

An examination of older people's
experiences of moving to residential
care.

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Abstract

Moving to residential care assumes particular significance for the increasing numbers of individuals who find themselves in need of support as they grow older. This qualitative research examined the experiences of twelve older people, living in an East Midlands City, who had moved into residential care in the late 1990s. The semi-structured interviews with older people, examining the impact of life histories, were preceded by interviews with twenty-nine practitioners working across a range of health and social care settings. Practitioners were interviewed in order to hear their perspectives on relocation to residential care and to contrast their broad experiences and ideas with older people's. The older people had been living in residential care for different lengths of time, some weeks and some months. They were located in private, housing association and local authority residential care homes. Other methods included an examination of demographic data and reflective analysis through a research diary. The research is placed within historical contexts, undertaken five years after the introduction of the 1990 NHS and Community Care Act

This research highlights older people's experiences in the journey from their own private home to residential care. It discusses how older people experienced residential care, compares the perspectives of older people and practitioners, evaluates the influence of the life course and various social actors and identifies successful movers. In identifying 'successful' movers the research critiques earlier research that has assumed residential care to be a default choice and has not accounted for the range of qualitative experiences of moves and their outcomes. 'Success' is evaluated using a conceptual framework that draws from the concepts of homeostasis, resilience and reserve. Successful moves are defined as those in which the older person displayed a sense of homeostasis and balanced their internal needs with the external surroundings of residential care. To do this they needed to have enough 'reserve' in terms family relationships and social networks. Others who did not achieve homeostasis did not possess sufficient reserve to feel comfortable in their surroundings but still utilised some coping strategies and had enough resilience in order to cope in the setting. Interviewed practitioners were unaware of the range of older people's responses to relocation and lived in very different conceptual worlds.

Whether older people were successful or not the research's contributions to knowledge include the finding that for some older people residential care was more of an active choice than a default one. They found an active expression of their own wants and needs, challenging the idea that community care is always preferred to residential care. The research also discovered that older people, whether achieving homeostasis or not can still show resilience within such settings and did this through family, social networks and coping strategies. The findings inform policy and practice by highlighting how older people can utilise resources to sustain themselves within residential care.

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Introduction

This thesis is concerned to know more about older people and their moves to residential care. The overall aim of the research was to find out what influences these moves, how older people manage change and make sense of living within residential care. My journey through this research saw me start with a wish to know more about residential care and older people's responses to it. Existing literature had provided a certain amount of understanding but there appeared to be a gap. I wanted to learn about older people's conceptual worlds and how they perceived their move and the setting in which they found themselves. I wanted to know about their experiences before and since relocation. I also sought to understand practitioners' perspectives on relocation and to compare and contrast their outlooks with those of the older people. The findings may help practitioners understand how older people adapt not only to residential care but to changes in their living circumstances. This has relevance for whatever settings older people may move to, residential or community based.

Relocation to residential care is singled out for study because within the context of demographic change it has an ongoing significance not only for some older people but also for family members and others involved in their moves. Older people will make a number of different kinds of moves in relation to care needs and this research highlights some key issues concerning the service delivery at these times. Practice needs to know about how older people potentially experience multiple stresses that may be associated with moving to residential care. This will enable more informed and timely interventions which manage older people's transitions more effectively.

I started the research as a qualified social worker who had experience of working with older people across a variety of settings. This experience had led me to form some impressions of older people's experiences and of the role of social work and social care in helping to shape their choices. I had worked for a housing association that provided housing for older people and had undertaken physical care work with older people in a residential setting. I had also carried out social

work in a residential care home, managed an information and advice line and counselled older people. This experience working with older people within different contexts has allowed me to develop a practice and personal experience of the issues and choices affecting older people and the ways in which some older people appeared to manage these choices. The research commenced in the late summer of 1996. The 1990 NHS and Community Care Act became operational three years before I commenced the thesis and five years before I started the fieldwork. This Act presumed that the ideal place for older people was their own private home and that this was the place where people felt the most comfortable (Barradell 2001). 'Home' was seen to represent independence and this was seen as the preferred choice. I was aware of a body of literature that suggested that institutions had adverse effects on people (Goffman 1959, Townsend 1965, Robb 1967, Libermann and Falk 1971).

I was also aware of emancipatory approaches to social work practice and research (Humphries 1997, Barnes 2001) that are critical of institutional living and was keen not to seek to 'justify' residential care. Townsend's (1962) research gave important recognition of the oppressive features of residential home living and it is important that research should not pathologise the experience of older people by suggesting that older people *should* accommodate experiences that may be oppressive.

I was keen to recognise these perspectives but also be prepared to question them or be alive to the possibility that there was much more to know about residential care than existing literature or theoretical approaches were prepared to recognise. My academic and practice experience had led me to question any presumption that the private home was necessarily the 'ideal' setting for older people. The older people I had worked with varied a great deal in their experiences and attitudes. The times I had listened to them talk about their lives prior to residential care, and to hear them contrast their lives then with their lives in residential care, made me question any assumptions about 'ideal' independent lives in 'ideal' private homes.

I saw no reason why it was desirable to assert that any given setting was ideal for all older people. Policy and practice may have moved in the direction of

community living, but this did not mean that all older people had necessarily done so or that they all even wanted this change. It was necessary to examine the thoughts and life experiences of older people and to hear their 'voice'. It was necessary to know not only why older people made the move to residential care, what affected it and what factors contributed to their admission, but equally how they made sense of their moves subsequently. I wanted to know not just about the desirability of the setting but to explore how older people reacted to the setting that was residential care. It was about exploring the nature of that relationship, if they felt any sense of community or belonging within residential care and if so what factors contributed towards it. I equally wanted to know of any difficulties they had within residential care and if they struggled to adjust.

Structure

The thesis, excluding this introduction, is divided into eight chapters. Chapter One reviews research related to older people and residential care and situates this thesis in relation to a body of knowledge. The review starts with a description and discussion of the literature review process. This highlights how I reviewed the literature and identifies the search terms that guided my review (reflecting my conceptual thinking), and the search tools that I utilised. I then describe the status of some of the key texts identified as relevant, distinguishing between published research, journalistic sources or otherwise. This is vital as it locates my work in relation to other research and literature. The review then offers a critique of the seminal work on older people and residential care by Peter Townsend (1962) and moves on to consider other subsequent work that has considered older people's relocation to and progress within residential settings.

Chapter Two identifies the policy contexts in which the research was undertaken. The work was undertaken over an extended period in which various policy developments took place. It is therefore necessary to situate the research within the time line of policy development from the 1990 NHS and Community Care Act to more recent policy initiatives. Whilst the research was interested in older people's conceptual worlds, and how they compared to those of practitioners, it was also necessary to locate these experiences within a world of policy and practice. These would have some bearing on the choices of older people and it is

necessary to understand which policies have occurred since the fieldwork was undertaken so that the choices the older people made at the time of the fieldwork are understood within their appropriate historical context.

Chapter Three outlines and discusses the methodology and methods adopted. My interest in an exploration of older people's conceptual worlds led me to adopt an essentially qualitative approach. It was interpretive and sought explanations of the 'lived experience' (Von Manan 1990, Denzin and Lincoln 1998). The research sought to give voice to older people but also wanted to hear other experiences and the chapter outlines interviews with practitioners as well as examining demographic data. Whilst the policy framework and the research literature provided context, practitioners' voices provided contrasting perspectives to those of the older people.

Chapter Four introduces the practitioners and the older people that were interviewed taking into consideration gender, age, social class and ethnicity. The research seeks to understand any patterns within their experience, together with similarities or differences between the older people in terms of their background and how these backgrounds influenced not only the moves to residential care but also their progress since moving there. I also sought to outline the roles and responsibilities of the interviewed practitioners, for these would influence their perspectives. Early, mid and late life change is evaluated by tracking some older individuals' moves to residential care and their reflections on their own experiences are contrasted with those of practitioners. Individual lives are explored within the contexts of wider social, economic and historical changes.

The demographic and policy contexts receive ongoing examination in Chapter Five, which discusses the different perceptions of the reasons why older people entered residential care. The chapter provides contrast between the perspectives of older people and practitioners as it tracks the journey of older people moving from their own private home to residential care. I identify critical incidents (Edvardsson and Roos 2001) and turning points in these moves and compare different perspectives on the relative importance of such events. Chapter six examines issues of power and influence as the relative influence of various 'social actors' is considered. I was concerned not to presume that any particular

relatives or practitioners were influential but to explore the nature of older people's relationships with these various social actors. Like others, this chapter considers the different perspectives of older people and practitioners. Chapter seven discusses the outcomes of moves to residential care and the final chapter eight presents conclusions and reflections.

Chapter One: Literature review

This thesis seeks to improve understandings of how older people experience moving to and living within residential care. This review critiques previous research to suggest how it has contributed to understanding moves and identifies the gaps in understanding that my thesis seeks to fill. The chapter has four main research questions and highlights the extent to which previous research has helped answer these questions. These four questions structure the chapter, which is divided into five parts. Parts one to four review the research questions and the fifth part outlines concepts used to analyse the data.

The four questions are

- **How are older people's experiences in moving to residential care to be understood?**
- **How do older people's perspectives on residential care compare to those of practitioners?**
- **How is older people's experience of moving to residential care affected by past life events, significant others, personal choice and other factors?**
- **To what extent can we talk of 'successful' moves to residential care and how is success to be conceptualised, measured and explained?**

The review process

The focus of the review process was driven by these four research questions and in particular by my commitment to understanding how these older people understood relocation to residential care within the context of their life in the present and their life histories. I undertook a data search and review of the literature at a very early stage of the work, prior to fieldwork. This was an early examination of the evidence and it helped me to generate ideas, to build on these early conjectures and helped me to shape the research questions. I was concerned to know what the literature was saying about issues of relocation. My conjectures

from earlier academic and practice experience centred around the idea that the literature was dominated by concerns about the unsuitability of residential care and supported community care. My initial searches involved examination of databases and book catalogues and produced a range of material on the lives and circumstances of older people, on issues of care in the community and residential care. Material on transitions and crisis theories also helped me to highlight issues of care and the community and broad issues of social gerontology. I therefore went into the fieldwork able to test out some theories on the desirability or otherwise of residential care for older people and the reasons they were in such settings. The questions that made up my interview schedule were shaped by these broad conjectures and these early literature reviews. I was also keen to generate theory from my interviews (explained in more detail in chapter 3 on methods and methodology).

I then undertook further literature searches during and immediately after the fieldwork was completed and these further enquiries identified the importance of the concept of 'homeostasis' (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002). This refers to the way individuals balance their internal wants and needs with their external surroundings and was a useful concept with which to analyse the relationship the person had or has with residential care. I identified this concept from wide literature searches concerning issues of coping and adaptation in residential care. Nottingham Trent University databases were scanned as was the book catalogue. I used terms such as 'coping' and 'adjustment' and although I only found some key references to 'homeostasis' they were still highly relevant to the work and consistent with my initial literature search findings and my emergent analysis as I undertook the fieldwork. The data analysis was informed by theories of homeostasis and other related literature on coping, adjustment and relocation to residential care. These terms were not prominent in the presentation of the PhD for the first viva as I focused on issues of emancipation rather than homeostasis. This focus was re-evaluated as I undertook major revisions for the second viva and returned to the original theoretical base that informed the thesis from the outset. This was more consistent with and true to the original data and the research strategy.

I focused in this later version of the PhD on the themes of coping and adjustment, ideas prominent in the earlier phase of the doctorate. I searched for terms that would assist the analysis of the older people's ability to adapt to residential care. My search terms included words such as 'coping' and 'adjustment' and this generated literature on the concepts of 'resilience' (Vandsberger et al 2005) and 'reserve' (Grundy 2006). I added these to the existing body of knowledge that I had identified at the earliest stages of the review, prior to the fieldwork. These terms were identified as relevant from extensive searches of databases. Both concepts, discussed in more detail at a later point, referred to how older people may cope in their current surroundings and the resources in terms of social networks they could utilise. Whilst homeostasis was familiar to me from previous analysis of the data resilience and reserve were concepts derived from this more recent analysis and literature review. It is necessary therefore to describe and then reflect on how I identified the sources that were eventually used in the analysis of the data for the presentation of the thesis at the second viva. This will now be detailed.

I consulted various databases via the Nottingham Trent University Library and Information Services Catalogue. My interest in understanding issues of relocation to residential care led me towards databases relevant to psychology, sociology and the broad interface between health and social care. My 'e-search' of the databases started therefore with examination of various categories of databases grouped under the heading of 'psychology, sociology, health and social care'. These databases had relevance to issues of demography, health and social care policy and practice as well as psycho-social issues of relocation. There were various databases grouped under this broad category with sub-sections including 'environmental health and safety', 'health and social care', 'psychology and counselling', and sociology. There were in total fifty-four databases. I scanned these for relevant articles and found the most relevant databases included ASSIA (Applied Social Sciences Index and Abstracts), BHI (British Humanities Index) and IBSS (International Bibliography of the Social Sciences). Other databases interrogated included Social Care On-line, Social Services Abstracts and Sociological Abstracts. I was interested to find research based articles but other literature of a journalistic nature could provide additional insight. I also searched Nottingham Trent University's book catalogue and made use of their

inter-library loan service in instances where I found potentially important literature held at other universities, identified from the databases, which were relevant to my thesis. I also searched internet sites such as the Department of Health and Age Concern, amongst others for other sources of material.

I had some existing references to homeostasis (as a result of my earlier reviews prior to the first thesis/viva presentation) but searched for other sources to compliment them. I searched across multiple databases initially searching for the key concept of 'homeostasis' and generated around 150 'hits'. The vast majority, perhaps 140 or more, related homeostasis to natural science with references to issues of balance and equilibrium within the human body but without the social relevance. There were, however, results that displayed research related to balance within organisations, well being and life satisfaction measures, although these searches did not highlight the concept in relation to 'health and social care', 'older people' or 'elderly'. I was to find more relevant references to homeostasis from book searches to other library catalogues from other East Midlands universities. I also searched for other concepts relating to adaptation and coping within residential and community settings and found a range of literature. In addition to this, I was also interested in literature that would identify practitioner perspectives on older people and residential care. There were few references to these issues despite searches identifying key terms such as 'practitioners' and 'residential care' or 'nurses/doctors' and 'care of elderly'. The literature searches did generate 'hits' when searching with such search terms as 'transition/residential care/relocation' and revealed comparable research, although relatively little of direct relevance to my subject.

I also attended the Social Policy Association Conference in Edinburgh in the summer of 2008 and identified further research into issues of resilience in later life, although in non-residential rather than residential settings. The combined effect of all my searches of databases was that despite extensive searches little literature focused on measuring outcomes of placements into residential care. There was little concerned with evaluating relocations without the presumption that community care was a preferable location for older people. Some evidence is drawn from disparate sources such as feature articles in magazines, small scale research studies or evaluations focusing more on reasons for relocation than

evaluation of placement in care in terms of older people and their progress in care. Some material was also rather dated such as Barbara Robb's (1967) book. Robb's book was, it must be acknowledged not in depth or published research. Leeson's (2005) work was journalistic rather than published research. Some research was international and much research was more focused on health than social care settings. There was a paucity of published research relating to how older people experience, adjust or adapt to residential care. There was little research that identified factors that lead older people to be in care and this only served to enhance the value of my research in terms of its contribution to knowledge.

The following literature review is arranged under each of the research questions in turn.

- *How are older people's experiences in moving to residential care to be understood?*

Research has often supported the findings of Townsend's (1962) study in portraying older people's move to residential care in distinctively negative ways. Various literature has often cited the adverse affects of institutions from Barbara Robb's (1967) book which explored the marginalisation and mistreatment of the elderly to a recent report by Age Concern (2008) which suggests that the human rights of older people are being violated across care settings. The most famous piece of research which influenced much thinking on residential care and how it is assessed and evaluated was Townsend's study. This built on his earlier (1957) research in which he studied the life of older people living at home with their families. This later work aimed to fill the gaps in knowledge by focusing on life within institutions for the elderly. The study was carried out within a certain policy context in which residential care was perhaps the only choice made available. Townsend (1962) informs us that governments in the post-war era were concerned to end the workhouse system and build smaller residential units where care was more personalised.

Various forms of residential institutions were visited as part of Townsend's research, including small and large homes, homes run by voluntary groups and

some private homes. The research included interviews with various staff that worked in the homes and for the local authority and this material contextualised the latter findings from interviews with the older people. The interviews with the older people included questions on home, family, physical health and capacities, occupations, social contacts, reasons for entering institutions and also responses to the move. The research drew upon statistical data from a wider sample in order to draw conclusions concerning care provision on a national scale.

Townsend's research reported on older people's experiences of relocation in negative ways. The research did not highlight or reflect any positive experiences but instead viewed moves and their aftermath as times of loss and disruption. This may have been partly due to the circumstances in which the older people moved into the homes. The research reported that older people appeared to have been given little choice and decisions were taken after a 'superficial examination of the facts' (1962: 128) by the welfare officer dealing with the cases.

Communal and private living has often been constructed differently in public discourse with 'home' constructed as a place of freedom, and 'care' as restrictive. Miller and Gwynne (1972) talked about people being 'warehoused' in institutions. Much subsequent literature has framed residential care in negative ways and understood older people's moves to care as negative status passages. We can see from *Table One* how much research has associated residential care with decline and loss of autonomy. Townsend made associations with social isolation, homelessness and poverty. Clark, Dwyer and Horwood's (1998) study involved in depth, loosely structured interviews with older people in their own homes. The research also involved group discussions with various pensioners' pressure groups. The research found that older people saw residential care as a default choice, a negative consequence of the withdrawal of services such as home care. The research did not discuss assumptions concerning the relative value of home and residential care but dismissed this as a line of enquiry, presuming it to be a default choice. Other research has given residential care negative associations and cited these as significant factors leading to admission, ranging from Wright's (2003) reference to 'illness' and fear to Morgan et al's (2006) 'erosion of autonomy'. Only Reed et al (2003) gave some recognition of issues of choice.

Table 1: Previous research and their findings: how they understood the reasons for moving to residential care

Researcher (s) and year of research.	Location for research	Type of Research and nature of respondents	Explanations for moving to residential care
Townsend (1962)	180 residential care homes across England and Wales	Semi-structured Interviews with older people in care homes. Scrutiny of case records.	Social isolation, homelessness, economic insecurity and inadequate domiciliary care.
Clark, Dyer and Horwood (1998)	Three local Authorities In South of England	Semi structured Interviews with 51 older people In their own homes	Withdrawal of home care.
Reed et al (2003)	Care homes in two local authorities in North East England. 44 residential homes 12 nursing and 26 Dual Registered homes.	Multiple methods: demographic data, focus groups and individual interviews with care home staff and semi structured interviews with older people	'Push' and 'pull' factors- various factors cited as reasons for moving to residential care .Some older people were able to exercise choice and autonomy in their decision making whilst others did not.
Wright (2003)	28 Independent care homes in the voluntary and 'not for profit' sectors 22 residential, 1 nursing, 5 dual registered.	Postal questionnaire to finance officers of social services. In depth interviews with other staff. Included 15 care managers, 6 legal advisers Interviews with 28 self funded residents of residential care homes.	Illness, inadequate support at home, fear, attitude of relatives.
Morgan et al (2006)	One residential care home within the UK (specific location not disclosed)	Interviews with staff, family members, other professionals and two older women in their late 80s living in a residential care home.	Erosion of autonomy, frailty, illness. The effect of earlier life events.

Townsend (1962) cited homelessness, poverty and lack of savings as factors leading an older person towards admission. Many either had no home or had an

insecure tenancy, with an income insufficient to give them other housing options. He also found a correlation between housing conditions and the likelihood of being vulnerable to residential care. Poor housing was a factor in old people's admissions, although loss of home or social isolation were found to be more significant factors. Townsend was very concerned with issues of social class and also income and its relationship to residential care home admission, remarking that 'economic insecurity' has a marked influence on the patterns of admission to residential institutions (1962: 169).

Moves to residential care were understood negatively but any critique of Townsend's work must acknowledge that social and economic realities provided specific context to his findings. He constructed perhaps convincing arguments when suggesting links between poverty and entry to residential care in later life. This does not mean however that all populations of older people were expected to move under these circumstances, neither are they expected to do so now. There are different contexts, choices and circumstances which have the potential to make some moves default options and others the product of positive choices. We would however need more research to be sure of the kind of relationships between poverty and the likelihood of entry to residential care in later life. Any statements about this relationship must be made with caution. We must be careful not to assume that people who moved to residential care at the time of Townsend's study, or at the time of my research in the late 1990s, are necessarily in some form of deficit or that they move to care because of reasons strictly related to poverty.

There may be correlations between income, social class and the likelihood of entering residential care, but that does not mean that care is the inevitable outcome of a life of poverty. Whatever the meaning of 'home' and 'care', the move to residential care has often been conceptualised as a time of loss. From the 1950s onwards there has been a great deal of literature that pays attention to the lifestyle of people within institutions who were old or had mental health problems (Barton, 1959, Townsend 1962, Morris 1969, Miller and Gwynne 1962). This literature highlighted the homogeneity of daily living, the lack of choice and personal autonomy and the distance between the world of paid workers and residents.

Goffman (1961) talked about the so-called ‘totality’ of institutions where all aspects of daily life are carried out under one roof and where the same group of people were all treated alike. Miller and Gwynne (1972) refer to the idea of ‘warehousing’ people in which institutions simply focus on prolonging life but no more than that. Leeson (2005) undertook some interviews with older people in residential care homes for a journal article, identifying issues of depression in residential care. Her evidence cannot therefore be regarded as carrying equal weight to that provided in published research, although her findings still have value. She found that residential care represented loss to the residents and was linked to the onset of depression in care homes.

Townsend does not identify depression or complex emotional responses to residential care but instead refers to ‘family’ or ‘lack of resolve’ as factors effecting older people’s relocation without discussing the meanings of these terms. The focus on the depression of older people within residential care has less stereotypical connotations than simply talking of or assuming advancing frailty (Morgan et al 2006) or ‘lack of resolve’ (Townsend 1962). These two sources of evidence are rather different, drawing on different types of enquiry, with Townsend’s research more substantial in terms of the depth and breadth of his investigation and the reliability of his data, and any comparison of the evidence must be made with caution. Very little research, Leeson’s journalistic piece aside, has focused on the complex relationship between the older person and the environment of residential care. There has been little investigation into how he or she manages to balance their own wants and needs within that setting. Nevertheless, Reed et al (2003) do cite the work of Groger (1995) who found that nursing care can appear or feel like ‘home’ depending on three factors: firstly, the circumstances of the placement; secondly, the residents’ subjective definition of home; and thirdly, the continuity achieved after moving to the home,

This recurring theme of residential care represented as a place of loss and disruption, highlighted in Townsend’s (1962) work, is featured across a range of subsequent research. Clark, Dwyer and Horwood (1998) found, for example in their research with older people in three local authority areas in the South of

England in the late 1990s, that older people feared residential care and saw it in a negative light. The research stated that older people valued 'low level preventative services'. The study sought to identify if or how the provision of 'low level' support may prevent the 'need' for residential care. They found that the older people wished to remain in their own homes rather than move into institutions and made a clear distinction between being at home and being in a residential care. Being *at home* was seen as representing the exercising of choice and control. The research suggested that the maintenance of services such as home care were very important to older people in lessening the possibility of moving into residential care.

Clark, Dwyer and Horwood's (1998) study refers not only to 'loss' and 'disruption' but also to older people's perceptions of the change of location. They see the meanings of private and communal living as significant for how older people may experience moves. This is a welcome development in understanding moves, seeing one setting and its meaning in relation to how other settings are perceived, even if residential care is viewed in an uncritical manner as something negative. This was not something reflected in Townsend's research and in this sense moves understandings forward. These arguments need to be seen within wider contexts. If we are to understand the meaning of residential care and the experiences of moves then we must not only understand the relationship between 'home' and 'care', but also the relationship between the individual and residential care. Clark, Dwyer and Horwood (1998) may recognise contrasts in how the private and residential home are viewed, but do not recognise the possible variation in older people's understanding of home and care or how individual wants and needs could be met in either setting given their individual histories and the particular nature of the setting concerned.

Later work also reported residential care in negative ways and understood older people's moves to residential care as something undesirable. Morgan et al (2006) analysed the moves and life histories of two women moving into residential care. The moves were analysed using field notes from social workers and other social actors but, unlike in Townsend's work, their housing and life trajectories were examined. Both resided at a small private care home although they had taken different routes to get there and their stay in this home was just one in a series of

former moves. They had both experienced various transitional events from falls to hospitalizations. Both were over aged 85 years, were white and had multiple health conditions. These moves were taking place in a very different context within a very different policy and practice climate, but still highlighted the deficiencies of care settings in terms of their ability to respond to individual need.

Unlike Townsend, Morgan et al (2006) investigated the personal relationships, social events and individual life histories leading up to old people's admission to try to get a more holistic understanding of their moves. One of the older people had dementia and this appeared to challenge her sense of autonomy as she made moves from one care facility to another. Each move weakened her resolve still further. She made a succession of different moves as her physiological condition deteriorated and the research referred to the failure of various care units to respond to her and her life history in ways that acknowledged her individuality. The other resident moved to a residential unit for medical reasons and also because the older person believed that her daughter was 'influential' in pushing her into care. Each move represented a continuing battle with her daughter whom she claimed challenged her wishes to make her own decisions.

Morgan et al's (2006) research reported the two women's experiences but in both cases, unlike Townsend's (1962) research, did not focus exclusively on portraying care itself as negative. Instead, it considered how older people were suited to each setting and evaluated practitioners' interventions as they moved. As the women's situations changed, finding places to fit their needs and respond effectively proved difficult. The facilities did not necessarily respond to the choices and wishes of the older people in terms of their meal choices, privacy or wishes to take risks.

The research acknowledges these issues more consistently than Townsend, but like Townsend it did not report on any positive experiences or times when the older people negotiated change more effectively, and instead focused on the inability of care settings to respond to the richness and variety of their life histories. Moves were still portrayed as events representing losses even if the life courses of the two women were offered as contexts within which these decisions

were made. Both pieces of research offer a negative view of residential care, even if the latter work considers the interaction between the person and their environment in a more holistic way. They both saw residential care as something that represents a deficit in itself rather than in relation to the individual and his or her aspirations.

In an article published in *Community Care* Leeson (2005) found that depression in care homes was associated with the routines of the care home and the way care was administered. The article develops our understanding of moves by linking reactions to late life change and moving to residential care with earlier life events. She suggests that a key factor in older people's moves is that many older people see moving to residential care as an unwanted life event and that this, combined with other losses in their lives happening in quick succession, leads to depression. She also suggests that the actual environment of care plays its part in this depression, although she does not explain or expand on this point. There is some reference to an older person's inability to take part in activities and she suggests that poor relationships with other residents and staff can affect their experiences in negative ways.

Leeson highlights how organisational and funding issues can be factors in shaping how far a move is 'successful'. More problematic moves are for her ones in which there are wider constraints, again moving the discussion on from simple associations between loss, old age, frailty and unhappiness in residential care. She said that well being was linked to how activities were organised as much as the 'reality' of residential care in itself as an institution. There was some focus on the interaction between the individual with a specific life history and the institution. There was however nothing to suggest from the research how depression was linked to the interaction or the balance between the individual's life history, wants, needs and their particular setting. This research did not seek to understand the complexities of these relationships between the person and the setting and the variation in response to residential care.

Wright (2003) studied the experience of self funding residents moving to long term residential care and found that not all the older people looked upon residential care in negative terms. The research, which aimed to identify the key

issues for local authorities, care home providers, self funding residents and their relatives, found that as people get older and frailer attitudes to residential care can change. The majority of the sample had not received any paid care support prior to admission and this lack of support was cited as a reason for admission to care. However, many of the residents interviewed said that residential care had been an option not so much because they could not access physical care support at home, but because they did not want to live alone. The research made contrasts between their previous lives at home and life in residential care to suggest that for many the care home represented a place where there was less pressure to cope, even if they did not report many difficulties living at home in a practical sense. The research in that sense commented upon how far residential care helped older people find solace within residential care, even if it did not go into much depth in analysing these psycho-social aspects of relocation or consider the impact of events through the life course on these attitudes.

Reed et al (2003) also found in their research that residential care is not necessarily a negative experience. They did not talk about the significance of the life course in determining if the older person managed the move or their subsequent progress in residential care. The research focused instead on events leading up to residential care. It featured interviews with older people living in residential care homes in North East England. The study wished to understand the experiences of relocation in relation to residents' individual needs and preferences, but also in relation to the organisational behaviours of those involved in their relocation. The research looked at assessment and placement processes and also family dynamics. It found that the process of moving was as important to older people's welfare as to the nature of the residential unit itself and the exercise of choice in the process was fundamental to their subsequent well being. The research concluded that residential care itself may not be the problem, but the way in which it is selected that is key to older people's sense of well being. Older people need to be able to make active choices concerning their living environments.

Reed et al (2003) did not view residential or nursing care as necessarily negative in ways that Townsend (1962) and Morgan et al (2006) did. Townsend (1962) expressed older people's experiences as those of loss and disruption in which

'resolve' is weakened, which is perhaps a similar theme to Morgan et al's (2006). They associate residential care and the time of change leading up to the move with advancing frailty as well as loss. Reed et al (2003) does this without expanding on the reasons why frailty and loss are so important or the details of the psycho-social aspects of what this loss entails or how it is experienced.

- *How do older people's perspectives on residential care compare to those of practitioners?*

My extensive review of databases has identified that there has been little research that has contrasted practitioners' with older people's understandings of residential care. Townsend's (1962) research included interviews with welfare officers in which their roles in trying to help older people remain in their own homes were examined. Whilst the research did acknowledge that residents and staff of the residential care homes had different perspectives, the research did not consider these issues in great depth. The emphasis was, however, on the role and tasks of staff. It did not seek to understand older people's or practitioners' perspectives on the relationship between home and care.

Townsend (1962) and his research team visited residential care homes across England and Wales between 1957 and 1961 interviewing welfare officers and residents of care homes. They wanted to explore the lives and circumstances of older people in modern society and to understand the effects of social change on older people. The research team were outsiders in that they did not work in or with people in social or health care. They had a political orientation and motivation to do the work. Reed et al (2003) were researchers working within the Centre for Care of older people at the University of Northumbria. They were more concerned with the health and social care needs of the older people they interviewed. They wanted to know about assessment and placement processes and were more on the 'inside' in terms of health and social care. They did not have the same political motivation or have the same sociological interest in the lives of the older people than was apparent with Townsend.

Wright (2003) reported on the senior finance officers' and care managers' perspectives on funding issues and how financial matters affected choice of care home, but did not explore wider issues relating to residential care or contrasting perspectives.

Morgan et al (2006) did to some extent contrast the different perceptions of relocation when his interviews with two older people who had moved into residential care were supplemented by interviews with staff, family and other related professionals. The research involved various methods including analysis of notes from social workers who provided direct services to these two individuals over a period of time, although like Reed et al (2003) and Wright (2003), it was only to provide contextual data rather than consistent comparison of different perspectives of service users and practitioners. Along with research from Townsend (1962) to Morgan et al (2006), does not offer competing perspectives on the reasons older people move to residential care or contrasting views or experiences of the process of relocation.

- *How is older people's experience of moving to residential care affected by past life events, significant others, personal choice and other factors?*

Townsend suggested that a lifetime of poverty had a cumulative effect on older people who were thus made more vulnerable to residential care. In this sense, he showed some recognition of the importance of life time events on the experience of relocation to residential care. The older people's past experience of housing in the years preceding residential care may be more 'significant' for the older person than their age or more immediate circumstances preceding the move. The decision to move can be linked to various events throughout the life course, both positive and negative. Increases or decreases in income have been found to be factors shaping decisions to relocate (Clark and Huang 2003) as much as factors related to ageing. These changes are accompanied by different expectations and meanings about 'home' and 'care' (Gurney 1993, Tinker et al 2001).

Residential care generates a range of emotional responses and so does the domestic home. However, it is important to point out that, rather than assume each setting is negative as Townsend appears to have done in his early work

(1962), it may be more helpful to understand the complex way in which home, including residential care, and personal identity are indelibly linked (Means and Smith 1998, Butler and Parr 1999, Morley 2000). 'Home' is as much a psychological concept as a physical space (Case 1996). People have abstract and emotional attachments to their homes (Butler and Parr 1999) but research needs to identify the meaning of 'home' in relation to residential care and vice-versa for each individual. Gurney (1990) argues that the meanings of 'home' can be specific to experiences at certain moments in time. Morley (2000) informs us that childhood memories and identity throughout the life can be associated with 'home' Those memories possess social and cultural meanings, but also can be deeply personal.

Morgan et al's (2006) study cited the effect of many life history events over the ten year period preceding entry into residential care. The study found that the erosion of the older people's autonomy with advancing frailty was a major factor, but that these changes happened gradually rather than suddenly. Other research (Miller and Gwynne 1972) also found that earlier life events had an impact on their moves. These included personal relationships, social events and family histories. This research looked at people entering both residential care and sheltered housing. They studied the impact of various life events on their eventual move to care and unlike Townsend (1962) acknowledges the impact of life histories in a more substantial way. The study talks about concurrent moves having a negative impact on their ability to control events. Morgan et al (2006) talks about the inter play between individual lives and wider social factors impacting on moves. In that sense, Morgan et al (2006) are less deterministic than Townsend (1962) and they offer a more detailed analysis that gives more credence to psycho-social factors in older people's lives and more immediate events leading to care than Townsend, although it is perhaps more negligent of the wider issues of poverty and homelessness.

Morgan et al's (2006) study does mention economic and familial constraints and the way they can limit older people's choices, although these are mere passing references. The work acknowledges how the patterns of people's individual experiences can shape relocation without acknowledging commonalities of experience. Individual reasons included those related to reduced functioning and

factors such as undiagnosed dementia and existing mental illness. There was diminishing personal autonomy, although these are perhaps over-emphasised in the explanations. The study illustrated its points with reference to one particular case study and talked about the experience of one older person. This older person had a declining ability to find places that suited her as her vulnerability became more intense. It does not however explain what vulnerability means in this context or recognise how housing choices may have limited her.

If we look at Townsend's work it is possible to see that he saw the influence of others on older people's relocation to care in negative terms in the sense that he identifies a lack of influence from close relatives and friends. He found that family structure and status go some way to explain the lack of social security felt by many older people moving to residential care. The fewer the relatives are, particularly the absence of a son or daughter, the greater is the likelihood of going to live in residential care. Townsend also found that the death of a close relative had a profound effect on the likelihood of living in residential care. He also reported difficulties within relationships, with relatives 'squabbling' over who should take responsibility for whom in terms of care.

Whilst Townsend identified the negative influence of relatives and socio-economic realities on older people's moves to residential care Reed et al (2003) analysed the influence not only of other people in older people's moves but the self-determination of older people in ways that Townsend did not. They suggested that there are various 'push' and 'pull' reasons for moving between care homes. Push factors are those that forced older people into residential care, and may be reactive to the current environment such as housing becoming unsuitable, as in Townsend's analysis.

'Pull' factors are those that attract people to new environments such as proximity or ease of access to amenities or families. Pull factors suggest that older people are making active choices to move to homes, targeting homes that they believe will be more satisfactory for them. Wright (2003) does not acknowledge this sense of being active in stressing strongly how older people can buckle under the intense pressures placed upon them from relatives. It may be that some older people lose a sense of their own autonomy and may appear powerless, but

older people may also take some control over their own decisions and it is important to recognise this possibility.

Liu and Tinker (2003) may have studied the experience of people moving into nursing care in Taiwan rather than the UK but their study still highlights issues of 'push' and 'pull' and in exploring the family context of decision making in the process of admission to a nursing home. They employed survey data from interviews with older people in nursing homes and their carers and key family members. They explored perceptions of alternatives to nursing care among family members who had relatives in nursing homes. This research found that decisions were made within a family context with the family considering their own views about alternatives to nursing care. Reed's (2003) push and pull factors were not in evidence, for it was more a case of joint decisions being made within the family concerning the resources available to them to help their older relative. The findings have to be placed within some kind of context and the lead role played by the son in family matters in Taiwanese cultures must be recognised. The research found that the son played this key role although the family as a unit still had an important say. DeMuth (2004) says that cultural values, transmitted through the family and community, influence the way each person manages the gains and losses of every stage of life.

Research by Sandberg, Lundh and Nolan (2002), carried out in Sweden and involving interviews with adult children, found that family care givers waited until their parents had made their own decisions before intervening. The caregiver spouse would often take the lead with children trying to create an atmosphere within which their parents could at least discuss the ideas in a sympathetic context. Once the initial decision had been reached, the children worked to ensure that a suitable home was selected. Often many siblings took on this advocacy role and would work in a collaborative fashion. They 'pushed' in taking active roles, but older people also expressed something of their own wishes and choices; these were 'pull factors' in evidence as they kept some control.

Children also often took an active role in helping the older people settle in and this activity took on two forms: first, supporting the couple's efforts to sustain

their relationship and second to encourage and adjust to new roles and relationships with staff at the home. The study by Liu and Tinker found that elderly patients and their families who were interviewed experienced a number of different circumstances and events that made the older person more vulnerable to entry to a care home. Their interviews with 235 elderly people in nursing homes in Taiwan found numerous physical reasons for entry to residential care. They found that physical disability, leading to strokes, falls, fractures and hypertension, was a factor, but it was the inability of the family to care combined with the physical deterioration of the older person that were the most significant features in the older people's admission to care.

Their vulnerability to residential care, in the sense of being potentially physically vulnerable and losing the ability to be independent, does not necessarily have to be linked to their age or ageing. This is said with recognition that later life does involve greater exposure to specific challenges (Grundy 2006). This does not mean that research from Townsend (1962) to Liu and Tinker (2003) that refers to old people's vulnerability should be taken as an indication that they are always vulnerable and in that sense susceptible to residential care without any resources or capacity for resistance. Indeed, older people may move for what Reed et al (2003) identified as 'strategic reasons'. Reed et al (2003) found that in these situations the older person was active in his or her search for a new place.

Morgan et al (2006) discussed how older people are active rather than passive in accepting what happens to them, or what others make happen for them. Reed et al (2003) also usefully recognise the ability of older people to make their own decisions when saying that some residents were more reluctant to move, thereby expressing their own 'voice'. These were people who were reassessed and after this reassessment were sent to a nursing home. They were relocated on the basis of this and had less choice. Some respondents in Reed et al's (2003) study were fairly passive in the decision making process. Reed et al indeed stress how relocation between care homes is a most complex process and that each move reflects the different ways in which older people relate to the care-home environment. They found that it was a continuum of involvement with some more passive than others, some having more sense of control than others. The identification of push and pull factors is useful, doing more in this regard to aid

understanding than Townsend (1962) and Morgan et al (2006), who all fail to make a distinction between push and pull factors in the way that Reed et al (2003) do.

