly younger) males talk about this experience. Being cared for is something that other participants referred to as something that has to be accepted.

> I think possibly because I um (….) I accepted my situation, I accepted I needed to be cared for which made things a lot easier, which I don't think some of the residents believe in, you know, but I think some of the residents believe they are interfering sometimes (….) which made life so much easier, because I wasn't like rebelling the system or thinking they were interfering -- it made life easier, well it made life easier for everyone, obviously you know, that I didn't sort of make a fuss, well I wouldn't have made a fuss anyway, but you know, that I didn't sort of put a spanner in the works, you know -- wanting something out of the ordinary that they couldn't provide for me. (Bob: 520-533)

Bob suggests that acceptance of being cared for can make life easier in RC, benefiting everyone. He also refers to avoiding putting 'a spanner in the works' of the RC system or 'rebelling' against institutional practices. This avoidance may be based on previous experiences of observing others challenging the system in his home:

> We have one or two here at the moment who are abusive, who are trying to get back out, get herself thrown out of here, of course it's not going to happen, because she can't see that, she has got nowhere to go even if she does leave here. (Bob: 378-382)

This experience may have shown Bob that both resistance and attempts to leave the institution are pointless. He later suggests that adjusting to the regime helps him get used to institutional living:

> SW: In terms of when you first came and the first few weeks or months were there any things that were really difficult or hard?
>
> I don't think there was really -- well, I think well, not, -- hard is not quite the right word, I think about adjusting to the regime if you like, once you get used to the order of things for the day, you know, then that was, that got me,

> I don't know if settled if you like, I didn't worry too much about anything after that. If I asked for anything they would get it -- once that was out the way, institutionalised shall we say, it was ok and I was quite happy with what they were doing. (Bob: 793-805)

Bob explicitly refers to becoming institutionalised as way of managing his new life in care. This process appears to involve coming to accept the regime and the system. For other participants previous experiences of institutional life, such as the army and boarding school were noted as making care familiar and easier to cope with:

> A lot of it didn't matter because I have been in the army see. So I have been in the showers with blokes before, and lived close courters. (Fred: 443-445)

Here Fred identifies that his past experience in the army may have helped him manage a lack of privacy. Whilst previous experience is something that can be drawn on to help participants cope with institutional life, for Pat, early life experience made 'getting used' to RC more difficult.

> SW: What do you think it is about you that make's it harder to adapt?
>
> I have always clung on to things by my fingernails, because when my mother died at 8 everything became slippery. There was a woman who lived in the house who looked after us who was good but inadequate, cooking, clothes and going to school became slippery. I thought I must not do anything new or I worried that things might go. Then evacuation happened and we went to live with our aunts. So since then I have worried about changes. (Pat: 698-708)

This suggests that early experience and attachments influence how participants cope with transitions, which may make it easier or harder to adjust to the home and its institutional practices. Some attachment experiences may be helpful:

SW: What do you think helped make it smooth? [the move into care]

I'm not a fussy person by nature is the answer to that question (….) I have never been fussy. My father was not a fussy person either, neither was my mother, I never saw that side of them, by nature they were happy people, happy go lucky people and I have always been like that. (Alan: 207-221)

This family trait helped Alan to adjust into RC. Charles also noted that being 'relaxed' helped him, further suggesting that personality or temperament may be a factor in aiding adjusting into RC.

I got settled very quickly. I think I am very relaxed in that way. (Charles: 289-290)

3.4. Its Harder to Connect

This super-ordinate theme highlights the challenges faced by participants in forming and maintaining connections to others, and to their past and present selves. It encompasses two sub-ordinate themes; 'To other residents' refers to the difficulties faced when communicating and connecting to people with dementia, disability or female gender; 'To me and my needs' refers to the challenges to identity, sense of self and meeting participant's needs posed by moving home and physical changes associated with illness or ageing.

3.4.1. To Other Residents

This sub-theme illustrates the many challenges participants reported in connecting to other residents. All participants had difficulties building relationships because of either; a lack of shared interests; an age gap; a preference for privacy; disability; dementia; and gender. Most participants acknowledged that they were able to make some connection but this was largely superficial.

SW: What stops you from talking to them [the other residents]?

> Well there not exactly approachable, and we don't seem to have any common, common interests (….) nobody in here I would say is a friend, just enough to say good morning and good day and that's it -- but nothing else. (Tom: 77-95)

As participants have not chosen their CH because of shared interests, they have little basis for developing relationships. The age difference, sometimes spanning twenty or thirty years between residents can make finding common interests more challenging. The younger participants reported this was a challenge to connecting with others:

> SW: What does it mean that they are older?
>
> I don't know what to say to the older ones -- I try and be considerate to them but they can't help this situation. I've got nothing in common with them but I will still pull their wheel chair about and wheel them in. (Fred: 248-251)

Some participants noted that despite wanting to interact with residents it requires reciprocation:

> SW: So thinking back then to other residents then. Were you able to make friends when you first came here with any residents?
>
> Friends is, too, well, yes, yes, but some of the ones I made friends with if you like were also the ones who kept themselves to themselves, if you know what I mean even to the point where they would stay up in their rooms most of the time, you know, so I didn't always get to know them. Whereas I might have done if they had been coming down here -- but, but, it's their choice, you know, I can't force people to come and see me -- but you know what I mean, it's er, something the same with me if I don't want to speak to somebody I don't have to. (Bob: 433-446)

Bob identifies that preferences for privacy, which may represent an instrumental approach to distancing of social ties, can be a barrier to interacting with others. Participants reported that many residents have a diagnosis of dementia and significant disability, making relating more challenging:

> Most of them here are stone deaf or Alzheimer's or Parkinson's, so I find it difficult to relate to these people because of their physical condition. (Alan: 356-358)

Participants reported that problems communicating with other residents lead to feelings of loneliness:

> Sometimes you feel loneliness, you can't communicate -- you want to say something and they can't hear or they can't understand. (David: 452-454)

Increasing frailty and illness of others in RC meant that some participants reported facing the loss of connections from dementia and dying:

> A handful of people I find good to talk to and interesting -- not a handful, it's less, one or two of them who have either died or had a stroke or gone into dementia. So therefore I feel no bond with them, I don't think I feel a bond with anyone. (Pat: 292-297)

For others, disability and frailty of other residents means that they are often unavailable to build relationships with:

> A lot of them don't come to meals, the very elderly. You see you don't miss them that way. I mean I don't know, I, I am not close to any of them so it doesn't matter. You can't be close to someone who is dotty, they really are not with it at all. (Charles: 547-551)

This reduced contact and thus lack of connection can protect against potential loss. Above, Charles also refers to the difficulty of being close to someone who is 'dotty',

a term he used to describe others with dementia. Other participants reported that being with people with dementia is made more difficult because of unpredictable behaviour:

> One of the women who lives here with -- what is it? Dementia? She hears voices all the time. She would sit where you are and all of a sudden she would say 'you fucking bastard' and I would say, 'who me'? And she would say 'no the geezer I'm talking to' -- so you would never know what was there, you know it was weird. (Fred: 272-277)

Participants managed these experiences in different ways, from avoiding communal areas, to using humour and seeing the funny side:

> I am not lonely and I have got companionship and I can see these funny incidents and I keep myself to myself really because I mean most of them go down into the sitting room and they sit in their chair and they probably go to sleep. I am very happy to be in my own room really. (Charles: 198-203)

Charles acknowledges that he can get still get companionship from residents with dementia; reducing the loneliness he felt living on his own. When participants talked about dementia many identified the inevitability of developing this in later life:

> Her [Bob's wife] dementia is such that erm, her short-term memory is very bad and her long-term memory is far too good. It will go back and back in time, and remember everything -- what she had for lunch she wouldn't remember or even if she had lunch. But no, but er, it's sad -- I'm just waiting till I get to that stage you know and see how it affects me.

Here Bob describes how his wife has changed as a result of dementia, something that was shared by two other men, making it harder for them to connect to their wives. Participants reported that it was often more difficult to communicate with women because of age related illness:

> The women here are all old. The communication is between me and the men -- any women here is the staff. I have no -- have no social connection with them much. (394-401: David)

A number of participants noted negative experiences involved in sharing the RC home with women:

> Well the chatter, the blooming noise, that's why I call the dining room the parrot house -- because they won't stop talking. (Tom: 41-43)

To manage the negative experience of sharing the home with women (as described above), many participants avoided communal areas:

> SW: How did you cope with this when you here these women's voices?
>
> I guess I learnt to avoid the dining room, especially when it's full of women jabbering on. I don't go in the lounge anymore unless it's late at night when they are all going to bed. (Pat: 377:383)

Some participants reported that it was easier talking to members of their own sex. This was because they were more likely to have shared interests:

> If you wanted a sort of er, conversation if you like, you are probably more likely to get it from a man than a woman. I mean my sort of conversation rather, you know. It is not as though I wouldn't speak to a woman, but you know, on a general basis I would probably choose a man to speak to for a proper conversation (….) I believe men think differently to women anyway so it is, it is a bit sexist I suppose -- they have got different interests shall we say to men, basically that is what I am trying to say -- so it might be a bit easier to speak to a man rather than a woman. (Bob: 490-504)

Here Bob marks out a difference between the genders, specifically in how each thinks. Many participants reported that a gender balance in the home could afford more opportunities to connect with others:

> It would be better if there were more men. Naturally, one tends to be more confident talking to men of their own sex. Women are the same I am sure. (Charles: 586-589)

3.4.2. To me and my Needs

This sub-theme explores some of the challenges participants faced to maintaining their lives before RC. Participants reported that the loss of their community, home and physical abilities posed challenges to their sense of self:

> People used to have respect for me there, they looked up to me for knowledge, looked up to me for personality, but not here anymore. (David: 246-248)

A disconnection to his community has led David to lose his social identity. He also reports that physiological changes has impacted on his sense of self:

> SW: Ok -- I guess I wanted to know if you see yourself differently since coming into care than before?
>
> Of course I do differently, as I said the difference is that I am very much disabled and communication is not as much as I used to have. You see I'm 93 years old and I look around me and I'm the most enlightened person of all the residents (….) so you see I'm not complete physically but I'm one who can think more clearly. (David: 438-447)

Whilst David reports changes to his physical abilities influencing his self-image, he also places emphasis on the stability of his mind. This marks out a difference to other residents and possibly absolves the challenge to identity presented by

physical changes. Bringing possessions from home offered one way to maintain identity and some participants placed more importance on this than others.