In citing social isolation as a major reason for admission to a care home, Townsend does acknowledge that this isolation may not be something specific to later life, but that the isolation of late life may be symptomatic of a life time of isolation. Such older people may have had a life time of relatively few social contacts, as relations with relatives and friends became weakened. He said that this isolation manifested in many different ways, with isolation from earlier stages of life perhaps continuing into later life, caused by sudden desolation or by a continuing reduction in contacts. The study did to some extent link up many different factors, saying that the loss of a close relative together with a number of different moves often combined to make relocation to residential care a reality. Antonuci and Jackson (1989) found that the ability to respond to change in later life depends to a large extent on the extent of convoys of support built up over a life time of reciprocal exchange, although this does not necessarily mean that these events and influences on older people will inevitably lead to vulnerability. It is the timing and severity of these 'events', coupled with the amount of support or resources available to older people, that will ultimately decide if residential care has to be the outcome.

Townsend talked about separation from family and community as key factors. Closeness of relatives was a consideration. However, he did not discuss the quality of geographically close relationships. He assumed too much about geographical location and reasons for care, assuming easy correlations between proximity and willingness or potential to care. More exploration of the psycho-social aspects, of the dynamics between the older people and their carers, of their personal and family histories and of their attitudes towards care giving and receiving, may have revealed more complex factors.

Joseph and Hallman (1998) found that patterns of caring by kin change, and studies have shown that the extent of caring for older relatives is affected by geographical location. They found that only 18% of older people receiving supportive informal care live with their carers and only 19% of carers live within

ten minutes of the care recipient. Geographical and social mobility affect contemporary relationships (Keeling 2001, Lee and Kin 2005). Keeling found that there were complex relationships between 'closeness' and geographical proximity of carers with immediate family members often 'substituted' as more distant relatives and others played caring roles. This is particularly important in that understanding patterns of caring by kin and others means recognising that wide social networks may provide what may be seen as unexpected caring functions for older people. Patterns of education and employment have meant that people move with increasing frequency (Dixon 2003), which can potentially disperse families and reduce options for caring by kin but this must be stated with caution for Keeling reminds us that caring is not just a function of immediate kin. New relationships with step families can increase other possibilities for caring, with some potential for more contact between the generations within step-families (McCrae 1999, Keeling 2001).

There is also evidence of fewer expectations and less involvement from step-parents in the care of older people (Gamong and Coleman 2006). There is also evidence of older people making use of other social networks, involving friends in their caring (Hirst 2001, Keeling 2001). These findings across various research studies show the complexities of these issues, although the data themselves do not inform us of the complex realities of these relationships as older people move to residential care. Understanding moves requires understanding not only of the resources available to older people in a literal sense as they move, but also knowing about their ability to draw upon them.

Townsend's (1962) study was weak in that it neither dealt with life course factors in detail nor give enough credence to the precipitating factors, those that tilted the balance in favour of 'needing' residential care. His study only referred to a wide range of factors that may be contributory to it. He cited predisposing factors but not precipitating factors that tilted the balance in favour of residential care. Wright's (2003) much later work shared Townsend's focus on identifying a range of factors leading to care in her work that looked at the reasons for care amongst those who are self funded. These older people admitted themselves to care without a formal assessment, so the findings have to be taken within that context; she was talking about a specific group of applicants. Other factors were

identified in this research, such as difficulty in carrying shopping and walking to the shops. The research had a major strength of identifying multiple reasons even if there was a differentiation between the experiences of funded and self funded service users.

The older people in Wright's study were relatively physically independent on admission to the care home and most respondents gave multiple reasons for entering care. This was a major strength of the work in identifying many different factors. These fell into four main categories. The first was illness, both physical and mental. The second was that the older person had received inadequate support at home. Another reason was that the older person feared continuing to live at home, without saying why, and the fourth was that it relieved the anxiety of children, without exploring in-depth family dynamics. If we look at the study in more detail, we can see that of those who presented illness as a major factor, half had been directly admitted from hospital or had experienced acute hospital admission during the preceding year. The study did not explore in depth some of the given reasons for care. Illness was presented as a reason without any exploration of how medical staff responded to illness to make this a significant factor. Like Townsend, Wright draws back from considering the complexities of family dynamics, health issues, psycho-social issues of fear and mental health issues generally and their relationship to physical well being.

Clark, Dwyer and Horwood (1998) identify the withdrawal of home care as a potential factor in leading older people into residential care. Home care is perceived as one of a number of 'low level' services that are of vital importance in preventing or delaying a move to residential care. They also cite the importance of laundry, home maintenance and getting repairs done around the house. They were linked to older people's confidence and coping skills, the exercise of choice and control, and in this sense the research attempts to identify the complex set of resources available to older people. Their study suggests that home care is in fact an alternative to residential care. Whilst failures of service delivery may well account for many unnecessary admissions, the study claims too much in suggesting that home care is an alternative to residential care or that these failures are by themselves preventative.

Perhaps the failures in service delivery may combine with other factors to increase the likelihood of residential care, rather than it being causal. There may be particular aspects of this service delivery that will contribute. Assessment itself may be a factor. Richards (2000) says that assessments can be rushed as social workers have to make quick decisions about placements. There can be hasty decisions that are not necessarily in the best interests of the older person, but are made within the context of organisational constraints. Davis and Nolan's study (2003) found that many decisions were made by carers or professionals with older people themselves playing a minor role. The study also revealed that many of the older people were too cognitively impaired to participate in the decision. The psychological impact of bereavement or a fall, and the failure of services to respond to that event may have greater impact than the daily delivery or otherwise of home care and other services.

Clark, Dwyer and Horwood (1998) acknowledge psycho-social aspects with their recognition of how older people may perceive unknown people undertaking repair and maintenance around the house negatively. They found that strangers have a possibly negative impact on the older people's mental state although do not pursue the point further to recognise how their involvement may be perceived as intrusive or controlling. This study also does not recognise how wider issues of poverty and social exclusion may also serve to heighten the likelihood of residential care in ways that Townsend (1962) identified.

There is little research to suggest that people may move to residential care for positive reasons, but these must be acknowledged. Tinker et al (2001) found that some older people welcomed moves to residential care as respite from the problems of poor housing and loneliness and in this sense these findings to some extent resonate with the earlier ones of Townsend (1962). Tinker et al (2001) like Townsend neither explore the complexities of older people's responses to these issues nor identify how older people make sense of the differences between home and care or discuss the amount of control older people had as they made these choices.

Residential care may also be seen as a sanctuary from the difficulties of living within a community. These are the communities that the Griffiths Report (1988), a forerunner to the NHS and Community Care Act 1990, envisaged should enable older people to live within their own homes rather than in residential care (as discussed in the subsequent chapter two). Research also needs to explore not only how far residential care was a sanctuary, a *last refuge* or a positive choice, but how far older people had the inner strength to cope with or even find strength within residential care.

Later life can also involve progress, development and change (Levinson et al 1978, Golan 1981). Some older people make moves from physical independence to frailty or dependence (Barrett 2005), but can also involve recovery and rehabilitation. Moves can involve physical movement from one environment to another (Wagner 1988). For some older people, that move may be from their own home to residential care. Ageing and physiological decline do not always indicate that the person will inevitably have to move to residential care. Moves will vary because individual older people have different life histories and different capacities.

Older people may also have limited choices. Townsend argued that choice was actually very limited, as one chief welfare officer reflected, “it’s not a question of choice; it’s a question of whether he or she wants the only accommodation that is available” (130: 62). Some older people in this study were compelled to go into residential care and authorities used the power of compulsion enshrined in the National Assistance Act, 1948. Most of the residents felt disorientated and the research concluded that only a third of the new residents wished to stay in a home and some did not want to stay in the particular home they were in. The finding that only 26% of the new local authority residents and 39% of the voluntary and private residents were content to stay where they were must be balanced with the fact that many suffered from chronic ailments and had known the death of close relatives. This and their lack of choice may explain their negative perceptions and experience of residential care.

Townsend’s research considered residential care as a place where the older people experienced loss and disruption of various kinds. However, the research

did not look closely at the reasons for this in terms of the psycho-social development of the older people, even if it did cite poverty and social and economic factors as important. The research did not put their experiences within a wider context of life time experiences, as Townsend acknowledged: “their behaviour may be attributable to their previous social history and environment: thus persons may have been apathetic, resigned or withdrawn even before their admission to an institution” (1962: 172). The research stated that male residents were less resilient than the women, but did not explain what resilience meant within this context. Moreover, it neither enquired further as to why this appeared to be the case, nor explored deeper relationships between past and present living arrangements. The methods and methodology did not perhaps lend themselves to such findings, as older people’s strengths and deficits, as well as their ability to cope and sustain themselves in residential care, were neither analysed nor discussed with the older people.

Understanding the experiences of older people moving to residential care requires some understanding of the circumstances of older people undergoing the moves. Housing histories, identified in Morgan et al’s (2006) research, play some part in developing older people’s understanding of a move to residential care. However, it may be more relevant to identify the nuances of a particular housing history and the complex way in which an older person understands their environment in relation to their past one, rather than in relation to their age or status. Moves to residential care have been seen as accompanying other life changes such as bereavement and other relationship changes. Moves can be seen as part of a ‘career’ of moves (Jamieson et al 1997). The literature reveals various themes and potential correlations between moving house and status. Boheim and Taylor (2002) found that the unemployed are more likely to move than people in work and manual workers have lower levels of migration than non-manual. Moreover, house moves in young life are more likely to result in a rise in status. Gurney (1993, Morley 2000) found that associated with events such as marriage, new employment or increased affluence. By contrast, accommodation change in later life is said to represent a negative status passage. These understandings may have some value but in terms of understanding relocation they can mislead. Relocation in young or later life can represent a rise

or fall in status rather than having any intrinsic positive or negative association with a person's age (Clark and Huang 2003).

Understanding experiences of older people's moves to residential care requires understanding of how services received within the private home will be received. Raithby (2001) found that home care may restrict older people in other ways with older people restricted in their daily routines by the work patterns and visits to the homes of home carers at specified times. There is indeed wider evidence to support this point. Hooyman and Kayak (1996) and Tinker et al (2001) argue that there are similarities between residential care and the domestic home. They claim that older people can be made prisoners within their own homes by being told that they can receive certain services at certain times. The limitations in frequency and length of home-based support prevent older people from maintaining their aspirations for dignity and personal standards.

The experience of moving to residential care requires some understanding of general issues of ageing. Ageing is a diverse process and moves are multiple and complex. It is important to contextualise understanding of moves to residential care with literature regarding issues of ageing in a broad sense. This helps one to avoid seeing older people and their issues and concerns in stereotypical ways and avoids the dangers of homogenising older people. Differences relating to age, ethnicity and social class shape experiences of growing older (Williamson and Colwick 2001).

Poverty and levels of income/wealth, poor housing and social and economic influences generally affect older people's lives, but in uneven ways. Price (2006) finds that pensioners cluster around the government's poverty line and that almost a third of pensioners live in poverty. Price states that the poverty line in 2004 was £178 per week for a couple or £98 per week for a single person, after housing costs. Research has also found links between life poverty and life expectancy. Ivory (2006), writing in *Community Care* identifies research by the Universities of Bristol and Sheffield that shows a maximum difference of nearly ten years in average life spans between deprived Glasgow City (72.9 years) and the more prosperous Kensington and Chelsea (82.4 years).

Relocation to residential care benefits from the concept of 'career' that recognises the dynamic features of social life (Jamieson et al 1997) and how current experiences can be viewed within the context of previous life events and experiences. 'Career' (Harevan 1978) defines movement or development across many different spheres of human activity. House moves and relationship changes can be regarded as 'careers', involving a series of changes or developments through a life course. 'Career' recognises that people develop in various aspects of their lives, including employment and family (Hareven 1978, Bertaux 1981, Hewitt 1984).

Guttman (1987) sees development as predictable and does not consider late life change within the context of the life course or that the life style and life choices of early and mid life will affect late life development. Huppert et al (2000) also refer to studies relating age to decline in a less than critical way, referring to ageing and its link to cognitive depression. However, they recognise how family structure and wealth through the life course can effect late life development. Kirkwood (2001) makes many associations between ageing and decline, and acknowledges the way social and political environments can serve to limit people in their later lives. Other human development theories centre on the idea that people continue to develop during the various moves of each life stage, including old age. Erikson (1965 1980 1986 et al, Levinson et al 1978) suggest that the concerns of earlier life transitions or eras can preoccupy people in later life particularly if there is unresolved conflict with issues at each life stage or point in the life cycle that carry through to subsequent eras.

Erikson (1965) identifies developmental phases throughout life that must be achieved if the person is to progress safely through to the state of 'ego integrity' in which the person is able to look back on a constructive and happy life. Freud (in Baumeister et al 1988) and Jung (Casement 2001) share a preoccupation with developmental stages, although Erikson is more age specific, detailing the stage of development at specified biological ages (Hergenhahn and Olson 2003). Erikson identifies developmental phases throughout life, although his theories are too precise in terms of age-related development. By this I mean that he prescribes with too much certainty the kind and level of development people should have attained at various times in their lives. He says for example that 'each step is

grounded in the previous one' (1959: 59) when referring to how people's development in one life stage is shaped by events happening at an earlier point in their development. The 'failure' to achieve certain development tasks such as 'intimacy' between ages 18 and 35 or 'integrity' by aged 55 will have a profound effect on subsequent development. He said that people search for 'the solution of an age specific conflict' (1962: 63)

This point is made by Crain (2005) who criticises the rigidity of such theory, suggesting that societal expectations may influence Erikson's sequence. Erikson's theories assume that the stages of development unfold in unvarying sequences (Crain 2005) and that these are a product of a biological process. Erikson accepts that development is life long and recognises later life as a phase, but does not give much emphasis to how the older person can experience growth, in comparison to his perception of earlier stages (Duck 1997).

This thesis explores moves to residential care within the context of other life course moves and seeks to highlight times of development or change within the context of the moves to residential care. The research is interested not only in loss and disruption but in all aspects of older people's experiences. Whilst it recognises themes such as Goffman's (1961) totality of institutions and warehousing (Gwynne 1972) as aspects of residential living, my research is interested in exploring further older people's perceptions of change.

My research identifies how residential care is perceived and understood in all its complexity in ways that Clark, Dwyer and Horwood (1998) to some extent identify with their concerns about how older people make sense of change. Townsend made some early references to the impact of life histories on moves when he referred to older people experiencing problems with housing and linked these to family disputes experienced at earlier points of the life cycle, which then impact on later life change. However, these are constructed 'abnormalities of family history or structure' (1962: 162) rather than as familiar life course events that will impact on many older people. Wright (2003) similarly recognises how tension within families can have an impact on progression without reflecting on the longer term or life course influences on moves. She reports on how older people had become 'fed up' living alone without seeking to understand

underlying influences on that mental state or factors from earlier life stages that may have contributed towards it.

- *To what extent can we talk of ‘successful’ moves to residential care and how is success to be conceptualised, measured and explained?*

The existing literature concerning older people and their move to residential care is not especially concerned with evaluating the outcomes of moves to residential care. There is little on how far older people are able to adapt or cope with change and no sense that older people may or may not have different levels of ability to cope or adapt. Townsend was concerned only with the factors leading older people to residential care and his only reference to their ability to settle or adjust to life in a care home was to comment on the ‘resilience of some individuals whom we met and interviewed’ (1962: 190). Clark, Dwyer and Horwood (1998) do not discuss the qualitative experience of living in residential care, while Reed et al (2003) and Wright (2003) refer to issues of choice and autonomy in the decision making process concerning moving to care, but stop short of evaluating older people’s progress beyond the decision to move.

There has been research that has identified the influence of some social actors without seeing this influence within the context of older people and their ability to adjust to change. Some research has identified the influence of social actors on relocation. General practitioners have been found in some research to be the most powerful, although hospital doctors have also been seen to exert a strong influence (Brierley 2003). Other research plays down the influence of social workers during moves (Wright 1998, Lymer 1998), although none of this research has discussed their influences in relation to the specific experience of living in residential care units and their part in making that experience a ‘successful’ move in the sense of helping them to integrate within the setting.

Davis and Nolan’s (2003) study outlines three phases to relocation. These are described as ‘making the best of it’ followed by ‘making the move’ and ‘making it better’. However, the homes in their study were still regarded by the older people as strange and less than welcoming places and so one of the key tasks was to make the setting as familiar as possible both for the older person and the

family carer whilst also creating relationships with staff that would help them to become more 'familiar' with the older person. Most entered the care home in a crisis situation, although 'crisis' is not defined in their study. Their study reported that there was plenty of effort made to make the homes easier to settle into, such as arranging the items of furniture in the new room, preparing information about the older person and decorating rooms. The study, focusing on nursing care, found that the period around the move into the nursing home was especially traumatic for many relatives and it involved a period of sudden adjustment to being without the older person on a day to day basis as well as the need to undertake practical tasks.

Davis and Nolan's study also found that the actions of health and social care practitioners had the potential to make a difference to experiences at this time. The day of the move to the home was a particularly hard time and practical arrangements like arranging appropriate transport, getting a warm welcome on arrival and ensuring that the older person's room was prepared, were important. The research found that the older person was not involved in discussions about how to make the move easier and it did not draw on the older person's experiences and knowledge. Practitioners' failure to respond to or involve older people in the process of change is also highlighted by Reed, Morgan and Palmer (1997). They also highlighted how staff did not negotiate with older people and this heightened feelings of loss and anxiety.

Careful management of such moves requires giving older people the chance to talk about their feelings at every opportunity. Older people, it is argued, need to be given every chance to have a say in each decision. The research of both Reed and Morgan et al (2006) and Davis and Nolan (2003) were both useful in that they both attempted to evaluate the initial phase of entry to institutionalised care, but it did not discuss the 'success' of these attempts in terms of outcomes. There was little in terms of how far these initial moves enhanced older people's ability to make sense of and adjust to these settings in the longer term.

Morgan et al come closest to an evaluation of moves as 'successful' in that the writers refer to the degree of 'fit' between the older person and their setting, in terms of past lives and needs from a life course, and they talk about their freedom

to take control within the residential units. However, the research does not compare eventual outcomes of older people's placements but talks only of the process of relocation as they actually move. Morgan et al (2006) do not seek to understand to what extent older people were able to adapt to settings or negotiate change. They also do not compare the ability of the two older people in their research in terms of being 'successful' in their adaptation.

None of the literature recognises the idea of a 'successful' move, neither does it seek to conceptualise or measure, in a qualitative sense, the outcomes of older people's placements (discussed in more detail in chapter three). This research however seeks to measure the outcomes of these moves. This is not to say that literature does not recognise issues involved in moving and settling in to such new environments. Moving to any new environment can be stressful both in terms of the anticipation and also the reality of actually moving (Reed, Morgan and Palmer 1997). The older person has many tasks as they move including the need to negotiate and learn about a new physical environment, but they also need to learn about a new social world. Reed and Morgan (1999) recognise that this can involve not only loss and disruption but that it also represents a life event that can have a strong impact on an older person. They do not however expand on the nature of this impact and the variety of responses of older people to residential care.

The lack of literature relating to evaluation of the outcomes of moves suggests that there is nothing to contest Townsend's assumption that residential care is for older people a 'last refuge'. There is some literature that seeks to understand relocation and the issues involved in adjusting to new settings in later life in a more general sense. Butler and Parr (1999) argue that some older people are able to settle into new accommodation and re-establish a sense of 'home' quite quickly. They transport their emotional security from one location to another. Some individuals are used to periodic house moves throughout adult life and thus may be less anxious than others when a further move is required in later life (Gurney 1990). Others might find relocation a new experience. Expectations may be shaped by the location of the new home and how much its environment differs from the areas they knew previously. Some people who have lived most of their lives within a rural setting might experience problems with adapting to urban

locations (Gurney 1990). Older people who have lived in more anonymous environments may struggle to come to terms with close-knit, informal communities (Case 1996).

My research and concepts used to analyse the data

Previous literature (Miller and Gwynne 1962, Leeson 2005, Morgan et al 2006) has not attempted to understand how older people make sense of residential care. We have instead a range of literature relating to the negative effect of institutions to 'explain' how older people relate to residential care. My research seeks to fill the gap in understanding and seeks to conceptualise 'successful' moves to residential care. This will be done with reference to some key concepts including homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002). This relates to the degree to which people are able to balance the needs of their internal selves with their external surroundings. To be 'successful' in the context of this research, the older person needs to show a capacity for homeostasis. If they do not achieve homeostasis, they may still have enough resilience which Vandsberger (et al 2005) defines as the ability of individuals to cope with and adapt to change, to achieve mastery (Vandsberger et al 2005).

Resilience

Blane (2008) identifies the concept of resilience as having its origins in the study of child and adolescent development. The concept has rarely been studied in relation to older age groups, although Blane studied it in the context of older people living in various community settings. In displaying resilience, one shows the ability to maintain healthy, symptom free, functioning following potentially traumatic events. Resilience can only be recognised in the presence of adversity and those who are exposed to it either maintain well being (become resilient) or suffer reduced quality of life.

Stewart, Reid and Mangham (1997) refer to resiliency being the capability of individuals to cope successfully in the face of significant change, adversity or risk. The concept of 'success' is also used by Wagnild and Young (1990) when

they argue that resiliency in old age contributes to successful adjustment and a sense of psychological well being.

When people achieve a sense of homeostasis, they can feel a sense of commitment or happiness or a sense of 'fit' with their setting. They may achieve this sense of 'fit' by drawing on various resources. These can be referred to as 'reserve' (Grundy 2006) and they include the support of family relationships and social networks generally (which may also be reflected in the support of a key practitioner) and levels of resilience. They may have accumulated this stock of reserve from their life course and if they can live their lives in residential care in such ways as to utilise these resources to make the residential care home feel like 'home', then they have achieved homeostasis. With less reserve they may not achieve homeostasis, but this research hypothesises that some older people may draw some resilience from their life time experiences in order to cope with life in residential care.

Without reserve or any sense of resilience, they may lurch into crisis. Crisis is defined as an acute disruption of psychological homeostasis in which one's usual coping mechanisms fail and from this the person experiences stress and an inability to cope or function (Roberts 2000). The person tries and fails to resolve the disruption by utilising previously used coping methods. Crisis according to Roberts has five main elements. These are a hazardous or traumatic events, a vulnerable state, a precipitating factor, an active crisis state and some sort of resolution of the crisis.

It is necessary to identify factors that may encourage or set back adaptation and in this sense it is important to talk about and identify these factors and to understand them conceptually. Risks, stressors and protectors affect individuals throughout their life courses (Falkon 1998). Loss and other negative life events and experiences operate as risks and stressors. Positive life events and acknowledged achievements act as protectors. It is necessary to do, in a sense, an audit of older people's lives and responses to the events of their lives so as to seek understanding of their potential for resilience in the face of change.

My research recognises the potential of institutions like residential care to restrict older people, limit their choices and deny their individuality, but there are dangers in research that may support or encourage people to comply all too easily with oppressive circumstances. My research is however equally committed to reporting older people's experiences of relocation and identifying and analysing their abilities to cope or 'fit' with surroundings that they may or may not regard as oppressive. It is not seeking to 'justify' residential care but to seek understanding of the qualitative experience of moving to and living within residential care and to understand the relationship between the older person and their settings. Understanding these relationships may actually promote emancipatory approaches so that services can be aware of how older people experience residential care in a holistic sense.

Research into older people and residential care has rarely focused on the ability of older people to adapt to change. Even if the older person may not achieve a sense of 'fit' with the environment of residential care, they may have the resilience to adapt or cope. Vandsberger et al (2005) advocates applying the concept of resilience to understanding lives and informing teaching of ageing issues across social work curricula. Rather than work with ageist assumptions about decline in later life, we should seek to understand relationships between older people and their social environment. DeMuth (2004) argues for recognition not only of people's capacity for resilience and homeostasis, but also for seeing people as active participants who are forever reacting to their environment.

Older people's reserve (Grundy 2006) may help them show resilience in the face of change and may also assist them to find a sense of homeostasis. Schroder-Butterfill and Marianti (2006) argue however that it is not just important to recognise and to understand the resources available to an individual but how the older person makes use of them. In other words, we need to know how much resilience they can draw from that reserve.

We may also need to know about patterns within older people's life courses and how older people find resilience from these patterns so as to measure the amount of reserve they have accumulated through the life. The data analysis will therefore scrutinise the details that older people report about their lives to

identify aspects which generated the accumulation of reserve and resilience. Older people's responses to moves may be shaped by events at any stage of the life course.

The work of Morgan et al (2006) showed recognition of the importance of the life course events to those in residential care, but did not work with concepts such as reserve (Grundy 2006) or resilience (Vandsberger et al 2005) in analysing progress or consider strengths or deficits arising from the life course that may help or hinder their development once in residential care. Grundy (2006) argues that the amount of reserve inherent within a person will be dependent on the extent of their family resources and support networks and these will be the outcomes of life times of experience. It is not just those family resources and support networks that could lead to these outcomes, but also the nature and number of relationships in a quantitative sense.

Attachment theories also contribute to understandings of moves as we seek to identify those factors that contribute to homeostasis. It may be that the amount of 'reserve' (Grundy 2006) displayed is partly dependent on how much or how far older people have a sense of attachment and that these patterns of attachment develop resilience. Attachment theories claim that human beings develop behavioural responses in childhood that elicit the attention of the parent and encourage attachment. Secure (and insecure) adult relationships can derive from early childhood patterns of attachment. Erikson (1965, 1980) argued that when a caregiver is consistent and dependable he or she will elicit trust, and that the first twelve months of an infant's life are dominated by a search for trust. Affectional bonds with the attachment figure (the constant caregiver) are essential to build trust. Attachments in early life can be crucial to people's development (Bowlby 1988; Yelloly 1980) and help them to achieve a sense of ego integrity (Erikson 1965, 1980; Sherman 1981).

Reserve and the resilience that can derive from older people's attachments to people can also derive from the memories of times when older people showed resilience in the face of change. They can draw strength from the memories. Schaie and Willis (2000) argue that when children find that they cope with a stressful life event, they do in the process learn strategies for future coping. They

also argue that older people have an even larger historical bank of coping strategies from which to help them cope in the present.

Older people can draw strength from knowing that they coped during previous adversities. Remembering provides continuity with the past, a sense that the past is part of them and part of who they are now. Other strategies involve forgetting in order to cope (Pearlin and Scholer 1978, Monat and Lazarus 1991). Painful or traumatic experience can be blotted out or denied. One specific coping mechanism is reminiscence (Lieberman and Falk 1971) when older people recall past experiences. By focusing on past experiences, the problems of the present can become more understandable. People retreat into the past for comfort (McCulloch 1985) by looking back to a time perceived as safe and secure. Older people's fears of the present can be offset by memories of their past selves in order to sustain them in the present (Baumiester et al 1998).

Reserve can also include belief structures, for these also can help older people to sustain themselves and they may also have relevance for adaptation to residential care. Coleman (2003) found that religion had meaning in the lives of people even if overall there was a declining commitment to a religious faith and to church membership. He recommended that religious meaning in later life should be integrated into an investigation of self and identity and of wider issues of meaning.

Smith (2004) identifies the psychological and physical benefits of religion or spirituality for older people engaged in potentially traumatic events. Krause (1998), in his research on coping with life in deteriorating neighbourhoods, found that people over the age of 65 years who were involved in organised religion were less likely than those with weak religious ties to experience a decline in their self-rated health status.

Koenig (2004) carried out a number of investigations on the benefits of religion to older people. He reported that nearly 90 per cent of hospital in-patients older than 60 years indicated that they used religion to help them cope. Half of these stated that it was the most important factor that kept them going. Among the evidence cited is the notion that religious beliefs may provide some older people

with a sense of control over health matters that their non-religious peers lack. The cultural dimension of this American research is acknowledged. Americans practice more overt religious beliefs than in the United Kingdom (Koenig et al 2004).

Coleman (2003) argues that the reported decline in formal religion during the life time of the current generation of older people has particular relevance because of its association with adaptation to change. Sadler and Biggs (2006) say that in considering what older people need to adapt to later life it is important to consider and recognise the importance of spirituality. They say that spiritual resources may help the older person to successfully adapt to some of the changes associated with growing older. This may be particularly important amongst the oldest people because of the more striking relationship between age and disabilities. Defining what is meant by spirituality is a difficult task, although Coleman and O'Hanlon (2004) talk about the older person becoming more receptive to the changing cycles and rhythms of nature. These issues may have specific relevance to health and social care and welfare provision.

Koenig and colleagues (2004) in a US study of 838 older adults admitted to a hospital ward found that spirituality and religiosity were significantly associated with social support and this was particularly the case amongst those aged 75 and over. The support they received was linked to issues of spirituality in that social support gave older people a sense of the spiritual. Fry (2000) found that spirituality was more associated with well being in general amongst older people living within the community whereas religiosity, such as frequency of church attendance or watching religious television, was of more value to those in institutions. Sadler and Biggs (2006) argue that it is important to consider the diverse ways in which older people may express their spirituality. Services also need to respond imaginatively. They argue that counselling services for older people should extend their remit to include consideration of spiritual and existential issues rather than just react to depression, loss and bereavement. International research also cites other coping mechanisms. Commitment to shared value systems, such as collectivism, has also assisted older people experiencing care moves in Hong Kong (Lee 1999).

The thesis will use the conceptual tools of homeostasis, resilience and reserve to evaluate the success of these older people within residential care, and in doing so will recognise the social and political dimensions. There are issues of structure and agency (Giddens 1986) as people move to residential care and their capacity for resilience and homeostasis will be ones where both are apparent. Social class and other societal structures such as family, peers, and the education system can also structure lives and impose order on the individual limiting the ability to exercise choice and take control. These structures shape the allocation of power and resources and constrain individual agency. Lerner and Busch Rossenagel (1981) argue people experience degrees of 'plasticity'. Social structures, norms and expectations can be both reinforced and challenged by the agency of individuals (Giddens 1986). People make choices from available options (Giddens 1990), but they can also retain a sense of agency within those constrained situations.

The resiliency framework (Vandsberger et al 2005) emphasises the importance of the social and political context in people's lives but also the capacity for change and development. Reed et al (2003) take up this theme when suggesting that many of the debates in environmental gerontology assume that older people are passive in their relationship with the environment. They say that environmental gerontology is now developing conceptual frameworks that more clearly identify issues of control and agency (Wahl 2001). This is very important if we are to appraise older people's ability to make sense of and adapt to residential care. It is important to observe the actions of these various social actors and to analyse their progress not as passive recipients of social care, as portrayed by Townsend, but as active participants in their own development. Older people are often portrayed as rather passive, with only Morgan et al (2006) and Reed (2003) suggesting otherwise. My research seeks to avoid seeing older people as passive but to re-address assumptions from much of the literature that suggests they have little control. There is a need to know how much control older people have. My research also seeks to identify any positive influences from friends and relatives in the way that Sandberg, Lundh and Nolan (2002) or Tinker (2001) do and address gaps in the literature that signify the extent of positive as well as negative influence.

My research therefore seeks to avoid seeing older people as passive but to address assumptions concerning the passivity or active nature of older people in the decision making process and instead seeks to find out how active older people are in decision making and to what degree this has significance for their subsequent progress in residential care beyond the initial move. The thesis will explore if and to what extent their own active or passive involvement in the life of the home was a factor in their ability to achieve homeostasis or if they showed resilience in the way they actively coped with change.

Reed et al's (2003) pull and push factor analysis accords with the homeostasis model. It recognises the complex ways in which individual and environmental or social factors operate through people's lives and how people struggle to achieve homeostasis and show resilience in the face of change. They will sometimes be 'pushed' by circumstances into residential care and sometimes they will express some choice and there will be a degree of 'pull'. There is always a negotiation between themselves and their environments, a degree by which the older person will try to find some resolution to their situation as they attempt to find homeostasis, a balance between what they wish and the external surroundings in which they may encounter. Vandsberger et al (2005) and Grundy (2006) both argue that older people will be exercising their resilience in this way as well as drawing upon their levels of reserve in this process.

Understanding moves therefore requires awareness of how life histories affect lives but not just in terms of power, wealth and opportunity, but also in terms of how events through the life course help develop attitudes and behaviours that may sustain older people in residential care. It is important to recognise the many times of life when there are long periods of development (DeMuth 2004) and many theorists can go directly from understanding the life course and its effect from the 'empty nest', when older children leave home, to the nursing home. Decline and loss will feature in that process and at many stages, but they can help the person to face up to the next challenge.

The thesis applies what Vandsburger et al (2005) refer to as a 'stress and resiliency framework' in that it works with the developmental theory that people's behaviour across the life span helps us to understand their lives in the

present. It is this approach that allows examination of the detail of these older people's lives to see to what extent they showed homeostasis, resilience and reserve in the face of change. It is an approach that draws upon bio-psychosocial factors but also acknowledges the spiritual domain (Conrad 1999). The approach wants to know which factors from within the life course serve as 'buffers'; in other words it wants to identify those personal characteristics or environmental events that prevent or moderate adverse reactions to stress.

Instead of seeing older people moving to residential care as necessarily deficient or link this situation to their age and assumed vulnerability, the thesis adopts the idea that one can understand the older person in relation to their social environment. The thesis tests the working hypothesis, applied to social work and social care more generally, that when strengths and stresses are in balance with one another, the practitioner will tend to regard the older adult within the context of his or her abilities rather than just disabilities (Kivnick and Murray 2001).

This thesis explores if and to what extent older people achieved this balance and how far this was a determining factor in the outcome of their moves. In seeking to understand their moves, the thesis does not make any assumptions concerning the development and progress of these older people concerning their attitudes, inclinations or abilities. Old age is often portrayed as a time when people experience multiple stresses and many of these are assumed to be inevitable consequences of the ageing process (Vandsburger et al 2005). This thesis does not presume that ageing in general and moves to residential care in particular always represent decline or that the moves were experienced as either negative or positive, but instead considers the variation in their experiences and draws conclusions from the older people's often quite complex experiences of residential care.

We cannot make too many assumptions concerning the capacity of these older people to cope with change simply on the basis of their age and instead consider the life courses and individual situations and aspirations of the older people concerned. Grundy (2006) points out that vulnerability does not always have to be associated with age and ageing and Schaie and Willis (2000) observe that many older people over the age of eighty are able to live full and active lives

even in the face of poor health or financial hardship. Baltes (1990) and Baltes and Baltes (1997) found that many older people can be adaptable to change. They can maintain mental agility and an active mind and do not require institutional nursing care until the very end of life or are cared for at home. This thesis seeks to find out if and how they show resilience in the face of change. Vandsberger et al (2005) argues that those involved in health and social care need to know how older people are evaluating change and this is particularly vital with an ageing population, ensuring that these issues will be relevant to a wider number of people over a longer period of time.

The resiliency framework (Vandsburger et al 2005) emphasises the importance of recognising older people's strengths and potential for resilience within a wider social and political context. Whilst these contexts are relevant, Blane (2008) has found that social relationships appear to be more important than material circumstances in determining whether older people display resilience. Family relations and social networks were considered most important. Netuveli et al (2006) found that good social relationships before the occurrence of adversity, as indicated by being integrated within their neighbourhood and having high social support, was vital to whether they had resilience to cope after the event.

Some older people may experience a sense of homeostasis within any setting and this thesis is open to the possibility that any given setting may present its own challenges and possibilities for individual older people. It may be that older people do not feel a sense of homeostasis in residential care, but it is also possible that they may not experience it in their own homes or in any setting, institutional or private. This research focuses on the relationship older people have with the settings in which they live and to which they relocate. Research to date has identified older people's experiences of moves to residential care in restrictive terms with little attention paid to issues of adaptation, coping and resilience. The research has not sought to understand the issues of the life course and how older people may draw strength as well as show vulnerabilities from their experiences.

Summary

The review of research has revealed that relocation to residential care has been portrayed as a default choice from Townsend (1962) onwards and there has been little consideration of the variation of response by older people to residential care and the private home or the way the two domains are perceived by contrast. There has also been little attempt to compare the perspectives of older people and practitioners and little consideration of the effects of the life course on the ability of older people to cope or adapt with change beyond the move. This research seeks to understand how older people experience life in residential care and seeks to gauge how far moves were successful in terms of the ability of older people to achieve a sense of homeostasis. Whilst homeostasis, reserve and resilience will provide the conceptual structure, understandings and theories will also be grounded in the data from the older people's lives. I will appraise the presence of resilience and homeostasis from the detail of lives, highlighting the existence or otherwise of coping strategies, social networks and belief structures and point to the words of older people as evidence of these outcomes. Concepts of resilience and reserve help to make sense of the resources used and utilised in the process of adaptation as the research seeks, unlike previous research, to measure the outcomes of moves as much as consider the process of relocation and what affects it. Research into understanding residential care in relation to the private home has worked with the presumption that 'home' is the preferred place for older people. Policy and practice, reviewed in the next chapter, have also worked with that assumption.

Chapter Two: policy contexts and demographic change

Policy and practice in the late 1990s

Policy contexts shape older people's lives. It is however very important to understand that these policy contexts change and the policy framework applicable when the fieldwork was carried out will be different to more contemporary contexts. This chapter will discuss policy as it applied in the late 1990s when the fieldwork was being carried out and consider more recent developments and their potential to affect the choices available to older people with health and social care needs. The chapter also considers demographic trends and in particular the impact of the ageing population on the delivery of care and in particular on the 'need' for residential care. The subsequent analysis of the findings from this research will need to be seen within these various contexts if they are to be understood for their wider significance.

This thesis identifies the experiences of older people involved in moves in the period from June 1998 to March 1999, some five/six years after the implementation of the NHS and Community Care Act 1990 in 1993. Other legislation relevant to older people's lives and relevant to the time when the fieldwork was being undertaken was that requiring older people to raise assets to pay for their residential care. This requirement was embodied in the 1948 National Assistance Act Section 22(1) which stated that local authorities have an obligation to charge for accommodation in registered care homes (Clements and Thompson 2007). This can, often result in older people having to sell their homes to pay for care.

Policy and practice may still be informed by such legislation but they have moved on since then and choices were in some senses different as policy and practice have attempted to address the concerns of older people and their carers. The research has however continued relevance in that highlights areas of concern felt by older people and identifies aspects of their moves shaped by life course events as well as policy and practice.

The NHS and Community Care Act 1990 was the most significant piece of legislation applying to this group of older people. It was theoretically significant to them in that it promoted home based care and yet they were moving to live within residential care. This was not uncommon at the time. The Act was fully implemented in 1993 but in the period after it was implemented, the numbers of people in residential care in the United Kingdom increased. The number of places available in residential care homes, local authority, independent sector and private sector, increased in the four years preceding the fieldwork by 18% from 1994 to 1998 (Office of National Statistics 1998). Crawford (1999) argues this increase in numbers of people going into residential care is due to a greater attention paid to responding to unmet needs since the community care policy became effective in April 1993. He suggests that long term projections indicate that by the year 2030 expenditure on long term care (residential and nursing care) will grow from 7.5% to nearly 11% of the Gross National Product. It therefore appears from this data that there is a ‘need’ for residential living rather than living in one’s own home or if not a need for residential care then a need for more intensive support.

The rise in places in residential homes in the years preceding the fieldwork was then followed by a slight decrease in the three years since the fieldwork was undertaken. The numbers of places and numbers of residential care homes fell between 1998 and 2000 (Table 2). At the same time there was an increase in the numbers of people aged 75 years of age of nearly a million from 3,866,000 to 4,305,000 (Haynes et al 2006).

Table 2: Numbers of older people in residential care between 1998 and 2000

	Numbers of places	Numbers of residential care homes (local authority, voluntary, private and dual registered)
1998	246,896	13,004
2000	240,458	12,177

Source: Department of Health (2007)

Although policy was favouring community care, the overall trend was towards an increasing use of residential care as it responded to the needs of an increasingly ageing population. The ageing population is most apparent when we examine the data. The Government Actuary's Department (2004) reports that there will be a 143% increase in the numbers of people over 65 by 2025. They also report that there will also be a 183% increase in the numbers of people over 85 during this period. This ageing population can have implications for people's care needs. 5% of people aged 65 or older in England lived in residential establishments in 2003 (Gibson, Gregory and Padya 2003). This figure is rather different as people pass the age of 85. Peace and Holland (2001) remind us that a quarter of people aged 85 or over live in nursing and residential care homes. 8% of the over-65s receive some form of community based services (Kings Fund 2005).

Sections of this ageing population are likely to need more support even if not necessarily residential or nursing care. There is a complex pattern of people and places involved in the housing and care of older people. Many older people use a complex pattern of support services in which paid and unpaid carers come into the home, they may go out to receive some care, use day care or take up respite care in someone else's home (Peace and Holland 2001). There will be occasions when older people might have to receive care outside the home for short periods. Any study of moves needs to be framed by understanding of these demographics so that the experiences of a small sample of older people are put into wider contexts.

The reasons older people moved to residential care in the late 1990s have to some extent been discussed in the previous chapter and this issue will be returned to in subsequent chapters. Age and ageing may be factors but there may be other demographic factors to explain how and why residential care was still playing a part in the care of older people despite the introduction of the 1990 NHS and Community Care Act. Moves to residential care need to be understood within wider contexts of geographical mobility. Champion (2002) informs us that between 9-11% of the population of the UK migrate within the country. The rates are highest for young adults, lone parents, non elderly loners, private renters, students and also non manual workers. Grundy (1996) argues that the number of older people with children close at hand has fallen as the proportion of people

living in institutions has increased. Caring and contact with older relatives may be limited, because carers live at further distances from their relatives (Phillips et al 2000). Relationships between geographical mobility and caring by kin are however complex and this will be discussed at greater length in chapter three.

The NHS and Community Care Act 1990 Section 47 (1) imposes on local authorities a duty for them to carry out an assessment of need for community care services with the implication that living in the domestic home will be the preferred choice. Even if this is not stated explicitly in the legislation, subsequent literature certainly presumes this to be the case. Godfrey and Callaghan (2000) highlight how the policy was to try and ensure that older people on the threshold of residential care remain in their own homes for as long as possible. Living in one's own home is viewed as the preferred choice; with residential care seen as the lesser option (Barradell 2001). Community is construed as more positive and less problematic than residential care, which is often constructed as negative (something alluded to in chapter one). Community care policy may have promoted home based care but this does not mean that the setting necessarily encourages dependency or indeed independence (Fine and Glendinning 2005). This thesis explores how far the assumptions of policy and research were supported by the experiences of this small group of older people as they moved into residential care in the late 1990s.

Understanding these policy and demographic contexts in which these older people moved to residential care in the late 1990s is important. It is important to recognise however that whatever the prevailing contexts helping to shape decisions individuals will still make private choices, however constrained they might be. This thesis will consider not only the social, economic, political and policy 'realities' that provided context to these older people's lives but will set this alongside more personal factors. The stress and resiliency framework (Vandsberger 2005) offers another equally important context to the research in that it examines people's behaviours across the life span to see which factors have helped shape reactions to change.

My research offers something distinctive in that it moves away from assuming that if we examine policy we fully understand older people's relocations and

moves to another understanding. Such an understanding recognises how wider social and political contexts affect lives, but it is how older people exercise choices over their lives, and understand and negotiate their way through those choices that is fundamental. The findings in that sense are relevant to many settings and many policy contexts.

Grundy (2006) argues that older people need resilience in order to cope and that only if they are depleted of resources do they become vulnerable. She says that people accumulate these resources both mental and physical throughout the life course. These will include material as well as psychological resources and that there will be structural factors that will restrict the older person in their ability to exercise choice and show resilience to change. The focus on an individual's resources is important if we are to understand the consequences of policy and practice.

Some examination of policy (developed in the 'implications for practice' section pages) is required whilst accepting that some policies developed in the last decade will not have had direct relevance to this group of older people.

Understanding older people's experiences of moving to residential care and the influences on those experiences requires some recognition however that older people may have a potentially wide range of different housing and support needs which might extend beyond residential care. Whatever the nature of these needs, policy guidelines have tried to ensure that people receive similar services wherever they live.

In 2002 the Department of Health issued policy guidelines on Fair Access to Care Services (FACS). This provided a framework for deciding on people's eligibility for all adult care services. Within resource constraints people with similar eligible needs should receive services that provide equivalent outcomes despite their geographical location. Provision of those services, assuming they are eligible have been organised through care management strategies. Care managers, who undertake needs assessments of adults seeking community supports or residential care, have been given the task of organising packages of care to meet their needs. They have been expected to utilise independent and voluntary as well as local authority services (Higham 2006)

This is the framework that has been adopted and policy since my research was undertaken has recognised that there may be other ways of meeting need for more intensive support, perhaps with the use of adaptations to the home (SEU/ODPM 2006). We have also seen a government Green Paper on adult care *Independence, well being and choice* (DH 2005a) that suggests that services tend to focus too narrowly on users' physical problems rather than on people's problems in relation to the rest of their lives. Specific initiatives have also included direct payments. Direct payments are cash in lieu of care services which originally came into force with the Community Care (Direct Payments Act 1996) but were later extended to older people, carers and disabled children (Hasler and Stewart 2004). The 2003 Hospital Discharges Act has also been introduced.

The Green Paper (Department of Health 2005a) suggests that older people should have the 'right to request' not to live in residential care. This policy context has in the last ten years witnessed the introduction of Intermediate Care, emphasised in the National Service Framework for Older People (Department of Health 2001), targets those with acute care needs and offers rehabilitation after hospital stays. This is consistent with the aim of developing preventative services, emphasised by the White Paper (SEU/ODPM 2006), which refers to targeting those in general housing stock and seeking to prevent admission to residential care in the long term. 'Connected care centres' (Rankin and Regan 2004), and adult placements have also featured in policy development (Department of Health 2005) and the Care Standards Act 2000 has set minimum standards for care homes for older people.

The National Service Framework for Older People (Department of Health 2001) focuses on setting standards for care and emphasises the importance of a person centred single assessment process. A single assessment process is particularly important when multiple agencies are involved in assessment of need (Mouraditis and Philp 2003). Person-centred assessments that seek to integrate older persons into the community require integrated health and social care teams that respond to the individual (Brown and Smith 2003). Person centred assessments place value on making provision match more closely to the

individual person so that supportive care moves to older individuals rather than older individuals having to make a move to residential care (Reed et al 1998).

Chapter Three: Methodology and methods: Reflecting on the research process

Introduction

This Chapter considers methods and methodology and reflects on a process of research in which various methods were used. The inclusion of the research diary was particularly significant as this allowed me to be critical of the process and to compare evidence and reflections from different stages of the research. This chapter refers to the main concepts that guide this thesis, homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002) resilience (Vandsberger et al 2005, Blane 2008) and reserve (Grundy 2006) and showed how these concepts guided the research. This was a study that sought to know more about older people's conceptual worlds and to contrast those perceptions with practitioners. The Chapter is organised into five parts. Part one discusses methodology, with further reference to the theoretical concepts that underpin the research. In part two, I describe and analyse the methods used. Part three examines the fieldwork process, setting out reasons for choosing particular fieldwork sites. Part four explains how I operationalised the research. Part five evaluates the research process and considers ethical issues.

Part One: Methodology: a qualitative approach

I undertook the research as a qualified social worker with a background in working with older people in a variety of settings. My methodological choices sought to give 'voice' to older people (Means and Smith 1998) during the research process and to illuminate their experiences in ways that earlier research in this area had not done. This research wanted to highlight all aspects of older people's moves, the negative and positive experiences and to not rely on assumptions about the value and experience of residential care. This idea of giving 'voice' has a long tradition (Mayer and Timms 1970) in social research. My research is qualitative and interpretive, seeking explanations of the 'lived experience' (Von Manan 1990, Denizen and Lincoln 1998) by exploring older people's interpretations of their moves, and relating them to their choices and circumstances in early, mid and late life. I also wished to give some 'voice' to

practitioners so that their reflection on relocation could provide contrasting perspectives.

Earlier research in this area, from Townsend (1962) to Morgan et al (2006) had not always given full voice to older people or practitioners in terms of all of their reflections on the process of moving into residential care and had not tracked older people's experiences over time. Despite extensive searches of databases (see my description of the process of research in chapter one) I found a lack of research highlighting practitioners' understandings of relocation. The thesis sought to rectify this and aimed to hear the practitioner's 'voice'. Qualitative research produces findings by analysing data to provide illumination and understanding of issues rather than by statistical procedures or by some method of quantification that provides 'proof' (Strauss and Corbin 1990). Qualitative research tries to get to the essence of phenomena (Denizen and Lincoln 1998) by involving the researcher in the process of ascertaining meanings (Lofland and Lofland 1984). I did recognise however that my involvement in trying to understand meaning through the process of research would not *guarantee* that I would get to the essence of phenomena (Denizen and Lincoln 1998). Research participants can still be unwilling to disclose information and meanings can be hidden rather than made apparent.

Interpretative research (Flick 1998) is part of the qualitative tradition that sees research as part of a social act, studies social phenomena within everyday contexts, and explores the researcher's role and influence on the process. I wanted to study phenomena within such contexts and to generate some theory through the process of data collection and analysis. The theories of homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002) reserve (Grundy 2006) and resilience (Blane 2008, Vandsberger 2005) not only informed the data; I also wanted to explore through the analysis how far these concepts had value in trying to understand the experiences and reactions of these older people to their moves. I wanted to see how far the resiliency framework (Vandsberger 2005) was applicable to these lives; to see how far they were able to draw on their reserve (Grundy 2006). An interpretative approach in which meanings and experiences would be scrutinised enabled me to seek to understand residential care through the lens of these conceptual tools. It enabled

me to understand the patterns within people's life courses and to highlight any particular features of their lives that had generated a capacity to 'successfully' negotiate their experience of residential care.

The positivist approach, with its assumption that there is no essential difference between natural and social phenomena (Buchanan 1998), was not compatible with my aim of exploring meanings. Positivism is concerned with testing observable phenomena without attention to human beings' abilities to reflect on their own experiences. By suggesting that reality consists in what is available to the senses (Giddens 1986), positivism becomes unhelpful to research that explores the unseen and the more abstract elements of experience. Exploration of issues relevant to the concepts of reserve (Grundy 2006) and resilience (Vandsberger et al 2005) required some examination of how older people perceived not only life in residential care but it involved looking back with older people on their lives to identify patterns in their responses to testing or difficult situations.

It is difficult to easily quantify such experience and so an interpretative approach was most suitable to such an enquiry. The research questions expressed this interest in the abstract aspects of older people's lives. They were interested in understanding the experience of moving to care, the different perspectives of older people and practitioners, the influence of past lives and the idea of a 'successful' relocation. These questions were about reflections and perceptions as much as they were about easily quantifiable phenomena. The research was interested in measurement of outcomes of residential care but in a qualitative sense in which social phenomena are analysed and discussed.

The biographical approach

The biographical approach was central to my research. My research explores the concept of human agency, the ability of human beings to choose an intended state of affairs and people as social actors that strive to make sense of their worlds as they relocate. This research was about appraising older people's ability to make sense of residential care and to see how over many months of interviewing they learnt to adapt (or not) to living within such settings. The

biographical approach followed older people's biographies through to their present lives within residential care. My approach was broadly to see how 'successful' they were in adapting over time. A biographical approach (Burgess 1984, Plummer 2001) is therefore relevant because it explores the changing experiences and outlooks of individuals' daily lives (Roberts 2002) even if it did not draw on diaries, letters, autobiographies, memoranda or other material (Denzin and Lincoln 1998).

Biographical research seeks to understand lives as processes rather than in static terms, showing how past events link with current ones. Roberts (2002) distinguishes between the 'life story' and the 'life history', arguing that the 'life story' denotes a story narrated by the teller. The 'life history' refers to the way that story is interpreted. Stories are always interpretations, both by the story teller and the person hearing the story. The biographical approach fits within an interpretive tradition (Flick 1998) in which the researcher seeks to interpret the 'stories' of participants as a way of understanding phenomena. Biographical research reveals how contemporary social contexts (Roberts 2002) influence individual accounts of life experiences. Through biography we can see not only individual choices but appreciate the constraints that people have to work under. Stress and resiliency frameworks (Vandsberger 2005) recognise the value of approaches that get to the underlying concerns and preoccupations of older people. Through biography we can get closer to understanding the patterns of resiliency displayed not only in residential care but in earlier settings and situations at other times of people's lives.

Individual and social worlds

The positivist paradigm sees human conduct as governed by laws (Cohen and Manion 1989), but research within the interpretative paradigm tries to discover and understand the rules that people follow how they negotiate between themselves and others. Certain 'rules' had to be comprehended to understand the meanings of people's behaviour across settings (Hughes 1980), but by choosing a qualitative approach, I adopted methods compatible with individual interpretations, to see how people followed or made sense of their own choices within various contexts. I argue that practitioner/researchers must be aware of

social contexts that shape their moves. Families, localities, cultural influences, gender, social structures and historical events influence individual lives (Clarke and Cochrane 1998).

The resiliency framework's (Vandsberger 2005) emphasis on understanding the social and political context was also important as social policies also help us to understand the wider context of rules that needed to be comprehended. It was necessary to understand how the terms of the 1990 NHS and Community Care Act, or the long standing requirement to raise assets usually by selling one's own home to pay for residential care home fees (Clements and Thompson 2007), helped shape the lives of this group of people living in residential care homes in the late 1990s. The norms of residential care homes and the regulations governing referrals to residential care, including the ways older people relate to staff in residential care homes, were other potentially important considerations.

Research and practice

As a practitioner/researcher I wanted to link my research to practice in some way, even if indirectly. Robson (1996) warns of the dangers of separating practice from research - practice can become distant from service users when it is not informed by research. My aim was to identify research outcomes to promote the development of service responses to older people. The findings would be relevant to older people moving to residential care but also other settings. It is an approach that draws from the ideas of action research although only in a limited sense. Action research involves planning, action, observing and reflecting (Robson 1996). Action research (Robson 1996, Winter and Munn-Giddings 2001) seeks to address issues in practice settings with its findings intended to facilitate and develop good practice. My research involved planning and various stages of involvement with older people and practitioners, interviewing them at various stages, reflecting on the data and returning to the interviews 'armed' with this reflection.

My research explored the nature of older people's situation as they relocated and wanted to identify any problems or issues as they made their moves. My research questions were designed to identify the problems experienced by older people

during relocations, and effective strategies for addressing these issues. I endeavoured to involve older service users in the research process as respondents, and developed constructive relationships with them. The research did however only partly reflect the ideals of action research in that I did not make any immediate recommendations for practice even if the findings have some theoretical and broad relevance.

Part two: methods

I chose methods compatible with the overall aims of the thesis - life histories, semi-structured interviews with both older people and with practitioners, and a reflective research diary. Semi structured interviews, typically wider in scope and frames of reference than more structured interviews (Burgess 1984), explored the reasons why older people moved to residential care. The research involved some degree of contextualising the findings with inclusion of some demographic data. I identified historical and social trends, and contexts in which to explore the significance of individual experiences.

Interviews were conducted with professionals and social care staff who were employed by social services and other agencies that work with older people. These interviews were more structured than the interviews with older people. They did however provide some scope for practitioners to talk not only of their own role but of themselves in terms of their background, attitudes towards their own social class, gender, ethnicity and if, or to what extent, those dimensions affected their work. It was important to contextualise their later reflections on their role and the lives and relocations of older people. I asked them about how long they had been in their roles, if they lived local to the homes, if they felt 'close' to the older people they worked with as I explored questions about the nature of their working relationships with the older people. Practitioner interviews were followed by interviews with older people. The research diary complemented these methods, helping me to reflect on the research process and outcomes.

The interviews with a sample of older people constituted a case study approach that involved a small number of cases in a localised setting (Hammersley and

Atkinson 1985). The case study approach (Yin 1989) asked explanatory questions of the 'how' and 'why' variety, for example, how the social worker intervened in the older person's life and why the older person was discharged from hospital later rather than sooner. All the main research questions guiding this thesis were of the how and why variety and all sought explanations not only from case to case but from interview to interview. An individual case study of each person noted accounts of earlier phases of their lives from young adulthood to old age, and from independent living to residential care. A collective case study approach (Firestone 1983) enabled me to conceptualise across individual cases.

The emic, etic, and the sceptical stranger

The research was driven by a wish to discover older people's conceptualisations of their moves. This commitment to the emic (Glasser and Strauss 1967), or insider perspective, was matched by my wish for some degree of detachment from the process - the etic (Glasser and Strauss 1967) or outsider view - the position of the sceptical stranger (Clarke and Cochrane 1998). I strove to maintain objective distance independence from the older people as well as from the social workers who provided access to them. As an outsider, I could stand back from older people's personal experiences to gain objective understanding of the norms and rules that influence behaviours (Hughes 1980, Cohen and Manion 1989).

With outsider status, I could analyse responses from case to case, developing concepts across individual cases and picking out generalities of experience without too much personal involvement. However, this aim rested uncomfortably with my other aim of being 'close' to older people's conceptual worlds. Detachment and distance from respondents were not entirely compatible with understanding older people's particular experiences of relocation or the details of their life courses. The tension over my roles as 'insider' and 'outsider' was also difficult. Being close to an individual's conceptual world could obscure my ability to identify findings from a generality of cases, but 'distance' could compromise a wish to understand the specific relocations and life changes of individuals. This dilemma was never fully resolved and I managed the tensions

with use of a research diary, constantly reflecting on the process as much as the outcomes of the interview process. This was carried out as I went about the task of identifying the experiences that were specific to certain individuals and highlighting themes that seemed to cut across different cases.

Part three: The fieldwork process

The fieldwork took place within an English city with interviews with practitioners taking place in the April and May of 1998 followed by interviews with older people in the nine months from June 1998. For the study, I selected samples of practitioners and service users. The people and sites chosen for the fieldwork had to reflect my research questions. In other words they had to help me to answer the questions guiding the thesis. Interviews with older people needed to include a certain amount of diversity within the sample in terms of their experiences so as to reach a more holistic understanding of how older people in all their diversity may experience residential care. I needed to understand the concept of a 'successful' relocation within the terms of different life experiences and to explore how different people may or may not have adapted to residential care. This would then allow a certain amount of generalising to other groups of people in other kinds of settings. I also needed to interview range of practitioners undertaking different roles and tasks so as to understand how older people's perspectives on residential care contrasted with diverse and competing ideas from health and social care practitioners working across different settings.

Claims for typicality in the findings were supported by the social and economic indicators of the chosen area which were fairly consistent with, and typical of, the average social and economic indicators for England and Wales. The area had 62.5% of the population employed, which compared with 60.6% of the wider population of England and Wales (OPCS 2001) and an unemployment rate of 2.6% compared with 3.4% nationally (OPCS Census 2001). Housing tenure data revealed 76.4% owner occupation level compared to 68.9% nationally.

Census data also revealed that 95.4% of the local population described themselves as "white", compared with 90.9% for England and Wales, 14.0% of

its population were aged from 65 to 74 and 7.6% were over 75 years, which compared with 13.3% and 7.6% respectively for England and Wales (OPCS Census 2001). The agencies chosen for the research included the local authority social services department, private residential care homes, a housing association and a NHS trust. The mix of care providers reflected the mixed economy of care provision following the NHS and Community Care Act 1990.

Selecting a sample and gaining access

I used an approach to sampling that can be described as ‘purposive sampling’ (Marshall 1998) for identifying both practitioners and older people. This approach sees the researcher trying to obtain a sample that appears to him or her as in some ways representative of the people that are the focus for the study.

Practitioners led me to other practitioners to interview and the same process applied to the selection of the older people. I decided on a certain numbers of social workers, care assistants and other health and social care workers to interview and tried to gain these participants through moving from some groups to others, using contacts to lead me to other contacts. Social workers, for example, identified other social workers, and residential care home managers led me to care assistants. I identified a cross section of key players involved in older people’s moves into residential care which included social workers, occupational therapists, home carers, care assistants, community psychiatric nurses, carers (formal and informal) and others. I identified respondents who fell into each of these categories of practitioners. Taken together they supplied a breadth as well as depth of experience of older people’s moves.

Community Psychiatric Nurses were interviewed even if I did not interview older people with mental health issues. This was because I still wanted the perspectives of a wide cross section of practitioners who have involvement with other populations of older people making similar moves. I wanted a generality of experience from practitioners even if my sample of older people and their situations was more restricted.

Residential care homes were selected through the contact of the acting service manager of the older people’s section of the social services departments. She

suggested some residential care homes to visit across the region and they were selected by her and me on the basis of their ease of literal access (within easy reach of public transport) and the likelihood of them wanting to be involved. My time commitments, combining paid work with the fieldwork, partly dictated which ones I could visit on a regular basis given the need to attend work at a certain place and time after the fieldwork was completed.

I wanted to gain the perspectives of practitioners involved with older people at various points during their moves. I began the process by speaking with the acting service manager for older people's services in the local authority area chosen for the study. She and I identified residential care home managers, care assistants and other staff at residential care homes who might wish to participate. The acting service manager suggested particular residential care homes across the local authority area as possible settings for the interviews with older people.

Tensions were apparent during the early stages of planning the interviews. Social services staff wanted control over selection of participants, expressing concern that older people and practitioners might be asked to divulge sensitive information. They wanted assurances that confidentiality would be respected. This clashed with my wish to gain a diverse sample of practitioners and older people. I needed the permission of service providers to access participants and gain their co-operation with my aims and objectives. Social service managers wanted to know how many staff would be interviewed, whom to involve, the content of interviews and the time scale. I identified heads of service, contacted them and gave them background information on the main aims of the research.

Service heads indicated that they would supply names of participants from each profession (such as the community psychiatric service). The meetings with residential care home managers served a similar purpose. I was given lists of staff, and I contacted social workers via the team leaders. Social care employees were contacted via managers of nine residential care homes. I attended two assessment and care management team meetings (in connection with the intended interviews with practitioners who worked in community settings). My attendance at team meetings led to dialogue with practitioners and dissemination of information about the project.

Choosing the residential care homes

This study focuses on moves to residential care and it is important to make a distinction between residential and other forms of care for older people. Residential care is a residential setting where older people live and receive personal care. They usually live in single rooms and have access to on-site care services. Such homes provide care only including help with washing, dressing and giving medication. Nursing homes provide personal care but also have a qualified nurse on duty twenty-four hours a day to provide help with nursing tasks (Elderly Accommodation Counsel 2007). Whilst the primary focus is on residential care, one older person of the twelve made a subsequent move to nursing care and others made moves to residential care from settings other than the private home, such as from sheltered housing. The Elderly Accommodation Counsel (2007) defines sheltered housing as housing in a group of flats or bungalows where all residents are older people often over the age of 55. Such housing provides independent, self contained homes and whilst they will have their own front door there will be common facilities such as a laundry, space for guests and a garden. They will have their own manager or warden living on site and services are often linked to a care line or emergency service so that residents can access help when required. There are often many different types of these schemes, to rent or buy.

The selection of homes was an issue but the category of ownership of the residential care homes was not central given the conceptual basis of my research. I was after all interested in what affects moves to residential care and to identify factors from older people's lives that would affect such moves. The research was interested in considering the conceptual worlds of both older people and practitioners and so from this point of view the management and ownership of the care home were not particularly central to the research process or the discussion. The Acting Service Manager for the district suggested three homes. One home was situated within a middle class area with at least one of the other two located within a more working class area. This did not guarantee that residents had lived in areas within the vicinity of the residential care homes. The homes were chosen for their accessibility by public transport within the time frame in which I was working. All three were local authority homes. After

ongoing dialogue with practitioners, I decided to include private residential care homes, to reflect a more typical representation of the residential care home sector even if this was not of crucial importance.

Table 3: The residential care homes chosen

Residential care home number	Ownership	Beds
1	Social services	30-40
2	Social services	30-40
3	Social services	30-40
4	Private	10-12
5	Housing Association	40
*Six residential care homes were originally chosen: see comments below		
* There is no information here on years that these residential care homes were in operation or registration status.		

This balance was still untypical of the mix of providers of such care with a disproportionate number of Social Services homes. The range of private sector providers of residential care grew during the 1980s (Residential Forum 1996). Until the end of the 1970s local authority homes predominated but by 1993, 72% of beds were in private homes (Residential Forum 1996). This typicality can be explained by pragmatic reasons with the homes chosen picked because of their ease of access in terms of closeness to my home and work. I was to spend a lot of time in the ‘field’ with regular visits that needed to fit with my other commitments.

After a number of visits to residential care homes across the district, five residential care homes were chosen as potential locations for interviews with care staff and older people (see Table 3). Choice of homes arose from dialogue with residential care home managers and after talking informally and in an unplanned way with residents. I chose six homes originally but decided to discontinue at one of the homes after speaking with residents in the residential care home lounges. The home took residents from a nearby residential care home that could

not cope with the needs of highly dependent residents. Conversations with residents at the home revealed that it might have been difficult for some residents to participate because many had speech difficulties, considerable mental and physical frailty, and exhibited memory lapses.

A similar decision was made about older people who attended a day care unit. I decided after meeting with them and the staff that it was not appropriate to continue. Users of the centre, as potential future residents of care, might have enriched understanding of the issues but the individuals themselves did not want to participate. There were sensitive issues; the older people at the centre did not want to identify themselves as future residents of residential care homes. They also indicated that they would find discussion too painful. Their right to refuse consent was respected (Butler 2000).

The majority of staff members at the residential care homes were asked to agree their involvement in the research. Some residential care home managers were reluctant to supply names of all staff, perhaps fearful that workers with negative feelings about their work might give a poor account of the homes. I drafted a letter to staff and presented this to residential care home managers for their approval prior to its circulation. Transparency about the aims of the research was emphasised in each letter. The letter also recognised the right to withdraw from participation at any point (see appendix 1 for sample letter). My research took place during a Social Services review of residential care homes that anticipated selective closures of particular homes. I informed managers that the research was not to examine the quality of the homes, but would study theoretical concerns about the nature of moves.

Choosing the practitioners to interview

I circulated letters to most staff at the homes, outlining the purpose of the project, asking for their co-operation and giving assurances about confidentiality although not discussing any issues such as the limits of confidentiality or being open about all aspects of data storage. Confidentiality needed discussion in relation to data storage. Davison (2008) points out that the Data Protection Act 1998 requires researchers to ensure that research subjects are given a unique

identifying code. The data must be anonymized and stored safely. These details needed to be shared both with older people and practitioners involved.

A similar letter was distributed to practitioners in community settings, via the section heads. These community settings included a psychiatric unit of a hospital, where I interviewed a community psychiatric nurse. Time was always pressured because I was reliant on public transport and undertaking the research on a part time basis. Timetabling and flexibility were issues at this early stage of the fieldwork. I needed to ensure that my research would not interfere with the task of care giving. The collection of data was dependent upon the planned interviews taking place as and when agreed.

Selecting the older respondents

I wanted to interview older people at different stages of their moves into residential care - the stage when an initial decision to enter care is made, the stage when decisions are made about a specific move, and the subsequent days, weeks and months after the actual move to residential care. I interviewed both men and women who reflected as much diversity in the sample in terms of gender as was possible, however the range of ethnic backgrounds was limited because of the characteristics of the local population. Selection of the residential care homes was followed by selection of the sample of older people.

I returned in the autumn, six months after my initial visit, to the five homes identified during the first phase of the fieldwork. The chosen respondents had been living in residential care homes for weeks, months or years (see Chapter 4). My decision to include a short stay resident in the sample was determined partly by availability and partly by chance, when she became available at a later stage of the research. Luck can be an apparent part of the research process of qualitative research (Bryman 1988) and can significantly affect its direction.

Dialogue with residential care home managers and care team staff gave me a chance to be involved in the selection of participants to ensure their diversity. Lists of potential participants emerged from my dialogue with residential care home managers and other members of the care teams. Each of the homes

supplied between half a dozen and over twenty names of potential participants. I anticipated that some people would not wish to be interviewed, because of the sensitive nature of the research. Some individuals might not be suitable, for practical reasons such as their impaired hearing, indistinct speech, emotional or physical vulnerability. I secured confidential information from care staff about any recent bereavement or health issues and this data assisted me in the process of making decisions about whom to interview.

Some individuals had experienced recent bereavement, specific health problems and/or emotional as well as physical vulnerability, so it seemed ill advised to approach them. I decided that there were issues of risk and a duty of care towards residents who may be too vulnerable or not ready to disclose personal information. Some possible respondents declined to participate after unplanned conversations with me within the residential care home lounges. Their decisions were respected. There were other more positive reasons for not interviewing some of these older people and these were related to some theoretical issues. The research was guided by a commitment to avoiding harm (Hollway and Jefferson 2000, BASW 2003) to research subjects and not in any way, directly or indirectly, exploiting any vulnerabilities.

I also wanted to give 'voice' to older people's experiences of residential care in terms of their ability to adapt to settings and whilst bereavement and health or emotional concerns were recognised as features of such an experience I did not want their specific concerns to dominate the agenda too much in any interview. The theoretical commitment was to evaluating moves in terms of older people's ability to adapt to or live 'successfully' within residential care. Too much focus on individual preoccupations with recent life events that may carry high emotional impact for the older people could obscure the more general lines of enquiry. I needed to know how older people were evaluating their own change in line with the approach consistent with the resiliency framework (Vandsberger et al 2005). I also did not want to blur the boundaries between researching and 'counselling' and was concerned not to include older people within my sample that might take the research in a direction not appropriate to the study.

I made visits to residential care homes to meet both practitioners and older people prior to formal interviews. I emphasised that all participants in the research had the opportunity of withdrawing from the research at any stage. Practitioners and older people were aware that the research was time limited. It was particularly important to emphasise this when talking with older people who may have some emotional concerns or personal issues that might lead them to want to discontinue at any point. The timescale of the project was made clear so that they knew when the interviews would start and when they would finish both in terms of the timetable of interviews and the length and format of individual interviews.

I became acquainted with the respondents over a long lead-in period before any formal research began. I demonstrated my reliability to the care staff during this period by appearing at times agreed and not overstaying my time or delaying or disrupting work practices. The visits to residential care homes had an additional purpose and advantage. They provided an opportunity to view the settings for later interviews with older people, so I could judge the suitability of residential care homes as places within which to interview (acoustics, confidentiality etc). I decided on interviewing twelve older people and the reasons for this number were largely pragmatic and determined by my work schedule with a certain number of time slots available during my working week to get to the homes and to enable a certain amount of time to be allocated to each individual older person. These were in-depth explorative interviews in which research subjects needed time and 'space' to explore their own perceptions and tell their own stories.

I was constrained with time because of my dependence on public transport as a means of getting between the care homes and my place of work. I decided to allocate at least an hour for each interview with time allowed to meet with care staff to discuss any general issues prior to meeting the older people. There were times when research subjects experienced bereavement or some difficulty and staff needed to share this with me prior to interviews so that I could be sensitive to them in terms of questions asked. Extra time had to be built into this schedule and my calculation of twelve to interview was based on these combined considerations.

Part four: operationalising the research

I conducted twenty-nine interviews with practitioners, using an interview guide. The interview guide facilitated a qualitative approach because it was designed to inform understanding, and helped me to get closer to discovering the underlying meanings of human behaviour. Questions to practitioners were sufficiently broad to allow practitioners to reflect on the particular practice situations in which they engage with older people. The questions also allowed practitioners opportunities to comment on any factors that might affect moves, including events from older people's life courses and the influence of other social actors. Practitioners were asked to reflect on their practice experiences in terms of length of service and any earlier work experience that may have had an impact on their current work and attitudes.

My interview schedule asked specific questions as well as open-ended questions that did not presuppose any specific explanations but gave practitioners the opportunity to mention factors from their own work with older people. I did not directly set out to ask about issues of homeostasis, resilience or reserve or use these concepts actively within the interviews. These conceptual tools emerged later as the data was analysed. There was however an interest in knowing if or to what extent practitioners recognised the potentially diverse ways that older people may experience residential care, if they recognised these complex psychosocial factors or if they saw residential care as the default choice portrayed by Townsend (1962).

Interview structure was less important for interviewing the older people. Their meanings and interpretations needed more scope for free expression as their responses to residential care were personal and potentially much more emotional. Resultingly, an aide memoir (Burgees 1984, Bryman 1988) with lists of themes and key words was more helpful to the interviews with older people than an interview schedule. The interviews with practitioners proceeded through the interview guide (see appendix 2) although I frequently asked supplementary questions to gain clarification about a particular point. Practitioners were free to depart from the interview guide as long as they stayed with the broad themes embodied in each question. My supplementary questions focused on specific

aspects of each practitioner's role or setting in which they might see older people.

Practitioners were asked to define a 'successful' move although this does not mean that it was practitioners that would be defining the terms of what makes for a successful move to residential care. Practitioners' understandings of a successful move were set alongside the ideas of older people. The emphasis was on broad areas of questioning to elicit broad responses and rich data. Interviews with practitioners usually took place in their offices or place of work. The one exception was with a care assistant who preferred to be interviewed in her own home. She was happier to talk in this environment, mainly because she preferred the interview not to be conducted within her work setting. This was for reasons of confidentiality but also because it suited her shift pattern that particular week.

Interviews with practitioners: design and piloting the interview guide

The interview guide was constructed from two key themes (roles and tasks of practitioners; understanding moves, appendix 2). It was piloted to ensure that its content was grounded in the viewpoints of those involved. A pilot interview with the acting service manager (older persons) of the local authority gave the perspective of a professional worker with experience of community based practice. The testing and piloting of the interview guide led to some revision. Pilot stages of research schedules are 'dummy runs', often the first stage of data gathering (Robson 1996) to test the research methods. The pilot allowed development of lines of questions and also provided conceptual clarifications.

The response rate

The response to my request for participants varied considerably. A good response was gained from the community-based staff. Service heads of teams of social workers, occupational therapists, and home care and community psychiatric nurses offered names of practitioners to interview. Most of these practitioners were positive about participating. Reservations about potential breaking of confidentiality and trust were not reflected in their eventual attitudes towards involvement. My contact letter to potential participants (see appendix 1) tried to

reassure them that the research would be ethically based although, as was stated earlier, it did not discuss any potential limits to confidentiality or any specific issues such as data storage or handling.

My attendance at team meetings allowed me to gain the perspectives of social service staff as I fielded questions of concern raised by team members. Sampling rates from staff at the residential care homes varied with, on average, one in five or one in six practitioners agreeing to be involved. Payment for interviews was not offered (and was not affordable within my self funding budget as a part time practitioner/researcher). Requests for involvement were based entirely on the willingness of professionals and carers to participate without financial reward. In all, twenty-nine practitioners agreed to be interviewed (Table 4). Thirteen worked with older people in community settings and sixteen in residential care home settings.

The quite lengthy period of negotiation with older people in residential care resulted in the selection of twelve older persons for a nine-month programme of interviews who fitted my requirement of diversity to some extent. There were men as well as women in the sample of older people, in different age groups and they had different levels of residency at their residential care homes. Some were widowed and one was still married (the older people selected are outlined in more detail in the next chapter). Although there was some diversity within the sample it was to some extent what could be described as an opportunity sample (Dyer 1995) with an element of design but also chance in the selection of people. Whilst I sought diversity and had a certain method there was an element of randomness or negotiation in the process.

Each of the twelve older persons was interviewed on a monthly basis for approximately one hour. Participants were partly self selected although there were lengthy periods of negotiation firstly between myself and the residential care home managers and then between me and the residents. For every one of the twelve chosen, around three or four others declined to participate, although the informal nature of the process made it difficult to determine a certain number. None of the residential care homes chosen for the fieldwork had any black or ethnic minority residents, reflecting the relatively low percentage of people from

ethnic minorities within the area. There were few black or ethnic minority practitioners amongst the staff group. Residents were not all local, although eight of the twelve were born within the same county as the residential care homes. Only some practitioners lived within the vicinity of the residential care homes.

The study was limited to interviews with older people and practitioners. I could have included others in the study to reflect a wider range of different perspectives including family members related to the older people and perhaps informal carers. I decided against this mainly because I felt that involvement of family members who knew the older people would introduce another dynamic into the research process with some ethical issues also involved for as researcher I would then be operating in the inter face *between* family members. Issues of confidentiality would have been heightened and made more complex and questions of 'voice' and whose voice is heard through the research would have been intensified and potentially confused. Family and carers would have had their own perspectives on the research questions that guided the thesis and they would have enriched the data but practical and ethical issues meant that the study had to be limited in certain ways (discussed in greater detail in the ethics section)

Interviews with older people: the format

Older people's interview participation was organised through a period of negotiation within the residential care homes. I met potential participants within communal lounges, which did not ensure privacy, but participants preferred to be interviewed there. A flexible approach was needed with older people just as it had been required with the practitioners. I negotiated with residents to secure their potential involvement. Flexibility meant being available to interview older people at times that suited them. The routines of the residential care homes (e.g. meal times) were factors. My dialogue with managers helped me to identify who wished to participate, suitable days and times for any interviews and to address issues such as older people's consent for interviews to be tape recorded.