> I am dependent on things such as my table that my wife and I bought, this is my chair and that came from her family and this over here came from my family, the mirror and things are all objects that I am clinging on to, to remind me of who I am -- things like that. (Pat: 213-217)

Pat identifies that his possessions remind him of who he is; they retain memories from his past, and memories of his wife who had passed away. Participant's reported some possessions were more important than others for maintaining a sense of self:

> I couldn't live without music particularly, its part of me. Yeah, I mean everything else was never, perhaps it would have been nice, but it wasn't essential. (Bob: 267-260)

Some participants who reported a number of loses seemed to have greater difficulty remaining connected to life before RC and illness.

> I had lost my wife, I lost my music, see I couldn't play anymore. I also am fighting to not lose my sexuality, which is sort of going and I am trying to hold on to it as much as I can. So all of these things rather piled up on to each other and I became more and more depressed. (Pat: 64-68)

Pat reports how losing his wife, his ability to engage in valued activities, and sexuality, has led to feelings of depression. Pat also found that these changes impacted upon his self-esteem and his prospects for future romantic and sexual relationships:

> I was proud of what I had done, playing or writing music when that all ceased, I thought who am I, what good am I, is there anything good or attractive about me, would anyone like to talk to me or be with me. That was

> the end of me having any affairs, liaisons or flings or things like that. It seems to be all gone. I just see myself as a sort of a dying person. Just sort of tapering off and that has nothing to offer and of course that is upsetting. (Pat: 547-555)

In the interviews three participants were asked explicitly about changes to their male identity since entering RC. Only one participant (Pat) identified changes to their identity, one felt no change had occurred and the other directed the answer about other men in care.

> SW: So to be more specific I wonder if there are any changes to the way you see yourself as a man since coming into residential care?
>
> Ah yes, I suppose you think of yourself as a man when you are a going concern and when you are in the market place so as it were, and meeting people and making liaisons with people and trying to pick up people and that sort of thing. I did at one stage think about getting married again but I was simply too late. My wife died when I was 60 and so I thought about and started thinking about death when I was 65 or 66, but lost the idea by the time when I was 68 or 69 and sort of guessing at things. Well then you just think well, I'm no good, I'm passé, past all that. Some people seem to feel ok with being past all that but I don't feel ok with being past it. (Pat: 562-577)

Pat's report's that sexual behaviour and relationships are a way of enacting and embodying a masculine identity. This response may also be in context to my identity as a younger man and gauged in terms of 'hegemonic' constructions of being male. Another participant reported barriers to forming intimate relationships and meeting his sexual needs:

> SW: And in terms of relationships and romance in here, is that something that was important for you when you came here?

> Oh yeah, I would like it if I could find somebody, but there isn't anybody, there is no one female I could inter relate with frankly.
>
> SW: What gets in the way of this?
>
> The ethos of the home, they made it quite clear that I can't go in a girl's room (.) that's unacceptable, sexual behaviour and you know it, we don't need to tell you that. There is an unwritten rule between Orthodox Jewish men and women that they are not allowed to be together, they are not supposed to be together unless they are brothers and sisters or husbands and wives. (Alan: 305-321)

Alan is faced with the problem that other female residents are much older than him. Furthermore, the rules of the home underpinned by Orthodox Jewish values result in him being discouraged by the management team from forming intimate relationships with other women. These barriers prevent Alan from connecting with his needs and he and Pat report that in RC there is little opportunity for a replacement:

> They don't seem to see that I need company, my wife not being here, I need female company and I'm just not getting it -- that is very, very frustrating ---- The TV is not a substitute, books are not a substitute, speaking to people is a substitute, there is just no one here. (Alan: 416-422)

The difficulties both Alan and Pat face with meeting their sexual needs are multi systemic. Residents, staff and management are influenced by culture and wider society. As men age they face challenges to their masculine identity, primarily from dominant discourses around ageing and othering by 'hegemonic' masculine practices. Pat illustrates the problem of a masculine identity in later life and also it's enactment within a RC home.

> I don't think there is much difference at this stage of life. I don't think that men are really exerting themselves in any aggressive or masculine manner

> anymore. They have stopped doing it. All these women would not put up with it anyway. They are against a guy that threatens people with his stick. (Pat: 669-674)

Pat reports that ageing equates to a loss of masculinity, a message perpetuated within society. Furthermore, the dominance of femininity in RC and dominant discourses of ageing poses a challenge to older men enacting and embodying a traditional masculine identity, particularly one of dominant ‘hegemonic’ characteristics.

CHAPTER FOUR: DISCUSSION

4.1. Overview

This chapter aims to examine the findings of the current study in relation to the research questions and the relevant literature. A review of methodological considerations and limitations of the study will be presented. A reflective account considering the research process and issues of professional development will be discussed and an evaluation of the qualitative methodology used will be presented. The chapter will conclude with a consideration of the wider implications of the research findings and possible directions for future research.

4.1.1. Research Questions

This study aimed to address the following research questions:

- What are the experiences of older men moving into residential care?
- How do men manage this move?

The research questions will be considered in the next section through a discussion of the main themes and the relevance of findings.

4.2. Discussion of Themes

4.2.1. Different Roads Same Destination

The first theme ‘different roads same destination’ illustrated the heterogeneity of the participant’s experiences along the road to becoming a resident. The stories told by participants varied considerably, and differences existed in the participation, planning, and support involved in the decision to move into care and reasons underpinning placement.

For all but two participants the events surrounding placement was characterised by significant changes to physical ability, independence and health. Physical changes

meant participants found it increasingly difficult to look after themselves, requiring professional support and assistance to meet domestic and care needs. Changes to health (and independence) occurred at different rates, with some participants experiencing a gradual deterioration, and others more acutely i.e. from a stroke.

One interesting facet of physical change was of self-neglect, which may suggest the presence of a problem with health help seeking. Traditionally, men are characterised as unwilling to ask for help when they experience problems in living, and a large body of evidence exists to support the belief that men are reluctant to seek help from health professionals (Addis & Mahalik, 2003). This may be compounded by social isolation, which is a significant problem for older men (Beach & Bamford, 2015), leading to the illness being obscured or even denied, with potentially disastrous consequences.

The inability to look after one-self was the primary reason participants gave for their move into care, supporting previous findings within the literature (Iwasiw et al., 2003). Involvement in the decision to move appeared to fall on a continuum of participation, a finding supported by another UK study (Reed et al., 2003). The decision-making process depended largely on the circumstances surrounding care placement and those with gradual physical changes were more likely to have been involved in prior placement planning, with some actively involved in researching their new home. This afforded the participants greater control and choice in the move (i.e. when and where), associated with an enhanced adjustment (Chao et al., 2008).

For half the participants the decision to move into care was made by a professional, family or friend. Participants with forced moves, either from hospital or from other care placements reported more negative experiences, either feeling ‘stuck’ and without possessions, or feeling as though people were ‘doing things’ for them, rather than with them. Forced or unplanned moves have been found to impede on adjustment in RC (Wilson, 1997) and lead to a loss of control and a struggle for independence (Iwasiw et al., 2003). For men who adhere to a more traditional masculine identity this may be more important, particularly as the

masculine role is associated with instrumentality, independence and control, potentially leading to a gender role conflict (O'Neil, 1981).

4.2.2. The Systems (At) Work

In the theme 'the systems (at) work' the men identified that whilst the working CH can meet their care needs, it does so in context to a continuous tension of control and personal autonomy. On the face of it, the CH can meet physical, social and even emotional support needs and in doing so many participants report positive experiences of professional support, helping them to feel secure and settled; a finding shared by Hvalvik & Reierson (2011).

Three out of four participants with significant ill health upon arriving into RC reported that professional care enabled recovery and improved mobility. However, this care could be experienced as 'irritating', particularly in the early phases where an interdependency of achieving autonomy relied on a certain level of dependency on staff, physical aids and specialist adaptations in the home. This dependency may have served to motivate the men to gain increasing levels of control in relation to accessing their home and local environment. Thus, care that enables physical recovery or improved mobility may help some men to enhance their self-efficacy and subsequent adjustment into RC (Lee, 2010).

One important feature of the professional support reported on was that of intimate care, such as bathing and showering. The men in this study identified that a choice of staff gender for this care was important, potentially enhancing feelings of control. Mostly, the men reported feeling more comfortable when male members of staff helped with washing or changing. For one man, the experience of being washed by female nurses was very different to his belief regarding his male fantasy. This disconnect between his view that he and other men should enjoy being showered by nurses, and the reality that it was 'embarrassing', may have led to gender role conflict, and a deprecation of the self for not being a 'normal' (younger) man.

A number of participants were receiving intimate care for the first time. This practice, designed to support residents, served to increase dependency – a

common consequence and currency of institutional care (Peace et al., 1997). Indeed, the youngest participant was being showered everyday despite being able to bathe him self, and do so less frequently before placement. This care was undertaken at 5am every morning, suggesting the presence of an inflexible routine, and one serving the needs of the home rather than the residents. Institutional environments for older adults can be iatrogenic, encouraging lower levels of wellbeing as residents internalise a 'sick role' (Donnenwerth & Peterson, 1992). Jilek's (2006) study found that male residents often report professional care being delivered in an environment of disempowerment and institutionalisation, reducing autonomy and independence.

A blanket approach to delivering 'tightly scheduled care' could be indicative of the 'total institution' described by Ervine Goffman (1961). Indeed, checking and risk procedures impeding on privacy and autonomy were carried out by staff, and done so seemingly without question and apparent consideration of individual needs. It suggests the imposition of procedures from a system above (management and care organisation), that serve the needs of the institution, enabling it to function, rather than putting the needs of residents first (Goffman, 1961). One may then question - what needs and functions are served by these practices?

Whilst these practices may help residents with the highest support needs and support the home in managing their care, monitoring residents en masse may have a number of functions that serve the needs of the institution. Firstly, social processes and systems can function to defend against anxiety (Menzies-Lyth, 1960). Checking and monitoring residents in the same way may support the staff team to deny the individuality of residents and maintain a degree of separation. This may operate as a defence against loss and the painful reality of death and dying. Secondly, frequent checking and intrusion upon the lives of residents may represent a form of 'surveillance' akin to the 'Panopticon' (Foucault, 1977). Whilst walls and doors create privacy in the home, the regular checking reported and that I witnessed first hand during each interview, suggests it is nothing more than an illusion, potentially functioning as a form of social control, restricting the lives of residents and older people (Townsend, 1981).