Interviews were carefully planned to take into account our mutual circumstances. Each interview was scheduled for an hour with some additional time built into the schedule to take into account unforeseen events. The aide memoirs focused

on themes identified from the interviews with practitioners and from the literature review. Each interview covered specific topics including their responses to major historical events during their lifetime and the ways they adapted or coped with change.

Analysing the data

Findings from my interviews with professionals/carers and with the older people are analysed and presented in Chapters four to seven. The method of data analysis derives from the choice of a case study method. The multiple case study approach built general explanations to apply to each individual case. The subsequent data analysis involved pattern matching (Yin 1989). This involved building explanations from case to case, identifying themes across cases, counting and coding the data. Data were coded into categories, providing scope for reflecting on older people's experiences. Phrases and words rather than numbers were analysed, with links made between different fragments of qualitative data, the different research phases and between the different cases.

The power of doctors and practitioners was identified across different cases, with two respondents perceiving strong practitioner power and their words reflecting this (see Chapter six). I identified, coded their words and then identified links to practitioner power and placed the respondents' comments in the same category. It was however important to be always critical of the data and it is important to recognise that older people may have perceived doctors as powerful but these are perceptions and interpretations. It must also be remembered that doctors themselves could not comment on these reflections. I was not interviewing the same practitioners involved in the older people's cases.

The data analysis involved listing, coding and identifying themes, which made it possible to develop broad understandings across the cases. It became easier to appreciate and reflect the complexity of an individual case but also to analyse across cases and pick out consistent themes or experiences. As I read through the transcripts of the interviews with the older people, I broke the text down into segments of meaning, by line or by paragraph, as appropriate. I then coded the reduced data. These codes operated at different levels of analysis from the

descriptive to the inferential. Sometimes older people reflected explicitly on the power of doctors whilst at other times it was implied. I created pattern codes, and used them to make links within the data, identifying patterns and themes. I linked different concepts and typologies, using the words of respondents (Lofland and Lofland 1995).

Organising the words of respondents made the analytical procedures systematically coherent. Ascribing codes and categories to each part of the data gave structure to the analysis and facilitated comparison of the relationship between two or more themes. Patterns and relationships were identified through a diagrammatic analysis (Lofland and Lofland 1995). Themes were listed in a chart form. This was undertaken with regard for contextual meanings (Lofland and Lofland 1995). Older people's interpretations of their own moves to residential care revealed their thoughts and feelings about where they lived and how they felt. Data reduction and coding need to be done in a way that shows contextual understanding of the actual circumstances because understandings can be lost in the drive to classify and group responses. However, typologising (cross-classifying people's actions and behaviours) can be a useful tool to thinking (Mills 1959). Diagrammatic representations allow the researcher to see the range of relationships between concepts (Mills 1959) but must be used with caution. Understandings might not be borne out in isolated words or even strings of words. The voice of older people and practitioners might be heard between the lines rather than in the actual coded data.

My notes on people's feelings and reactions and my interpretations of body language were built into the analysis (reflected in my comments on the body language of Debbie, Janice and Bernard, Box 3). I did not reduce everything to a matrix or a typology. I have displayed the data in subsequent Chapters within the text, using vignettes and tables to summarise findings. The family, educational and employment background of one individual is contrasted with the backgrounds of other lives, identifying patterns from one life to another, and from one description to another. These descriptions form bridges between existing conceptual categories and those that emerge from the data. Data from general observation and reflections from the research diary provided additional

contexts. The constant comparison of data enabled the research questions to be explored and understandings to emerge.

Part five: Evaluating the methods

This evaluation of methods is an examination of how effective they were as ways of addressing the research questions. The methods adopted needed to enhance the overall research aim of learning about older people's conceptual worlds as they relocated to residential care and to see how they compared with practitioners. It was very important that I reflected on the process as much as the outcomes of the research. The research diary was therefore an important method. Reflection on the process helped me become aware of how my research plan and its execution did not always recognise that older people should have been equal participants (Snelling 2005). Corti (1993) emphasises the value of research diaries by highlighting some major benefits from using one. First, they can provide a reliable alternative or supplement to the traditional interview by allowing the researcher the chance to recall sensitive information that may easily be forgotten. Secondly, they can provide a rich source of material on research subject's behaviour. Diaries can also make the researcher more reflexive, providing insights into the methodological process (Nadin and Cassell 2006). The diary was also useful as a means of knowing research subjects much more and thereby getting closer to them as equal participants. This equal participation mattered not just for some abstract principle but because through this involvement I sought to get closer to respondents conceptual worlds so that it would be easier to understand the various influences on older people's moves and their conceptions of them. This would then allow more effective and rich comparison with the more generalised practice perspectives of practitioners.

Mixing methods

Combining different methods proved successful in that I was able to identify some sharply contrasting perspectives on older people and their relocation to residential care. Studying the issues from different experiences provided contrasts between practitioner and service user reflections not given in any other previous research into relocation to residential care. This approach cannot be

called triangulation for although it combined methods it was not strictly triangulation, which studies the same phenomena using different data sets. (Denzin and Lincoln 1998). This was the same phenomena in that both sets of interviews involved exploration of issues affecting relocation but older people's narrow and specific experiences were very different to practitioners more generalised findings. The same concerns were implicit in both sets of interviews. I was interested to know how practitioners and older people understood residential care and the influences taking people there and how practitioners understood the concept of a 'successful' transition.

The data sets were both concerned with the same issues but it was not a comparison of like with like. The life course and the life events leading to residential care were contexts outside practitioners' experiences. Similarly, contemporary practice experiences were outside older people's experiences although this did not mean that a comparison of the data sets could not be made.

Understanding issues of homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002) is served by knowing not just about older people's accounts but also about how practitioners make sense of these relocations and how they determine the features of a 'successful' move. Practitioners working with older people in these settings and in field locations will be guided by their own perceptions. To know of the different perceptions and how they see issues of community, care, residential care and 'fit' between older people and their settings are important because they might affect how they work with older people and the decisions they make.

Overlapping data sets

One might argue that it would have been more appropriate and productive to interview older people and the health and social care workers specifically attached to their cases. This would then have been authentic triangulation as the same phenomena would have been studied from different perspectives (Denzin and Lincoln 1998). There would however have been many ethical and practical problems with this approach and it would have not provided the sharpness of contrast between perspectives. To know the sharpness of this contrast in

perspective is to get closer to knowing how older people and their social workers may be more broadly 'detached' from each other in terms of their conceptual understanding. It is also important to emphasise how older people's own specific emotional experiences of relocation would differ from practitioners' wider and more detached experience of the issues from a working perspective. This difference in perspective was important and would not have been so acute if practitioners and the older people's cases had been shared and specific moves discussed by older people and their social workers and other practitioners.

It would also have been practically difficult to talk with all involved in each specific case. There would have been ethical and other issues when operating between different parties in the same cases. My role would have been less clearly defined and there may have been more uncertainties getting involved in the same cases and moving between older people and their social workers/others.

Managing the tensions

Each method of the research required a certain management of the tensions between the plan and its execution. Unforeseen events can sabotage research plans, schedules of events, and checklists of things to do. Chance events cannot be controlled no matter which method is used. Events that occurred during the fieldwork period included the death of an older research participant and relocation of a respondent to nursing care. One older person died before the completion of the schedule of interviews. Another had a fall when in residential care, moved to hospital and then to a nursing home. Participants would forget interview times or double book with a visit of relatives (Box 1). On another occasion, an interviewee preferred to talk through personal photographs rather than discuss issues on the research agenda. This was not according to plan although the discussion revealed informative data about the respondent's life course.

My research diary helped me to reflect on my plan and methods. Whilst I was aware of possible tensions in the early stages before approaching respondents, I was initially unaware of any tensions between my research plans and participants' wishes. Practicalities of carrying out the research meant that there were times when participants' needs took precedence, but too often I regarded

their needs as a 'problem' rather than as an opportunity to involve them more fully in the research. For example, I could have shared and discussed my research plan with the older respondents. Snelling (2005) refers to the biographical narrative method in which the researcher asks few questions but lets the respondent talk freely with minimal intervention (Roberts 2002). I was however committed to the well-being of older people and maintained that kind of focus on their experiences. I did not see my role as a campaigner but saw myself as committed to a line of enquiry about residential care and how it is experienced.

Ethical issues

Peled and Leichtrentritt (2002) claim that there are five assumptions that should guide their approach to the ethics of published research. First, research ethics should be integral to the research so much that they guide each research act. Second, they should empower research participants and especially those that are vulnerable or marginalised. Third, they should benefit participants. Fourth, they should prevent harm for participants and also fifth, they should require some technical competence. To ensure that things are done well the project should describe and outline how each of these five measures were achieved. Each of these issues concerned me. Ethical issues mattered as it was important to work with older people in ways that did not exacerbate any sense of vulnerability that some may have been feeling.

Avoiding harm (NASW 2008) was very important as I sought to understand older people's relocations. Getting 'close' to research participants was important so that their conceptual worlds would be brought into focus and the absence of homeostasis or resilience could be recognised through the detail of their stories and experiences. But disclosure on their part may have made them more vulnerable. The research needed to be carried out with due regard for issues of confidentiality and other ethical concerns and an amount of technical competence was needed to ensure that I carried the research out with both vigour and efficiency but also sensitivity. These same principles applied to both older people and also practitioners and even if older people may have seemed more vulnerable

in many ways the rights and wishes and interests of practitioners both in care and field settings were also very important considerations.

Research ethics mattered in that it was important to conduct the research in a way that did not compromise certain ideals. I had an ethical awareness in that I was concerned with the rights and dignities of the research subjects (Munro 2005). I wanted to prevent harm and enhance the well being of older people through providing research findings to support good practice and enhance the well being of older people. This principle of protecting research participants from harm is supported by the NASW (2008) who say that “Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger or deprivation” (21:2008)

There are also issues of harm when discussing relationships between the researcher and the researched but not only from the point of view of research subjects. Davison (2008) reflects on the issue of harm and distress within the research process but from the point of view of the researchers. Social work researchers may be particularly conflicted by combination of the ethics and values of their professional training and the research methodologies they choose that stress empathy and emotional reflexivity. She raises the issue of trying to evaluate how sensitive subjects are and the fact that research can become so as it evolves. Modern social work research supports the idea of a reflexive style of social work research but Davison (2008) argues that the researcher is not necessarily emancipated by the process of research. Part of that rapport building involved the researcher actually revealing quite intimate details of their own lives. There are dangers in moving from being an interested researcher to a personal friend or informant or from a researcher to a social worker.

There are dangers for a researcher involved in health and care settings in terms of their aims, values and priorities. They may not only have a responsibility as a researcher to give ‘voice’ to research subjects. They may also have a duty of care and this may manifest in attitudes towards confidentiality. There are questions of whether a researcher is prepared to break confidentiality if for example, details of abuse to or by any research participants is revealed through interviews. If such

breaches are to be made then they must surely be agreed in principle by the researcher with the participants at the outset of the research.

The issue of confidentiality also needed wider discussion and a greater recognition of the complexities of these issues. Davison (2008) highlights the importance not only of confidentiality but of its limits. She says that it is very important that there are clear explanations of the limits of confidentiality and that these are outlined to participants and that all issues are discussed in detail with those giving and being given access to field work sites and participants. These limits should be acknowledged and outlined to participants and the agency before fieldwork begins. There could have been various adult protection issues and it was important that there was some discussion surrounding any situations in which disclosure (of abuse) may have to be undertaken. I felt that my primary responsibility was as a researcher and that I was not there to assume other roles as quasi social worker or social care worker. I did not see myself as having a responsibility to necessarily report issues of abuse or neglect although recognise that there are moral and ethical dilemmas here. Personal reflection since the fieldwork has led me to believe that there may have been some responsibility to 'whistle blow' in more extreme cases. There may even be legal obligations to do so although I was not aware of them. I was not at the time of the fieldwork guided by any specific professional or legal code. Nottingham Trent University did not establish their own Research Ethics Framework until 2005 although these regulations also do not refer specifically to 'whistle blowing' concerns or protocols. Clarity of role was however important and this needed full discussion with all parties, including older people themselves. I did not talk about or agree any limits to confidentiality at least not in the formal sense and perhaps failed in this sense to deliver a duty of care.

There are also tensions in the roles, alluded to earlier when discussing the possibility of interviewing the social workers attached to the specific older people identified as research subjects. The practical issues meant it was difficult to find the social workers concerned and to co-ordinate the task of interviewing both sets of research subjects concurrently. There were however more pressing ethical dimensions to this as boundaries to confidentiality would be more complex if moving between older people and their social workers. My role as

researcher may have been compromised in working at this interface especially if asked by the older people to be more actively engaged in supporting her/him via my liaison with the social worker involved. I may have wanted to empower research subjects as Peled and Leichentritt (2002), suggest but I was also seeking to 'prevent harm' as well as keep some 'distance' between myself and the research participants.

Access to the older people, the practitioners and the fieldwork sites generally was both a practical and an ethical issue. The research governance for health and social care (Department of Health 2001) set out good practice in this and other areas and recommend that a research ethics committee should be set up to ensure that ethical guidelines are followed. Ethical issues were apparent from the start of the research. Initial meetings with staff groups included discussion of ethical issues. The visits to residential care homes to interview practitioners from residential care home managers to care assistants involved interviewing staff who needed to be aware of the purpose of my visits. Some expressed concern that I may have been there as part of an ongoing staff review and this issue needed addressing. Staff were informed that I was not there as part of a review of staff competence and that I would not break confidentiality by divulging the personal experiences and reflections of either the older people or practitioners.

Written informed consent from participants is considered good practice (NASW 2008) and this should include information about the nature, extent and duration of the participation requested and disclosure of the risks and benefits of participation in the research. I did not attain written consent from either the practitioners or the older people even if I did talk with prospective participants about the research and its purpose. I explained in some depth about the research and my reasons for undertaking it. I also discussed my commitment to producing findings that might influence practice in ways that could assist residents and also practitioners by heightening awareness of issues surrounding their care and the process of relocation. I emphasised to all those interviewed that all had the opportunity of withdrawing their involvement in the research at any stage. Their cooperation would be voluntary at all stages. The older people were aware that the research was time limited. The timescale of the project was made clear so that they knew when the interviews would conclude.

I became acquainted with the respondents over a long lead-in period before any formal research began. I demonstrated my reliability to the care staff during this period by appearing at times agreed and not overstaying my time or delaying or disrupting work practices. The visits to residential care homes had an additional purpose and advantage. They provided an opportunity to view the settings for later interviews with older people, so I could judge the suitability of residential care homes as places within which to interview (acoustics, confidentiality etc). My withdrawal from contact with the respondents was gradual as I counted down the number of sessions and talked openly with participants about ending the interviews. I thanked them for their participation not only at the last session but as we approached the last interview.

BASW (2003) requires social work researchers to keep an active, personal and disciplined ethical awareness at all stages of research. Avoiding harm (Hollway and Jefferson 2000, BASW 2003) was demonstrated on an occasion when Mary, one of the older people selected for interviews, experienced the death of her husband in a nearby nursing home. She expressed a need for a break from the interviewing whilst she dealt with feelings of loss. I respected her wishes and agreed.

All of these issues were relevant to access issues. The Department of Health (2003a) say that access to fieldwork sites should be one of those issues that requires an independent review and monitoring. Staff expressed ethical concerns based largely on a fear that older people, already potentially vulnerable during their moves, would be made more vulnerable by involvement in the research. These concerns were perhaps motivated by concerns that the rights and dignities of research subjects should always be assured (Munro 2005). I had different interests from the practitioners, interested in gathering data for some research whilst they were interested in practice and practice issues even if all of us were interested in protecting the well being of vulnerable groups. The research process can be undermined by competing interests (Munro 2005) although my use of a research diary helped me to keep track of those competing perspectives and also monitor my research and evaluate the process, allowing me to reflect on ethical

issues also. NASW (2008) state that monitoring and evaluation of research is vital to keep a strong ethical awareness.

These different perspectives were reflected in the details of the meetings. Staff did not trust me to make judgements about what was appropriate and apparently did not recognise the older people's rights to decide for themselves whether to participate. I tried emphasising my commitment to respecting older people's wishes at all stages of the fieldwork process and affirming my belief in older people's ability to make their own judgements and choices. It mattered to me that people engaging in the research were able to make their own decisions at every stage of the research process about if and how they wished to participate.

This did not however translate into gaining any formal ethical clearance and my approach was more informal through the team meetings and discussions with members of the social services department. I did invite social services to contact the university to verify my role and the university provided references to support this wish for access but that was the extent of my ethical clearance. I undertook the research informed more by a value base and less by ethical clearance.

It must be acknowledged that ethical clearance and matters of ethics have assumed much more significance in social research in recent years than at the time of the fieldwork. In recent years, the Department of Health (2001) has codified research governance for health and social care, affirming the importance of the dignity and rights of research participants as part of a general code of guidance on research ethics. Social work research has also developed a research code of ethics (Butler 2000). Both of these codes of research ethics were consistent with my values of respecting individual choices about participation in the research.

The code of social work research ethics highlights the need to have special concern for those who are made vulnerable by age, health, disability or social disadvantage. Accordingly, my research was guided by the principle that every human being has intrinsic value (Butler 2000) and the right to well-being, to self fulfilment and as much control over their lives as is consistent with the rights of others (BASW 2003). Respecting respondents' individual autonomy in the

research process, and treating them as moral agents rather than just as a means to achieve my research goals were important. I had to recognise that older people might 'agree' to participate because they feel coerced by the perceived power of the researcher.

The research diary

The research diary was an important tool because it led to reflection and a greater awareness of the process as well as monitoring how the outcomes were achieved. The diary also gave me opportunity to note the unforeseen and the unexpected events that are outside the researcher's control (see box 1).

Box 1: Notes from the research diary.

Tuesday, January 26th

*Today I returned to *Wordsworth house, a social services home in the north of the county. The purpose of my visit was to see one of the research participants, *Bernard. The original plan had been to see him the previous Thursday. I did actually visit the home and to my surprise and disappointment he had forgotten that I was coming and had gone for a walk into the local town. Bernard was apologetic in forgetting his appointment with me the previous week. Misfortune and the unforeseen occurred again, however, when, shortly into the interview, my dictaphone malfunctioned and I had to continue with written notes. I felt dismayed. There have been a few technical failures with tape recording and numerous rearrangements of interviews. Many aspects have not gone strictly to plan.*

**This is a pseudonym to protect confidentiality*

The research diary helped me to reflect on how to respond to changing circumstances, to anticipate things going wrong (as much as possible), and adapt accordingly. The diary was useful in recording the mental conversations that I had with myself although these were not shared with respondents.

Gaining the trust of the acting service manager of social services was important to gaining access to the research participants. Her role was to manage the general direction of services to older people within the district. She had been a practicing social worker but now was responsible for service delivery on a much wider scale. She oversaw the role of social workers but also occupational therapists, home care workers and a range of residential care home and community-based practitioners who work with older people. Her knowledge and potential

awareness of moves from a wide practice and operational perspective were useful for the research. She gave advice on the use of language in a questionnaire directed at a range of staff with different roles and responsibilities.

Close involvement with the acting service manager sharpened the focus for the questionnaire, although involvement placed doubt on my independence as a practitioner/researcher. The researcher should be accountable to a research advisory group or committee (Humphries 1997, Snelling 2005). I needed more independence from the acting service manager and more accountability and discussion with the research respondents during the whole process of the research.

Access to respondents rested on good relationships and building of trust with service heads who acted as gate keepers. Whilst I established a degree of trust and co-operation I also compromised some of my integrity and independence. I was at times too eager to co-operate and did not assert my values and beliefs about the self-determination of respondents or my own independence from the agencies involved. This had the potential to bias the findings towards experiences that reflect positively on service provision. Respondents or individual residential care homes might have been chosen to reflect positively on the service rather than give a more of detached account of experiences.

Staff were satisfied that I would not betray trust, although I felt that control by social workers over such issues such as the selection of residential care homes compromised the research's rigor and depth (Denzin and Lincoln 1998). The social services department attempted to control who would be interviewed and this compromised my ability to fully involve service users in the process of the research. The irony was however that in some ways I was as intent on controlling the process as the social services staff. The method of opportunity sampling (Dyer 1995) did involve older people in the process of decision making about who should be involved and this method was in that sense empowering as they had some control over the process. Older people could decline involvement, but this must be tempered with an acknowledgement that older people might not have perceived this freedom. They may have felt obliged to be involved.

The tension between my need to be both 'close' and 'distant' was less of an issue with the practitioners than it was with older people. I needed practitioner data that would help me to understand how their perspectives might differ from those of the older people. Perhaps I was too anxious about the possibility of practitioner's withdrawal and compromised my independence by working so closely with them. My relationships with practitioners needed to be sustained over time, to ensure continued access to older people for the latter stage of the research. My involvement had to be consistent and reliable and I felt that I could not abuse the trust they had in me that research respondents would not experience harm from participating in the research and that I would not betray confidentiality.

Strong and supportive relationships were fundamental to the research. I spent time fostering these by attending meetings to ensure that I listened to professional concerns and then acted upon them. I managed the tension by accepting that I needed to work 'with' practitioners to realise the long-term goals of the research. Later reflection on the research process made me realise that I also needed to work 'with' older people as much as I needed to work alongside staff. Some social researchers (Bloor 1978, Bryman 1988) engage with participants in activities such as viewing transcripts. I accepted the principle of sharing understandings but did not share transcripts, explained by my anxiety that relationships would not be sustained in the light of such openness. This was in that sense betraying the principle that research subjects should enjoy some self determination (Weheymer and Palmer 2003), a point made earlier in the chapter. There were however some strong arguments against sharing transcripts. The transcripts revealed powerful emotional responses from the older people and I felt that reading their own words might make them feel uncomfortable and unsure about their involvement. This was consistent in this sense with wanting to protect older people in particular from harm and showing a duty of care.

My own background had some bearing on issues of trust. My gender, class, race, and upbringing affected how I was perceived and the extent to which I could be trusted. I was aware that my identity influenced my own understanding of what and whom I researched (Devault 1990, Williams and Heikes 1993). Social class and educational differences between the older people, the practitioners and

myself (Boxes 2 and 3) may have reduced the closeness and reduced the trust. Participants could be unable or unwilling to share information with someone who appeared neither socially nor emotionally close to them. I noted reactions, when older people in communal lounges frequently expressed their 'difference' from me. I was a relatively young man interviewing predominantly older women. My differences operated on many levels, with gender and age compounding the social class differences. The older people were sometimes less willing to invest time and emotional commitment with someone who was 'alien' to them. They emphasised that I was from the 'college' (university), not from the locality, and how it was difficult to share personal stories with someone who was not 'family' or who did not share their experiences of life.

The issue of being 'alien' to the respondents is particularly pertinent to the research. Recent developments in research practice have emphasised the collaborative and reflexive role of the researcher in which researchers indicate their relationship to the study (Roberts 2002). They are asked to 'own' their gender, race, social class and religion and be transparent about all aspects of the research process. I could have reflected more on my own life experiences in relation to the respondents. I thought about my own life and how it compared with theirs but did not share these thoughts. Snelling (2005, p139) asks: 'do we make the connections to our own biographies explicit or do we leave them unspoken and implicit but still present in their absence?' I did not make my biography explicit or even refer implicitly to it. The researcher affects the research and it is important to understand this effect in terms of power and control.

Whilst I did not want to be a 'counsellor', my reluctance to talk about my own experiences may have been construed by older people as 'withholding'. The researcher should take some responsibility for their part in the research development, including recognition of their personal connections and motivations for undertaking the research (Winter and Munn-Giddings 2001).

**Box 2: My part in the process of research: awareness of my own role.
Reflections from the research diary**

Thursday, March 26th

Visit: To *Wordsworth House

Comments: I was invited to a staff meeting at the end of March in order to introduce myself in person. The issue of social class arose quite subtly throughout this meeting. Whilst speaking I was aware of my own middle class status and higher education in relation to staff (and I assume residents). Whilst I have said on a number of occasions that I favour closeness between myself as a practitioner/researcher and those I research, there is always going to be

some distance, without choosing it. I am at present on a low income but my upbringing could be described as middle class in terms of education, culture and values. The residents and staff of local authority residential care homes may be working class, although this is speculation.

Box 3: Reflections from the research diary.

Wednesday, June 3rd

Venue: *Wordsworth House

Comments: I felt relaxed although there was one moment within my interview with the female carer Debbie that had the effect of making me feel an outsider. Talking of her experience as a care assistant she said, quite pointedly "not that people like you would understand". I was highly aware of my own role in the process of research at this point, about how I might be perceived.

Friday, June 12th

Venue: *Montgomery House

Comments: I was immediately aware of the effect of the social services review when interviewing my third and final staff member of the day, Janice. She was a senior care assistant. She came straight from the meeting into the interview and showed tension with the nervous swaying of one of her legs. At the end of the interview she remarked that she did enjoy her job but expressed doubt as to whether she would still be in post at the end of the review. This seemed very poignant as she expressed how much she valued her work and she felt it was not so much a job as a way of life. Her feeling for the residents shone through.

Continued on page 103

Thursday, February 18th

Venue: *Montgomery House

Comments: Today I interviewed Bernard, a resident at residential care home number 2 (interview five). He was very emotional. He responded to my knock on the door very promptly and seemed quite eager to see me. Kleinmann and Copp (1993) observe that researchers probably feel most comfortable when they like participants and participants like them. I felt and feel half comfortable and half not so comfortable. Why? This is because I feel I need some detachment in order to remain analytical and keep the distance of a researcher. I wanted to be differentiated in his and my mind from 'friend'.

*These are pseudonyms to protect confidentiality

Summary

The methodology and methods adopted for this research supports the aim of finding out about the conceptual worlds of older people and practitioners. A research diary particularly suits research that relies on a lot of reflection on the experience of relocation and a questioning of assumptions about residential care around which much policy is and has been based. Although this research is interpretive research and from the qualitative tradition there is some interest in pointing to specific empirical evidence to support propositions. I am still testing propositions and in particular the idea that some older people will experience residential care in ways that show resilience and reserve. I am working with the idea that some will be able to balance their wants and needs in residential care settings than others and thereby achieve homeostasis. (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002).

This research is therefore interested in the details of older people's lives including the details of the life course and also details of their particular journeys to residential care. It is interested in identifying aspects from childhood, early and mid life that may have shaped their development and attitudes and also the detail of social work and social care interventions that also may have shaped progress. The mixing of methods is therefore appropriate to this research with semi structured interviews with practitioners and older people supplying facts and empirical detail. The research diary provides material to support reflection on that data. Both elements are important to this research and it is this mix of methods that provides a particularly distinctive feature of this research. The research diary has also pointed to some tensions between the various roles of researcher and practitioner and highlighted ethical issues such as confidentiality.

Previous research into older people and residential care has not compared and contrasted perspectives of older people and residential care in this way before.

Whilst previous research has involved interviews with different social actors the focus has been on identifying of factors leading to residential care rather than identification of factors and different perspectives on their subsequent experience of such settings. This combination of methods encourages original contributions to knowledge and the mix of perspectives about the whole process of moving to residential care that previous research has not identified.

The next chapter will introduce the older people and practitioners involved in the research and locate them within social and historical contexts. This chapter will identify the detail of these lives with the mindful appreciation that these are taken from selected accounts. They will be discussed with the acceptance that these facts are taken from accounts that are interpretations rather than unquestioned truths. Chapter four will outline practitioners' roles and outcomes in order to locate their perspectives on relocation from the perspective of working within certain practice situations. The detail of older people's lives will allow analysis that may highlight patterns or themes within their lives and identify the potential source of any resilience (Vandsberger et al 2005) reserve (Grundy 2006) or homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002).

Chapter Four: Introducing the practitioners and older people.

Introduction

This Chapter introduces the practitioners and the older people and gives background information on all the participating interviewees. Practitioners roles and responsibilities are discussed but there is also information on their backgrounds and attitudes as these will inform their outlooks. This will allow the reader to consider how and why they adopted certain perspectives on older people and their relocations. I then outline the details of the older people and discuss the significant events in their lives leading to residential care as they understood them. Understanding how older people coped with residential care in terms of their resilience and homeostasis is dependent upon knowing about the dynamic features of the social lives of research participants that can be understood as ‘careers’ (Jamieson et al 1997). It is important to understand and recognise that people will develop across many different spheres of a life (Hareven 1978, Bertaux 1981, Hewitt 1984).

Older people will experience many life events, often unpredictable. The developmental theories embodied in the resiliency framework (Vandsberger et al 2005) recognise how these patterns of experience may be even or chaotic but whatever the nature of these patterns of experience they have the potential to inform later development. Understanding the ‘pushes’ and ‘pulls’ that may lead older people towards residential care (Reed et al 2003) requires some initial examination of how their lives have developed and this chapter provides that. Similarly, an understanding of how practitioners are where they are in terms of their world view of residential care is dependent on some examination of aspects of their experiences.

This thesis gives full recognition of the way stories are always interpretations (Flick 1998, Roberts 2002) and that the ‘significance’ of various life events can be contested or seen in different ways. It is still however important to present some data on the lives of these older people so that we can identify events from

their biographies that may have gone on to influence their development and progression to and within residential care. The data includes information and discussion of issues of social class, culture and ethnicity so that any patterns of experience across the different cases can be identified. There will be similarities and differences between the older people and these will be reflected on later on in the thesis when we come to evaluate the 'success' of the older people in terms of achieving homeostasis. The Chapter recognises that these moves can be different experiences for men and women of different social classes and cultural backgrounds.

It is important that detail of the lives and circumstances of the older people is set alongside detail of the practitioners. Effective contrast of the conceptual worlds of practitioners and older people requires that both groups of research participants are made visible. Both must be placed within contexts so that their perspectives are understood in relation to them rather than in isolation from social, economic or organisational terms. Examination of the presence or absence of homeostasis between these older people and their environment requires recognition that it is a complex interplay between individual and social or environmental influences (Grundy 2006). This biographical data help us to understand the nature of this interplay by understanding the social environments that people have struggled or negotiated with over the course of their lives through to residential care. Patterns of resiliency (Vandsberger et al 2005) can only be reflected upon if we have a systematic and thorough examination of the details of these lives.

The first section introduces the practitioners. The second section outlines the older people, asking about them and their lives, their social class and housing arrangements and other facts from their life courses. The third section charts disruption and stability and gender influences in the older people's early and mid-life experiences during the 1920s and 1930s, World War Two and the post war era. The fourth section recognises the importance of their emotional attachments. Section five analyses late life change, including bereavement, living alone, and moves in later life, and section six concludes the chapter with a summary of the issues with reflection on the findings to date in relation to the research questions.

Section one: The practitioners

The practitioners included qualified social workers, community psychiatric nurses, residential care home managers, and care assistants, domestic workers in the residential homes and home care workers (see table 4 for full list). The selection of practitioners resulted in a range of health and social care workers who engage in organising and providing support for older people in residential care and in the community. In all, twenty-nine practitioners agreed to be interviewed. Thirteen worked with older people in community settings and sixteen in residential care home settings. Four of the twenty nine practitioners were male, a typical gender distribution amongst health and social care staff. The social care workforce is mainly female, constituting 80% of the workforce within the United Kingdom (Department of Health 1999), and the gender distribution of 24 women and 6 men in the practitioner group of interviewees was therefore typical. There were three kinds of professionally qualified workers - social workers, community psychiatric nurses, and occupational therapists. Other practitioners fitted under the general designation of 'social care' workers'.

The social workers

The social workers included hospital social workers (Linda, Julie), and field social workers (Karen, Keith, Paul, Roberta) who operated from within different community based teams. The social workers undertook assessments of need and organised packages of care. Their experience ranged from two to twelve years. Hospital social worker Linda had worked for her authority for three years and was therefore relatively new to the role. She felt very committed to her role and had worked in a variety of other social care posts prior to training as a social worker. She was from the locality and felt she knew quite a lot about the area and the services available to older people in the locality in terms of the residential care homes and other health and social care services. She said that she valued her role and wanted to get a better understanding of the older people and their lives but that the job did not always allow time for reflection. Her colleague Julie, in post four years, also felt that she needed to have more 'connection' with older people and their lives. She like Linda had been brought up in district in which

she worked and also felt knowledgeable about the place but less so about the lives of the older people that she saw in hospital settings.

The field social worker Karen described herself as working class as she felt her background in terms of the area that she was brought up in and her values made her fit that classification. She also alluded to her cultural interests which she said defined her as working class. Culture and cultural values can be one way in which class can be expressed. (Polsky 1969; Argyle 1994). Social workers Keith, Paul and Roberta expressed their social class in more ambiguous terms, acknowledging their professional role did in some ways make them 'middle class' they like the hospital social workers also expressed frustration at not feeling they knew that much about the lives of older people they saw within the context of their work even though they felt in another sense an empathy with them. Keith had trained for social work in mid-life and had practised for only two years even though he was in his early fifties.

Community Psychiatric Nurses (CPN's)

The community psychiatric nurses (Susan and Jim) assessed mental health needs, planned, and evaluated programmes of mental health care for older people, including assuming responsibility for monitoring and evaluating the use of medication. Susan had worked as a CPN for six years and had a lot of experience of working within mental health settings. She says that she did not believe that social class is a big factor in her work and she says that for her neither she or her service users social class is a particular issue as it is about understanding mental health and these issues are not necessarily class issues. Susan did however feel that her age, 53, was important as she felt this gave her a better understanding of issues of the life course and mental health as she understood issues of young, middle and late life from her perspective of being in mid life. Jim had worked as a CPN for three years and had relocated from the south of England for the post. He said his gender was an important factor in his work as he believed that men and women experienced these issues in different ways, although he did not elaborate.

Occupational therapists

The occupational therapists (Heather and Wendy) worked in community settings, helping older people to regain or develop the skills necessary to participate in all aspects of their lives. They organised treatment programs to help with daily activities, advised on adaptive equipment and gave advice to family members and caregivers. Heather was quite new to the role and felt a little 'raw' and still finding her way in the work. She said she had worked in the voluntary sector before and wanted to broaden her experience. Only eight months in post and commuting she said that she felt a little bit on the 'outside' of things at this stage of her career and was anxious to build on her experience. Wendy also was fairly new to the role having been in post for a year but felt enthusiastic about the work. Neither Heather or Wendy thought that social class, gender or indeed ethnicity were that important an issue in their work although conceded that they were dimensions that mattered and that services should respond to them empathetically.

Residential Care home managers

The four residential care home managers (Alison, Helen, Pauline, and Shaun) were in charge of running two of the local authority residential care homes within the sample. They lived within two miles of the homes, were born and brought up within the local area, and therefore possessed local knowledge of the community. All four said that they thought they could relate well to the service users and all had many years of working as managers in residential care, between eight and twelve. Alison felt she was not as 'close' to the people in the residential care home as she could be and felt that policy and procedures had created a 'distance' between herself and the older people. She still however enjoyed her work and living nearby was very helpful in terms of organising her work and family time. All three female care home managers felt that their gender was an issue in that female residents felt 'comfortable' talking with them. Shaun felt that he felt more distant from many of the older women on grounds of gender and also felt coming from another part of the country created another 'distance' as the local care home was strongly connected to the locality.

Care Assistants

I interviewed ten care assistants (Jane, Tanya, Susan, Carol, Melanie, Linda, Juliette, Belinda, Suzanne and Stephen) who undertook personal care duties: Five were based in one of the local authority residential care homes, three worked for a housing association, and two were employed by a private care home. They had three to five years' experience of care work and all lived in the local area, within a five-mile radius of the homes. Three of the care assistants, Jane, Susan and Carol all said although they worked in a close intimate role with older people they still felt they did not always know them very well as people and that many of the older people kept a distance from them. Susan felt that she did not know that much about the life histories of the older people she worked with. Living locally and having experience in the role did not necessarily mean that she easily was able to connect with the older people. None of the care assistants, with the exception of Melanie, had worked with older people in other roles and did not have any experience of working with older people in their own homes. Seven of them disclosed their ages and they were ranged in ages from nineteen to thirty five. Some of them felt social class was important although they tended to feel that it was an ability to relate to older people that was the most important.

Domestic workers

The two domestic workers (Selina and Lucy) worked in the kitchens of one of the residential care homes, and combined meal preparation duties with laundry responsibilities, thus having experience of seeing the older people on a day-to-day basis. Selina lived very close to the residential care home where she worked and knew many of the residents at the care home as they came from the locality. She was aged fifty-seven and felt an 'affinity' with many of the residents even though she was much younger. Selina identified herself as working class and felt that this was an accurate assessment given her occupation and lifestyle. She had worked in the kitchens at the care home for twenty years and said she felt almost like 'family' to many of the older people in the care homes even if her role did not entail close daily contact. Lucy, in post eight years, felt she did not have much connection with the older people in the home and felt that her role restricted her understanding of them. Lucy was aged forty six and her mother was resident in a residential care home a few miles away.

Home Care Workers

The three home care workers (Dawn, Claire, and Hilary) provided assistance with personal care that helped to promote older people's independence. Dawn had worked in the post for five years, lived a few miles away and found the shift quite demanding on her life as she had a husband and three children. She felt that ethnicity played a big part in affecting older people's lives and she said that her ethnicity, she was 'black' and originally from Jamaica was a barrier at times. Claire, in post three years, felt the job was quite demanding and that she was quite ignorant of the lives of people in residential care as it was something she did not have any experience of in her particular role. Hilary said that she had worked for social services for seven years and had seen the role change and this had changed her. She felt a little 'disillusioned' with the job at times.

Table 4: The practitioners: Who they were, where they worked.

Name *	Role	Years in Post	Sector	Number Interviewed
Karen, Paul, Keith and Roberta	Social worker (Field)	Between 2 and 12 years	Community Settings	4
Linda, Julie	Social worker	3 and 4 years	Hospital	2
Susan and Jim	Community psychiatric nurses	Six and three	Community settings	2
Heather and Wendy	Occupational therapists	8 months and 1 year	Community settings	2
Alison, Helen, Pauline and Shaun	Residential care home managers	Between 8 and 12	Residential care	4
Jane, Tanya, Susan, Carol, Melanie, Linda, Juliette, Belinda, Suzanne and Stephen	Care assistants	Between 3 and 5	Residential care	10
Selina and Lucy	Domestic staff	20 and 8	Residential care	2
Claire, Dawn and Hilary	Home care Workers	5 , 3 and 7	Community settings	3

Note *: these are pseudonyms to protect confidentiality

Section two: The older people

The sample of twelve older people ranged in age from 79 to 95 years at the time of their moves to residential care. Nine of the twelve were in their eighties, one was in their seventies and two were in their nineties. This age band reflects the general profile of older people in care (Meadows and Cook 2004). Ten individuals within the sample were female and two were male. The sample was

typical of the gender balance in residential care homes (Department of Health 1999). At the time of the first interview, five of the sample of twelve had been in residential care for three months or less (Table 5). Three had been in residential care from six months to a year (Table 6) and four had been in residential care for a year or more (Table 7).

Table 5: In a residential care home up to three months (at the time of the first interview)

Note: The names of older people are pseudonyms, to protect their confidentiality.

Name of Older Person	Year born	Age entering residential care	Status of residential care home
Elsie	1920	79	Social Services
Edna	1915	84	Housing Association
Barbara	1914	85	Social Services
Dora	1910	89	Private
Teresa	1913	86	Social Services

Table 6: In a residential care home for six months to a year (at the time of the first interview)

Name of Older Person	Year born	Age entering residential care	Status of residential care home
June	1906	93	Private
Catherine	1915	84	Social Services
Maud	1912	87	Housing Association

Table 7: In a residential care home for a year or more (at the time of the first interview)

Name of Older Person	Year born	Age entering Care	Status of residential care home
Bill	1912	87	Social Services
Bernard	1917	82	Social Services
Mary	1912	87	Social Services
Lauren	1904	95	Housing Association

Social class

The majority of the older people in my research left school early to take up paid employment in their locality. Nine of the respondents left school in the 1920s at the contemporary school leaving age of 14 and took up unskilled or skilled manual work within a rather narrow range of employment sectors, e.g. clerical work or industrial occupations. Only Bernard, Catherine and Teresa continued into vocational training or higher education (Table 8). The occupational backgrounds of the older people differed minimally from the backgrounds of their parents with little social mobility between generations. The majority of the older people were from families where unskilled or skilled manual work had been the norm. Occupation is one of a number of indicators of social class (Argyle 1994), including cultural and lifestyle indicators (Polsky 1969; Argyle 1994). The data reveal some fairly uniform patterns across their lives. This is not to presume that social class necessarily patterned these experiences. To draw such an easy conclusion would be to make some assumptions about the nature of social class and the experiences of this group of older people.

Table 8: Leaving home: education and employment.

	Bernard	Teresa	Lauren	Dora	June	Maud
Age left school	14	14	14	14	14	14
Age left home	0-5 (approx)	19	Mid 20s	30	25	27
Paid employment	Armed Forces	Nursing Agricultural College	Manual Work	Clerical work	Clerical work	House Keeper
Higher Education	No	No	No	No	No	No
	Catherine	Barbara	Mary	Bill	Edna	Elsie
Age left school	16	14	14	14	14	14
Age left home	Early 20s	Not Known	27	24	20	18
Paid employment	School Teacher	None	None	Miner	Factory Work	Clerical Work
Higher Education	Yes	No	No	No	No	No

There did appear to be a certain uniformity to their early lives with all of them leaving school at fourteen and going into often routine manual or semi skilled employment. There was a lack of social mobility in the first half of the twentieth century (Argyle 1994) and this data may support this. There was certainly some patterns in their employment and its relationship to marriage. Eight of the ten women were in paid employment before marriage, although all ceased work when marrying, which made them invisible in social class terms if we adopt the ‘employment aggregate approach’ (Crompton 1996) that defines class by employment. Also, some experiences of social class may not be reflected in official definitions (Argyle 1994).

Similarities were apparent when lifestyles were considered. Dora’s husband was a ‘high achiever’ at school and became a businessman, reportedly accumulating

wealth and status. Dora did not undertake paid employment but she discussed how close they were and how they moved in similar social circles and shared similar interests. Box 4 reveals the importance of shared cultural and social class backgrounds. Sometimes the older people worked in similar occupations, such as Mary and her husband (Box 4). Barbara and Teresa both shared an agricultural background with their prospective husbands. Their choices of spouse were related to locality and shared social networks.

Box 4: Congruence

- Barbara was brought up on a farm and had been relatively affluent; she married a farmer with a similar background.
- Miner Bill met and married Norma who was not employed outside the home and came from the same locality.
- Dora's husband was a 'high flying' businessman, and although she gave up work when marrying, both emanated from more affluent parts of the city.
- Edna's husband was employed, like Edna, in manual work and they had similar backgrounds.
- Lauren's husband was a manual worker and she was employed in factories before giving up her job when she married.
- Mary and her husband both worked in shops before she ceased work when marrying.
- Teresa's husband was a farmer and she came from a similar background.

The more I examined older people's life stories, the more some consistencies and inconsistencies between housing, income and social class designation become apparent. Listening to older people's life stories revealed the inadequacies of employment-based social class designations. The older people and their spouses came from similar backgrounds or localities, but their hobbies or interests were not always shared and they did not necessarily share the interests of their parents or conform to social class expectations. The mother of Dora was a schoolteacher, and her father was a manual worker. Dora's husband worked in a Royal Ordnance factory. Dora liked classical music. She and her husband were both members of a local musical society and sang in a choir. Maud, from a working class upbringing, loved ballet and opera and belonged to various societies. She met her husband when they took piano lessons together.

It became evident that occupation, lifestyle and social class did not always correspond to each other in any predictable pattern. Nothing could be inferred in

a straightforward way about the social class of Dora or Maud by their lifestyles or interests. The complexities of social class and the apparent lack of congruence between their backgrounds and interests provides potentially rich data for a study of reactions to residential care based that uses homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002) as a conceptual tool for analysis. This thesis wants to discover the unpredictable nature of the responses of a group of people to residential care. Knowing about their interests and beliefs and how they may or may not be congruent with their social class provides important information for an examination of their ability to achieve homeostasis in residential care.

Whilst Townsend (1962) worked with the assumption that it was older people's social class and socio-economic status that affected their lives going into residential care my thesis explores this dimension in relation to others. I want to discover the interplay between the internal and external environment and if and how interests and cultural factors shape homeostasis in residential care as much as at earlier points in life.

It is important to understand people's choices and restrictions, but also to recognise that people can aspire to make choices beyond their restrictions or presumed behaviours. Exploring older people's individuality does not preclude recognition that lifestyle can be a visible indicator of social class positions (Argyle 1994). Barbara, Bill, Lauren and Mary shared similar occupations and/or geographical locations and these shaped their later choices of spouses, but their occupations did not define them or their interests. Maud's love of ballet could not be guessed at by knowing that her father had been employed in manual work. Recognition of older people's individuality allows social workers to accept the apparent inconsistencies between life style and social class.

The older people expressed different interpretations of their social class. Their reflections on their lives and choices revealed their affinities. Barbara, for example, compared her fellow residents in residential care: "It seems to be a different class of people here". This comment certainly seemed to reflect an attitude related to where they saw themselves in relation to some social groups although it is perhaps problematic to assume that this comment alluded

specifically to issues of social class. She may have been using the term ‘class’ in another sense other than social class. Barbara lived on a farm after marrying a man who was reputedly a wealthy farmer. Brought up in a rural area that she described as affluent, she and her family moved when the land was developed. She recalled her father saying, “We are not stopping here if they are going to build council houses”.

Home ownership and possessions

Five of the twelve older people owned their own home at some stage prior to residential care (Box 5) but three did not (Box 6). The data revealed that half of the respondents had been homeowners at some point in their lives. Their degree of affluence varied. Dora and Teresa (Box 8) occupied more affluent housing and had more income than Catherine. Many of the older people had married early, and although they experienced low income during their early lives, home ownership gave them financial stability. Many had few possessions (Box 7) although some had more (box 8). They began buying their houses during the boom in owner occupation in the 1920s and 1930s (Holmons 2000). Dora and Teresa accumulated many possessions, although most of these had to be relinquished or put in storage elsewhere when they moved into residential care (Box 12). Catherine had to give up her home to pay for residential care in accordance with government legislation (Baldock 2003) and within the rules established within the National Assistance Act 1948(Clements and Thompson 2007).

Box 5: Home ownership.

- Barbara owned a house in a location just outside the city.
- Catherine was brought up in what she described as “an ordinary terrace” before moving to a council house. Her first marital home was a newly built house that she and her husband bought in a northern city. She later had to sell this house to pay for residential care.
- Dora spent most of her married life in a house owned by her husband and herself in a more affluent part of the city. When she moved into residential care she employed an accountant to advise her. Her family upbringing was affluent; she talked about her sister having a “big house”.
- Edna owned a house near to the residential care home.
- Teresa, together with her husband, owned a farm.

Box 6: Paying the rent: Those who never owned a house.

- Bill: After living with his parents for the first three years of his married life he spent the remaining years in council housing.
- Bernard lived in fairly affluent areas all his life, including the period just prior to residential care, although the property was always rented.
- Lauren lived in private rented housing all her life before becoming a tenant of sheltered housing prior to moving to residential care.

Box 7: Ownership: Possessions and relocation into the care home.

- Bill had few possessions when he moved into care. Talking about the furniture he sold when moving to care, it was significant that he expressed regret that he had to leave some furniture behind. He said he “had some good stuff, three-piece suite, and sideboard”. The over riding impression was of someone who had very little throughout his life. He said that the reason he and his wife only had one child was financial, that they could not afford more.
- Maud did not have a life of wealth. With no private pension she was on income support. As a child of a father who constantly faced redundancy during the 1930s depression, she grew up poor. Early married life was not easy. Her husband earned three pounds a week and they had one pound a week rent to pay.
- Lauren was born and grew up within a traditional working class district, and the entire family needed to work to support themselves. Lauren said she had been poor in early life although she was careful with money.
- June’s upbringing suggested a lack of wealth or ownership. In later life, adaptations to her home to make it more amenable for her increasing frailty included installing a toilet inside the house.

Box 8: Ownership: Possessions and home ownership

- Dora had accumulated many possessions. It was hard for her to know what to bring to the residential care home and what to leave behind. She said that she brought what she could but had to leave a lot behind, including favourite paintings such as watercolours of local parks. She had favourite corner cupboards that she gave to a “good home”. Many of her possessions were considered to be valuable and she sold her remaining possessions in an auction.
- Teresa and her husband owned their own home. She stored many of her possessions in her bungalow that was looked after by one of her two sons when she moved into residential care.

Section three: Early and mid life experiences

Disruption

The respondents referred to geographical relocations when discussing childhood. Most of the older people were children and young adults in the 1920s and the 1930s. House moves in earlier life were often made because of the father's employment changes (Table 9). The employment changes of the older peoples fathers were disruptive events stemming from the economic slump of the 1920s and 1930s, which limited employment and housing choices. The American economic depression had a worldwide effect. By the end of the 1930s unemployment in the United Kingdom had more than doubled from 1 million to 2.5 million (Edsforth 2000). Unemployment of the father, and subsequent house moves, affected the respondents' lives.

Table 9: Early life: change and disruption

<i>Name of older person</i>	<i>Disruptive life events</i>
Barbara	Frequent house moves.
Bernard	Death of father. Relocation to children's home.
Bill	Absence from work (nine months) due to tumour. He was in his early 20s at the time.
Catherine	Bereavement as a child. Frequent house moves.
Edna	Mother died when aged 15.
Lauren	Frequent house moves as a child due to change in father's occupation.
Maud	Frequent house moves in early life due to change in father's occupation.
Teresa	Left home at 19. Car crash, time in hospital.

Personal explanations of the change and disruption in their lives were recalled as significant events, in contrast to World War Two, which was rarely singled out

as personally significant. Edna recalled the death of her mother and the effect it had on her with detail and the emotional impact on her was clear (Box 9)

Box 9: Edna and Bernard: Shocked by early life events

Edna: “My mother’s loss was horrible and it is not something I like to think about too much, it is too painful. But one thing it did do was make me stand on my own too fight. Had to rely on my father more but also on myself. I was so young as well. Really don’t like to think about it too much as I get upset, even now” (Interview 2)

Bernard: It is such a long time ago and it is not something to dwell on. There were too many better times anyway than my father’s death you know. Meeting my wife and our child is something that has had a massive effect on me, more than you would know really, more than anyone would know.

(Interview 6)

For Bernard also the death of his father and his own relocation to a children’s home had a marked effect on him for he felt a sense of shock and bewilderment. He was unable or unwilling to recall too much detail (box 9). He instead focused on the importance of meeting his wife and adopting a child. This switch of attention from issues surrounding the death of his father and relocation to a children’s home towards more comforting memories showed an ability to deploy diversion tactics. DeMuth (2004) contends that one strategy for deploying resilience is to use compensatory tactics, to compensate one loss or deficit with a positive. Bernard was actively moving his and my attention away from certain more stressful memories to less stressful ones.

Gender, employment and marriage

Older people emphasised themes of change, continuity and disruption in their accounts of housing and employment changes. Gender was an important influence on the respondents’ lives. As with social class, understanding gender influences requires reaching beyond surface interpretations. The female respondents, like their mothers, gave up paid employment (primarily manual work in the brewery trade or cigarette and pharmaceutical companies) when they

married. Several of the women expressed satisfaction with their jobs but they also accepted their roles as wives and mothers, which conformed to social expectations that reduced their life choices for employment. Married women were expected to form 'traditional' households headed by a male breadwinner and become an economically dependent married woman at home (Muncie et al 1997). Catherine, a teacher, was affected by the prevalent 'marriage bar', which stipulated that married women in professional occupations should give up employment upon marriage.

The majority of women that were employed in the 1920s and 1930s were younger women (Summerfield 1984). National data for 1931 show that 77% of employed women were single, 6% were married and 7 % were widowed or divorced. Eight of the ten women worked before they married in the pre-World War Two period. Edna and Lauren referred explicitly to giving up paid work in their 20s. Both women had mixed emotions about leaving their jobs in the brewery trade and in a cigarette factory because they felt attached to the workplace and their work colleagues. Although Catherine was "pleased" to give up teaching for marriage, she also expressed some regret, because teaching was the role for which she had trained. This feeling of being 'pleased' needed more exploration than I recognised at the time.

Gender issues are important to this research. The lived experience of these older women reminds us that it is important to take account of how older people's early choices in their lives, in terms of employment in particular, were constrained by gender and societal expectations at that time. Gender does have the potential to shape lives (Oakley 2005) and in fact choices. Understanding issues of homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002) requires understanding of how restrictions can shape the patterns of lives through all their life stages and their ability of someone to show resilience in the face of change. Only three of the older people lived away from the parental home prior to marriage (Box 14) and the importance of leaving home was made clear by many of the respondents. Its importance made a lasting impression on them.

Box 10: Leaving home: major events for the older people

Bernard: I have moved home many times in my life or at least had to move in some way. I mean as a boy I had to go and live away (the children's home) and then there was the upheaval of the war. All these changes have had an effect on me there is no doubt about that and now here I am, here, in this place. It is hard to take sometimes that it has all come to this and reminds me of then, even if in other ways it is all so different now. Still, one has to get used to it and I have done. Nothing can compare with my early life; no one here understands that, I wonder if you do? It is hard to make sense of anything any more but I go out and have my pal that comes to visit me and take me out. I can't say anything here is the same as anything else I have done. My life had just started then and the place here is not really my own or my home in a way, its just somewhere that I have ended up (interview 4)

Catherine: Well when I moved up there (north of England) to begin teacher training it was all so new. I remember all the detail of that, the room I used to stop in, the driveway up to the hall. It seems so long ago and yet as fresh as I talk about it now to you. Here I am doing the same thing again, moved to a new place and yet in the time in the middle I was married and felt settled. But that first time away stays with me, it does doesn't it, I mean I was a young girl and it was all new. Met some good friends there and for that time I felt part of it in a way.

Interviewer: Is it all different now or was that move in any way similar to this one?

Catherine: Different really but also the same in that I had to make the most of it and get on with it, I mean you can't moan can you, have to make the most of things that happen. It is not that that I was always happy then, never easy when you go away, doesn't matter how old you are. (interview 1).

Teresa: moving to those lodgings made an impression on me and even now after all those years I still remember it, how it felt. It was rural down there, bet it isn't like that now, things have changed. But I loved it and we were all a big family in a way. Moving into lodgings like that with a family was strange but I kind of got used to it and it was perfect in many ways that life. The car crash was a blow that is true but I liked the house and the people and it felt like an adventure to be there. Here, this home is also alright really, its all here for me.

Interviewer: Is moving here also an adventure?

Teresa: Not in the same way but it is a change that is alright, I mean I am not unhappy about it at all and I find that we have these changes in our lives, its all part of the plan really and we fit in with it don't we ?

The circumstances of leaving their parents' home differed. Bernard's move to a children's home, in a state of trauma and shock at an early stage of development when he was a boy, can be contrasted with the moves of Teresa and Catherine,

which were related to professional development. Bernard's relocation can be regarded as potentially damaging to his self esteem and later life. Catherine and Teresa made choices as young adults to move from the family whilst Bernard had choices made for him. Of the others, three moved for the first time with their parents, but six left the family home for the first time when they married. If the circumstances of their leaving home differed they all shared experiences that appeared to make quite an impact on them.

Leaving home was for Bernard, Catherine and Teresa the first major time of change for them, an event that had the potential to affect other parts of their lives. The stoicism of Catherine and Bernard contrasts with Teresa's more positive interpretation of this early life event (box 10) but all three were able to reflect on its impact and were able to offer reflections on how those moved compared to their relocations to residential care. There appeared to be signs of resilience (Vandsberger et al 2005) in terms of their display of emotional stamina (Wagnild and Young 1993) in all three older people in the way they talked about their moves to residential care as well as in the way they reflected back on their earlier relocations. Later chapters, particularly chapter seven, will reflect in more detail on how far these early experiences of moving conditioned their subsequent experiences of moving to residential care.

Marriage and leaving home

Three older people left the parental home prior to marriage (box 11). Marriage followed childhood and the first phase of adulthood. Eight of the sample married before World War Two. Six of the sample married five years and two married two years before war broke out (Table 10). Respondents married mainly in their twenties although one of them, Elsie, married at eighteen. Three were married in their thirties (Box 16). The average age for marriage was 25 (Table 10). Couples tended to wait until it was financially possible to marry. Lauren was a typical example. She expressed caution at the idea of an early marriage because of not having sufficient capital to build a life together. Her husband had worked in a succession of manual occupations and they felt that they could not afford marriage for a long while. Dora had to wait until her fiancé returned from his military service after the end of World War Two.

Box 11: Moving out: The three who left the parental home prior to marriage.

<i>Name</i>	<i>Their experiences</i>
Bernard	Moved to a children's home on the death of his parents.
Teresa	Moved to lodgings to start work as a nurse. Relocated to another town to begin teacher training in her late teens.

Box 12: Those who married aged 30 or over.

<i>Name</i>	<i>Their experience</i>
Catherine	Trained as a teacher before she married a 32 year old divorced man.
Dora	Married at 35, later rather than sooner, because she needed to wait until her husband had finished his military service. He was then away for a long period after the outbreak of war. Their marriage was childless.
Lauren	Waited until marriage was financially viable. She consequently married at 30 and had her first child within a few years.

Dora's and Catherine's marriages (Box 12) took place later (at 35) than others in this sample. The average age for marriage in 1931 was 27.4 for males and 25.5 for females (Howlett 1995). National data point to a steady increase during the early part of the century of the ratio of women marrying, from 35.1% in 1911 to 40.7 % in 1931. My sample was typical because most were in their late 20s or their early 30s when they married (Table 10).

Catherine had to wait for her spouse's divorce papers to come through. Divorce rates were relatively low at this time (Howlett 1995) before the 1969 Divorce Law Reform Act. Divorce was not possible without proof of fault or blame until the late 1960s with the 1969 Divorce Reform Act. The law did not make divorce easy particularly if the couple had dependent children. Section 42 of the National Assistance Act 1948 stated that a man shall be liable to maintain his wife and children and that a woman shall be liable to maintain her husband and children. A woman's children included her illegitimate children and a man's children included any children of whom he had been adjudged to be the putative father (Muncie 1997). Separation or divorce was economically difficult, particularly if they had to run two homes.

The postponed marriages of this group of older people may have been related to the poverty of the 1930s that may have left many older people unable to afford marriage. Lack of savings, high unemployment, ineffective birth control and the tradition that women gave up work on marriage could all have been factors which meant that they preferred to wait before committing to marriage. This contrasts with the marriage rates in the early 1970s when men and women were most frequently marrying in their early 20s (Office of National Statistics 2007) because of increased prosperity, availability of birth control and easily available credit terms.

All of the older people discussed their experiences of what they regarded as long and seemingly happy marriages. Divorce patterns of this sample differed from national trends. None of the twelve older people divorced as a consequence of the war despite the wartime increase in the divorce rate. Divorce increased between 1938 and 1940, from 17.6 in every 1000 of the population in 1938 to 22.5 in 1940 (Howlett 1995). None of the respondents lost their spouse during the war. Changes in contemporary patterns of family life indicate higher incidences of divorce, co-habitation, and re-partnering (Office of National Statistics 2007). Contemporary families have become more dispersed (Office of National Statistics 2007) which may impair the ability of the immediate family to provide care, leaving older people increasingly isolated (McCrae 1999). Although none of the respondents were divorced, marital breakdown occurred amongst their children. Maud's son was involved in an acrimonious divorce and

Edna’s son separated from his wife. Most of the respondents were married about forty or fifty years, but by 1997 the average duration of marriage was ten years (Office of National Statistics 2007). By the end of the century, divorce had become more a feature of social life than it was for this group of older people.

World War Two

World War Two was potentially highly disruptive for this age cohort but the respondents differed from the national picture partly because they lived away from areas that had been affected by heavy bombing. Two of the sample married during the war. Bernard met and married his wife within a year of coming home. Seven had children born during the war (Table 10). None of these were born out of wedlock, although the number of children born to unmarried mothers in England and Wales rose during the conflict from 4.2% to 9.3% (Howlett 1995).

Table 10: World War Two: Marriage, family and employment during World War Two.

	Bernard	Teresa	Lauren	Dora	June	Maud
Age when marrying	29	25	30	35	24	27
Year of marriage	1945	1937	1933	1945	1929	1938
Employed during the war	Yes	No	No	Yes	No	No
Spouse in combat	No	No	N/K	Yes	Yes	Yes

Table 10 (continued): World War Two: Marriage, family and employment during the war.

Name	Catherine	Barbara	Mary	Bill	Edna	Elsie
Age when marrying	30	N/K	27	24	20	18
Year of marriage	1940	N/K	1938	1936	1934	1938
Parted during the war	Yes	N/K	N/K	No	N/K	Yes
Children born during the war	Yes	N/K	Yes	Yes	Yes	No
Employed during the war	Yes	N/K	Yes	Yes	No	Yes
Spouse in combat	Yes	N/K	No	No	N/K	Yes

NK: Not known

Five of the respondents were parted from their recently married husbands when husbands had to serve in the forces (see Table 10). The experiences of the other older people were different. Two couples stayed together during the war. Teresa's husband was a farmer and contributed towards the war effort by working on the land. Bill made a contribution as a miner. Three did not volunteer any information about what their spouses did, despite prompts. It was not clear whether Mary's husband, unable to fight on health grounds and stationed in a conscripted capacity in the pay corps at a nearby city, lived with his wife. Some relationships were subject to relatively little change whilst the war affected other relationships. Perceptions of war experiences were tempered by more vivid accounts of their relationships with family and friends. As with Bernard's reflections on his life, emphasising marriage and adoption of a child and down playing less comfortable experiences, many of the older people preferred to talk less about some experiences than others. They were reluctant to talk about many issues and these selective accounts provide more evidence to support the idea

that people employ compensatory tactics in order to cope (Demuth 2004). Catherine, Teresa and Bill (table 11) all expressed an active disinterest in the war in terms of talking about it and directed the conversations away from these subjects towards others. Reference to family seemed to provide meaning to the older people as they sought comfort rather than pain from the past. It has been found in studies of resilience that people are able to recover from loss and trauma when they are surrounded by adequate nurturance and when they are able to create a sense of meaning through this (Rutter 1987, Flach 1997).

This sense of meaning had been long standing. The majority of the older people had established secure relationships prior to the war. The war did not sever their feelings of attachment (Bowlby 1988, Yelloly 1980) and sense of belonging. They were not all shaken out of established patterns of behaviour or relationships during the war in ways that have been generally documented (Marwick 1976). None of the women were exposed to the likelihood of being killed despite the 130,000 civilian adults killed or seriously wounded of which 48% (63,000) were female (Summerfield 1984). Their geographical location, in and around a city that experienced fewer bombing raids than some other locations, was a factor. Catherine, who had experienced frequent house moves in young life, during World War Two, lived through bombing raids in the city to which she relocated. Teresa, who had left home at aged nineteen (Table 8) and had married before the war, also experienced bombing. In recalling the experience of women such as Teresa, it is important to recognise that her experience during World War Two was also a gendered account. Summerfield (1998) and Coslett, Lury and Summerfield (2000) have addressed these issues, highlighting how women's stories of war are often made invisible in historical documents.

Table 11: War and daily life.

<i>Name of older person</i>	<i>Effects of war on daily life and the things that mattered to older people</i>
Catherine	<p>The city to which she relocated was bombed. Her main talking points: the war years, the new house and garden.</p> <p>“The house was lovely and we worked on it together. He (husband) was a loving husband and we had been through some hard times before but we were happy then and that was what mattered” (Interview 2)</p>
Teresa	<p>Married two years before war started. She lived in an area bombed during conflict. Main talking points: Ambivalence towards the war. “The war was not something that worried me, well of course it did a bit but for me marriage meant so much to me, those happy times” (Interview 1)</p>
Bill	<p>Married when war broke out. Became a father only two months after war began. Main talking points: Childhood and disruption at that life stage.</p> <p>“We had those times, those good times and the boy also, that made it special” (Interview 4). “ this is what really matters isn’t it , happy times with family, the war was not something one wants to dwell on really (interview 5)</p>

My interviews discovered that conscription did not have a significant impact on the lives of the women. Only one older person, Dora, said that she had been conscripted. She referred to working in an administrative capacity for the Ministry of Defence. This employment was near her home and fitted in with the

pattern of what was, within the context of war, a relatively ordered life that took place within a wider context of change and disruption.

Conscription was introduced for women in 1941 (Marwick 1976) and married women not living apart from their husband, such as Teresa, were exempt. All but one of the women were over the age of 25 in 1941 and in practice only women of the age group nineteen to twenty four were conscripted (Marwick 1976). The overall pattern showed that conscripted females increased from 55,000 in 1940 to 105,000 in 1941 (Hancock 1951). Many women were conscripted into clerical work (Marwick 1976) and most of the women recruited for the new postal censorship departments were women. As many as 95,000 women were employed in the non-industrial Civil Service in 1939, but by October 1941, 320,000 women were employed.

My interviews recorded women's experiences although I could have been more active in contrasting the different experiences of men and women. I noted the very emotional experiences of the two men in the sample, Bernard and Bill. They were both called up for military service. When Bernard said (Interview 5) that it was "all so different then" he was referring to the fact that he had a wife and personal relationships that mattered to him in a very deep sense. His tears were not related to combat or the death of fellow soldiers but more to the fact that he was physically distant from the family bonds that mattered so much to him. Bill discussed with great feeling the bond he had with his son. Bill recalled (Interview 3) how much "he meant to me". Whilst their emotional accounts of bringing up a family and of war were important, their emotional accounts contrasted with a stereotypical expectation of male working class identity.

Bernard served in the armed forces and discussed experiences that shaped his life, his choices and his attitudes. Bernard said, "nothing has affected me more; it has shaped my life; no one here (the residential care home) could imagine what the war was like" (Interview 5). His experience in combat clearly made a lasting impression on him. This revelation contrasts with many of the other older people who often preferred not to talk about the war. There was an undercurrent of unhappiness in his accounts that is often a feature of the responses of people that do have a certain amount of resilience. DeMuth (2004) refers to studies by

Werner and Smith (1990) and Anthony and Cohler (1987) found that this unhappiness can be masked by an otherwise well functioning coping strategy and this seemed to be the case with Bernard (as will be revealed in subsequent chapters).

Male conscription was introduced in 1939. Under the National Service (Armed Forces) Act passed on 3rd September 1939, all men between the ages of 18 to 41 could be called up for service in the armed forces (Summerfield 1984). The total number of males within the armed forces and auxiliary services increased from 480,000 in 1939 to 2,218,000 in 1940 doubling to 4,653,000 in 1945 (Hancock 1951). By the end of the war, 63% of men aged 20-29 were serving in the armed forces (Howlett 1995). Miners were exempt from active service. Bill worked as a miner during the war and combined this employment with bringing up a young child with his wife. The air raids and other wartime contexts influenced his experiences and his home life. Times were difficult despite his exemption from conscription.

Wartime events did not affect the majority of these older people's housing situations. Only one of the respondents moved house during the conflict. Almost all of the older people, with the exception of Catherine, lived at one address from the time war broke out to the day it ended. The respondents experienced stability in their wartime housing situations, in contrast to their pre war experiences. A pattern emerges of individuals who moved home frequently in early life. Most lived with their spouses and offspring from their twenties until they went into sheltered housing at around seventy or entered residential care in their eighties. The war did not change patterns of household stability in adulthood and did not change aspects of lives that were to a large extent gendered. The five female respondents who were separated from their spouses during World War Two were reunited after the war. Women married pre war and resumed domestic lives of stability in the post war years, but their lack of opportunities for employment is an aspect of older women's lives that reflect more restrictive aspects of their experiences.

Teresa was married two years before the war started (Table 10) and this made a more lasting impression than the war itself. Mary experienced her first wedding

anniversary in the early days of the war. For her, these were the happiest times despite the country being at war. Her experience of war remained relatively invisible. On reflection, I failed to search for the women's wider recollections of the conflict in that I did not focus my attention on their experiences of the conflict as they experienced it at home, away from the conflict overseas. (Summerfield 1998, Coslett, Sumerfield and Lury 2000). This was an opportunity lost in the sense that the detail of these experiences may also have revealed much more information on how these older women managed their time away from husbands and coped with the experiences of living alone. These experiences may have encouraged the building of some reserve (Grundy 2006) and fostered the development of resilience (Vandsberger 2005, De Muth 2006).

Their later experiences of living alone after spouses deaths prior to their moves to residential care may well have required them to draw upon that reserve and resilience. Personal events stayed in the respondents' memories in ways that international crises such as the war never did. Respondents' experiences did not fit with impressions given by national data. For example, approximately 2, 250, 000 people were relocated during the first month of the war. By the end of the conflict there were 60 million recorded changes of address (Howlett 1995) because of the government's evacuation scheme to remove young mothers and children from danger areas. Six women of the sample had young children born during World War Two but most were based in areas that escaped the most ferocious bombing and their children were not evacuated.

They were fortunate that the disruption to their lives caused by the war was not as severe as it was for others living in different locations. When reminiscing, reflections of the war were placed at the margins of their thoughts. Memories of times spent with spouses, children, their parents and other relatives were central.

Few of the respondents discussed the impact of bombing on daily life. Rationing, the black out and other aspects of wartime life did not feature in their conversations despite regular prompts to discuss these matters. Older people recalled relationships as most important. Bill, who was based on the 'home front', discussed (as did the women) his pattern of home life during the war

without too many specific references to the war itself. The bombing raids were mentioned only in relation to the effect they had on the family. Bill recalled (Interview 2) that, “the raids would mean we could not get the boy to sleep through the night.” Bill and his wife relied on each other to sustain their morale during this period.

Bill, like the other older people, was vague about the effects of war upon daily routines and was more concerned with life events such as marriage, childbirth, work and domestic concerns (Table 11) that gave structure and meaning to his life. Bill observed that becoming a father gave him a sense of purpose and responsibility just as much as his employment did. Bill had to juggle responsibilities with shifts down the mine and with a young baby waking in the night. The subsequent death of his son at a relatively young age was devastating and he returned to this theme often throughout the course of the interviews. Bill’s individual personality was apparent when showing his reaction to the death of his son, to whom he was particularly attached. Similarly, recollecting his wife’s death also reminded him of his attachment to her.

Mary discussed her marriage and her first wedding anniversary that took place during the first year of the war. She constantly declined to talk about bombing raids or rationing and instead referred to the feelings of intimacy she felt towards her husband and the way marriage gave her a new lease of life. When she did mention the war, it was in relation to how she felt about it in the absence of her husband and how she feared for herself and her daughter. This may have disguised more complex reactions to the conflict. The patterns of her home life were not highlighted or given focus. She recalled that she “was worried for him (husband) and my girl”. Catherine recalled her new house and garden and in particular how she and her husband worked together to create their new home. These older people were not just using compensatory tactics (DeMuth 2004) to help but were ordering parts of the past in their minds in such a way as to find some sense of satisfaction (Rylands and Rickwood 2008). More complex reactions to trauma and loss were disguised or covered by other experiences.

Post war stability

Relationships with spouses changed little from the pre to post-war period. All ten of the women respondents described themselves as housewives in the post war era, and their households retained the stable traditional pre-war structures, with husbands engaged in paid work outside the home and women working unpaid in the home. Most women did not undertake paid employment after the war but stayed at home to look after their children, despite a post war increase in the percentage of married women entering employment (Office of National Statistics 2007). In 1931, 10% of married women were employed. This had increased by 1951 to 21.74% (Department of Health 1999).

Bill and Bernard were in stable and secure employment when the war finished and they both remarked that the patterns of their lives were made more secure by having full time employment. Bill continued as a miner and Bernard worked for a printing firm after returning to civilian life. Bernard had many employment options and choices and found it easy to obtain work. The post-war stability of the older people was indicative of national patterns of employment, marriage and relationships. The percentage of the male labour force in employment stood at 87.6% in 1951 and was maintained at this level until the last three decades of the twentieth century (Halsey and Webb 2000).

None of the older people in the sample experienced any immediate household change or difficulties with their housing situation in the post war period, despite a national shortage of housing (Halsey and Webb 2000). With the exceptions of Barbara and Bernard, most of the respondents lived in the same house until they were into their seventies, over periods of at least forty years. The relative absence of bombing in their own localities meant that their homes had not been destroyed during the war. The home-owners in this sample purchased their homes during the pre-war housing boom (Holmons 2000) and continued to live in the same house. Nationally there was a post war increase in marital stability (Smith 1986) reflected in the durability of the respondents' marriages.

Eight of the respondents were married at least sixty years and three for more than fifty years (Table 12a). Respondents moved (on average) four times in a

lifetime (Maud moved seven times). Half the moves made by the older people throughout their lives took place in later life. This may have particular significance for analyses of their reactions to the subsequent relocation to residential care. It will be necessary to ask if their frequent house moves in the earlier part of their lives had significance for their later adaptation or otherwise to residential care (discussed in more detail in chapter seven).

Table 12a: Attachments: Number of times married and length of marriages

	Bernard	Teresa	Lauren	Dora	June	Maud
Number of times married	1	1	1	1	1	1
Length of time married (In years)	52	61	65	52	69	60
	Catherine	Barbara	Mary	Bill	Edna	Elsie
Number of times married	1	2	1	1	1	1
Length of time married (in years)	58	Not known	60	62	64	60

Section four: Attachments

Attachment to others established in young life and developed through the life course (as discussed in Chapter one) mattered to older people. Their stability gave them a sense of attachment (Bowlby, 1988, Yelloly 1980) and from these long standing attachments came some feeling of trust. Men found stability through employment. Both men and women experienced marital stability. Whilst older people's responses to moving to care varied (as will be seen in later chapters) the need for bonds of attachment and to trust and be trusted (Erikson 1965, 1980) was common to all. These bonds of support provided potential reserve (Grundy 2006) for the older people although it does not mean that homeostasis in residential care would necessarily be achieved. These older people may still have to have a sense of attachment to people or places within residential care and may have to experience a sense of stability in order to feel a

sense of 'fit' with such environments. Attachments had the potential to foster resilience even if they may not necessarily go on to experience a sense of homeostasis (discussed in more detail in chapter seven).

The older people experienced and remembered attachments to people, places and beliefs during their moves. Teresa talked fondly about her marriage and she, like Mary, rejoiced that she was not parted from her husband during the war. Both gained comfort from this continuity. The older people's recollections revealed their attachments and feelings of trust that sustained them in later life (discussed further in chapter seven). Those who were parted from their spouses during the war retained a sense of attachment. Catherine, for example, was parted from her husband but said how much she was comforted by her knowledge of their secure relationship.

Employment, housing and marital stability were accompanied by other attachments and associations, notably religious beliefs (Table 12b), which did not always comprise formal association with a church or an established religion. National data suggests a decline in religious affiliation (Brierley 2000) but the respondents' life histories revealed diverse attachments to religious or spiritual beliefs linked to relationships (Box 13). The respondents in this research had strong connections with established Christian denominations. These beliefs were sustained through their life, beyond their initial move to residential care (see Chapter seven). Lauren (Box 13) met her husband through church. Her connections with the church were linked to long-lasting friendships with people all over the country. Maud also had lasting relationships formed through her connections with the church.

Table 12b: Attachments: Religious Faith

	Bernard	Teresa	Lauren	Dora	June	Maud
	None Stated	Yes	Yes	Yes	Yes	Yes
	Catherine	Barbara	Mary	Bill	Edna	Elsie
	Yes	None stated	Yes	None stated	None stated	None stated

Box 13: Attachments: to home, locality and belief.

Lauren

Lauren developed strong attachments throughout her life. These attachments were formed in early life. She was attached to the area where she grew up. She knew the landmarks of her area, which she referred to as “the four corners”. She talked about the pub, the school, the pawnbrokers and the church and referred to them as “damnation, education, ruination and salvation”. Close to her parents and supportive family, she was brought up a Methodist and went to Sunday school, where she later taught and met her husband. She married within those “four corners”.

Bill

Bill felt a sense of attachment to the area in which he grew up. He worked in the nearby mine for most of his adult working life. He met and married his wife in streets near to the locality of the residential care home in which he now lived. He said that the area had been his “home” for all his life and he could recall people, places and incidents that were close to his residential home.

Dora

Dora was attached to her locality. She worked during the war in a local factory and had spent most of her life in the area where she grew up. The residential care home was very near to the domestic home where she spent most of her married life.

Maud

Maud was strongly attached to her son and her attachment to him was matched by a sense of attachment to her religious faith. Her son lived locally, which provided a great source of strength to her. There was evidence to suggest that their relationship was reciprocal, with his decision to relocate near to her after his divorce and change of employment. Maud felt attached to her locality, expressed in her network of friends. She said they belonged to the same church, which helped her feel a general sense of attachment. Her faith connected her to other people and provided continuity.

Box 13: continued

Bernard

Bernard was attached both to locality and also to people. He expressed great affection for the area, recollecting past experience in the area, particularly young married life. He also had a friend in the vicinity of the residential home with whom he shared memories of their time in the forces.