4.2.3. Making It Easier

In the theme ‘making it easier’ participants reported a strategy for coping with institutional practices that they had limited or no control over, typified by the turn of phrase ‘I got used to it’. This phrase appeared to represent an acceptance of a loss of certain rights such as privacy, akin to ‘institutionalisation’. Indeed, the importance of not ‘rebelling the system’ or refraining from ‘putting a spanner in the works’, was outlined by one participant to ‘benefit everyone’ - typifying the docile and self-disciplining subject (Foucault, 1977).

A ‘passive’ acceptance (without resistance) has been identified in the literature as a way of managing a loss of control, and involves conforming to, but not embracing the norms of the RC home (Iwasiw et al., 1996). In this study, the men reported that ‘getting used to’ institutional living was made easier because of past experiences of similar systems (i.e. the army), along with a relaxed and non fussy temperament. This may represent a cohort effect, when national service and conscription dominated the lives of men in their late teens or twenties. Furthermore, the men in this study often used the phrase ‘I got used to it’ to describe difficult experiences, and did so with little expressive emotion in the language used and in their presentation. In this way, ‘I got used to it’ may also represent a ‘stoic’ form of acceptance, representative of the masculine gender role.

The support of friends and family at points throughout the journey into care was critical for some men, helping them to identify suitable homes and with practical arrangements of moving. Research suggests that practical help from the support network aids adjustment (Proctor, 1995). Once in placement, the support network enabled participants to engage in social interaction, meaningful activity, and connect to life outside of the home, helping them to manage the move into care. Remaining connected to life before care was also achieved by engaging in activities, helping some men to maintain their social identity. Activities and a role in RC offer a way for male residents to preserve meaning from their past and present lives (Jilek, 2006).

Participants without available family and social support emphasised the importance of support and intimacy from members of staff. Men without available support networks, who may well be the most vulnerable, may choose to connect with staff to meet their social and support needs rather than other residents, whom were reported more difficult to connect with. Indeed, emotional support from staff members has been associated with positive adjustment in RC (Lee, 2010) and reported as important for newly admitted residents (Coughlan & Ward, 2007).

4.2.4. It's Harder To Connect

In the theme 'it's harder to connect' it was reported that all participants faced difficulties with building connections and relationships with other residents that included; a lack of shared interests; preferences for privacy; physical disabilities preventing communication (hearing loss or being bed ridden); behavioral symptoms of dementia; age of residents; and gender. Men have been found to face challenges to building relationships in care (Moss & Moss, 2007), despite intimacy being important for them (Bullard-Poe et al., 1994) and their wellbeing in RC (Jilek, 2006).

The participants reported that the proliferation of the barriers described above presented a lack of socially desirable relationships, found to be a deterrent to building connections for men (Park et al., 2009). Participants also reported having difficulty communicating with the older and most disabled residents. Problems communicating with others is concerning, given that connecting to other residents is reported to help in establishing a new home in RC (Heliker & Scholler-Jaquish, 2006) and is associated with adjustment (Lee, 2010).

Many participants reported negative experiences of sharing the home with women, and were dismissive of the way they sat and chatted in groups, seemingly unable to find a way to connect socially with them. Men are in a minority in RC (CPA, 2012), and those with a preference for speaking with other men are presented with a significant hurdle. Sharing a home with men without communication problems and with shared interests potentially poses an even greater challenge. That some participant's report a preference for social interaction with other men is supported

by another study that identified men needed ‘mateship’ and gender appropriate social activity (Jilek, 2006).

All participants reported unusual or intrusive experiences of residents with dementia, leading some to feel helpless. This finding was consistent with a case study of a male resident George, whose private bedroom did not prevent other residents entering at will (Bland, 2005). One participant reported using humor to manage these experiences, though this was not always possible.

A number of men, particularly those with increased physical disability and a limited support network reported the challenges they faced connecting to valued activities and a preferred (social) identity. Physical disability prevented some men from engaging in writing, playing the piano and sexual intimacy. A loss of meaningful activity has been found to be more important to men than women in the transition into care (Barredo & Dudley, 2008). Increasing frailty and physical disability in later life may prevent men from expressing the task-orientated aspects of their masculine identity (Segal et al., 2010), potentially impeding on their adjustment in care.

A few men spoke explicitly about difficulties connecting to their needs for sexual intimacy. According to Maslow (1970) after the need for food, water and safety is met, comes the need for intimacy and love. For two participants the loss of reported sexual intimacy was due to the unavailability of age appropriate partners, a system reflecting a particular religious or cultural ethos, or because of a diminishing sexual identity and drive (following physical disability and ageing). This finding was not reported in studies on men moving into care or in the wider literature on transition. One study examining the importance of sex in NH residents found sex graded as “moderately important” and more so in males (Aizenberg, Weizman, & Barak, 2002). Sexual intimacy may help men in care, bringing gratification, potentially enabling a greater locus of control and increase in self-esteem (Lui et al., 2005). Despite this, staff and the families of residents have been found to hold negative attitudes towards the expression of sexuality in older adults in RC (Hajjar & Kamel, 2003). These beliefs potentially underpin the rules and

regulations around sexual contact between residents in CH's, likely regardless of the resident's attitudes, beliefs or views (Aizenberg et al., 2002).

4.3. Summary of New Contributions to the Literature

The themes developed within this study appear reflective of the research literature, both of the studies of older men moving into care and more generally in the wider literature on transitions. However, unexpected facets of the current findings can be seen to contribute new understandings about the older male perspective, particularly within the UK. Firstly, despite the reported need for intimacy and contact with others (family, friends outside of RC, women and even staff) no participants reported being in current supportive relationships with other residents. Whilst it has been identified that older men may face barriers to building relationships in RC (Moss & Moss, 2007), and more generally in society (Beach & Bamford, 2015), the stark reality of the limited friendships available in RC has not been made so explicit before. The difficulties men faced in connecting to other residents because of either a lack of shared interests, gender, or communication problems, mean that finding suitable or desirable partners for relationships is a considerable challenge. Thus, older men without family and friends outside of RC may be at a considerable disadvantage in meeting their social needs, and may rely heavily on members of staff for their emotional and social intimacy and support.

Secondly, the theme 'making it easier' highlighted a process of acceptance, helping men to manage institutional life (and the 'total institution') that was represented through the phrase 'I got used to it'. Different types of acceptance (i.e. passive) have been identified in previous studies on transitions into RC (Iwasiw et al., 1996). However, the men in this study may have been using a different form, a 'stoic' acceptance, represented by an emotionally inexpressive description of events of varying challenges (intimate care, rules, checking, extreme behavior of other residents). Furthermore, a cohort effect of men who have experience of similar systems of RC such as the army, that makes getting used to institutional life easier, may have been found. However, both the concept of a stoic acceptance, and the cohort effect identified, requires further research and examination.

Finally, the theme ‘its harder to connect’ reflected how some men face challenges to meeting their need for identity and sexuality in RC. This study found that the loss of reported sexual intimacy was due to individual and systemic barriers. This finding was not reported in studies on men moving into care or in the wider literature on transition.

4.4. Methodological Considerations

4.4.1. Design and Analysis

Qualitative research is mostly critiqued in comparison to quantitative research in relation to small sample sizes, researcher interpretation and subsequent bias, and issues of validity (Willig, 2008). However, qualitative research can provide an in-depth and detailed account of data and lead to unanticipated insights (Braun & Clarke, 2006). This is important given that there are very few studies on older men following the move into RC and none were identified within the UK. The TA method chosen enabled the summary of a large body of information, whilst retaining a ‘thick’ description of the accounts of moving and adjusting to life in RC (Braun & Clarke, 2006).

4.4.2. Interview Schedule

The schedule devised created a useful framework for interviews. Whilst this was shared with clinicians (a male and female clinical psychologist in a CMHT for older people) it was not piloted directly with older men. Two participants required more prompting than others, possibly due to cognitive impairment following ill health (i.e. from a stroke). This was more challenging to manage and involved asking more direct and closed questions to clarify their experiences, potentially influencing their responses. Thus, piloting the schedule with older men in care with varying levels of cognitive ability may have led to questions that were less demanding, helping those with impairment or concrete thinking styles. Furthermore, involving service users in the development of the schedule may have identified additional questions and areas of interest.

4.4.3. Retrospective Accounts

The period of time between the participants move into RC and the interviews was highly variable, ranging from 8 months to 6 years. For those later on in placement the memory of the move may have been harder to access, influencing the accuracy of their reports. Furthermore, three participants were significantly unwell upon arrival potentially making it harder to recall the first few days and weeks in care. As a researcher this presented a challenge of navigating the interview across past and present experiences.

4.5. Limitations

4.5.1. Sample

The present study is limited by a small sample size and a wider sample may have accessed other diverse accounts of the move into care, potentially enriching the findings. Excluding people with dementia, a group that represents a significant proportion of the CH population poses problems for generalising the findings across RC. Residents with dementia may face additional challenges to the move in terms of their identity and independence, and arguably this group warrants attention in their own right.

The current study cannot distinguish between the effect that being male or a 'higher functioning' male has on managing the move into care. Therefore, the results found and reported on can only be generalised to 'higher functioning' men. Further research is needed with different samples i.e. men with dementia, or 'higher functioning' women. This would clarify what generalisations can be made across different groups in RC. However, the present study will provide a useful comparison group for future research.

Whilst all participants were white and all but one were British (one Irish participant), a high level of heterogeneity in participant characteristics remained. Firstly, the significant variation in length of stay may suggest that participants were at different stages in the transition process (Brooke, 1989). Participants earlier on in placement may still have been establishing their life in care, potentially influencing

their reports of what was helpful or unhelpful in the transition process. Secondly, there was an age difference of twenty-three years between the youngest and oldest participant. This largely represented significant differences in physical abilities and opportunities for independence and instrumentality. Additionally, a cohort effect related to the formative experiences of different age groups may influence the findings. This latter feature of the sample may also impact on future research, as later generations of CH residents may have had very different life and employment experiences. Finally, participants varied in socio-economic status, with five participants self-funded (of varying degrees) and others funded by the local authority. This variation may signify differences in financial resources and possibly feelings of control and power, influencing placement experiences and avenues for managing problems in care.

4.5.2. Data Collection

During each interview interruption by staff occurred at least once because of checking procedures, refreshments, cleaners, or general enquiries. Privacy needed for the interviews was never fully secured, potentially impeding on participant accounts of the move and reported experiences may not be a true reflection (i.e. minimised).