Elsie

Elsie entered a residential care home with which she had been familiar for a long time. She had lived near the residential home all her adult life. She, like Lauren, knew the local landmarks and was previously acquainted with other people in the home who were from the local area. She expressed some comfort in the fact that she felt familiar with the surroundings even though she wanted to return to her own domestic home.

Teresa

Teresa had a sense of attachment to her religious faith, a constant in her life, and to her surroundings. She expressed contentment with being in residential care and part of that was based around her sense of attachment to one of her two sons, who lived in the vicinity.

Section five: Late life change

Relationships with others

The events of early and mid life had the potential to influence late-life development. Marriages remained stable but relationships with other relatives, notably children, were less stable or continuous but nevertheless represented significant ongoing attachments. These attachments later became crucial elements in the moves to residential care (discussed in Chapter six).

Geographical proximity of these potential carers was a key issue. Children were the main relatives mentioned by the older people, perhaps because many of their contemporaries, friends and other relatives were dead. It may also have been because the older people saw their children as potential carers and other relatives were not considered 'important' in this regard.

The data reveal that the children and other relatives did not always live locally. Seven of the respondents had relatives who lived within the county where the residential care home was situated. Four of them had close relatives who lived outside of the local regional area (see Table 12c). Ten of the respondents had relatives living nearby (defined as within the county) but local family members were few in number, and were usually sons or daughters. More than half of those with local relatives (sons, a sister in law and a nephew) had only one relative living nearby (Table 12c). Two of these were sons; there were also a sister in law and a nephew.

Table 12c: Attachments: Relatives within and outside the county (of the residential care home)

	Bernard	Teresa	Lauren	Dora	June	Maud
Relatives within the county (of residential care home).	Yes (2)	Yes (1)	Yes (3)	Yes (1)	No	Yes (1)
Relatives outside of the county.	No	Yes (2)	Yes (1)	Yes (0)	Yes (3)	Yes (2)
	Catherine	Barbara	Mary	Bill	Edna	Elsie
Relatives within the county (of residential care home).	Yes (5)	Yes (94)	No	Yes (1)	No	Yes (Number unknown)
Relatives outside of the county.	No	No	No	No	Yes (2)	No

Adult children lived further distances from home, work and their older relatives (Phillipson et al 1998). I identified earlier the work of Joseph and Hallman (1998) and their finding that only 18% of older people receiving supportive informal care live with their carers and only 19% of carers live within ten minutes of the care recipient.

Contacts with relatives

Relatives who lived locally (Table 13) played strong caring roles and were usually attentive, sustaining the respondents' sense of attachment. Teresa, Maud, Bill and Dora relied on their relative's emotional and (sometimes) physical support. Some of the key relatives were male, with whom the older people developed relationships of some depth (to be discussed in Chapter six). Local relatives tended to visit at least once a week. These visits were regarded as highly important, especially in the aftermath of a spouse's death.

Table 13: Those who offer support: Local relatives

<i>Older Person</i>	<i>Significant relatives.</i>
Teresa	Son
Maud	Son
Bill	Sister In Law.
Dora	Nephew

Table 14: So near and yet so far: The geographical distance of children.

<i>Name of older person</i>	<i>Location of children</i>
Teresa	One son in Scotland, but felt estranged from him.
Lauren	Daughter in Canada.
Maud	One son in Wales, although he relocated back to her city upon divorce. Daughter-in-law in southern England.
June	Three sons: one in south west of England, one in south east England, one in Canada.
Edna	Daughter lives in another city in the south of England. Mother and daughter are estranged.
Bernard	Daughter in law in south of England

Geographical distance between relatives affected their moves, as Maud reflected (Box 14). At least six of the older people (Table 14) had relatives living at a

distance. The distance meant that frequency of contact was limited and consistent support was hard to achieve, although only Edna and Teresa admitted feeling estranged from relatives who were geographically distant (Table 14). McCrae (1999) argued that maintaining intimacy from a distance is not easy because contact with older kin declines. Geographical and social mobility affects contemporary relationships (Keeling 2001, Lee and Kin 2005). Patterns of education and employment have meant that people move with increasing frequency (Dixon 2003), which can potentially disperse families and reduce options for caring by kin. New relationships with step families can increase other possibilities for caring, with some potential for more contact between the generations within step families (McCrae 1999, Keeling 2001).

There is however also evidence of less expectations and less involvement from step parents in the care of older people (Gamong and Coleman 2006). There is also evidence of older people making use of other social networks involving friends in their caring (Keeling 2001). Decreases in mortality (McCrae 1999), evident since the 1950s, may facilitate more sustained, generational ties. Demand for formal care rather than that provided by kin has risen (Stoddart 2002). The complexities of caring at a distance are such that geographical mobility makes caring harder, yet, as Maud highlights, (Box 14), this can make contact slightly richer as a result, although one can add that Maud may have put this interpretation on her situation to compensate for the lack of geographically close relationships.

Box 14: Thoughts about a caring relationship. Geographical distance and care.

Researcher: Did the physical distance between you (and your son) make it difficult (to see him)?

Maud: It did really. I used to see him about five times a year, same as I'd see my widowed daughter-in-law. She'd come down to see not only me but also her son and daughter as well.

Of course the daughter is now in another city.

Researcher: It seems that the geographical distance between mothers and fathers, and sons is quite important?

Maud: It does make it really difficult. Going again years back you didn't get a separation like that.

Researcher: People stayed within quite small areas?

Maud: Our grandmother lived with us that sort of thing. One thing David (the son) used to say, "I must get down here more often". I said "I see you far more often than some of the people here whose family live in the village." That was quite true.

Researcher: It does seem to be an important aspect of how caring for parents is. The mobility of people seems quite a thing.

Maud: I think when families live at a distance; more thought is given to parents. It does seem to happen quite a lot.

Living Alone

The widowed status of respondents is indicative of the wider population, because single or widowed people are more likely to live in a residential care home than married people (McCrae 1999, Grundy and Jijtlal 2007). The fact that the majority of the respondents were women was also indicative of the fact the women live longer (National Statistics on Line 2007). The respondents actually experienced rapid late life moves when they were aged 70 plus, after longer periods of marriage and household stability (Table 12a). Respondents' isolation could be attributed to their relatively late marriages and relatively smaller families, resulting in fewer younger family members to provide potential care as well as the geographical dispersal of relatives. Five of the respondents had two children. Two respondents had only one child and one, Dora, did not have any children.

These data are broadly indicative of their era. People of the 1912-1921 cohort, the years when these older people were born, married late and had small families relative to other historical time periods (McCrae 1999), indicating the influence of economic and social factors. One-child families were quite common during

this period. Parents of the 1912-1921 cohort were, on average, five years older at the birth of their last child than parents born in the 1937-41 period. Only 53% of the 1912-21 cohorts had at least two children compared with 73% of the 1932-1941 cohort (Department of Health 1999). The trend towards smaller families is consistent with general post war changes in England with a marked trend towards single households or households of only married or cohabiting pairs amongst the white population (Philipson, Bernard, Phillips and Ogg 1998).

Living alone had the potential to be a significant factor in the lives of these older people preceding the move to residential care. Some of the older people moved into a residential care home after a long period living alone after their spouses had died (see Table 15 and Box 15). Many of the respondents lived alone for periods up to and beyond twenty years. This experience of living alone was in many ways unique for them. They had not previously experienced long periods living alone. Only the war provided a period of being alone, for some, and this was not of a long duration. Learning to live alone was an important feature of the women's experiences. The women did not reflect to any significant extent on these experiences of living alone and I also did not focus particularly on this time in their lives. I should have made more efforts to probe the significance of the change from living alone to living in communal situations for older people who had had long periods of living alone. These older people went from a situation where they suddenly had to share living spaces where privacy may be at a premium and this may have affected their ability to achieve any sense of homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002) within these settings (explored in later chapters). Snelling (2005) argues that those engaged in research should involve participants in discussion about all areas of lived experiences, something I was sometimes reluctant to do. The research questions would have been more effectively answered had I been willing to explore this line of enquiry.

Understanding how older people experience the setting of residential care requires understanding how they experience one setting in relation to others and if this new setting 'fits' with the expectations derived from living in other places. The older people were not willing to share their thoughts on living alone and how the move to residential care was experienced in relation to that move. It may

have been regarded as a very personal and difficult area for some of the older people to talk about and my commitment to not causing undue harm led me to avoid further prompting (Hollway and Jefferson 2000, BASW 2003)

Table 15: Bereavement in later life: Marriage, death of a spouse and move to care

Name	Bernard	Teresa	Lauren	Dora	June	Maud
Marital status when entering residential care.	Married	Widowed	Widowed	Widowed	Widowed	Widowed
Length of time widowed prior to residential care.	N/A	12 years	Not Known	12 years	18 years	23 years
	Catherine	Barbara	Mary	Bill	Edna	Elsie
Marital Status when entering residential care.	Widowed	Widowed	Married	Widowed	Widowed	Married
Length of time widowed prior to residential care.	3 months	Not Known	N/A	8 years	Not Known	N/A
Age when spouse died.	87	Not Known	87	77	Not Known	Still alive

Notes

N/A: Not applicable. Bernard's and Mary's spouses entered residential care with them. Elsie's husband moved into a nursing home when she moved into residential care (See Chapter 5).

Box 15: Living alone in later life

- Eleven of the twelve older people moved into residential care after the age of eighty and the average age at which they made their move was eighty-five.
- Of the nine whose spouses died prior to entering residential care, two had lived on their own more than twenty years.
- The average time spent living alone was fourteen years.

Section six: Summary

Understanding older people's experiences of moving to residential care requires one to understand how these moves and these lives are located within historical contexts. This chapter has placed the lives of older people within contexts. It has identified periods of stability but also uncertainty, of isolation and attachment. Their stability was mainly located in their relationships with spouses but sometimes with children. These older people had left the parental home for reasons related to work and family but also in some instances because of illness, or moving to a children's home or to hospital.

The economic depression of the 1930s influenced their housing choices. Their social and historical contexts included World War Two that affected the timing of marriage and provided a significant influence on their young married lives. However, World War Two did not affect patterns of stability in marriages and households that had been established before the war. These older people led predictable lives except for the war. They mainly married pre-war, husbands had stable employment, they had children in the early years of their marriages and they did not move house. They made personal choices within the restrictions of class and social mores. The women's stability was founded on marriage that also reduced their opportunities to work outside the domestic home.

Women's experiences differed from those of men. The introduction of the welfare state in 1948 coincided with the respondents' young adult lives (Hill 2004). Change was embodied in the Butler Education Act and the Family Allowances Act that were enacted by the coalition war government (Hill 2003). The establishment of the National Health Service and the pursuit of full

employment as a policy goal represented the creation of new 'rights' of citizenship for many (Alcock et al 1998). The replacement of the Poor Law by state pensions and the emergence of health and social care provision were supposed to insure against poverty (Baldock 2003). Finch (1989) argues that the development of state pensions and other policies have given older people a sense of independence. Most of the older people experienced growing prosperity. Some respondents owned their own homes and felt financially secure (Box 5).

Understanding older people's experiences of residential care requires an understanding of sociological realities that can affect lives and help structure them. But this does not mean that older people's individual responses to these events can be ignored. Understanding relocation also requires awareness of the more individualistic detailed responses to change.

The individuality of the older people was apparent in their expressed interests and beliefs. It is this individuality expressed in religious faith and/or cultural interests that may reveal itself as particularly important. Their ability to achieve homeostasis in residential care settings may be influenced by the patterns of their lives and the way they express their own ability to adapt to change.

Understanding their moves to residential care requires seeing the patterns of their lives but also understanding and being aware of their patterns of response. They may or may not have consistently shown resilience and their levels of reserve (Grundy 2006) and resilience will be expressed through the detail of their lives and responses to set backs and change. We need to discover how much emotional stamina (Wagnild and Young 1993) older people have to cope with change.

This chapter has also introduced the practitioners and encouraged some early reflection on how their perspectives on relocation may differ from older people. The most common theme amongst the practitioners, whether field or residential based was a feeling of some detachment from the older people they worked with. Social workers with just two and up to twelve years experience of the roles often felt detached from the older people they worked with. Residential care home managers felt sometimes close and sometimes distant from the older people. Many of the care assistants also, and perhaps surprisingly given their close physical working with older people, expressed some 'distance' between them

and service users. This was expressed by those working in community and field settings and even amongst those with many years experience. Geographical proximity to the homes was not often a factor to generate closer affinity or coming from the local area, with some notable exceptions. Issues of social class, gender and ethnicity were sometimes felt to be important factors in how the practitioners related to older people.

Practitioners' perspectives on residential care, discussed in subsequent chapters, provided context in which their reflections will be contrasted with older people. Their thoughts on older people's relocations may be partly shaped by their general feeling of 'detachment' from the lives of the service users and this may have implications for practice. We should expect older people's accounts to be different from practitioners for as has been argued previously their experiences are very different. Older people have specific and emotional experience of relocation whilst practitioners have generalised practice experience.

Older people's experiences of moving to residential care may be partly shaped by past life events and reactions and their outlooks shaped by how they have made sense of these changes and learned to adapt. Their very emotional and personal experience of residential care will guide their thoughts as practitioners' more detached experience of relocation may influence their conceptual worlds. Understanding something of the background of practitioners involved will however help to contextualise the discussion as the data is scrutinised in the subsequent chapters. Chapters five to seven will track and analyse experience of residential care, comparing and contrasting the thoughts and experiences of practitioners with older people. Evaluation of older people's moves in terms of their ability to achieve homeostasis (will be based on the evidence of older people's experiences and reflections and on how they reacted to settings).

Chapter Five: Understanding relocation to residential care: Critical incidents and turning points.

This Chapter analyses different perceptions of the reasons why the older people made moves to residential care. Section one considers perceptions of critical incidents in older people's relocations to residential care. Section two considers individual explanations of moves to care, contrasting practitioners' reflections with older people's individual stories. Section three analyses moves that have multiple explanations, and section four considers moves that apparently lacked a critical incident. The Chapter concludes, in section five, with a summary of the issues presented in this chapter.

Section one: critical incidents

Previous literature concerned with older people's relocation to residential care has not examined in any detail the immediate period leading to relocation. There has been an absence of examination of the events leading them to residential care. Morgan et al (2006) refers to family dynamics affecting the move in the period leading to relocation and Reed et al (2003) refers to ' push and pull' factors without consideration of the chronology of events in detail. My research did however identify a passage of events with critical incidents (Edvardsson and Roos 2001) being central to these moves. The 'critical incidents' were the times when older people realised that they needed more help and support and residential care and they saw residential care as a way of responding to these needs.

The concept of homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002) has relevance here in that these older people's wants and needs were not being met in their existing living spaces. Their sense of 'fit' with their private home had gone and residential care was now the alternative environment seen as the most likely place where they may find this sense of 'fit' .Whilst the circumstances of each move differed the lack of 'fit' with their existing environment was the defining element across all of the cases.

None of these older people had enough reserve (Grundy 2006), mentally or physically or in other ways to sustain themselves in this setting and therefore not enough resilience (Vandsberger 2005, De Muth 2006) in order to stay there.

Whilst the early research of Townsend (1962) only saw residential care as a default choice and did not seek to understand the process of relocation or consider the details of this process my research takes much interest in this process. This 'critical incident' was the event that brought that issue to the forefront. It often occurred some time before eventual admission to residential care (Table 16). Practitioners did not identify this event and it seemed outside their conceptual understanding but for older people this was the time that meant most to them in terms of how they went on to understand their situation. It was the defining moment, from older people's perspectives, that began a move that ended in residential care. It was important to this research that I sought to understand the older people as individuals with complex pasts and sometimes contradictory reactions to present events. It was also important to situate their turning points (Table 16) within the wider contexts including, socio-economic and policy contexts, acknowledging factors like lack of finance as potential reasons for relocation. In identifying turning points it was important to see these turning points not necessarily as times that heralded unprecedented decline. It may be a time that symbolises loss but a resiliency framework (DeMuth 2004, Vandsberger et al 2005) encourages us to consider development as inconsistent and there will be many stages. The turning point may be a time that in the long run helps the person to face up to the challenges presented beyond the turning point.

Table 16: Older people’s perceptions of their reasons for care: critical incidents and turning points (Notes to this Table follow).

<i>Respondent</i>	<i>Living in their own private home</i>	<i>Living in relatives home</i>	<i>Living in sheltered housing</i>	<i>Living in hospital</i>	<i>Living in residential care</i>
<i>Bernard</i>	Spouse’s illness.				
<i>Dora</i>	Illness.			Needs support and personal care.	
<i>June</i>	Panic attack.			Needs support and personal care.	
<i>Maud</i>	Bereavement.	Stroke	Needs support and personal care.	Needs support and personal care.	
<i>Catherine</i>	Bereavement.	Anxiety, unsuitable housing.			
<i>Barbara</i>	Illness.			Needs support and personal care.	

Table 16 (continued)

<i>Respondent</i>	<i>Living in their own private home</i>	<i>Living in relatives home</i>	<i>Living in sheltered housing</i>	<i>Living in hospital</i>	<i>Living in residential care</i>
<i>Mary</i>	Stroke				
<i>Bill</i>	Stroke				
<i>Edna</i>				Needs support and personal care	
<i>Elsie</i>	Housing circumstances		Illness		Emotional vulnerability

Notes to Table 16

- a) Both Dora and Barbara referred to illness as the reason for entering a residential care home but did not tell me of the nature of the illness, whether acute or chronic.
- b) Maud, Mary and Bill experienced strokes but did not specify whether those strokes were mild or severe.
- c) The move to care of Lauren and Teresa are not represented in this Table. This is because neither perceived a precipitating event leading to care. Both said that they needed support for personal care.
- d) Stroke or cerebrovascular accident (CVA) is the sudden damage to brain tissue caused by either a) lack of blood supply or b) rupture of a blood vessel. Degrees of severity rang from temporary loss of blood supply through to loss of consciousness (Macpherson 1995). I was unable to ascertain the type or severity of the strokes experienced or the prognosis for each of the older people.
- e) All five who said that they needed support for personal care did not specify in detail which tasks they could not perform. It was also often unclear who was defining their situation and if this term was one they had learned from professionals and carers.

Only two of the twelve, Teresa and Lauren, did not attribute their move into residential care to a specific turning point. In trying to understand these moves and the turning points leading to residential care it is important to recognise that older people's accounts of their moves were partial and selective. It could have been that these people may not have 'needed' residential care and there may not have been other options available to these older people. This cannot be said with any sense of certainty however. More information, such as social work

assessments, may have indicated more ‘justification’ for residential care. Their may have been more ‘pull’ factors (Reed et al 2003) and more medical reasons (Tinker 2003) than appeared present. It may have been that these older people’s reserve (Grundy 2006) had been depleted to such an extent that they had become vulnerable and residential care was one ‘solution’ to that vulnerability.

A resiliency framework (Vandsberger et al 2005) suggests that as people age they can experience the loss of many meaningful relationships such as a spouse, a close relative and friends. They also may gather and utilise strengths of reserve. Social support from family and friends and social interaction may help the older people to sustain themselves. The experience of a lot of change may make a person in that sense more vulnerable, more in need of support, and may make residential care something of a preferred choice. This however needed some empirical testing.

Section two: Individual explanations – practitioners’ views

Practitioners gave various individual explanations for the moves to residential care although tended to refer to the older person’s ‘failure’ to remain in their own homes and a need for residential care rather than discussing the nature of the relationship between their internal selves and their external surroundings.

Strokes

Three of the twelve older people (Maud, Mary and Bill) emphasised strokes as precipitating factors in their moves to residential care. Practitioners working in community settings (see Table 4 for a full list of practitioners) were more aware of the significance of strokes than practitioners in residential settings. Field social workers and occupational therapists were most aware of the potential impact of a stroke on future moves (Box 20). Only eight of the practitioners in care settings gave a particular emphasis to strokes, with residential care home managers being most aware. Eleven of the thirteen practitioners in community settings referred to strokes as a significant reason for entry into residential care. Occupational therapists discussed the physical limitations arising from strokes; and community psychiatric nurses emphasised how a stroke can make a person less adaptive to

new environments. Home carers and social workers emphasised that strokes can make living in the community harder, depending on their nature and severity (Box 16). Social workers in particular had a broad understanding that strokes can change attitudes and increase vulnerability. Practitioners in community settings (social workers, occupational therapists etc) were aware of how strokes affected older people in the short term but did not recognise the longer-term emotional consequences of strokes. However, they were aware of consequences for older people of living within environments that may restrict their choices. Residential care was however seen as such an environment whilst the private home was not considered a place of restriction.

All of the practitioners assumed that older people's 'failure' to adapt to these new surroundings was the key issue. It is however perhaps too easy to assume that older people 'fail' to adapt to particular settings and locate the 'problem' with them rather than see problems with the care settings themselves (Thompson 2001) or in the interaction between the person and her/his environment. Practitioners Roberta, Heather, Susan, Claire and Paul suggested (Box 16) that older people react in similar ways to strokes. Research evidence suggests however that people will react in many different ways to strokes and their potential for rehabilitation will also vary in its nature and pace (Faucus 2000). The resiliency framework (Vandsberger et al 2005) incorporates a strengths perspective which suggests that problems reside in the transactions between the person and his or her environment, something practitioners were not recognising in their assertion that stroke has such limited and 'inevitable' consequences.

Box 16: Practitioners' views (names are pseudonyms)

“Strokes can be very debilitating for older people. They can change their whole outlook. I have seen people change beyond recognition, become a stranger who cannot connect with you. Relatives find it particularly disturbing” Roberta, Social Worker.

“Move will be experienced differently for those that have had a stroke. They may feel completely disorientated to their new surroundings in a much more exaggerated way than people who have not had a stroke”. Heather, Occupational Therapist.

“People who have had strokes are generally less able to adapt to new surroundings. They have less ability to cope.” Susan, Community Psychiatric Nurse.

“The person who has had a stroke often finds that he or she cannot relate to their home environment in the way that they used to. The place becomes alien to them; they cannot connect to surroundings that once were so familiar. It is not good to see this happen.” Claire, Home Carer.

“I have seen the damaging affects of a stroke where the person can no longer function in their own home. Daily tasks become so much harder if not impossible”. Paul, Social Worker

Comparing the perceptions of older people with practitioners it is curious to note that there was some convergence between them in terms of attitudes towards strokes. Older people's perceptions of strokes were similar to practitioners, sharing a pre-occupation with medical conditions. Maud (Box 17), Mary and Bill (Boxes 18 and 19) said that the strokes themselves made them vulnerable. Maud's first stroke, which led to a fall, made a lasting impression on her. She could recall the detail of the stroke in vivid detail (Box 21).

Mary said that staying at home after her stroke had been a possibility (Box 18). Bill was offered the choice of living with his daughter-in-law (Box 19). Their 'preferences' for residential care were based on their fear of living on their own in the way that Wright (2003) discusses or reluctance to live with relatives (Bill) or in the cases of Maud (Box 17) an apparent lack of adequate community care support (which is difficult to verify or contradict without specific evidence). Residential care appeared however less fearful to many of these older people than the possibility of another stroke or subsequent 'event' experienced in the domestic setting of their own home.

These older people may have felt that they had the resilience to cope in residential care whilst they did not feel they had sufficient reserve or resilience to be able to experience this within their own home. This point was made by Mary. Mary felt vulnerable (Box 18) but did not want services coming into her own home. She was however ready to accept residential care where she thought she would be monitored twenty four hours a day. She did not want her personal space to be invaded and yet was 'happy' to relinquish much of her own privacy to live within residential care. She had been unable to balance her wants and needs within her own home and thus had neither a sense of homeostasis or the resilience to cope within that setting.

Maud's assertion (Box 17) that she was 'advised' that she would have difficulty getting her own meals and that only a limited amount of community-based support could be provided may have pushed her towards residential care. Bill was as much concerned with his daughter in law's needs as his own (Box 19). His 'preference' for living in a residential care was made for the sake of his daughter in law. He also suggested that his private home had become 'alien' to him and he, like Mary, had become detached from it emotionally as well as in other ways. Here again was evidence that one of the respondents felt he could not experience homeostasis within the private home.

The practitioners generalised about the effects of strokes and did not show any recognition of individual responses to strokes, or question their own presumption that the 'solution' to older people's needs had to be residential care rather than an alternative form of support. Older people also did not question the reasons they had been given for undergoing moves to residential care. Maud (Box 16) was not critical of the reasons given to her for residential care and appeared to accept her situation.

Box 17: Maud

Maud experienced a series of strokes, in different settings and circumstances. She went to live with her daughter-in-law after the death of her husband. His death was the first point of change but it was not the catalyst. She was still able to live independently. Whilst living with her daughter in law she experienced her first stroke, which she said made her feel vulnerable.

“I got up that morning. Got myself a cup of coffee and toast. I called out to ask her (daughter- in- law) if she would like another coffee. I took it to her. She suddenly said to me are you all right? It was just as though I saw red sepia. Without hesitation she rang for an ambulance. She thought I was having another heart attack. Then, when I went to move I couldn’t get out of the chair”.

Maud moved into sheltered housing. She made a considerable recovery, and could have gone back to her daughter in law, but she felt comfortable in sheltered housing and decided to remain there. She had subsequent strokes, and an angina attack whilst living in sheltered housing. One of her strokes took her to hospital. She then moved to residential care. Maud almost went back to sheltered housing after her stroke and subsequent hospitalisation. The inadequacy of home care was, she said, a significant factor that made it impossible to return to sheltered housing. She said that her social service assessment for community care could only offer a certain amount of support. She said that a maximum of twelve hours was not considered enough although she did not specify clearly who determined this or why. Maud was also advised that she would have difficulty getting her own meals.

Box 18: Mary’s experience of a stroke.

Mary’s fall caused her great distress. Her husband had gone into hospital recently. “It was during the night. I fell down and then couldn’t get up again. I stopped on the floor until morning came, when they came to see what had happened. Of course I should have knocked on the neighbour’s door. They had to break in. I couldn’t get up. I had to go there for a bit (hospital) stop in bed a bit.”(Interview 5).

From hospital she went to residential care. Her attitude towards continuing to live at home was heavily influenced by the fall. She had a different perception of her own domestic home ever since and felt vulnerable rather than safe there. She did not welcome the intervention of home care workers.

Remaining at home, with support services coming in to her own home, was unwelcome to her. This attitude and expectation may have contributed towards her going into residential care. “I thought I didn’t know if I want people coming in every day, you’re no better off are you. I wouldn’t like to be at home with them (home carers) coming in every day. Wouldn’t like them to come with meals on wheels for a start.”(Interview 5)

Box 19: Bill's strokes

Bill had three strokes, the first at home and subsequent ones in hospital. Bill's attitude was a factor in his move to care. He went to a rehabilitation flat at hospital after a fall. Bill said that the assessment revealed that he had difficulty with tasks such as washing and could not look after himself. His daughter-in-law wanted him to live with her, but he was insistent that he would prefer to live in a residential home for he said that his daughter-in-law needed a break from caring.

He also said that his home no longer felt like somewhere that he could live and he felt 'out of sorts' there. His insistence that he should live in a residential care home was partly due to his sense of sacrifice for his daughter in law and partly due to his own sense of not being able to relate to that setting any more.

In all three cases it seemed that both the physical circumstances and the emotional outlook of each older person influenced their moves. Mary, Bill and Maud experienced a loss of confidence and Mary and Bill also felt uncomfortable in their own homes, for various reasons. A social worker commented that she was aware of how "stroke can reduce confidence in a person to such an extent that they do not want to take even the slightest risks". It is necessary, however, to be aware of any presumptions concerning the effects of strokes and attitudes to risk. It is important to question medically influenced opinions that do not acknowledge the influence of factors in the wider environment (Rankin and Regan 2004). Older people and practitioners can have different perceptions of risk (Davies 1997) but some argue (Thompson 2001) that services should not passively accept or respond in ways that do not encourage older people to challenge their fears or understand their choices (Thompson 2001).

This is not however to presume that this group of older people were necessarily unaware of their own choices or that challenging their own fears was necessarily the most appropriate way forward. It can be important to maintain control over one's life and taking care of one's personal health can be another resiliency factor and they can in this way maintain a sense of safety (Vandsberger et al 2005). The ability of an older adult to maintain a sense of safety and care for basic needs such as nutrition, housing and health can signify strength within the ageing process (Lewis and Harrell 2002). The need to be safe and secure must

not be underestimated and perhaps something that policy and practice could show greater attention towards. User choice may be a fine policy objective but there are also issues of user safety and older people's valid interpretations of their own wishes, rights and risks. If older people perceive residential care as more safe and a place where they can maintain control of their lives than in their private home then this perhaps needs fuller recognition.

Illness

Whilst practitioners in community settings were more aware than practitioners in residential settings that strokes were apparent reasons for relocations to residential care, residential staff were more aware of the inter-relationships of physical and mental health and how physical illnesses can mask an array of other concerns (Box 20). None of the practitioners were however able to talk about the psychological impact of illness or explore what it means in a sense to be 'vulnerable'. They mentioned how older people may be 'emotionally unwell' or struggling (box 20) but were unable to talk about the complexity of these emotional responses, despite my prompts. The medical reasons for relocation to residential care included 'illness', although, as with strokes, other factors were apparent. Two of the older people, Barbara and Edna, mentioned 'illness' as the catalyst for being in residential care. Both also expressed an absence of trust in others, that affected their mental and physical health (Box 20).

Box 20: Practitioners' views

"When older people come here (to the residential care home) they can feel quite vulnerable. Their emotions are all over the place sometimes and this can often manifest itself in physical ailments. They can get quite unwell and it is the emotional aspect that can have an impact on their overall health". Helen, Residential Care Home Manager

"Older people can feel emotionally unwell in a sense and this can trigger physical ailments".
Pauline, Residential Care Home Manager

"I have known many older people struggle emotionally and when this happens there can be a deterioration in their physical health. It can bring on a cold or something much worse, I really believe that". Carol, Care Assistant

The close association between older people's physical and mental well-being was illustrated most graphically by Barbara's situation. Her physical condition was the perceived reason why she was in residential care, but her emotional needs played a part in compounding the physical problems. She moved to residential care for emotional security as much as because of her physical health. She entered the residential home from hospital but was just as despondent in residential care. She felt unable to find anyone to help her through this move and felt cut off from her family who lived some distance from the residential home. She could not rely on the convoys of support that are said to build up over a life time of reciprocal change (Antonucci and Jackson 1989) and appeared to neither have the resilience or reserve to cope with life at home or in residential care (Box 21) as reflected in my research diary

Box 21: Barbara: unsettled in all settings

June 14th 1998

Barbara appeared unsettled in the residential care home and the way the room appeared suggested this. Her room appeared empty of any personal belongings or signs that she had made it her own. It looked like she was only there on a temporary basis. She expressed her lack of contentment to me when she said "I really don't think there is anything for me here". She also said that her own home

Had become 'worrisome' for her and the only place she wanted to be was near her daughter". The anxiety within her was manifest in the way she looked at me in a very edgy sense, looking anxious and introspective.

Edna moved to residential care from hospital, after having lived in sheltered housing. She was generally unwell and had influenza as well as pain in her legs, which affected her mobility. These were the reasons that had been given by doctors, although she disputed the doctors' views. She also felt that a stay in hospital that was unnecessarily long caused the weakness in her legs and that this made her susceptible to residential care (see Box 22). She said that she could not trust either family or practitioners (discussed in Chapter six).

Box 22: Feeling the strain: Mental and physical factors

“By the time I had been in hospital twelve weeks my legs were weaker than they had ever been. When you are in a place where everyone is in bed you can’t do much walking around can you”. (Interview 1). Edna

Yes, I was sent to hospital at the end of March. The consultant said afterwards that I was lucky to be alive. I had pneumonia and a chest infection. I was in intensive care. It took a lot of getting over. Don’t look back. Let’s hope next year is better, I know no reason why it shouldn’t be” (Interview 3). Dora

Note: these cases occurred before the introduction of intermediate care services. Intermediate care services are delivered either at home or in a designated care setting, to prevent unnecessary hospital admissions, support timely discharge and prevent unnecessary admission to residential care. Intermediate care involves nursing staff and various community health workers, rehabilitating older people and helping them maximise their independence within the community (DH 2005a).

Dora’s pneumonia sent her to hospital where she was placed initially in intensive care. This illness drained her of physical and mental energy (Box 22). Barbara, Dora and Edna experienced their illnesses as emotionally difficult. They said that their emotional responses to physical problems made considerable differences to their subsequent ability to care for themselves. They said that they were unable to cope with daily tasks, including shopping and preparing their own meals. It was not clear if or to what extent these thoughts had been discussed with practitioners.

Some older people said that they had developed a need for support and personal care although many of the older people did not elaborate on this. I could have asked them to elaborate further. I was after all concerned with the nature of their interaction with their home environment, to see how they may have been unable to reach a state of homeostasis in such settings. The older people did however express some reluctance to elaborate as noted in my research diary (box 23). This did however demonstrate my commitment to not in any way exploit vulnerabilities and in this way showed a commitment to avoiding harm (

Hollway and Jefferson 2000, BASW 2003) to research subjects and not in any way, directly or indirectly, exploiting any vulnerabilities.

Box 23: Research Diary: Unwilling to talk

September 8th 1998

I have noticed throughout the interviews that some older people are reluctant to elaborate on some themes. One of those is the subject of the reasons for their admission to residential care. Many of the older people do not want to elaborate on their assertions that they could not any longer care for themselves. It is not so much a direct refusal but a wish demonstrated with body language and in pauses to move on with the interviews and not pursue some issues more widely. They have in fact given me clear notice that they do not wish to discuss certain subjects at length and it is important that I respect this. Whilst it would serve the purpose of the research and illuminate the findings the wishes of the research participants are paramount.

The three older people who specified ‘illness’ as the precipitating event that led them to residential care explained their situations in these terms but it is important to recognise that there may be other ways of defining or understanding their choices. Their emphasis on the physical “event” may have obscured other reactions that accelerated their admission process. The older people indicated that their illnesses had affected their abilities to perform many tasks but both Dora and Edna experienced psychological problems that compounded their physical difficulties. Barbara, Dora and Edna cited their illness as a catalyst for residential care but preferred not to discuss the state of their mental health at each stage of the process (showing again a reluctance to answer certain lines of questions).

Two of these three older people, Barbara and Dora, had relatively affluent backgrounds but their affluence did not prevent them from entering residential care. This finding supports my emphasis on needing to understand psycho-social reactions of older people in order to understand their lives and responses to residential care. For these older people were not in residential care solely as a result of poverty or disadvantage. Their moves appeared to be influenced by fear

as much as other considerations. This kind of evidence gives reason to question research that over emphasises structural reasons such as poverty for entering residential care suggested in earlier research (Townsend 1962, Tinker et al 2001). Money might have provided more choices of home-based care, but their emotional vulnerability influenced their decisions. Neither could achieve a sense of homeostasis within their own private homes and this was exemplified in their words (box 24)

Box 24: Barbara and Dora: Unable to cope with life at home

Barbara: It was just not the same at home any more. Yes, there was the incident on holiday I know but it was becoming difficult in my own place. When I was younger it was more like home really, if you know what I mean. But everything was so much harder around the house that I did not feel that I belonged there in a way anymore. Isn't it strange? I felt more unsure as the years went along (interview 3)

Dora: I had my Doctor telling me what to do and you know I felt I could in a way live at home still but no one can pretend that it was the same as before. I mean when I was married and totally at home in a way, if you understand. Things were in a way frightening, I mean getting older is (interview 4)

These older people appeared to have many issues related to their mental health and these were factors leading them to residential care. There did not appear to be any evidence that these matters had been addressed by any services, although this is hard to conclude without discussion with the practitioners involved in their individual cases. Older people can in principle access psychological therapies as part of their health care (Department of Health 2004) including therapeutic interventions such as cognitive behaviour therapy (Evans and Reynolds 2006). It must however be stressed that these services may not have been available to older people when I undertook the fieldwork and whatever services were available it was not ultimately clear if they had been offered to the older people at any point. The resiliency framework (Vandsberger et al 2005) recognises the importance of addressing psychological issues when working with older people,

studying the effects of life stress later in life rather than assume that adverse psychological reactions are some inevitable consequence of ageing (Schriver 2001).

Bereavement

Practitioners in residential settings were more aware than those in community settings of the impact of bereavement, with nine mentioning its importance. They were aware of the effect of bereavement on couples that have moved into residential care together. A care assistant remarked that when couples move into residential care together and one dies, the other may become physically and emotionally weakened by the death of their spouse. They also implied that residential care was an inevitable outcome for older people experiencing psychological as well as physical difficulties. The comments of Jane and Tanya (Box 29) illustrate this.

Box 25: Practitioners' views

“The death of a loved one can weaken resolve. They can feel in fact that they cannot cope with the stresses and strains of daily living when this happens. Residential care sometimes becomes a reality and bereavement makes the physical tasks that much harder” Jane, Care Assistant.

“They become weaker, yes, more likely to enter care I would say”. Tanya, Care Assistant.

“Bereavement can weaken older people and I have noticed this in my work. It is quite common”. Paul, Social Worker.

“I have seen it many times. The older person is bereaved and suddenly they lose their ability to cope and every-day tasks that used to be easy become harder”. Dawn, Home Carer.

Practitioners in residential settings recognised bereavement as a factor in admission to residential care, supporting some earlier evidence (Department of Health 2004). Practitioners' statements (Box 25) suggest that older people will

experience inevitable decline rather than have the possibility of potential development in later life. There was again a lack of attention to the complex interplay between emotional and other factors and they tended to talk only of people in terms of deficits. There was no recognition of the strengths that people can show or the possibilities of development as well as decline as people respond to set backs (Grundy 2006, Vandsberger 2005).

Practitioner's lack of recognition of the subtleties of older people's emotional responses contrasts with the evidence of how complex and subtle their responses can be, as exemplified by Catherine's situation. She did not simply become 'weakened' or just 'lose the ability to cope' but became generally more vulnerable. The idea that older people may enter residential care as a result of their vulnerability (Morgan et al 2006) is supported by Catherine's situation. Catherine suggested that she became vulnerable and susceptible to residential care after the death of her husband, which occurred in the twelve months prior to her move to residential care. She felt that she could not cope in the house alone. The death of her husband was the event that sparked a chain of subsequent events that led her to seek 'safety' in residential care. Her fear and isolation were also compounded by her housing circumstances. Neighbours might have provided support in her domestic home, but shortly after her husband's death, one of Catherine's neighbours died and another neighbour moved to the south west of England. She expressed her reaction to this chain of events to me in one of the interviews (Box 26)

Box 26: Catherine and a chain of events

"I could not really cope after the Alan's death (her husband) and this really made it more likely I would end up in a care home. I was frightened and it has affected me badly to be honest. Losing Alan reminded me of when my father died and it still affects me, still there at the back of my thoughts. Then there was living in that house, not easy. Things have happened so quickly and I still feel out of sorts, just not right, perhaps I have not got over it all in a way, never really got over it." (Interview 4)

Catherine then went to live with her daughter, whom she trusted. Catherine's daughter visited on a regular basis but feared that Catherine would fall and after a

series of short stays at the residential care home, Catherine eventually moved into residential care. She agreed with her daughter that the stairs at her daughter's house were becoming too difficult to manage (explored in more depth in Chapter six). The influence of psychological factors ran through the accounts of many of the older people, although most of them preferred to mention physical reasons for their admission.