4.5.3. Data analysis

The heterogeneity in the experiences of the participants enabled a rich and diverse picture of the move into care to emerge. However, for analysis purposes this meant that an expansive list of codes was generated, posing a challenge to the researcher in producing themes representative of all accounts. The diversity in experiences meant some were only shared by few of the participants, reducing the representativeness of the data.

4.6. Reflective Account

This section will consider a reflective account in relation to personal and epistemological reflexivity (Willig, 2008).

4.6.1. Personal Reflexivity

My position/s influencing the development of this study have been presented in the method section (see 2.6.). This was my first experience of conducting a qualitative research study. Early on I was aware that the role of the researcher was distinct from that of clinician; a qualitative researcher's focus is on analysis of language and meaning; and a clinician on building therapeutic relationships and engagement. However, as I have progressed through the research process I believe integrating these roles will enhance my practice and professional development as a clinical psychologist.

When recruiting participants I experienced first hand the challenges faced in making contact with residents in an institution. I was surprised by the apparent gatekeeping by managers of the RC home, and I was often denied access to suitable participants. Primarily, I was told that limited resources would prevent them from helping me to access the home and the participants within them. Some of the homes had recently taken part in research studies and reported that this process had been demanding for them, particularly in relation to resources. This made me aware that one role of the researcher is to leave the door open for others; conducting research with as little disruption as possible and providing a positive experience of the research process.

4.6.2. Epistemological Reflexivity

This study aimed to explore the specific experiences of older men. The questions, whilst relatively broad, were underpinned by values and beliefs about age and gender. Throughout the research process I became more aware of my assumptions and beliefs about these constructs. As a thirty three year old I consider myself to be young. Participants in this project were not invited to conceptualise their age using their own categories and some of the participants may not have considered themselves to be older adults. As a younger person I drew on the idea that I could access their direct experiences of being older through their stories and observation. My own ideas about old age come from many contexts (i.e. personal and professional) and draw on conflicting ideas i.e. ‘you can live in later life’ and ‘old age is a time of slowing or decline’. This moderate view,

one that emphasises possibilities and one of limitations, I believe is reflected in my reading and writing of this study.

As a younger man who has conducted research on males at Masters Level, I have written previously about masculinity and the male gender. Both my assumptions about the binary notion of gender and model of masculinity, was evident in the interview process, for example in the following exchange:

> SW: More directly, [moving into RC] has it meant anything different about being a man?
>
> I'm not quite sure what you mean -- ask a direct question?
>
> SW: Some men have said that not doing what they used to do made them feel less of a man.
>
> No, no this is not something that has worried me.

In this section, the first question illustrates my assumption that being a man leads to different experiences, and that men are able to tap into a male identity, and one that exists. In asking the second question I have eluded directly to a loss of maleness as a result of losing independence, an idea prevalent in the 'hegemonic' model.

Following this interview I began to consider how I tapped into the construct of masculinity. In interviews and in reading the data this required interpreting the accounts of the participants in relation to masculine characteristics, such as independence, instrumentality, and emotional inexpressiveness (Courtenay, 2000). However, when interpreting the accounts of the participants from the position of being a younger male and member of the 'hegemonic' group, both false positives and false negatives may occur in the identification of 'male' experiences of the move into RC and its management. The process of asking about and interpreting masculine qualities, potentially reifies this construct, and more nuanced older male masculinities may be missed.

4.7. Evaluation of Current Research

Quality in qualitative research can be assessed against a number of criteria (Braun & Clarke, 2006). The following section will consider the quality of the current research using Spencer and Ritchie's (2012) three principles framework, applicable to all qualitative research.

4.7.1. Contribution

This refers broadly to the value and relevance of the research evidence. The population under study has had limited attention in the research literature and has not been examined within the UK. To help support the reader to reflect on the contribution of this study the results have been summarised, evaluated and considered in context to the current literature. The limitations of the study have been reviewed and the wider implications of the findings are considered in the next section.

4.7.2. Credibility

This relates to the plausibility of the claims made by research, the believability of findings and the transparency in how claims and conclusions are reached (Spencer & Ritchie, 2012). The research process has been outlined in the method and an example of data analysis and transcription conventions has been provided in the appendices. The findings have been compared to the research literature, with similarities and differences reported on, meeting a facet of triangulation. However, the findings of this study were only connected to participant reports and the views of staff, relatives and female residents were not obtained. Practical limits meant analyses was conducted solely by the researcher, though, the analytic process was discussed regularly with my supervisor and a draft of the method, results and discussion were shared and reviewed.

4.7.3. Rigor

Spencer and Richie (2012) suggest that rigor in research can be assessed by considering the following:

4.7.3.1. *Reflexivity*

A challenge for qualitative researchers is to provide an objective account of the findings (Spencer & Ritchie, 2012). A reflexive account has been considered above (see 4.6.)

4.7.3.2. *Audibility*

Decisions regarding the process of qualitative research should be documented (Spencer & Richie, 2012). The TA utilised and the steps taken in the analysis have been outlined within the method section. Examples have been provided (see appendices) to help the reader understand what was of interest to the researcher.

4.7.3.3. *Defensibility*

It is important to document a clear rationale for the sample and method in qualitative research (Spencer & Richie, 2012). This has been outlined and the rationale for using the qualitative design and TA method has been provided. The fit with the critical realist epistemology adopted has been stated and described.

4.8. Wider Implications of Findings

4.8.1. Research Implications

Current findings have implications in relation to understanding older men's transition into RC, particularly within the UK. The findings support the use of qualitative research with a group who largely remain invisible within the literature. The analysis of participant accounts in relation to notions of masculinity is different to studies that have solely reported on (Bland, 2005) or been conducted on men moving into RC (Jilek, 2006). Whilst this study was conducted on residents in a RCH the findings can potentially be generalised to other institutional living environments such as NH's or sheltered housing.

In light of the current findings, future research could focus on conducting additional studies with larger numbers of men across the UK. This would help build a greater picture of the social support needs of men and barriers they face in connecting with other residents in RC in the UK. In order to find out more about this, the views of

staff, family and friends could be sought. Further research could examine the notion of a 'stoic' acceptance and whether this enhances or impedes adjustment. The intersection of gender and other layers of difference i.e. race, sexuality and culture may tell us more about the experiences of different male groups. As one participant identified a cultural ethos in the home preventing him from meeting his needs for intimacy with women, examining the experiences of residents in different homes (i.e. ones with strong religious or cultural values) is important. Finally, an ethnographic study of the current RC system may tell us more about the tension between the needs of the institution and those of the residents. This may be particularly salient in a time when the government is under pressure to reduce spending, especially on people without political power, who are increasingly vulnerable to 'austerity'.

4.8.2. Professional Implications

The current findings have implications for those working with older men in RC and more broadly for clinician's working in older adult services. The men within this study reported great difficulty in building relationships with other residents. Staff may play a significant role in the social and emotional needs of men with limited support networks. This poses an interesting dilemma for staff, particularly as maintaining professional relationships and limiting intimacy may protect them against loss. 'My Home Life', a project supporting those in RC, suggests that care staff need to be supported to appreciate the psychosocial aspects of their caring role and be given space for their own reflection (Owen et al., 2012). However, relying on under resourced and underpaid care staff to meet the social needs of some men in care, may be an unrealistic expectation.

Clinical psychologists have a role in supporting CH's to help men meet their social and emotional support needs. This may involve supporting care teams with the emotional impact of building relationships with men who are often at the end of their lives. Clinical psychologists are well placed to support CH's with service user consultations. This may reveal more about how men wish to meet their social and emotional support needs.

4.8.3. Service Level

The findings suggest that services should emphasise the social and sexual intimacy needs of male residents in staff training. Services should consider how they facilitate connections between residents. When CH's have a lack of socially desirable relationships for men and a high proportion of residents unable to communicate, there is a greater need for the staff team to provide for the emotional and social needs of residents. This should be identified in placement planning and provisions made.

The men in this study highlighted the limited availability of suitable residents to socially connect with. Barriers to communicating and connecting to others included physical disability, diagnosis of dementia and gender. Services should consider developing homes that have increased numbers of those who are 'higher functioning', and possibly increased numbers of men. However, this may not be in the interests of the institution, whereby 'higher functioning' residents maintain a manageable level of care in the context to limited resources (Peace et al., 1997). CH's should consider tailoring activities in care just for men as research suggests that activities for men can enhance feelings of 'mateship' and potentially reduce the 'black hole' of social isolation faced by men in RC (Jilek, 2006).

4.8.4. Policy Level

Models of care need to broad enough to allow for individual variation (Oliver et al., 2014). Meeting the needs of individuals and helping them to make choices about their routines and regimes is central to person-centered care. Despite this, participants identified that many practices failed to take into account their individual care needs. The CPA's (1996) code of good practice guidelines on living in RC outline that a loss of control and independence occurs when residents are all treated alike. The code of conduct asserts that rules and routines should be kept at a minimum to promote rehabilitation or fulfill statutory requirements. Indeed, standard seven of the national minimum standards (DOH, 2003) outlines that a comprehensive individual assessment should be drawn up with service users, providing the basis for their care. However, a number of participants reported that

despite protesting against risk or checking procedures they could not effect change and had to ‘get used to’ these practices. Thus, more could be done to monitor the use of the national minimum standards, meeting the needs of individuals over and above the needs of the institution.

4.9. Conclusions

This study aimed to contribute to the limited understanding of older men’s experiences of moving into RC. The use of TA provided a flexible approach to identifying and organising the findings, helping them to be placed in context to the current literature. As no published studies have been identified that are solely conducted on older males in the UK, the current findings offer a unique insight into this group’s experiences. Older males seek social support in care but are prevented from meeting these needs because of individual and systemic barriers within care homes and the social care system. Clinical psychologists have a role in supporting services and men in care with identifying ways in which their social and emotional support needs can be better met.

Institutional practices of surveillance and treating residents en masse can serve to reduce independence in older men. The construct of masculinity and male identities should be considered and held in mind to empower men when moving into and building a life in care. In managing the move and the institution older men may use a distinct type of acceptance that is influenced by their cohort specific experiences to help them get used to institutional living. However, it is acknowledged that further research worldwide and in the UK is warranted.

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APPENDICES

Appendix A: – Literature search: Terms, strategy and results

A preliminary literature search identified relevant papers that were scanned for key words. The key words and their paired terms are below:

S1	Men
S2	Older men
S3	Elderly men
S4	Transition
S5	Adaptation
S6	Adjustment
S7	Adaptability
S8	Move
S9	Gender
S10	Gender differences
S11	Nursing home
S12	Residential care
S13	Residential aged care
S14	Residential aged care facilities
S15	Assisted living
S16	Long-term care
S17	Long-term care facilities
S18	S1 or S2 or S3
S19	S4 or S5 or S6 or S7 or S8
S20	S9 or S10
S21	S11 or S12 or S13 or S14 or S15 or S16 or S17
S22	S18 + S21
S23	S18 + S19 + S21
S24	S19 + S21
S25	S19 + S20 + S21
S26	S20 + S21

The search strategy was devised to increase sensitivity and take into account the specific nature of the review. The terms were searched in the following databases: PsycINFO. PsychARTICLES, CINAHL, and MEDLINE. The search took place in June 2014 and re-run in February 2015 to identify any newly published studies. Retrieved studies were subject to three phases of filtering, including (a) removing duplicate, (b) a title sift, (c) abstract sift. From this fifty-eight studies were retrieved for the literature review. Included studies were also cross-referenced and reference lists were searched to increase the identification of potential research evidence.

PsycINFO, PsycARTICLES, and CINNAHL (via EBSCO) literature search

Search Number	Search Criteria	Number of articles
S1	Men	266,834
S2	Older men	7,545
S3	Elderly men	2,674
S4	Transition	64,228
S5	Adaptation	95,951
S6	Adjustment	160372
S7	Adaptability	7,043
S8	Move	44,521
S9	Gender	222,739
S10	Gender differences	54,004
S11	Nursing home	44,908
S12	Residential care	22,539
S13	Residential aged care	888
S14	Residential aged care facilities	420
S15	Assisted living	3810
S16	Long-term care	34,517
S17	Long-term care facilities	3,671
S18	S1 or S2 or S3	266, 834

S19	S4 or S5 or S6 or S7 or S8	347,971
S20	S9 or S10	222,739
S21	S11 or S12 or S13 or S14 or S15 or S16 or S17	85,451
S22	S18 + S21	1,628
S23	S18 + S19 + S21	172
S24	S19 + S21	4,599
S25	S19 + S20 + S21	165
S26	S20 + S21	1,794

MEDLINE (via Pub med) literature search

Search Number	Search Criteria	Number of articles
S1	Men	380,968
S2	Older men	33,695
S3	Elderly men	237,087
S4	Transition	217,169
S5	Adaptation	245,980
S6	Adjustment	228,365
S7	Adaptability	6,188
S8	Move	40,869
S9	Gender	781,302
S10	Gender differences	148,184
S11	Nursing home	72,315
S12	Residential care	9,001
S13	Residential aged care	4,654
S14	Residential aged care facilities	2,147
S15	Assisted living	20,141
S16	Long-term care	91,417
S17	Long-term care facilities	7,183
S18	S1 or S2 or S3	379,993

S19	S4 or S5 or S6 or S7 or S8	644,507
S20	S9 or S10	781302
S21	S11 or S12 or S13 or S14 or S15 or S16 or S17	178,509
S22	S18 + S21	5,443
S23	S18 + S19 + S21	514
S24	S19 + S21	10,529
S25	S19 + S20 + S21	994
S26	S20 + S21	10,238
S27	S24 Narrowed by age (+65 years)	4890
S28	S26 Narrowed by age (+65 years)	3648

Appendix B: UEL registration of research confirmation

Simon Weighell
Flat 4
3 Hawley Road
London NW6 1SL

9 May 2014

Student Number: 1236180

Dear Simon,

Registration as a Candidate for the University's Research Degree

I am pleased to inform you that the Research Degrees Subcommittee on behalf of the University Quality and Standards Committee, has registered you for the degree of Professional Doctorate.

Title of Professional Doctorate: Professional Doctorate in Clinical Psychology

Director of Studies: Ken Gannon

Supervisor/s: Chanelle Myrie

Registered Thesis Title: The experiences of older men who have moved from home into residential care

Expected completion: According to your actual date of registration, which is **1 October 2013**, the registration period is as follows:

Minimum 18 months maximum 48 months (4 years), according to a full time mode of study.

Your thesis is therefore due to be submitted between:

1 April 2015 – 1 October 2017

I wish you all the best with your intended research degree programme. Please contact me if you have any further queries regarding to this matter.

Yours sincerely,

James J. Walsh

Dr James J Walsh
School Research Degrees Leader
Direct line: 020 8223 4471
Email: j.j.walsh@uel.ac.uk

Cc: Ken Gannon, Chanelle Myrie

Appendix C: UEL ethical approval document

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Kenneth Gannon **ASSESSOR:** Elizabeth Attree

STUDENT: Simon Weighell **DATE (sent to assessor):** 07/03/2014

Proposed research topic: "The experiences of older men who have moved from home into residential care"

Course: Professional Doctorate in Clinical Psychology

1.	Will free and informed consent of participants be obtained?	YES
2.	If there is any deception is it justified?	N/A
3.	Will information obtained remain confidential?	YES
4.	Will participants be made aware of their right to withdraw at any time?	YES
5.	Will participants be adequately debriefed?	YES
6.	If this study involves observation does it respect participants' privacy?	NA
7.	If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically?	NA
8.	Is procedure that might cause distress to participants ethical?	NA
9.	If there are inducements to take part in the project is this ethical?	NA
10.	If there are any other ethical issues involved, are they a problem?	NA

APPROVED

YES	~~YES, PENDING MINOR CONDITIONS~~	~~NO~~

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: EA Date: 11/03/14

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Kenneth Gannon **ASSESSOR:** Elizabeth Attree

STUDENT: Simon Weighell **DATE (sent to assessor):** 07/03/2014

Proposed research topic: "The experiences of older men who have moved from home into residential care"

Course: Professional Doctorate in Clinical Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

1	Emotional	NO
2.	Physical	NO
3.	Other (e.g. health & safety issues)	NO

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / MED / LOW

APPROVED

YES	~~YES, PENDING MINOR CONDITIONS~~	~~NO~~

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: EA Date: 11/03/14

For the attention of the assessor: Please return the completed checklists by e-mail to ethics.applications@uel.ac.uk within 1 week.

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of East London
www.uel.ac.uk

School of Psychology

Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology

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The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853

POSITIVE ABOUT DISABLED PEOPLE

Appendix D: UEL confirmation of change of thesis title

Simon Weighell
Flat 4
3 Fawley Road
London
NW6 1SL

Date: 27th March 2015

Student number: 1236180

Dear Simon

Notification of a Change of Thesis Title:

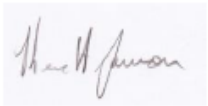
I am pleased to inform you that the School Research Degree Sub-Committee has approved the change of thesis title. Both the old and new thesis titles are set out below:

Old thesis title: The experience of older men who have moved from home into residential care.

New thesis title: Older men's experience of moving into residential care

Your registration period remains unchanged. Please contact me if you have any further queries with regards to this matter.

Yours sincerely,



Dr Kenneth Gannon
School Research Degrees Leader
Direct line: 020 8223 4576
Email: k.n.gannon@uel.ac.uk

Appendix E: Participant information sheet

UNIVERSITY OF EAST LONDON

Simon Weighell
Tel: xxxxxxxxxxx
Email: u123680@uel.ac.uk
University of East London
School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

Dear resident,

My name is Simon Weighell and I am studying to become a Clinical Psychologist. This letter is to tell you about a research project that I hope to undertake.

What is this research project about?
This project aims to ask men about their experiences of moving into residential care. This information may help services and professionals support men through the process of moving and settling in to residential care.

What is required of you?
Should you agree to take part, this study requires that you are able to talk with me about your experiences of moving into care. You will need to be able to talk with me for up to an hour and be able to reflect on your experience. This will take place at your care home in a room that you feel comfortable talking in.

What will happen during our meeting?
I will ask you some questions about what it was like moving from your home into care. The questions may vary from person to person but may include how you coped with your move. You will be able to request a break at any time during the interview or if you decide we can finish it at another time.

There are no dangers to taking part but some people may find they get upset, particularly if our discussion touches on something that is difficult or emotional. If this happens I would be happy to let the care home staff know should you wish and/or give your contact details for other organisations that can offer support. I will be available to discuss any concerns or questions you have throughout and after the interview.

What will happen with the information that we discuss?

I will audio record our interview and only I will be allowed to listen to this recording and this will be typed up into a transcript. The recording and the transcript will be held on a password-protected computer. Your name and any names that are discussed, and anything that you say that would mean someone could identify you will be changed.

This information will form part of an academic thesis and later on I may turn this into an article for publication for other professionals to read. A summary of the research will be available should you request it. After the thesis is finalised and accepted I will delete the audio recordings. The written transcript will be kept as a computer file for three years at the University of East London Library repository.

What should you do if you are interested?
If you are happy to take part in this project please let your care home manager know. They will contact me to give me your details and I will organise a time to meet with you to tell you more about the project and organise a time for the interview. You will be asked to sign a consent form before your interview. Please keep this letter for your reference.

Important information
If you choose to take part you can withdraw from the study at any point. If you do pull out, your relationship with me and the care home will not be affected.

Who can I contact if I have any questions now?
If you have any further questions please contact me on the details above. Or you can contact the study's supervisor, Dr Ken Gannon (School of Psychology, University of East London, Water Lane, London E15 4LZ, email K.N.Gannon@uel.ac.uk).

Kind regards,

Simon Weighell
Trainee Clinical Psychologist

Appendix F: Participant consent form

UNIVERSITY OF EAST LONDON

Consent to participate in research study

"Older men's experience of moving into residential care"

I have the read the information sheet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the experimental programme has been completed.

I hereby freely and fully consent to participate in the study that has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the programme at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Investigator's Name (BLOCK CAPITALS)

……..

Investigator's Signature

……

Date:

Appendix G: Interview schedule

The following provides a guide to the topics covered in the interview. The progress of the interview will depend on the participant's responses.

Introductions and engagement

• Confirm consent, confidentiality and that the participant may withdraw at any time.

• Agree approximate length of interview. Build rapport e.g. how are you today? What did you eat for breakfast? What have you done today?

Question Guide

1. Why have you moved into residential care?

2. How was this decision made? Who made it? Were you involved? How did you choose the care home? What were you opinions on coming to care?