Older people were acutely aware that physical factors affected their emotional states. They expressed a range of feelings about their reactions to the turning points of their moves, with fear being paramount. They did not specifically identify 'mental health problems' as the reason for their moves. The only older person who identified mental health reasons as a primary factor in her move to residential care was June (Box 27). June said that there was little wrong with her physically at this stage (Box 27) and it may have been that residential care was offered as the solution to what were primarily psychological and social difficulties. Again however it is as stated on other occasions not easy to collaborate this claim without recourse to further evidence.

Box 27: June's move to residential care

June made many adaptations to her home when her husband died. Support services such as home care and meals on wheels were provided and were sufficient to allow her to stay in her own home. Her nephew helped her obtain a new handrail up the stairs. When stairs became difficult, the house was altered sufficiently to facilitate living downstairs. She wanted to stay at home for as long as possible and had believed, especially given the alterations, that it was possible to remain there until she died. She was coping, mentally and physically until one night when she had a panic attack that for her was the defining moment that led to residential care. Physically, there was not much wrong with her at that stage, but she had lost confidence in herself.

"I had this sort of panic in the night. Actually I thought I was dying. I pressed the lifeline button. I didn't know anything was happening so I pressed it again. Then my nephew came down. My nephew was a bit worried so he rang for an ambulance. I don't think there was anything wrong with me. I had just lost confidence in myself. I had just got to the end of my tether". She went to hospital and from that point her mental vulnerability was accompanied by physical problems. She acquired an infection in her bowels, walking became very difficult and she became more frail. After transferring to another hospital, suitable to her specific care needs, she went to live in a residential home.

The reasons so few of the older people highlighted mental health as a reason for their moves to residential care may have been due to the stigma associated with mental health conditions (Corrigan et al 2000). The older people emphasised their physical troubles and ignored or denied their underlying mental health issues.

Finances

Practitioners emphasised financial resources as factors in older people's moves to residential care (Box 28). Thirteen of the twenty-nine practitioners thought that availability of sufficient funding from social services was an important influence on individual moves, whilst only seven did not consider money to be an important factor.

Box 28: Practitioners' views about finances.

“Money influences things; it gives more choice to older people that have it. They can then afford to pay for their own care. It is a powerful influence that I don't think should be underestimated”.
Roberta, Social Worker

“Money shapes things on so many different levels and in so many different ways. Social service budgets influence things enormously and if older people have money then they will have more choices in terms of care”. Paul, Social Worker

“You cannot underestimate the importance of money. It widens options”
Tanya, Care Assistant

“Yes, move will be affected by money; it is hard to argue a case against that. It is all about power and money gives older people, and their relatives, more power over their own futures. The timing of entry to residential care can be affected by how much money one has at their disposal”. Helen, Residential Care Home Manager

“The fact that people have to sell their own home will influence things. Some are reluctant to do this and really want to pass it on to their children; it can even mean they resist going into residential care for this reason”. Pauline, Residential Care Home Manager.

The other nine practitioners (twenty-nine in total) were not sure how to rate the impact of financial resources. Six practitioners in residential care settings and seven in community settings highlighted the importance of money. Practitioners

argued that charges for privately funded care could be expensive. The average weekly cost of a place in residential care in England and Wales is £370 (Wanless 2006) but although after a means test of the individual applicant, some beds in private, voluntary or local authority homes are fully funded by state support. Others are self funded or partly funded, with the older person, or (if they are willing), relatives paying the difference although relatives in the United Kingdom are not obliged to offer financial support (Thompson and Wright 2000). There is evidence that those who receive local authority funding are having their fees topped up by third parties in order to meet the charges levied by the homes (Laing and Buisson 2005) and to meet the standards of care that users (and care regulators) expect.

Practitioners thought that financial considerations could keep people living in their own domestic homes even if residential care might have been more appropriate. They did not expand on what ‘appropriate’ means within this context or acknowledge the costs of home care, which like residential care is subject to means testing and is either wholly or partly self funded (Wanless 2006). Instead they focused on legislation requiring older people to sell their own homes to fund their residential care as an important influence (Box 28).

Practitioners said that financial issues shaped choices, and crucially, attitudes, but did not relate money to the range of other physical and emotional factors that influenced moves to residential care. My research encourages a more holistic understanding of the factors involved in relocation. Understanding relocation through the lens of concepts such as homeostasis and reserve (Grundy 2006) and resilience (Vandsberger et al 2005, De Muth 2006) encourages us to see finance in relation to other factors which combine in certain ways to make the older person able or not able to live ‘successfully’ in any given setting. Single factor explanations are not as compatible with this approach.

Older people saw the importance of finances in relation to other aspects of their lives, rather than as a single factor leading people to residential care. Only two older people gave financial resources a specific emphasis. Lauren seemed more aware of her physical condition as a reason for moving to residential care and

said that money may have slowed or postponed a move to residential care rather than prevented it. She regarded residential care as something of an inevitability and emphasised the day-to-day deterioration in her physical abilities and how much this gradually impaired her ability to function independently.

Edna also emphasised her day-to-day changes as she gradually 'weakened'. Whilst she mentioned the lack of finances and the role of the doctor as factors in her move to residential care, Edna, like Lauren, did not mention the lack of home-based support or other care choices as factors influencing her move. All the older people who owned their own homes had to sell their homes to pay for the cost of residential care. The sale of Dora's house was a significant event in her ability to 'settle' in residential care (see Chapter 7). Dora, like many of the older people, did not attribute much importance to financial resources and its impact on choices. Their understandings and reactions to their relocations were guided essentially by emotions.

The care roles of family members

Three of the older people (Bill, Lauren and Maud) made active decisions not to live with relatives. Their decisions were affected by wider relationships within their families (explored in much more detail in chapter six). The older people did not consider living with their family as an alternative to residential care. Only two of the older people acknowledged that living with their family was a choice at earlier stages of the move and three declined offers to live with their families. Nine of the twelve older people did not consider living with their family, to the extent of not even mentioning it. Maud expressed a strong conviction that older people should not depend on relatives (Box 29) and Lauren considered that it would put too much strain on her family (Box 30).

Bill insisted that he should live in residential care rather than reside with his daughter-in-law. Lauren was concerned about her eyesight and general health. Her daughter in Canada offered her a home as an alternative to residential care, but although Lauren was emotionally close to her daughter, she felt it was not right to relocate and 'put on her'. She was afraid of being dependent; her daughter lived too far away for her to 'settle'. The older people were concerned

with the dynamics of living with their family and preferred to live apart from them, even if this meant that they would live in residential care.

Box 29: Not wanting to be a burden: Maud and her thoughts.

“I think there are certain things you have to accept. I mean I’ve had my life in a way. I do get a little impatient with people in the way they don’t want to leave the family. They forget that they have had their day and that younger people have to have theirs. I could not just rely on my son, I know he offered help and a place for me at his but that is really not the point, it is not fair on him. We are lucky these days that there are these places to come into. In my day my grand mother lived with us. No complaints but I remember the difficulties.” (Interview 3)

Box 30: Lauren chose not to live with her daughter.

“I said I am refusing you but thanks very much. I didn’t believe in living with the family. They have their ways and I might have been doing something, which might not suit them. I know I would have been alright with any of them but as I am now, not being able to see, that’s it”.

Section three: Multiple reasons for moves

Some older people had multiple and quite complex reasons for relocation where the ‘truth’ concerning why they moved was very hard to gauge. Elsie was somewhat confused when interviewed and said that the reason she was in residential care was because her house was being decorated (she was in residential care on a short-term basis whilst her house was being underpinned). Her husband’s short stay in a nursing home for an occupational therapy assessment was an additional factor. Elsie had cancer, but the care staff told me that her physical functioning was ‘quite good’. She was at the residential care home on a planned stay of two weeks only because, she said, of the house repairs. The house repair situation might have been the precipitating factor leading to residential care but her emotional vulnerability appeared to be as significant to her move. The idea that vulnerability can be understood by knowing when a persons reserve capacity falls below the threshold needed to cope (Grundy 2006) is useful to understanding Elsie’s situation, as expressed in her own words (box 31).

Box 31: Elsie was ‘vulnerable’

“the thing is I really did not feel very strong when I moved here (to the residential care home) with so many things happening to me. It all really became too much and I felt sort of vulnerable. In the past it seemed easier but coming here and all that was the final straw. It pushed me too far really, I mean one only has so much strength to deal with all this (interview 1)

Bernard’s move to residential care and his wife’s ill health was the presenting reason. His wife was a diabetic, who was judged to have low care needs but had multiple difficulties including poor mobility and overall poor health and illness. **Catherine’s** daughter’s house was not suitable and that could be cited as *the* reason for entering residential care. Housing circumstances were the catalyst for **Elsie**. She said that her son and husband colluded in sending her into short-term care (discussed in more detail in Chapter six). Practitioners, obviously unaware of the detail of these individual stories, referred simply to the lack of suitable housing for older people with increasing mobility problems as a leading factor in triggering entry to residential care (Box 32).

Box 32: Practitioners and their views of older people’s housing needs

“If the housing is not there in their area they can become more likely candidates for residential care. They may be better off in sheltered housing but if it is not available then options reduce”.

Jim, Community Psychiatric Nurse.

“Housing choices are massive influences and housing must suit people’s specific mobility needs at certain times in their lives”. Paul, Social Worker.

One respondent, home care worker Dawn said that housing was a particular factor for those living in rural areas. Her view was that the availability of more sheltered housing in remote rural locations might reduce the likelihood of older people moving to residential care. The evidence suggests however that there is a lack of supported or alternative housing in rural areas and that this was the case at the time of the fieldwork in the late 1990s. The provision of social housing as been lower in rural than urban areas where it accounts for only 15% of the housing stock compared with 23% nationally (Thornicroft 2001)

Section four: Moves without an “event”

Only two of the twelve older people, Lauren and Teresa, made the move to residential care without perceiving of a precipitating event. Practitioners did not conceptualise moves without apparent reasons or were unaware that some older people failed to acknowledge turning points. Lauren and Teresa were no different from the other older people in that they experienced their moves as gradual (Box 33). Both experienced bereavement, ill health and changes in housing circumstances prior to coming into residential care but they did not identify these events as pivotal to their moves. They also suggested, as with many of the other older people moving to care that their private home became somewhere that no longer met their needs. Lauren said that home had become ‘rather frightening’ to her and not somewhere for her to feel comfortable (interview 4).

Box 33: Teresa, Lauren and their moves to residential care

Teresa

The reasons why Teresa came to residential care were vague. She entered the residential care home on a short stay basis to give her son a break. Practical tasks around her flat such as getting her meals prepared and managing her laundry were getting more difficult. Her mobility was not good, but the lack of support from her son, who found it difficult to provide support even on a casual basis, was a factor. She said that she felt vulnerable in her own home. She talked about having a fall prior to coming into care and losing some confidence. Residential care provided comfort, security and peace of mind for her and her son. “Came here for a holiday, liked it. Easy move really. I didn’t get my washing done (at home), things like that. Here you get everything done. It’s nice to be waited on” Interview 3)

Lauren: Unsure why really I came here but things were worrying, at home (interview 4).

Section five: summary

My research suggests that moving to residential care is as much explained by the way older people felt about living in their own private home as much as how they felt about residential care. Many of the older people felt uneasy about living at home, they felt that they did not belong there, there was a lack of homeostasis in their own private space. This is not something policy and practice has recognised to any great extent, that home itself could be alien to them. Whilst

some research (Hooyman and Kayak 1996, Raithby 2001 and Tinker et al 2001) recognises the potential similarities between home and residential care previous research does not suggest a preference for residential care based on a lack of 'fit' between the person and their private home. Many of these older people felt 'vulnerable' at home.

Ageing itself will not explain the older people's vulnerability although there is some research (Evans 1988) that suggests that ageing can bring decrements in the homeostatic mechanisms that allow for more adaptive responses to environmental challenges. This does not mean that these older people's responses to change were uniform and their levels of vulnerability were as much a function of their lack of reserve (Grundy 2006) as their ageing.

Life time factors influenced their levels of reserve and the source of many of the older people's resilience (Vandsberger et 2005) was to be found in the details of their life courses (to be explored in much more detail in chapter seven). When the older people emphasised specific explanations for moving to residential care, such as strokes or 'illness' they often obscured other factors such as their increasing sense of unease at home or psychological factors that made them feel more vulnerable. Whilst the significance of the 'critical incidents' cannot be underestimated or physical realities of strokes or heart attacks under played what made those events critical was their emotional impact. The findings from this chapter inform understandings of how residential care and the experience of moving there is to be understood as an emotional experience. This was an emotional experience punctuated by 'critical incidents' and 'turning points' that were critical and significant as turning points in the way they turned emotions. These older people's levels of reserve and resilience were challenged by these events.

Practitioners often emphasised the physical limitations brought about by strokes and other physical aspects and they understood them as key reasons for admission. Practitioners did not recognise from their generality of experience of working with older people how the relationship between social and medical circumstances may combine to lead people to residential care. They were unaware of the detail of older people's life histories and how they were factors

leading people to residential care. They were unaware of the interplay between past events and more immediate concerns as expressed to some extent in earlier research (Miller and Gwynne 1972, Leeson 2005, Morgan et al 2006).

The interplay between housing circumstances, finance, emotions and medical issues all combined as factors making residential care their destination. This interplay was however more complex than much previous research has recognised. The relative affluence of two of the older people, Barbara and Dora, was not relevant to their situation. Their vulnerability and their lack of psychological comfort or homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002) within their private homes influenced their moves to residential care.

Practitioners did not recognise the complexity of factors involved in the lives of these older people any more than they did not recognise multiple causes that other research (Townsend 1962, Reed et al 2003, Wright 2003) has to varying degrees cited. Issues such as loss of confidence or the general sense of vulnerability combined with physical and other factors in ways that practitioners did not acknowledge. We can expect that practitioners' perspectives on the experience of moving to residential care would be different (a point made earlier) but the sharpness of these contrasts was perhaps slightly unexpected. Practitioners' revealed virtually no recognition of the emotional impact, from broad practice experience, of moving to residential care. They were unable to understand how different settings may be perceived differently and the complexity of older people's emotional responses.

Practitioners general sense of lack of attachment from older people's conceptual worlds (as illustrated in chapter four) whether employed for months or years or even if working in close physical proximity to older people, may explain their lack of understanding of the complexity of these issues. Other social actors had an influence on the moves of these older people and chapter six will examine these influences in more detail. This will show some recognition of the 'push' and 'pull' factors emphasised in Reed et al's (2003) research and how these various influences on older people affected them as they tried to achieve a sense of homeostasis or cope with change effectively.

The vulnerability of these older people had significance in terms of how they viewed their choices in terms of home and residential care. It may be said that they often preferred residential care to living in their own private home and residential care in that sense became not so much a default choice identified in earlier research (Townsend 1964) but an active choice. Older people relocating to residential care did not make these moves outside of social contexts. Their lives would to some extent be subject to, but not necessarily determined by, power and resources and these will constrain their agency (Giddens 1990). These issues of power and resources will be looked at in greater detail in the next chapter as the role of various social actors on older people's relocations is examined.

Chapter Six: Power and influence: different perspectives

Introduction

Drawing on reflections from my research diary as well as the interview data, this chapter examines issues of power in relation to the relative influences of key social actors on older people's moves (twelve older people and twenty-nine health and social care practitioners). The research diary provides a reflective commentary on the findings, particularly important when analysing issues of power and influence. The diary enabled me to 'stand back' from the data, draw out wider issues of power that cut across the individual cases, and reflect on the dynamics between the social actors. The various sections discuss the power and influence of Doctors (section one); family members (section two), social workers (section three) and other practitioners (section four) before summarising (section five).

Section one: the power and influence of Doctors

My research diary notes my reflections on older people's deference to authority and their perceived acceptance of their situation (Box 35). Bernard, Edna and Dora (box 34) and Mary (Box 35) it seemed all learnt to accept residential care and this was certainly reflected in their words. There was a kind of resigned acceptance that helped them to adapt to residential care. They appeared to have complied with authority, or at least that is the impression given. Older people's experiences, portrayed in this research, illustrate how doctors are regarded differently from non-medical practitioners. Both Dora and Bernard attributed little importance to the roles of practitioners, except for doctors. Dora's doctor (Box 34) advised her against continuing to live in her own home. She reluctantly agreed to go into residential care, although she felt her doctor was pushing her there. She said that when her husband died things became hard. Dora considered warden-aided housing but the consultant favoured a care home. She said she "needed to think about it" but implied that the decision had already been made for her. Her initial reluctance to agree to her doctor's decisions was accompanied by a compliance and deference to his authority, stating "a consultant is an expert isn't he?" (Interview 8).

Bernard felt that his wife was rushed into residential care and that both he and his wife had “little control over it” (Interview four). Bernard felt that the doctor was not taking enough time over the issues, and did not discuss the range and type of supportive services. Bernard felt a lack of control and perceived that the doctor was using his knowledge and professional power. Bernard also appeared to defer to this authority, saying “in the end it is the doctor’s say so and that needs to be respected, even if we don’t always like it” (Interview 4). Edna also perceived the doctor’s powerful influence as important. She felt that he kept her in hospital too long and that her son and daughter worked against her by promoting residential care as the ‘best’ option for her. Dora objected to taking medication and said that she was being given medication when she was not entirely happy about taking it and she said she would have preferred to make her own choices (Box 34). Edna suggested that doctors were discriminating against her on the grounds of her age in their presumptions (Box 34) but felt powerless during the assessment process.

Box 34: The perceived power of doctors

Dora

“The doctor said that we don’t think you are well enough to go and live alone. When they said that, what can you do but accept it (Interview 5). About taking medication: I don’t like them because of the side effects. Affects the bladder. I said to him that I don’t like having to go to the toilet. He said that when you lie down your bladder fills up more quickly. I thought oh dear. So I could not go against that really. A consultant is an expert isn’t he? (Interview 8)

Edna

“Doctor came one day just after Christmas and I’d have him thinking I was not looking after myself. He said that perhaps I was not feeding myself. I did feed myself, I had a cold. There was nothing wrong with me physically; he said I was not looking after myself. My daughter used to come and see to my son and me.

They pushed me into hospital, I don’t think they like old people, doctors, too much trouble. You do have to accept it all I suppose; I mean what else can you do? (Interview 1)

Bernard

“My doctor suggested it, that we got in touch with these people and suggested that we come here and who were we to argue” (Interview 3)

Box 35: Excerpt from the research diary: Deference to authority

Thursday February 18th

“I returned today to see Bernard and Mary. Both seemed to have an acceptance of their situation that was perhaps surprising. They appeared in their own ways to have come to terms with the fact that they were in residential care and had adapted to it. Mary had been very fearful living in her own home and residential care appeared to offer her respite from her fears. She commented “what can you do, anyway, it’s for the best”. Her separation from her husband, in a nearby nursing home, also seemed to be accepted with a passive resignation “it’s not ideal that he is there and me here but that’s what they have decided”. Bernard also appeared resigned to his fate, even though physically it appeared doubtful at times if he needed residential care.

Medical decisions and their impact on the outcomes of older people’s relocation.

The older people talked with a sense of conviction about the role of doctors in their relocation and they appeared to feel a sense of injustice and powerlessness in the way they related to doctors. It must be remembered however that I did not interview any doctors directly or indirectly involved in these older people’s relocations and therefore direct contrast of these perspectives has limitations. Their reflections are like many life stories are interpretations and can be read in different ways (Flick 1998, Roberts 2002). It is however possible to reflect on the impact of this apparent disempowerment of older people in terms of the process of relocation and adjustment. Older people’s levels of reserve (Grundy 2006) can be affected by levels of personal autonomy. The failure of others to provide opportunities for the exercise of self determination, particularly for those with disabilities but also older people can challenge levels of reserve (Grundy 2006). There were signs of resignation in the words of these older people and a suggestion that doctors not only restricted their choices but limited their sense of autonomy.

Grundy (2006) suggests that older people in residential care or in need of care may be one of those groups most at risk from this process and that ageist discrimination may also compound this problem. Bowling (et al 2001) found that older people’s access to medical care was restricted by decision making that does not fully involve older people. De Muth (2004) refers to how practitioners

including those in medical settings can restrict older people with ageist presumptions and deny their capacity for strength or their own ability to make their own decisions. Edna (box 34) alluded to the possibility of ageism and this was implicit in the words of Bernard, Dora and Mary. Levels of autonomy can impact on levels of reserve (Grundy 2006) which in turn can affect their levels of resilience (Vandsberger et al 2005) making it harder for older people to achieve homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002) or adapt to change.

Issues of control and autonomy are important issues in understanding how older people make sense of change (Wahl 2001) and the role of social actors needs to be carefully examined for the effect they have on older people's subsequent progression. These older people were reflecting on their own roles and the roles of Doctors and the effect they were having on their development and choices. These findings supports earlier research (Reid et al 2005) that says that families may ultimately leave decisions about health and social care to professionals (Reid et al 2005) but suggests that older people were still highly aware of these dynamics and were not passive in the sense that they reflected on them. They were not the passive recipients of the service portrayed in Townsend's (1962) work and in much subsequent research. The older people were not just aware of ways in which they felt disempowered but were also aware of how this disempowerment, as they saw it, may affect their subsequent progress. The very process of decision making impacted on how they saw themselves and the settings in which they now found themselves. (Box 36)

Box 36: Bernard and Mary: lacking autonomy and failing to adapt

Bernard

“I really think that the Doctor has held me and my wife back in so many ways. He never really listened to either of us and made decisions on our behalf and he did not involve us. That is so annoying to be honest and these decisions affect the rest of our lives. I mean how could I or my wife feel good about coming here

(residential care) when decisions were made for us? How were we supposed to settle here when it does not feel like a place designed for either of us”

(interview 3)

Mary

“ It is not good that he (my husband) is at that other place (nursing home) and I am here and with them deciding that for us kind of thing then this place really is somewhere that would never be a place for me in my heart and I would never have settled and still can't”(interview 4)

Section two: The power of family members

It is possible that older people may accept or leave authority with doctors in the belief that they will help them to come to the ‘best’ decisions and it may also be that this for some may be perceived as the best way through to achieving a sense of homeostasis .These older people did not seem content with giving authority as there was a sense of discontent and also resignation in their words. Relationships with family members were however more complex in that older people appeared often to want to concede authority. Older people sometimes had little involvement from families and declined to get involved in decisions made by practitioners. Dora’s nephew displayed passive acceptance of her doctor’s influence. Dora said that her nephew was “supportive” but did not “get involved or anything” when it came to decisions made by the doctor (Interview 3). Barbara’s three daughters had no discernable influence on practitioners and June observed that her daughter “was not involved in the decisions” (Interview 1). There appeared to be an absence of family influence in these instances and less sense of attachment.

This was not however always the case and in many other cases there were strong bonds of attachment (Bowlby 1988; Yelloly 1980) that had much significance for the progression of these older people from their private home to residential care.

Bill, Maud and Teresa appeared content in a sense to be in residential care and content with the role of others in their relocation. Bill's 'preference' for living in residential care rather than with his daughter in law showed a wish to reciprocate the help and support she had in his view given him over the years (box 42). It also demonstrated a sense of autonomy, resilience and reserve in his capacity to make his own judgements and draw from his own strength of mind. Maud also had enough reserve and indeed resilience to make an active choice not to live with her son who had offered help (Box 37). Teresa also expressed a sense of conviction that she had been in charge of events (box 37).These were not always older people buckling under the pressure from relatives, as has been reported and assumed in earlier research (Wright 2003).

Box 37: Maud and Bill: Content to be where she they were and happy with the role of others

Maud

"I am certainly glad I came here and how my son has helped me out. I have left it to him because I could trust him. He has helped me to get some order back in my life and that is what is most important".

(Interview 4)

Bill

"I am here now and that is that. I have left it all to her (daughter in law) and thanks to her I have some peace of mind. It doesn't matter if she took all the decisions, what counts is my peace of mind, I am telling you"

(Interview 3)

Teresa

" I am so pleased for what my son did for me in that at last I can find some peace of mind and have a rest (in residential care) as things were just getting too much for me. After all this is what I want and I have made sure of it at the end of the day , it is about that really above all else"(

Interview 2)

Maud, for example, appeared unaware of any potential power dynamics within her relationship with her son in which he made many decisions on her behalf during moves, stating (in response to a question about power and who had most influence during the move) that " I do not have the time to think about it. We're

happy, I know that”. (Interview 4). These older people had formed emotional bonds with specific individuals rather than with a collective family unit, different perhaps to the experience of older people in other cultural contexts (Liu and Tinker 2003). Their emotional bonds with these specific relatives assisted them in their wish to live in residential care. There is evidence also that they saw residential care as a place where they would achieve some sense of homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002). Bill’s ‘peace of mind’ (interview two) and Maud’s reference to residential care helping her to get some ‘order in her life’ (interview four) suggested that they saw it a place where they could accommodate their wants and needs. Practitioners did not suggest that they understood how older people may not only wish to move to residential care in the name of ‘fit’ but how they may see relatives as a means to achieving this end. They in this sense saw residential care in restrictive terms. I made these general reflections in my research diary (Box 38).

Box 38: Excerpt from my research diary: Practitioners perceived family and their influence in restricted terms

Monday June 22nd

Practitioners appeared to lack complexity in their understandings of issues of who had power and influence as older people moved to residential care. They appeared to see relatives as influential and older people as rather passive. Families were portrayed as making decisions on behalf of older people and of almost forcing them into residential care. They were the ones with the agenda and older people were portrayed as lacking in any sense of personal decision making. Psychiatric nurse Jim said that he thought “family influenced decisions” without going into much detail even when pressed further. Occupational therapist Wendy showed no recognition of how older people may have their own wishes and may help to control decisions to go into residential care. “ I can’t see how older people would really want to go into residential care or see how they would influence this in that way, it is more likely to be the family member forcing his or her ideas on them rather than the other way around” by practitioners working in all settings

Only twelve of the twenty-nine practitioners acknowledged that individual family members had a significant impact on older person’s moves and when they did refer to their impact they referred to it as completely negative. Older people, in contrast, emphasised the power of specific individuals who each evoked an emotional response. They identified the positive and negative influences of

family members, depending on what they wanted from them. Sons or daughters (including a daughter in law) were the most powerful influences (see Table 17). Although there were other social actors involved these were the individuals that older people referred to as most influential.

Table 17: Key powerful influences: The older people and their children

	<i>Sons</i>	<i>Daughters</i>	<i>Key powerful influence on moves</i>
Elsie	0	0	Non
Maud	1	0	Son
Teresa	2	0	Son
Bill	None *	None	Daughter in law
Catherine	None	1	Daughter
Edna	1	1	Daughter
Dora	None	None	Doctor
Lauren	0	1	Warden
Mary	None	None	Social Worker
Barbara	0	1	None
Bernard	0	1	None
June	0	3	None

Notes: * Bill's only son died aged 38.

The power of sons

Some older people (Maud and Teresa) perceived their sons as influential in a helpful way and this was usually in terms of helping them to get into residential care and achieve a sense of homeostasis (Rinhomota and Copper 1996 Wilson and Barrett 1998, Kinwelli and Stilwell 2002). Their emotional responses to their sons featured consistently in their accounts. It is not especially unusual that children should be seen as helpful as their older relative moves to residential care and is supported by other research (Sandberg, Lundh and Nolan 2002). Maud's son, who was divorced, was emotionally attached to his mother. He was her remaining child after the death of her other son, and this strengthened the bond between them. Maud's son was geographically close to his mother and available to offer support. In contrast, Edna was not emotionally close to her son after his

wife died. She alluded to her son's bitterness towards life; he was distant from her and everybody else.

Teresa had one son who was very close to her both geographically and emotionally, but Teresa was estranged from her other son who lived in Scotland. Teresa's son managed his mother's financial affairs. Teresa's son helped her move into the residential home, by preparing her bedroom. The sons of Maud and Teresa provided their mothers with information about choices of residential home and acted as advocates (see Box 39). When the sons of Maud and Teresa took responsibility for their mothers' lives (Box 39) they also gave older people the chance to move to settings where they believed they would achieve some control over their daily choices. Elsie regarded her son differently and felt that his son, together with her husband was making things more difficult for her. She believed that they were not being totally honest with her concerning the situation. She believed her son to be powerful but was not necessarily acting in her interests (box 39)

These older women were prepared to concede some decision making in return for the love they needed from their sons. James's reported 'relief' (Box 39) when his mother (Teresa) went into residential care may have been based on his wish to retain his independence and avoid daily responsibility for her care but the relationship was still one of reciprocity where Teresa gained something from her apparent lack of control. She said in interview three "yes he does it all for me I know but isn't this the way it should be now for after all I did bring him up and I told him I wanted a rest and to live somewhere where it is all laid on".

Maud's son appeared to be involved with her move at every stage (see Box 39) even to the extent of saying 'we' were advised to accept the place in residential care. This closeness was embodied in the fact that her son wished to remain in the room when I interviewed her. This observation was noted in my research diary (Box 40). She found comfort in this involvement and she expressed this to me quite strongly in interview four, saying "he has been there all along and I wanted him there for I needed to be sure he was behind me and that I would get the place in this home, it really mattered to me". These older people felt less vulnerable and had greater reserve (Grundy 2006) because of the fact that they

had these sons who acted in such a way as to give them strength. Regular contact with relatives has also been seen to be vital to that stock of well being or reserve (Grundy 2006) and sons provided that and also the reassurance that their mothers be able to move to residential care.

Box 39: Powerful sons

- James, one of Teresa's two sons, played an important role in the decision to enter care. He provided ongoing support through the move. He managed her money and gave her information about the home before she moved in. "I think my son was quite relieved when I did move to care. Much easier for him to pop in and see me" (Interview 1).
- Maud's son John chose the residential care home for her. She said he visited the home and told her all about it. He was the information provider and also the advocate. He liaised with care staff and promoted her concerns to them.

Maud: "When I travelled up before I stayed at my son's house but under those circumstances I couldn't have stayed. I couldn't have looked after myself there. Naturally I relied on his judgment. I knew it would be all right. Although I didn't see the place until I lived here, until I actually moved in" (Interview 1).

Maud: "Then we had to wait to see if we were accepted, and we were. Then we had to wait to see if there was a vacancy. In a way it was rather sudden and unexpected because he rang me up on the Wednesday. There were six people on the waiting list and it looked as if we would have a bit of a wait. I said all right

John, something is going to happen, and there will be a vacancy. Friday he rang to tell me there was a vacancy. We were advised to take it within a week, it was all go, and then we had to get up here" (Interview 2).

Elsie believed that her son was 'not being totally straight with her' and suggested that the reason she was in the residential care home was to 'get me out the way' (interview 1). It was not totally clear what she meant by this and when prompted further she would not elaborate.

Box 40: Excerpt from the research diary: Mothers and sons needing each other:

December 10th

Today I interviewed Maud in her room and her son insisted that he stayed in the room as I interviewed her. This seemed a strange decision initially but it was something they both appeared to want. Maud remarked that she felt she had 'nothing to hide'. The two of them seemed very close and each seemed to draw comfort from each other. The fact that he lived so close to her, literally around the corner, gave Maud much comfort. Her son appeared to be equally happy with the fact that she lived nearby, stating that he likes to 'look after mother'.

January 7th

I visited Teresa today and she wanted initially to talk about her son and the bond they had between them. This departed from my agenda but it did not matter much, there should be scope for older people setting the agenda themselves. The closeness between them was evident in Teresa's words for she said that she 'treasured' her son James.

The power of daughters

Daughters were equally powerful in their influence on moves (Box 41).

Catherine and Edna were most influenced by their daughters or, in the case of Bill, by his daughter in law. Edna was involved in a conflict with medical personnel that also involved her daughter. Edna felt that her daughter, together with her son, wanted her in residential care. She said that her son and daughter were afraid that they might want to assume care responsibilities for her if she went back to sheltered housing. She would be 'off their hands' in residential care. That was a power struggle that Edna perceived as one where she and her daughter vied to assert their influence over doctors. Her daughter allegedly conspired with the doctor to 'push' Edna into residential care, justifying this with a medical interpretation (that Edna was too weak in the legs to return to sheltered housing) that contradicted Edna's wishes.

Bill, in contrast, did not interpret his daughter in law's influence in the same way, regarding her 'guidance' (in leading him to residential care) as compatible with his interests. He was content to let others make the decisions, showing the trust characteristic of an apparently loving and reciprocal relationship (Reid et al 2005). Catherine, like Bill, trusted her daughter implicitly. They felt attached to

them and this sense of attachment made them feel stronger. Catherine and Bill (box 41) alluded to how these bonds made them feel stronger.

Box 41: Powerful daughters

- Catherine's daughter managed her money for her and took her laundry home to wash. She said that she felt close to her daughter and that closeness helped her to feel stronger and more able to deal with things.
- Bill's daughter-in-law 'guided' him through the process of decision-making. He said that she helped him to make the 'right' decisions, giving him the opportunity to weigh up the options of moving to residential care. This made Bill feel 'closer' to her and he said that "this gave me a source of strength in a way to have someone doing all this for me".
- Edna thought that her daughter had been 'pulling the strings', colluding with medical personnel to keep her in hospital. She felt that her son and daughter 'talked' to the doctors. "Twelve weeks with a colic. My daughter has been trying to tell the doctor I can't go home. I have been paying to keep that on (her place in sheltered housing)." (Interview 2)

The ties of love

Homans (1974) argues that human relations are determined by systems of social rewards and profits. People perform tasks and actions for recognition and love in the same way that they may exchange monetary rewards. Exchanges continue only when both parties gain something from them. A sustained social relationship rests upon a balance of mutual profitability. Reciprocity theory (Carruth et al 1997, Reid 2005) argues that rules of social engagements can apply at all stages of life but the power balance between parents and children can change.

Exchange relationships are also power relations (Homans 1974). The resources people bring to exchange relationships will not always be the same and rarely will be equal. Both the older people and their sons and daughters were aware of the long-term benefits in each reciprocal exchange. Blau (1964) argues that people can recognise the long-term costs and benefits in their social relationships. These older people appeared at times to concede power to their sons and daughters in exchange for the long-term feeling of security that they perceived could be found only in residential care. But in another sense they

empowered older people in that they gave them the chance to be more safe and more able to achieve homeostasis. These patterns of attachment. (Bowlby 1988; Yelloly 1980) helped older people to be more resilient in the face of change.

These attachments were crucial to their moves and the nature of these relationships affected the nature of their moves in terms of outcomes (discussed in more detail in chapter seven). The relationships with relatives, sometimes defined by them as positive and sometimes negative and destructive, notably Edna's, were still exchange relationships. They were ones in which power was given and received and were also ultimately important for older people. Edna's ability to achieve homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002) was affected by her relationship with her son and daughter (as well as her Doctor) in that it affected not only which setting she moved to but the nature of her relationship with that setting. Residential care went on to be a place where she did not experience homeostasis and her relationships had some effect on the process as well as the outcome of her move (also considered in more detail in chapter seven).

Homans (1974) argues that if people are able to obtain a particular goal only through one specific social relationship then they become highly dependent on that relationship. The older people may have become dependent on specific sons and daughters in this way, investing their attention on them in the understanding that these particular relatives alone could provide the rewards they sought. They were perhaps not so much dependent on their sons and daughters or in fact independent but there was a sense in which they were interdependent (Fine and Gladdening (2005). Homans (1974) also argues that as people age they can see the care given to them as dependent older people as nothing more than 'pay back' for the care and attention they gave to their offspring in their youth. This view is in fact expressed by Teresa, interview three (box 45) although other older people's relationships and bonds had been formed many years before and were often remembered.

Box 42: Remembering the past and bonds established

Catherine: “My daughter has always been there for me and this is never forgotten, through the more difficult times and now. We have always helped each other” (interview 3)

Bill: “ she(daughter in law) was always close really, like my own in a way and we have always helped each other” (interview 4)

Maude: “ I was there for him at the time of his divorce and through all that and now he is here for me, it’s a case of give and take or something like that but we are very close (interview 3)

Teresa: I am close to James then and now, all along and we have helped each other as much like friends as mother and son. It has been a bit of a roller coaster at times but James has looked after me” (interview 5)

These were lives as processes, with the past and the present overlapping. Older people’s underlying concerns were with the bonds they had formed and sustained and their shared biographies were shaping reactions to each other in the present. Control over events was in a sense more shared and if there was pressure applied by key relatives to assist their mothers in their wishes to move to residential care it was pressure that was welcomed. This was something that practitioners did not comprehend. Practitioners believed that families applied subtle pressure on their older relatives to choose residential care but did not understand the nature of this relationship. Care assistant Beryl said that families often “do not tell their older relatives they are going to live permanently in care. They do this to protect them, making them feel it is just for now, that they will be ok”.

Practitioners thought that sons and daughters were under a great deal of stress when trying to cope with their older relatives at home. Twelve practitioners (of twenty-nine interviewed) stressed the negative rather than the positive power of families and thought that family members pushed their older relatives into care. Nine accentuated the positive influences of family, how they can support their relative, and the rest were more ambivalent. Whatever the nature of their responses, these reflections of practitioners were not based on deep knowledge of the older people but from the detached perspectives alluded to earlier in the thesis (chapter four). They could not recognise that exercising control over one’s resources and showing resilience (Vandsberger et al 2005, De Muth 2006) from a base of reserve (Grundy 2006) could be demonstrated through a wish to move to

residential care. It was not part of their conceptual world that relatives may be those they may call upon to exercise that control rather than relatives necessarily taking it away from them.

Practitioners only alluded to the positive influence of relatives when they referred to relatives who may help maintain them in their own home rather than assist them to go into residential care. They did not identify the 'positive' influences or reciprocity in the family relationships that helped them move into residential care. There was perhaps an underlying belief or presumption that residential care was by definition undesirable and that any moves by relatives to assist them in their efforts to move into residential care will be negative. These thoughts came through in their words (box 43)

Box 43: The unsuitability of residential care: Practitioners thoughts

Social worker Julie

“Older people do not want to be in residential care and so relatives who push them in cannot be acting in their interests I would have thought. They want to be in their own homes. I mean it just is not fair to push them in”

Social worker Keith

“ relatives should not push older people into care and if they really want to help they should just give them choices about what is available and leave it up to them”

Care Assistant Susan

“It (residential care) is unsuitable from every point of view and I would have thought that a truly caring son or daughter would not make any efforts to get them in such a place”.