3. What was it like leaving home? How did this affect you?

4. What was it like coming into residential care? What were the first few days like?

5. How did you cope? What helped you? Have your ways of coping changed in any way?

6. Have you been able to make friends here? Who with? How do you compare with others here?

7. How did you see yourself before coming into care? How do you see yourself now? What has changed/not changed?

Prompts:
What do you mean? How does that make you feel? What did you think of that? Can you give me an example? Please, tell me more about……

Debriefing: What was it like talking about your experiences? Is there anything that troubles you about the interview? Do you have any questions?

Ending: If you want to ask me questions after today you may contact me. Should you wish to speak to someone about what we discussed I will provide you with contact details for support organisations

Appendix H: Transcription conventions

TRANSCRIPTION SCHEME

The following scheme was adapted from Bannister et al. (1994)

- (.) Pause
- (2) Two second pause (number corresponds to length of pause in seconds)
- [Inaudible] Inaudible section of transcript
- Emphasis Word spoken with more emphasis than others
- (Laughter) Laughter during the interview
- Where an interruption by another speaker is brief it is placed in parentheses <>
- Other longer interruptions and overlapping talk are marked with **
- Extracts are punctuated to facilitate reading
- Pseudonyms are used in place of all names including people, places and organisations (including the interviewee's)
- Interviewers speech denoted by an ‘I’ and participants speech by a ‘P’
- Lines are numbered (000 at start of interview)

Appendix I: List of codes

Code No.	Code Title
1	Period in hospital before RC
2	Self neglect led to significant health consequences
3	Living alone before RC
4	I didn't think about care until I had to
5	Crisis event leading to consider RC
6	RC as a solution to marriage problem
7	I realised I couldn't look after myself
8	A crisis event leading to hospital stay
9	Increasing physical disability before care
10	Before care became critically unwell
11	Decision to stay in RC made by doctors
12	Went in for hospital treatment thinking would come back home
13	I couldn't look after myself anymore
14	Discussed RC with children
15	Discussed coming into care with professional
16	Issue of RC raised by professional or children
17	Researched RC
18	Care home already known to children
19	Choice of care home by children
20	Family brought me into care home
21	Children helped with move
22	I had the capacity to make the decision to come into care
23	Move from home into RC
24	Previous care home closed
25	Family or friends fought the authorities to secure placement
26	Knew of care organisation
27	Impressed by organisation
28	Chose home because of reputation
29	No prior experience of RC
30	Negative experience of first care home
31	Hardest part of the move is making the decision

32	Visited home before placement
33	Not visited RC before placement
34	Experience of wife in care was positive
35	Felt lonely living alone
36	Religious affiliation of home not important
37	Positive experience of previous care home
38	Religious affiliation of home important
39	Settled in previous care home
40	Issues of local environment
41	Stressful transport from hospital into RC
42	I don't like it here
43	I’m stuck in RC
44	RC better than hospital
45	First few days painless
46	Leaving home was a relief
47	RC provides security
48	RC is a relief
49	I saw residential care as an opportunity
50	RC provides companionship
51	Acceptance of move
52	In RC I can be looked after
53	Being looked after provides security
54	Problem of what to do with my flat and organising sale
55	I sold my home
56	Possessions organised by children
57	Selling home to fund care
58	Problem of funding care
59	Physically unwell upon entering care
60	Regular contact with children helped me settle
61	Possessions remind me of who I am
62	Some possessions are more important than others
63	Accepting you can’t bring all your possessions
64	I don't want to sell my flat it's precious to me
65	I don’t have my possessions

66	Family and friends have own lives to lead
67	Friends passed away
68	Practical help from social network
69	Regular contact with family
70	Family gives life meaning
71	Important to have good family relationships
72	I am lucky to have a family
73	Seeing friends and family keeps me connected to my life
74	Contact with family and friends means I'm not forgotten
75	Would like more contact with family
76	Loss of social support network
77	Reduced contact with social network
78	Responsible for wife in care
79	Important to have channel of communication with wife
80	Wife in care close by
81	Wife in care far away
82	This care home compares favourably to others
83	RC leads to physical recovery
84	Positive experience of staff care: Kind
85	Positive experience of staff care: Sensitive
86	Positive experience of staff care: Emotional support
87	Positive experience of staff care: Caring
88	An adapted environment helped
89	Wheelchair/tricycle increased independence
90	Developed a proper friendship with a female member of staff
91	Developed relationships with staff
92	Getting to know staff
93	I can only have relationships with staff
94	Staff relationships helped me settle
95	I can only communicate with staff
96	Friendship keeps me going
97	Friendship with a volunteer
98	I can only have relationships with staff
99	I am valued because I don't have dementia

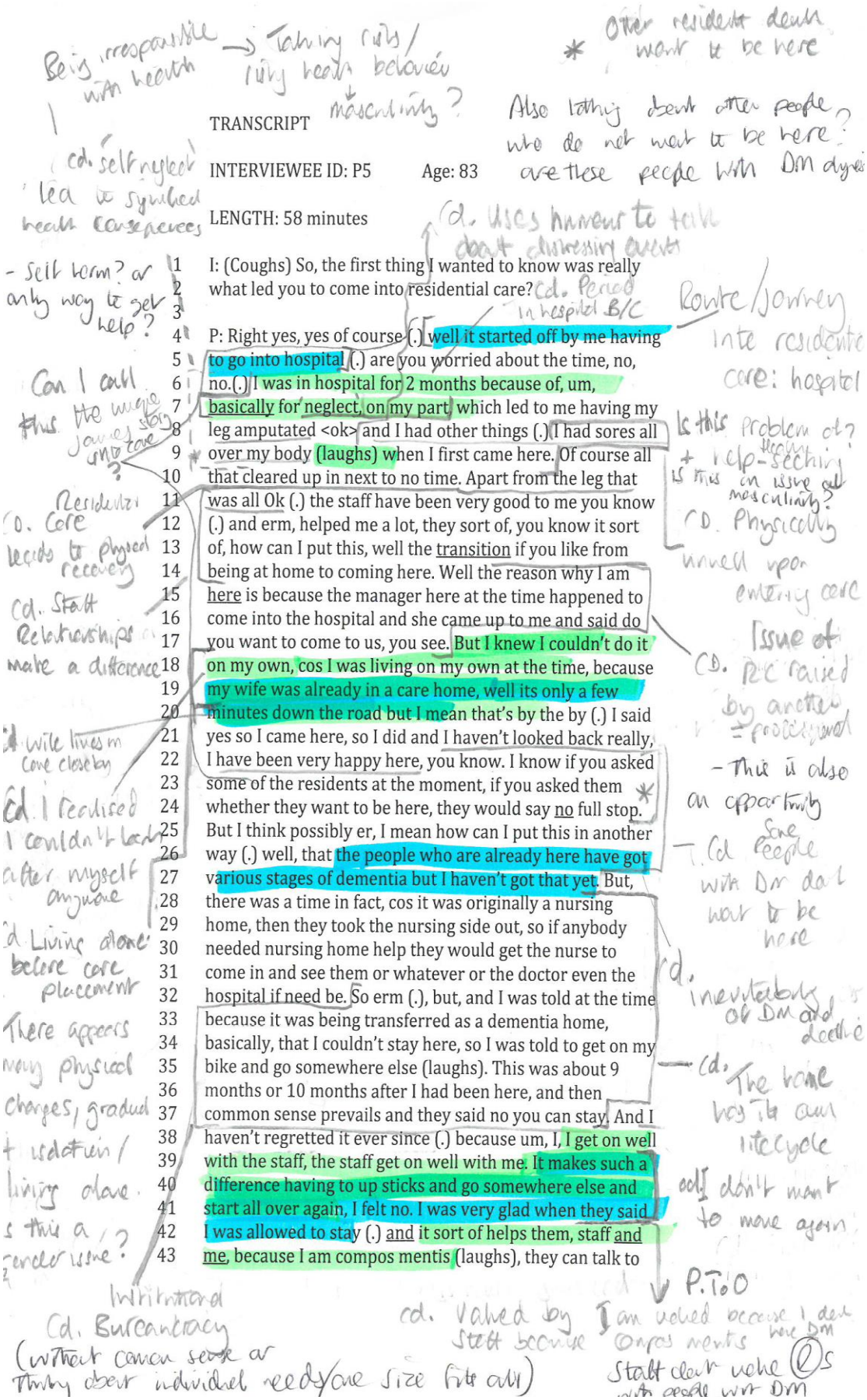
100	Most residents have Dementia
101	Negative beliefs about dementia
102	People with dementia seem to have difficulty adjusting to RC
103	You can't build a relationship with others with dementia
104	It's harder to connect with the very old
105	Feel helpless with people with dementia
106	Negative interaction with people with dementia
107	Unsure about wanting close friendships
108	Prefer to invest in family relationships
109	If your not intimate you don't feel loss
110	Privacy is a barrier to making friends
111	Compares self favourably to others
112	Ignore people
113	Only talk to people who share my interests
114	I don't have a bond with any other residents
115	I feel lonely
116	I can't connect with others
117	Lonely not being able to connect with others
118	Cope with loneliness by connecting as much a you can
119	A search for friendships and common interests
120	The home does not facilitate building R's
121	Difficulty finding shared interests with others
122	Others illness and disability makes relating difficult
123	I have nothing in common with older residents
124	I would prefer residents my age
125	You can't make people socialise
126	You can’t connect to women because of dementia or disability
127	Negative experience of women in care
128	Negative beliefs about women
129	More likely to have a proper conversation with a man
130	Easier speaking to men
131	Men are in a minority
132	Ability to communicate is more important than gender
133	Men and women think differently

134	My wife has/had dementia
135	You can't have a proper conversation with people with dementia
136	Some people with dementia do not want to be here
137	Inevitability of dementia and decline
138	There is a skill to communicating with people with dementia
139	Dementia changes people
140	People with dementia display extreme behaviour
141	Seeing the funny side - coping with people with dementia
142	Avoid communal areas
143	People with dementia can provide companionship
144	Prefer to spend time in my room
145	Before care adjusted to a hospital regime
146	Institutionalisation begins in hospital
147	Pointless procedures
148	I got used to it
149	Temperament or personality trait made settling in easier
150	Accepting care was the best place for me
151	Accepting being cared for
152	Importance of acceptance
153	Adjusting to RC involves becoming institutionalised
154	Care is familiar
155	Becoming institutionalised benefits everyone
156	There are limits to care
157	The care home has it's own life cycle
158	Institutional bureaucracy
159	Placement is never a guarantee
160	I don't want to move again
161	Limits to resources in care
162	Dependent on care staff
163	RC leads to increased dependency
164	Negative experience of institution: Regime
165	Negative experience of staff care: No time
166	Negative experience of RC: Unhappy with facilities
167	A change in self image because of disability

168	Disability meant I was dependent on care staff
169	I don't like being dependent on staff
170	Dependent on others to see my wife
171	My wife is unhappy in care
172	Systems prevent me from helping my wife
173	Physically disabled for the first time
174	My disability limits my independence
175	I can't cope how I used to
176	Loses
177	Hopeless
178	Trying to retain sexuality
179	Lack of physical recovery leading to depression
180	Recovery affected by depression
181	A Lack of meaningful activity
182	Importance of meaningful activity
183	Physical recovery leading to increased independence
184	Embarrassed being washed by women
185	Reality of intimate care by women is different to a male fantasy
186	First time I had intimate care
187	Choice of carer gender important for intimate care
188	Control over medical care
189	I maintain an independence
190	I try to look after my physical and cognitive health
191	Time spent working out a preferred routine
192	Maintain religious practice
193	Maintained routine from before care
194	Valued for my role in care organisation
195	A role in organisation
196	A role in the home
197	Life in care is very different
198	Interest in sex diminishes with age
199	Sex is important in my life
200	Belief that a successful life buffers against old age
201	I'm at risk of losing my libido completely

202	Masculine ID related to having romantic/sexual relationships
203	Belief that ageing equates to a loss of masculinity
204	I haven't replaced my need to play music or have sex
205	No change to how I see myself since coming into RC
206	Loss of identity in care
207	Trying to maintain identity through relationships
208	The rules of the home prevent me from intimate R's with women
209	The management discourage close relationships with females
210	My religion makes romantic relationships with women difficult
211	I'm interested in a romantic relationships
212	There are no women I could inter relate with
213	I need female company
214	There is no substitute to female company

Appendix J: Coded extract example



TRANSCRIPT

INTERVIEWEE ID: P5 Age: 83

LENGTH: 58 minutes

I: (Coughs) So, the first thing I wanted to know was really what led you to come into residential care?

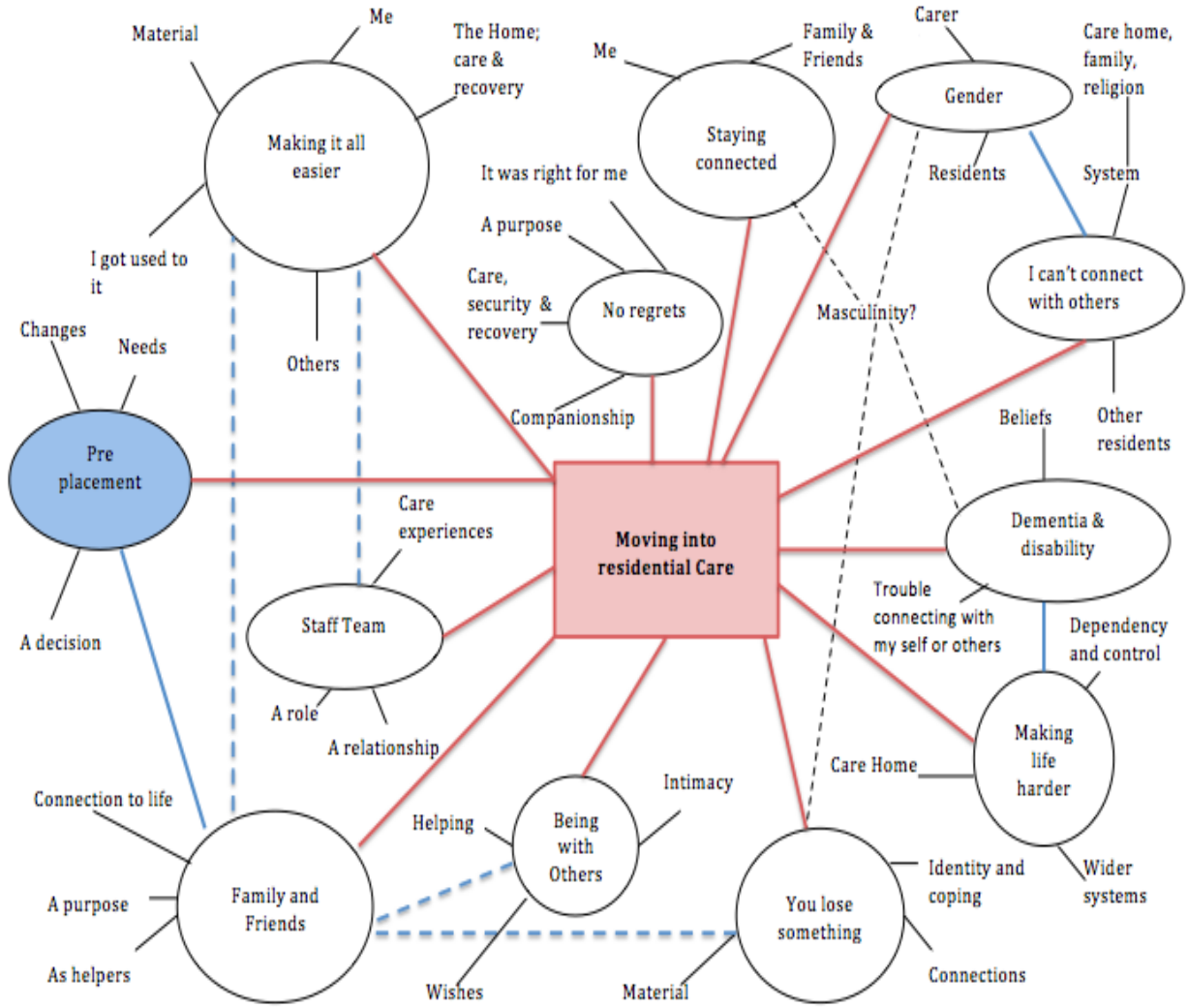
P: Right yes, yes of course (.) well it started off by me having to go into hospital (.) are you worried about the time, no, no.(.) I was in hospital for 2 months because of, um, basically for neglect, on my part, which led to me having my leg amputated <ok> and I had other things (.) I had sores all over my body (laughs) when I first came here. Of course all that cleared up in next to no time. Apart from the leg that was all Ok (.) the staff have been very good to me you know (.) and erm, helped me a lot, they sort of, you know it sort of, how can I put this, well the transition if you like from being at home to coming here. Well the reason why I am here is because the manager here at the time happened to come into the hospital and she came up to me and said do you want to come to us, you see. But I knew I couldn't do it on my own, cos I was living on my own at the time, because my wife was already in a care home, well its only a few minutes down the road but I mean that's by the by (.) I said yes so I came here, so I did and I haven't looked back really, I have been very happy here, you know. I know if you asked some of the residents at the moment, if you asked them whether they want to be here, they would say no full stop. But I think possibly er, I mean how can I put this in another way (.) well, that the people who are already here have got various stages of dementia but I haven't got that yet. But, there was a time in fact, cos it was originally a nursing home, then they took the nursing side out, so if anybody needed nursing home help they would get the nurse to come in and see them or whatever or the doctor even the hospital if need be. So erm (.), but, and I was told at the time because it was being transferred as a dementia home, basically, that I couldn't stay here, so I was told to get on my bike and go somewhere else (laughs). This was about 9 months or 10 months after I had been here, and then common sense prevails and they said no you can stay. And I haven't regretted it ever since (.) because um, I, I get on well with the staff, the staff get on well with me. It makes such a difference having to up sticks and go somewhere else and start all over again, I felt no. I was very glad when they said I was allowed to stay (.) and it sort of helps them, staff and me, because I am compos mentis (laughs), they can talk to

Appendix K: Codebook example

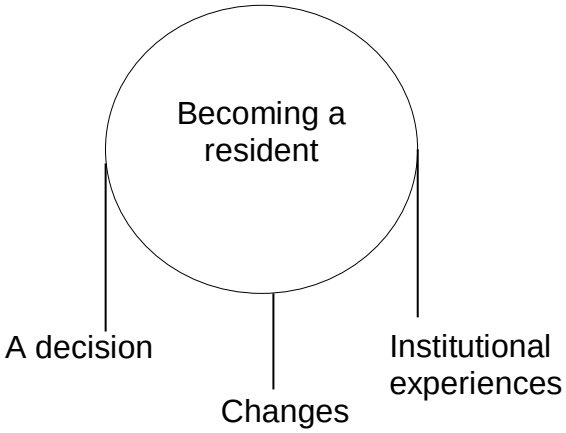
N.	Code	Participant No. & line No.	Extract	Reflections
1.	Period in hospital before RC	P5: 4-5	It started off by me having to go into hospital (.) I was in hospital for 2 months	One route into care involves moving from home to hospital because of ill health – what was hospital like?
		P2: 34-36	I was in intensive care, in a bad state and I had to stay in hospital for five months, I think because I had no place to go to	A serious illness requiring intensive hospital treatment. This seems to be part of a period of being homeless. How does this feel? What led him to chose the care home?
2.	Self neglect led to significant health consequences	P5: 5-8	I was in hospital for 2 months because of, um, <u>basically</u> for neglect, on my part, which led to me having my leg amputated <ok> and I had other things (.) I had sores all over my body	Is this a problem of health help seeking? Perhaps this an issue of being unable to request help when it is needed? Was this compounded by social isolation and does it tell us something about 'masculinity'?
		P5: 112-116	I was in a bad state anyway without <u>realising,</u> you know (.) my body gradually sort of declined and my mind was going as well, (.) <u>my mind</u> wouldn't take in what was going on	This suggests a significant deterioration in health and one that led to confusion, further compounding problem solving and identification of the need for help and support. The
3.	Living alone before RC	P7: 5-8	My wife died in 2006 and for four years I lived in my house (….) I found it very lonely.	A long period of living alone led to feelings of loneliness and increased isolation. This underpinned placement in RC
		P1: 6-7	When she died I carried on living alone	Again following a death of spouse a period of living alone increases isolation. What support was available?

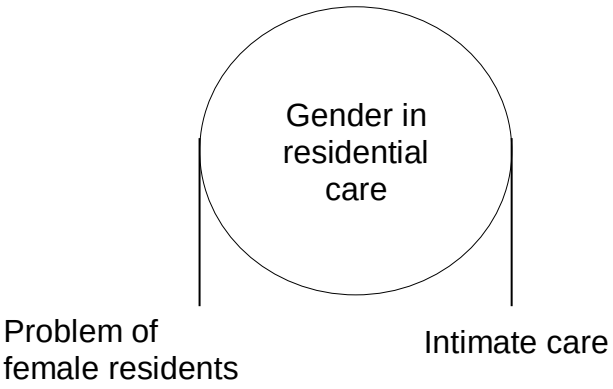
Appendix L: Thematic maps

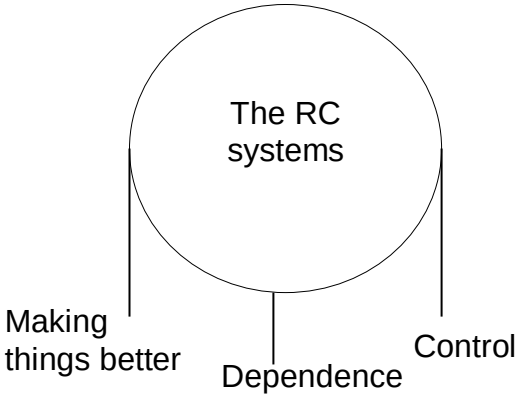
Thematic Map 1

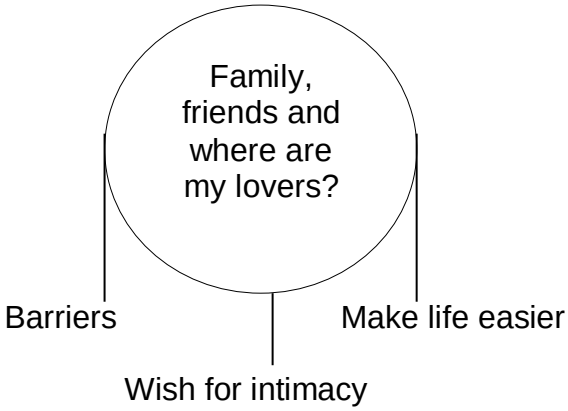


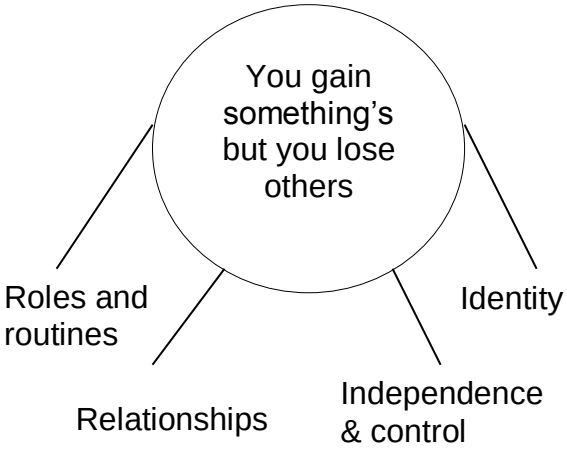
Thematic Map 2

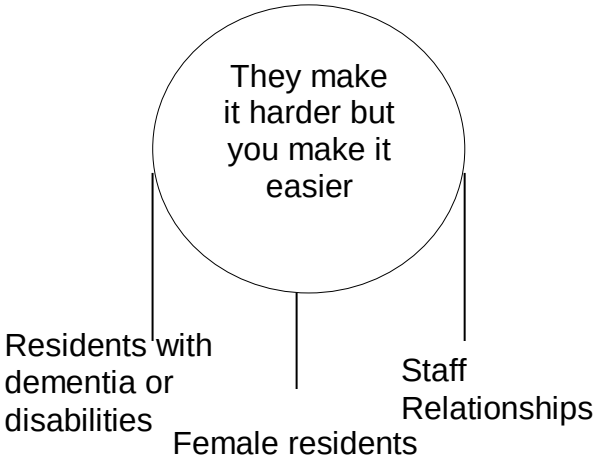


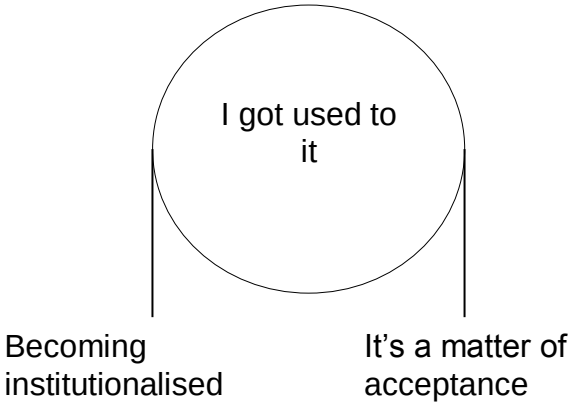




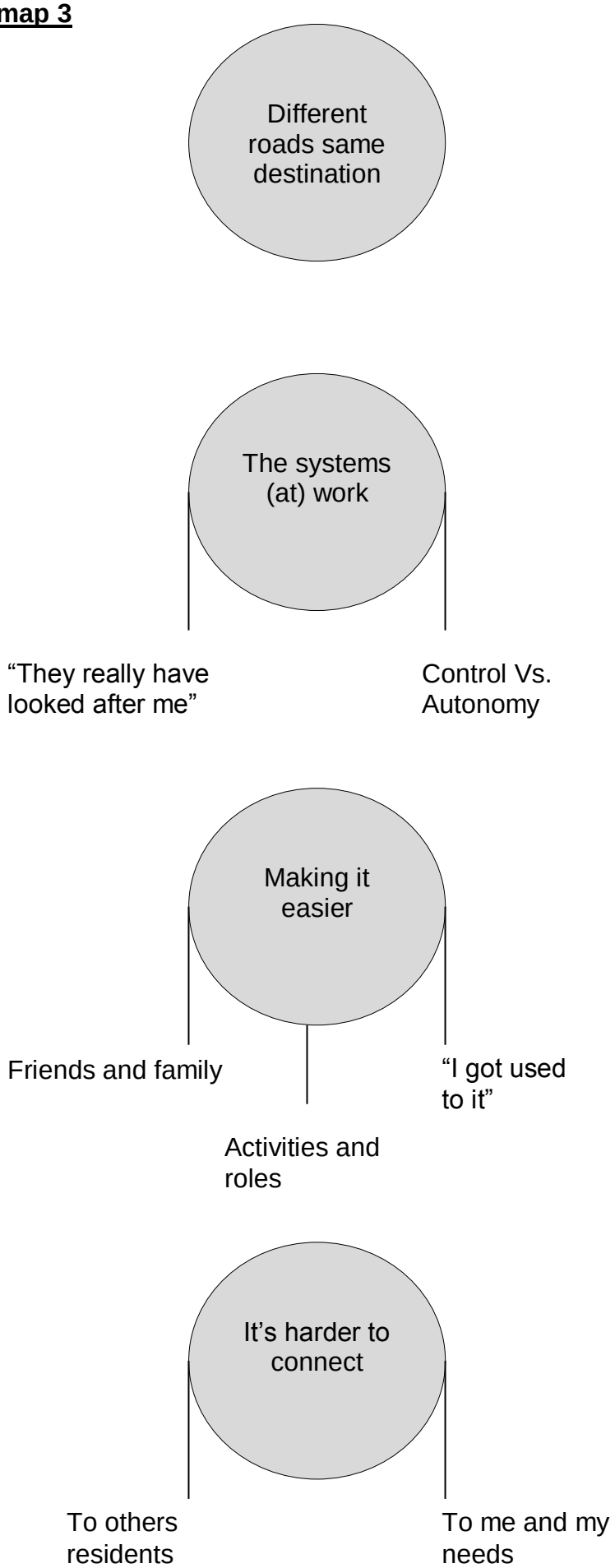








Thematic map 3



Appendix M: Braun and Clarke's (2006) 15-point checklist of criteria for a good thematic analysis

Process	No	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a onceover lightly.
Written Report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as active in the research process; themes do not just 'emerge'.

Appendix N: Sample extracts from reflective journal

Interview 1: Tom

I met with Tom for a brief introductory meeting at his care home and I was impressed with the autonomy he had in organising his own appointments and meetings. At this first meeting he wanted to talk with me about his war experiences and I wonder whether this will be something specific to his cohort. The home was quite large and as I left I heard screaming from a number of residents in the communal area. The other residents and workers did not seem too concerned so I wonder whether this was a regular experience. I think this would unsettle me if I lived here.

I come to see Tom again a week later and I am a little nervous, particularly as it is my first interview. I wonder how he will respond to my questions and I wonder what I will find out. During the interview I began to notice that Tom has a more concrete style in his thinking, he provides short answers and things seem either black or white. During the interview we were interrupted twice because staff wanted to check on him and bring him a cup of tea. The staff seemed nice and polite but I couldn't help but think that this was quite intrusive, though, Tom seemed used to it.

During the interview I was intrigued to hear about his experience of the female residents. Tom seemed to hold some negative beliefs about women and appeared dismissive of them in the home. In fact for Tom the women seemed to be the only negative feature of his life here. After the interview he tried to show me some jokes he had typed on paper. The jokes were quite sexist and this seemed in keeping with his negative experiences of women. I was not sure how to react to these jokes and I felt a little uncomfortable. I wonder whether I will have similar experiences with other men? I wonder if other men will share his beliefs? Does this tell me more about rigid gender roles that he may have been socialised to? Is this gender role socialisation more likely because of the time at which he grew up?

Interview 5: Bob

This was our third attempt at an interview, I hope Bob recovered from his illness and I was not imposing or too demanding of him. I wonder whether he felt comfortable talking or whether I should have waited and re-organised a time when he was stronger?

I met with Bob in his room and he seemed happy and despite a cough he seemed well. He said he was much better and was in hospital as a precaution. He does not like hospital: he finds the food and routines very trying. Bob's room seemed very nice, he has a door leading out into the garden and I can't help but think he must be well liked by management in order to have this opportunity.

During our interview it became clear that Bob has a special relationship with the home and a few members of staff. It seems he is unique, he does not have dementia like other residents and he has a role on a scrutiny panel for which he was invited. It is almost as though the staff have removed the normal barriers that are in place between residents and staff.

Bob appeared reflective and willing to answer any question that I posed. I am very interested by his close relationship with a female member of staff and I wonder whether he has romantic feelings for her? However, I did not feel comfortable asking this and I was worried that I may come across as disrespectful, so I did not find out.

Again we were interrupted on more than one occasion, with staff knocking and just bursting in without waiting for a response. This has happened in every interview, I feel very frustrated by it and I wonder what is going on? I wonder whether they are checking on me? Or is this just part of the daily routine and part of institutional living, giving up ones privacy. Bob did not seem bothered by it, I don't know if I would be so accommodating.