Table 18: Influences on twelve older people's moves

	<i>Primary Influence</i>	<i>Secondary Influence</i>	<i>Other Influences</i>
Elsie	Non	None	None discernible
Maud	Son	None discernible	None discernible
Teresa	Son	None discernible	None discernible
Bill	Daughter in Law	None discernible	None discernible
Catherine	Daughter	Social Worker	None discernible
Edna	Daughter	Doctor	Son
Dora	Doctor	“ Family”	None
Lauren	Warden (Sheltered housing)	Daughter	Son in Law
Mary	Social Worker	None discernible	None discernible
Barbara	None	None discernible	None discernible
Bernard	None	None discernible	Doctor
June	None	None discernible	None discernible

Section three: Social work influence

Social workers have a statutory obligation to assist older people under section 21 of the National Assistance Act, 1948, supported by section 47 of the NHS and Community Care Act 1990. However, these older people perceived social workers (care managers) as peripheral to their moves and did not recognise social workers' power that derives from their statutory responsibility for assessing older people's care needs (unless the older person is self funding). Ten of the older people were dismissive of social worker roles. The majority of the older people made their decisions about moves without any apparent involvement of social workers, despite the fact that only Dora was a self-funding resident. This finding does have to be stated with a degree of hesitation. It may be that they made their decisions with social work involvement and that this involvement did not carry any emotional weight behind it.

Mary and Catherine were exceptions. Mary said that her social worker offered information, advice and support, took her to see different homes and gave her

choices. She liked the fact that he gave her time to talk (Box 44). Mary's feelings towards social workers were none the less ambiguous (Box 44). She was also less positive about her second social worker (it was not clear when and why she was given a different social worker). He was "less of a friendly type, not like the first". He was, as she said "more business like" and not interested in sustaining a relationship with her. She implied a kind of powerlessness in her relationship e.g. "as long as they come to tell you what to do" (Box 44) and an acceptance of a power imbalance. Catherine had one social worker who provided positive support (Box 44) and with whom she developed an ongoing, trusting relationship. Catherine also said that the social worker gave her information about life in residential care.

Box 44: Influenced by a social worker: Catherine and Mary.

Mary: The social worker was her most important influence.

"He was lovely. The minute I saw him I got on well with him, yes. He understood things so well, our point of view on things. I wish I could have had the same one, this new man (social worker) not the same. (Interview 1)

Researcher: Social workers. Is it better to see them a few times?

Mary: No. I don't think you need a lot of contact with people like that, as long as they come to tell you what to do, suggest things to do and all that."(Interview 1)

Catherine: I am trusting the social worker. She has done so much for me

Researcher So you got on with your social worker?

Catherine: Oh yes, I liked Susan. Has she had her baby? She will have had the baby by now.

Researcher: Did that help, feeling close to your social worker?

Catherine: Yes. Susan used to work here. My daughter knew her when she worked here. She contacted my daughter. They had a natter and arranged for my visit. She was a nice girl Susan. (Interview 2)

Bill implied that social workers were absent from his move to residential care (Box 45). Social workers appeared to make little impact on Edna or Elsie who said that they were not offered any information by the social worker. They also made little reference to the interventions of home care workers and other health

or social care practitioners. Barbara was not clear about how she first came to be living in residential care. Moving was a blur from the time she went on holiday with her daughter to her arrival in the residential care home. She said she did have a social worker but had nothing to say about his or her influence. Bernard was in a state of shock when he moved to care. He could remember few details of his move. He did not make any reference to social work intervention or to any social care involvement more generally.

June, Maud and Teresa, like Bernard, made no mention of the social worker's involvement. Maud's lack of interest in her social worker was manifest in her words. She said that social work assessments were 'adequate' without expanding on this. Social worker involvement in moves appeared to be something of a mystery to these older people. Although social workers had assessed these older people for residential care, their power and involvement in decision-making appeared to make little impact and the older people were unaware of the social worker as the potential gatekeeper of residential care. The reasons for this may be complex or there may have been confusion or even memory loss on the part of the older people in respect of recalling their involvement.

Box 45: Bill: Minimal involvement of the social worker:

Impressions of social workers

“ Ask you what you get, put two and two together, charge you so much and that's it”
(Interview 9)

Some social workers were 'liked' by older people who recognised that they had been offered choices. Mary's preference for her first social worker (Box 44) suggested that she valued the choices offered. Catherine's social worker also demonstrated involvement (Box 44) although did not appear to be involved at later stages of Catherine's move (see Chapter seven).

The apparent invisibility of social workers in the lives of these older people contrasted with the perceptions of the interviewed social workers. The six social workers interviewed (box 49) said that apart from family members, social workers exerted the strongest influence on the older people's decisions. Justifying their own role perhaps, four said they gave advice “a lot of the time”

and two “some of the time”. All said that they gave older people information, advice and support and emphasized their assessment roles. These social workers saw themselves as supportive to older people.

Box 46: Seeing themselves as important: Social workers’ perceptions.

“My greatest influence is in giving them information so that they can make a choice”.
Karen, a field social worker.

“We give advice and information on benefits and money entitlement. We give people a booklet about residential care”. Roberta, a field social worker.

“You are talking about a major change in a person’s life. If you are talking about entry into a residential care home then often it is a crisis. People are in crisis, which means a state of confusion and shock. There are many bereavement type feelings. There is uncertainty. Carers can feel guilty. There can be family conflict. We (social workers) have a role to play in giving reassurance and emotional support.” Paul, a field social worker.

Social workers’ sense of their own value in offering support to older people was stated with a degree of recognition of their own sense of detachment. Social worker Linda felt that although she could offer support she felt that she could do much more if she had the time to involve herself more in individual cases.

Section four: The power of other practitioners

Older people considered the influences of other practitioners on their moves in much the same way that they considered social workers’ influences. Practitioners were not part of older people’s personal or conceptual worlds in the same way that family members were. There were few significant professional relationships with practitioners. Only Lauren and Dora (box 47) felt that practitioners played a key role in the decision to enter residential care. Lauren’s sheltered housing warden was influential because of the absence of her only surviving daughter (who lived in Canada). A doctor influenced childless Dora. Only eight of the twenty-nine practitioners who were not social workers regarded family members

as the most powerful influence on moves. Practitioners working in the community all mentioned the importance of family members but referred to a general rather than a specific familial influence. The eight residential care home staff (residential managers, care assistants and domestic workers), in contrast, saw their own advice giving roles as the most important ones. They did not question the nature of this ‘advice’ or discuss the extent to which older people were involved in the process.

Box 47: Lauren and sheltered housing

Lauren

“She (the warden of the sheltered housing unit) said I think you need help. You see I could not use this hand. She said I don’t want to lose you. She said that I would do better if I get help with dressing, with fastening buttons. I said to her (the warden) give me time to think about it. On the Wednesday after that Friday morning I went to the lounge, I was playing scrabble. I rang my son in law and my daughter was at work and I said John have you the time to spare? I will like to go and look at the *Appletrees (residential care home)... He asked me if I was sure. I said that I would go and have a look at it. Anyway, he came and packed me. He was going to fetch my daughter from work. He brought me here. That was on the Monday. On the Wednesday I came again. I got this room, no I didn’t. I asked for one over the gardens. I moved over. I have been happy here ever since” (Interview 1).

*Appletrees is a pseudonym to protect confidentiality

Section four: Older people whose moves appeared to lack a discernable powerful influence.

Barbara, Bernard and June were not clear about who had influenced them to enter residential care. Family members, social workers and social care practitioners were not mentioned in their conversations. Bernard received some guidance from his doctor but did not perceive him as a key influence. These three older people consistently denied any influence on their moves (Box 48) although there is some evidence that they were compliant with practitioners’ power, as noted in my research diary (Box 48).

Box 48: The three older people who did not cite any influences on their moves.

Barbara was not clear about how she first came to hear about the residential home. She did not mention social workers, hospital or care staff. Care staff said that her subsequent move to nursing care was not because of her health but to be near her daughter (who lived in the vicinity of the nursing home). Care staff said she did not have nursing needs. Her move to nursing care, like her move to residential care, was made without apparent guidance or information.

Bernard moved into residential care to be with his wife who was a resident. He was convinced that this was the right thing to do. Input from practitioners and family members were almost absent.

June's move to residential care happened very quickly, rushed from home to hospital, to another hospital and then into residential care. June did not mention any influences upon these moves. Decisions were taken very quickly. Practitioners did not address the issue of her lost confidence, which was the precipitating factor in her move. She could not recall who advised her during these hectic times. Life in her own domestic home suddenly was gone and she was living elsewhere, but did not recall any influence of family or practitioners.

Box 49: Excerpt from the research diary: Accepting the decisions.

Friday, November 20th

I only saw Barbara once but this was enough to know that she was very much alone with her decisions. How much she was making decisions was never clear to me. She appeared to have a casual acceptance of her situation, suggesting that she was powerless to do much about it. She suggested, in the fatalistic manner typical of many of the older people I talked to, that she had little control over things. She referred to 'decisions being made' but at the same time not identifying any one individual who was making these decisions. Barbara seemed not to want my presence in the room for too long and appeared slightly impatient.

Bernard seemed to not really know or understand the process by which he came to be in residential care and the only thing that came across was his acceptance of things. This was not so much evident in his words, but more his attitude, as if things were happening to him (and his wife) beyond his control and at a pace that was hurried. He was ultimately passive in his acceptance of his move, holding his hand up as a display of helplessness as we talked. He stopped me at one point in my questioning of things and preferred to talk about a photograph of his wife displayed on the wall.

June also showed compliance, preferring to talk about how she can make the most of her time in the care home and brushing over my questions about power and influence.

Section five: summary

Older people's experiences of moving to residential care were affected by relationships with 'significant others'. These were very often relatives rather than practitioners and the nature of these relationships were ones in which it was hard to ascertain where 'control' resided such were the complexities. Many of the older people saw themselves as taking control of their own decisions regarding where they wished to live and whom they wanted to involve in their relocations. They were not passive or necessarily controlled and did not view residential care as something necessarily negative. They saw relatives as important to them in their efforts to find living spaces that suited them. Many of these older people showed a capacity for changing their situations for the better and saw residential care as something of a positive development in their lives. There is no reason why older people should be passive in their relationship with other social actors or the environments in which they move an idea consistent with the resiliency framework (Vandsberger et al 2005).

Whilst Reed et al (2003) recognised older people's self determination with their 'pull' as well as 'push' factors their research did not recognise the extent to which older people may use reciprocal relationships with sons and daughters for their benefit. My research goes further than earlier research in noting the reciprocity (, Kelly 1995, Pyke 1998) in these relationships and how some of these older people took charge of them to ensure that their need for homeostasis was met. These were however not just reciprocal relationships formed in the immediate context of the move to residential care. These were relationships formed through time and the patterns of these relationships could only be understood by looking at the older people's biographies and family histories. Lives were processes, something recognised in biographical research (Roberts 2002).

There were patterns of attachment (Bowlby 1988; Yelloly 1980) in these relationships and these patterns of attachment helped older people to show resilience as they negotiated change. The influence of other social actors in older people's relocation to residential care was complex and power was a continuum of involvement (Reed et al 2003). This means that the different social actors had

not only relative influence but that each influence was not straightforward. These relationships were neither coercive or benign, active or passive but were variable and interpreted in different ways by the older people. Barbara, Bernard and June may not have been clear about who influenced them to go to residential care but one can also argue that the nature of the influence other older people received was also not easy to interpret. Maud's son, for example, was perceived in a positive light by her son when he chose the care home but at other times and in other ways this caring may also be interpreted as controlling. Sons and daughters were often recognised as powerful and this support was recognised in some cases as supportive and in others as harmful. Strong emotional attachment reflected in the relationship that Maud had with her son, expressed themselves in their sons offering practical support to their mothers.

Their geographical proximity added to the strength of that support, making it easier, literally, to care. Their behaviour could be regarded as coercive if residential care is assumed to be negative or if issues of interdependency are not recognised (Fine and Glendinning 2005). The same or similar behaviour could also be regarded as caring rather than coercive in the same way that other research has interpreted such responses from relatives (Sandberg, Lundh and Nolan 2002, Liu and Tinker 2003). It may also be that older people can express some control when they call on such support. They may also be 'happy' to receive such support however others may define or interpret it. Relationships can also be reciprocal ones (Kelly 1995, Pyke 1998), and supported by feelings of attachment. (Bowlby 1988; Yelloly 1980).

Some practitioners however did appear to exert influence over the older people. Doctors had influence over Bernard, Dora and Edna, or at least that appeared to be the case. There was evidence of compliance towards authority and it may have been that medical knowledge was used to support this demonstration of power (Edna's experience seemed to exemplify this more than most).

Some of the older people appeared at times powerless not only at the hands of practitioners but also in respect of more general 'push' factors (Reed et al 2003) but wider social and economic factors, something noted in earlier research

(Miller and Gwynne 1962, Townsend 1962, Davis and Nolan 2003) are acknowledged. The research diary was useful in providing a reflective diary on the process of the research and to generate discussion of evidence concerning power and influence as older people moved to care. There was some evidence of practitioner power and other evidence of relatives assuming aspects of control but the relationships were often complex and the dynamics not easy to interpret.

Practitioners made implicit and sometimes explicit assumptions that residential care was not somewhere that would 'fit' the wishes or expectations of older people and so relatives roles were seen in narrow terms as pushing them into residential care. Whilst some practitioners recognised that some relatives may be supportive they regarded being 'supportive' as helping them to find alternatives to residential care rather than helping them to move there. Social workers saw themselves as influential although older people did not recognise this influence from the specific social workers involved in their relocations, although it is hard to ascertain the true nature and extent of the involvement of the specific social workers involved.

Older people's capacity for a 'successful' relocation to residential care was influenced by their relationships with and the impact of their 'significant others'. Key family influences helped older people to move to residential care where they felt they would achieve homeostasis) with such an environment. For the other older people relatives and practitioners were perceived as less constructive. Practitioners were less aware of the complexity of these relationships and appeared more detached from these perspectives and experiences. Chapter seven will evaluate the outcomes of these relocations to define which of the older people achieved homeostasis with residential care, which ones did not achieve this but had enough resilience (De Muth 2004) to cope. The impact of their life histories, practitioners and relatives on their progress beyond the initial move will be examined.

Chapter Seven: Evaluating the outcomes of moves

Introduction

This chapter evaluates the outcomes of moves in terms of how far these older people were content or 'happy' with their move to residential care. It is divided into four sections. The first section reiterates the conceptual base of this thesis with a review of how older people's relocations would be evaluated. The second section outlines the successful movers in terms of who achieved homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002). The third section details the experiences of those who did not achieve homeostasis. The third section details the experiences of those who did not achieve homeostasis and were thus unsuccessful in their moves. Section four summarises the outcomes.

Section One: Conceptualising a 'successful' relocation

It is important to point out that references to 'achieving' homeostasis do not imply a value judgement. Those did not 'achieve' homeostasis were not 'failures'. I do not presume that older people 'should' adapt to these setting but rather to report on if and how they may have done. The mechanism by which these older people achieved homeostasis is that detailed in earlier chapters, namely those mechanisms of reserve and resilience. The quality of their family relationships and social networks were sources of reserve and were important as they moved into residential care. A key practitioner could also provide reserve to them if they provided similar support. These social actors promoted a sense of homeostasis. These people would help them balance their internal needs with their surroundings and to feel a sense of belonging and attachment (Bowlby 1988, Yelloly 1980).

Social networks (Phillipson et al 2000, Tanner 2001) either within and/or outside the residential care home also encouraged this. Those that did not achieve homeostasis could still show resilience, even if they did have enough support from family or social networks to achieve homeostasis. Their resilience was achieved from a stock or reserve of coping skills learned from past life

experiences. If they were isolated from family and social networks, did not have the support from a key practitioner and also did not have sufficient reserve to utilise resilience then it was possible that they may move into crisis (Roberts 2000). It is important to point out that much of this reserve was acquired from relationships forged through earlier periods of their lives as much as in the immediate period leading to relocation to residential care. Development can indeed be a circular process and decline and loss can be expected through life as can positive growth (De Muth 2005).

Section two: Those that achieved homeostasis

Table 19: those that achieved homeostasis

Name	Supportive family relationships	Support Of a key practitioner	Strong Social Networks	Resilience
Bill	Yes	No	Yes	Yes
Lauren	No	Yes	Yes	Yes
Maud	Yes	No	Yes	Yes
Teresa	Yes	No	Yes	Yes

Supportive family relationships/key practitioner

The four who experienced a sense of homeostasis in residential care, **Bill, Maud, Teresa and Lauren** (table 19) benefited from the supportive presence of one key person (not necessarily a family member) who helped to manage their moves. They also had good social networks within the home or had good contacts with people outside the home who helped them to accept their life within residential care to such an extent that it made sense to them.

Bill had what he interpreted as the supportive presence of his daughter in law. **Maud and Teresa** had geographically and emotionally close sons (in Teresa’s case the one supportive son was more important to her homeostasis than the other more distant one who also helped with some practical aspects of the move. **Lauren** felt supported by her warden from her time in sheltered housing and she provided the continuity of support in the absence of any family living near by.

All four had a locus of control and confidence to let others make arrangements for them as they relocated. Although Bill played a more passive role he accepted and trusted his daughter in law to act in his interests in a relationship of reciprocity (Reed 2005). Trust was very important to these older people, trusting that others would be there to support them during difficult times in their lives. Trust was evidence of stable, ongoing and secure attachments. Attachment (Bowlby 1988, Yelloly 1980) was so important to these older people through life and into later life. These older people did not consider social workers to be important to them as attachment figures or those they could necessarily trust and other social and health care practitioners were also seemingly at the periphery.

Strong social networks

Strong social support networks, often the outcome of life time experiences were important features in their homeostasis. All four were now in a new and unfamiliar setting but rather than decline or accept the loss of social networks they adopted 'compensatory' strategies (Baltes 1990 Baltes and Baltes 1997) and reacted to deficits by utilising strengths. Their physical limitations were not necessarily a great problem. Grundy (2006) argues that not being able to go out unaided is likely to have less impact on the quality of life of a person who has frequent visits and can call upon others to help someone who lacks such resources. The experience of these older people shows that this can also apply to those living within residential care

All four found of the older people that found a sense of homeostasis sustained social networks either within the residential care homes or maintained connections with others. These were often through their church contacts but they also involved friends in the residential care homes and some taking part in activities within the homes. These contacts were long standing ones (box 50)

Box 50: Networking: These older people found sources of social support when living in residential care.

Bill: “I have my mates come and see me. They know me from years back and know I am in here. They bring a spot of whisky for me and come every Tuesday in the afternoon. With this place being so close to the town it is easy for them to get here and when they come we do have a talk and a laugh about old times. The girls here are also very good (care assistants) and make the place homely to me.

So overall it’s not bad here, I am quite content” (Interview 3)

Lauren: I am comfortable here and what helps is that things carry on. I mean the girls (care assistants) manage to take me out to my local church here each week and this means I can meet with people that know me from a long time back. Going there means the world to me. I also feel I am part of the life here and perhaps that is because I know the place and knew it long before I actually came here. The staff are my friends as much as anyone you know” (Interview 5)

Maud: “I have church friends from the past and pen friends that I still contact. I am not someone to just sit here and do nothing. I have a friend in the south and she writes to me often and I reply. Then there is the son of course who visits me but also I go on some visits with those here. They take us out on local tours of the area and this is good, just once every week or two or when they can” (interview four)

Teresa “I have friends all over the world, you know from my church. I also have friends within this place, I mean at least two that I consider friends. We talk a lot and that helps. We are almost like a family in that way, I mean maybe not like blood, no of course not, but we certainly are close (interview 2).

The support of key relatives was vital but their support must not however be seen in isolation from other factors. All also had a sense of continuity and this continuity was very important. Social networks provided continuity and these friendships and bonds expressed some stability. These moves were seen in relation to stable life courses. They managed to accommodate residential care into their understanding of how their lives had gone and together with the support of a key person negotiated an understanding of their situation. Davidson (1997) refers to finding homeostasis or balance between past phases of a life course and with other social actors helping them to find that balance.

A level of acceptance of where they were and how this fits into the overall scheme of their lives emerged. The older people’s reflections on the continuity of their lives (box 51) and how past links to present confirmed how earlier phases of life can impact on later phases and between their internal self and their external

surroundings. This was a continuity that was found not only in the pattern of their lives but in the patterns of their social networks. There were people in their lives that had been there a long time and remained constant figures in their lives even when living in residential care.

Box 51: The older people and their continuity

Bill: The move to residential care, like all the other changes in his life, took place against a backdrop of continuity. He had spent his whole life within a few miles radius of the residential care home. Bill went to school just a few roads down from where the residential care home was situated. The site of the mine, where he spent all of his working life, was located nearby. He met his wife locally and they lived in the same house for sixty years. The house was situated very near to the residential care home. The continuity his parents knew (their stable marriage, housing and employment) was something he went on to experience. The support of family and friends provided stability during change and disruption. His family was supportive during the war and when his young son died. It was not only his parents who provided stability but also people within the local community, they all “rallied round” he said. Bill then reflected on his past and current life “well it seems that was a long time ago but I’m alright with thing, it all happens for a reason” (Interview 4).

Lauren: “Born at number nine. It’s near the baths. If you walked up the lane there is a small bridge running over and a canal running through. There is the pub and then there are the ironmongers. When my aunt left we went to a public house up the road. Stayed in that house until I was 22. We then went to live in a public house on the main road before moving to the Cat and Fiddle. We stayed there until my dad was coming out (retiring from work at the pub)”. (Interview 1)

Maud: “I did not have an unhappy childhood. We were very supportive of each other, if ever anyone was in trouble we rallied around. We had to move a lot, my father had to always be looking for work, you see, but I remember it all fondly. I learned such a lot from my father” (Interview 3). This all seems right, thinking back and now, at this stage, it all fits, in a way” ((interview 5).

Teresa: (Interview 3) “very pleasant memories, all of it, loved going up to Scotland and the time on the farm was lovely” She talked fondly of parents, “I loved them dearly” (Interview 4). Her parents supported her early life change, such as moving to live in lodgings and going to agricultural college. Family provided a solid base to return to at times of potential crisis or change and this made a lasting impression on her. She reflected on how these memories helped her cope with or adapt to her current situation saying “Yes, I understand things quite well. Coming here was a bit of a shock in some ways but it is nothing new, having to adapt, my whole life has been one of change in a way” (Interview 5)

Resilience

These older people displayed resilience and were able to manage change. The resiliency framework applies to these older people in many ways and certainly in the way they maintained and also forged social contacts in residential care. These older people showed mastery and competence in the way they interacted with others and this supported the idea that many older people can seek to develop themselves through their activities rather than only correct deficits of ageing (Miley, O'Melia and Du Bois 1996). Their resilience helped them do this.

Resilience has been shown to be relevant in childhood and young people leaving care have coped better with their changes if sustained by a sense of resilience (Sinclair et al 2005). This resilience was shown to be stronger if they had had a history of adapting and coping. The older people in my research were also more resilient if their lives had been ones where coping and adapting had been negotiated. It is important to recognise that life events and the ability to adapt to change can be shaped as much by environmental factors as genetic ones (Tenant 2006). Understanding how these older people responded to life events and how they made sense of the patterns of their lives is important to understanding their sense of resilience.

Faith and religion

Social networks were established through the church but so too was a sense of resilience. Three older people who achieved homeostasis (Rinhomota and Cooper 1996, Wilson and Barrett 1998, Kimwelli and Stilwell 2002) were supported by their religious beliefs. These gave them an additional feeling of inner strength and acted as a stabilising influence that gave pattern to their lives. Faith was a constant for Lauren, Maud and Teresa three older people (Box 52) Bill did not express a religious conviction. These religious convictions acted as a source of reserve that supported their resilience. Their religious faith gave them a sense of acceptance and this acceptance acted as a source of resilience.

Box 52: Faith

Maud had strong religious and moral convictions. She was at peace with the many of losses of her life. These included her husband's death and the tragic loss of one of her two sons at the age of thirty-nine. She had also had to endure geographical moves as a child and then as an adult, in response to the detrimental circumstances from a father's unemployment and later, husband's death. She reacted to these crises with an attitude of acceptance.

Teresa's strong religious faith provided stability. She became a Jehovah's Witness at twenty-five. Her faith provided a network of friends worldwide. Teresa was reasonably content to be in residential care and reflected on past events.

Lauren appeared to be coping well with the move. She was secure with her past and with her present. She had faith in herself, and religious faith, regularly attending Church of England services. Her belief and conviction in herself is illustrated in the following two statements.

Of marriage: "I said we shall get married when I feel ready for it" (Interview 8).

Of moving to care: "I came in here when I was ready for it. I make up my own mind" (Interview 8).

Religious faith provided meaning and continuity to their lives in ways that Coleman (2003) suggested. It was part of their identity, part of their adaptation, made them resilient and helped them to cope with change in later life in ways that other research has identified (Sadler and Biggs 2006). But the ways in which it helped them were not uniform but diverse. Maud had strong religious convictions whilst Teresa and Lauren referred to how church played a part in her life as a means of a social network as much as a conviction in itself.

Acceptance

These older people also showed resilience in the way they found some 'acceptance' of their situations. This was an expression of their resilience but also of their personality and their ability to make sense of change. This was part of their reserve (Grundy 2006) and it showed how they could accommodate the move to residential care within the wider patterns of their lives. Bill, Lauren, Maud and Teresa were comfortable discussing their previous life stages and events. Bill enjoyed talking about his life in the particular community where he spent most of his adult life. Lauren expressed a wish to see her home area again as part of a residential care home outing. Maud expressed the same sentiments.

The state of homeostasis that these older people achieved was due in part to the continuity of their lives. It is this continuity that is so important to the build up of reserve. Exposure to favourable environments, and by which is meant any external factor, over a life time builds reserve and makes it easier for someone to adapt to more challenging situations (McGue et al 1993, Sayer et al 1998). All four older people had a sense of purpose and optimism, a belief that they could overcome adversity and this stemmed to a large extent from life time experiences.

None of them experienced the death of a parent in childhood to give them a secure psychological base (Bowlby 1988). Life course perspectives are important but it is also important to acknowledge the important effect of current circumstances and behaviours on the well being of older people (Grundy 2006). None of the four older people that experienced homeostasis in residential care failed to accept or come to terms with the circumstances surrounding their relocation. Bill may have had a stroke but he accepted this and was more focused on his daughter in law than his own situation (Box 19).

Maud may have experienced some loss of confidence after her strokes but she had accepted the events into her overall understanding and her wish not to be 'a burden' (Box 29). Teresa and Lauren did not even cite reasons for relocation and instead emphasised how much residential care fitted with their wishes (Box 33). They may have had more specific reasons for care then stated but it ceased to matter to them. The incidents leading to residential care were not necessarily 'critical' to the outcomes if there were support systems in place and an attitude of acceptance and understanding of events.

Teresa's son helped sustain her in residential care and so did her religious faith. Maud and Lauren displayed similar trust in their own ability to cope and had faith that others would support them. Bill did not express religious faith but he had secure attachment to his community. A key person acted as a guiding influence to these four older people, sustaining their trust through what they perceived as difficult times. The immediate journey to care was potentially difficult but it was interpreted and regarded as less important in the light of earlier experiences and in the light of their sense of reserve and resilience drawn

from that past. This was evident in the way they did not talk so much of the immediate events leading to care and instead focused more on previous episodes in their lives.

Older people who did not experience homeostasis

For eight of the twelve older people the outcome of their moves to residential care were not positive in that they did not experience homeostasis. Most of this group did not have the supportive presence of a family member or even the support of a key practitioner. Their social networks were weak. Seven of them did however have enough resilience to sustain them in residential care with only one of them, Barbara, descending into crisis. This was crisis not only in terms of what Roberts (2000) refers to as an ‘upset in a steady state’ (516) but also in the way she interpreted events and in her failure to use coping strategies effectively to resolve her problems.

Table 20: those that did not achieve homeostasis in residential care

	Supportive Family relationships	Support of a key practitioner	Strong Social Networks	Resilience
Barbara	No	No	No	No
Bernard	No	No	Yes	Yes
Catherine	Yes	Yes	No	Yes
Dora	No	No	No	Yes
Edna	No	No	No	Yes
Elsie	No	No	No	Yes
June	No	No	No	Yes
Mary	No	Yes	No	Yes

Lack of supportive family relationships/ key practitioners

All eight older people who did not experience homeostasis either did not recognise any supportive influence or perceived a negative influence during their moves. Critical incidents leading to residential care had more critical influence on the outcomes of their relocations for these older

people. The reason for this relates to their lack of supportive family or practitioners at the time of the turning point. **Mary** felt vulnerable after her strokes (box 18) and she moved to residential care not only in fear and in need of safety and security but without any supportive influences. **Edna's** move from hospital became more critical to the outcome of her placement in residential care because of her lack of support. In fact it was interpreted less as lack of support and more as antagonism, pushing her into residential care (box 34). Similar situations arose for **Barbara, Elsie, Dora and June**, moving in isolation, lacking support, making their 'illnesses' and other circumstances, more critical for them in the short and long term. **Bernard** moved initially into residential care with his wife but without any other support and this, together with what he saw as obstructive interventions from his Doctor had a long term negative effect on his move made the move and the aftermath critical and negative in outcome (box 35).

These older people's levels of reserve in this sense were low with no one to guide them through the different stages of relocation. This reduced their chances of them finding any sense of homeostasis as there was no ongoing link to someone during the process. They had little or no positive contacts with either family or practitioners. Dora regarded her doctor's influence as negative (box 24) appearing to not support her during her move. Edna perceived similar negative influences from her doctor and her daughter. Elsie's perception of her son's influence, together with her daughter had a similar impact (box 39). June, Barbara and Bernard did not perceive any influence and said they lacked guidance and support (box 48). Only two of these eight older people, Catherine and Mary expressed any sort of attachment or had any positive influence from a particular person (box 47).

Catherine was close to her daughter but Mary's relationship with her social worker appeared transient rather than sustaining. She said of her social workers "I don't think you need a lot of contact with people like that" (box 47). This seemed to suggest a certain antipathy towards social workers in general. These older people did not have an ongoing sense of attachment to anyone and this lack of attachments depleted to some extent their levels of reserve (Grundy 2006). They did not have emotional bonds to help them adjust to and accept the

residential care home. Attachments in early life may be crucial to people's development in young life (Bowlby 1988, Yelloly 1980) but they also serve older people in later life and these lack of attachments were significant deficits for these older people.

Box 53: Lacking guidance from family

June: It would have been nice to have someone help me really as I moved but then there is not really any family around who can do that. It hurts me to say that but it is a fact (Interview 3)

Barbara: No one here to help me really as I moved in and it feels like well, what can I say, just terrible. I mean we all need that little bit of support (interview 1)

Bernard: "there is no one local to help me. I mean I came in here with my wife and that was all there was to it and since then no one local to help me with things apart from that. To be honest we both could have done with more support but my daughter lives so far away (Interview 2)

Lack of social networks

Seven of those who did not experience homeostasis did not have strong social networks. They did not have contacts within the residential care home or evidence of any networks outside the homes. In fact when asked they expressed a sense of isolation within the residential care homes.

Box 54: Research diary: Catherine appeared lost and alone at many times.

Tuesday March 11th

I visited Catherine today in the care home and what struck me about it was how Catherine seemed alone. She did not speak of her daughter so much, even though she lived next to the residential care home and worked in the home itself. It ceased at times to matter to her and there was a lack of connection at times. Her social worker also appeared less important now, only perhaps important at the time of the move. There was no ongoing support and this was expressed by

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Catherine (interview 3)

Researcher: Do you see much of your daughter here?

Catherine: Not that much , we live different lives, even if she is here as well

Researcher: And your social worker?

Catherine: She was good to me but since I have been here it doesn't matter so much.

Thursday April 9th 1999

I visited Catherine in the nursing home today and after her fall and visit to the hospital she seemed lost and disorientated. Her isolation from both other people at the home and from any other support seemed more apparent than at any other time.

Researcher: How have you been?

Catherine: I don't really know you; you're just someone from the university I think. Anyway I have no idea about it all. I don't have any one coming here and you're the only person I have seen today.

Her photographs were placed in a pile on the cupboard and she looked like she was here on a temporary basis.

Catherine could not accept the idea that she 'should' be living in residential care. This factor had a more negative impact on her than any positive influence from her daughter or social worker. Mary and Catherine also lacked any sense of connection to the residential care home (box 55) and Catherine's daughter and Mary's Social Worker did not give them any sense of belonging. They did not have social networks inside or outside the residential care home (box 58). Her daughter and social worker also seemed absent from her at times, as she also expressed at an earlier point (Boxes 57).

Box 55: Feeling isolated: These older people lacked social networks

Barbara: "I don't have any friends here and feel pretty much alone. I always knew it would be like this. I mean these aren't places like that are they, it is not like being in your own place with friends and neighbours nearby (Interview1)

Catherine: " friends here, not really, there was one woman who used to come to my room for a natter att one point but generally I am on my own apart from my daughter" (interview 2)

Dora: "Not really part of anything here, never was. My carer is nice enough and there is some nice chat sometimes but its not as if it means a lot is it (interview 3)

Edna: “ I have not been here five minutes but I never wanted to be here, as I have said and so I don’t feel like mixing or anything, all I want to do is go home”

(interview 3)

Elsie “I am not here long as you know. It is not a case of making friends or anything, I am here whilst things are being sorted out and that is about the end of it I suppose. My son hasn’t helped, forcing me in here (interview 1)”

June: “Wish it was the case that I could say that I feel I belong here but in all honesty I do not and that affects things. I don’t feel I really know anyone here, your one of the only people I have talked to today apart from to Gail (the care assistant) (interview 1)

Mary “I am alone here. There is my husband in that other place and that is it and I do not see much of him now. I just sit here and its very lonely you know

(interview 2)

Box 56: Bernard had active social networks

Bernard had a network of contacts from his naval days. One man lived locally; he took Bernard to band practice. Bernard also attended a men’s group in his home area.

Bernard did have some contact with people outside the residential care home and made reference to contacts within the area (Box 56). He did not however express any great sense of attachment to the residential care home itself and these outside contacts appeared like places to get away from the residential care home rather than as networks to support any feeling of homeostasis within the home. He expressed this quite strongly to me in one of the later interviews (box 57).

Box 57: Bernard did not feel ‘at home’ in residential care

“Yes, I know I go out once a week to that band practice and it is good but it does not make a great deal of difference to me. The fact is that I came in here with my wife and things have not really worked out since. I mean I can’t say going out once a week makes all that difference. I feel different to the people here, it is hard to explain but I do. The place is just somewhere to stop really and nothing more than that” (interview five)

Bernard’s lack of homeostasis in residential care was linked to his feeling of isolation within the home and lack of support from any family member or practitioner. The lack of consistent support in the immediate circumstances in which he found himself was not the only factor in his discontentment. He also linked it to the pattern of his life and felt that much of his life had involved disruption (box 58).

Box 58: Disruption in mid life.

Bernard “I left the army, got a job, big change. Being made redundant, another big change. I was made redundant three times. I really got upset each time. Being made redundant is terrible” (Interview 8)

Researcher: Will you say that you had any crisis in your life? Will you ever put it like that?

Bernard: Crisis all the way.

Researcher: Crisis in the war situation?

Bernard: That is all crisis.

Box 59: Bernard: shocked by the crisis of the move

It appals me to think that I had to move. I don’t know how I could stand it” (Interview 5)

“I never thought in a hundred years I would land up in a place like this. If I had known that my wife was going to die, I could have been at home, looking after her” (Interview 9).

Bernard could not believe that he was in residential care. He felt disbelief at the turn of events (Box 59). Mid life also has been viewed by Bernard as traumatic. He perceived his life course as a crisis (Box 59). He had lost his father when he was a very young child, and he was sent to a children’s home. His childhood was

hardly mentioned. Any reference to the death of his father in Bernard's childhood was distressing for him. No mention was made of his mother; all that he recalled was arriving at a children's home, and then later being sent to a council boarding school.

The older people who did not experience homeostasis in residential care displayed a sense of vulnerability. Grundy (2006) suggests that this sense of vulnerability means not experiencing a good quality of life. Poor social networks or lack of supportive family ties reduces quality of life making the person more vulnerable to the negative consequences of challenging life events. Quality of life is a difficult concept but it has been articulated in policy documents of organisations who work with older people. Age Concern England (2006) stress several key elements as expressed in the United Nations Organisation's (1991) Principles for Older Persons. They suggest that material resources, family friends and social ties, care when needed, health and opportunities for autonomy and self-actualisation all affect quality of life. Older people's lack of social networks when in residential care appeared to have a very detrimental effect on many of these older people's relocations. Family were very important although material resources were less vital to both of those who achieved homeostasis or those who did not.

Owning one's home and losing it to fund a place in residential care had marginal impact on these moves. It is possible that issues surrounding loss of a home or retention of furniture within residential care may affect hopes and aspirations and their ability to find a sense of fit or accommodation to their environment (achieve homeostasis). My research found however that resilience or lack of it was determined by the extent of family, social networks and coping strategies rather than through the maintenance or loss of material possessions. This was consistent with Blane (2005) who, although considering the effect of loss or retention of material possessions amongst people in non-residential rather than residential settings, found that social networks rather than material resources were central to the resilience of older people. Although five of the twelve older people had been home owners only one, Dora, seemed affected by the 'loss' of her home in terms of affecting her ability to settle in residential care.

Lack of social networks also seemed to combine with unresolved feelings from events through their life histories to instil a feeling of lack of homeostasis. None seemed to have the ability to negotiate change confidently. Catherine's move to care was not, for example, a positive experience. She found change difficult, although relocation was a familiar event to Catherine. She had known a series of house moves at other stages of her life. Catherine was haunted by the death of her father, which still troubled her (box 26) and that combined with other events happening through her life affected the outcome of her move to residential care.

Bernard, Catherine and Edna experienced the death of a parent when they were children. Edna lacked confidence in her new environment of residential care and was shaken by events that led to care. This was a crisis for Edna, although it was not the first time she had experienced crisis. Her mother had died when Edna was only fifteen and she literally looked after herself from that point. Her father worked long hours and she was left at home to fend for herself. The death of her mother shocked her (box 9).

Edna was in a state of anger when I first interviewed her at a point only two weeks into her time in residential care (box 22). She resented her excessively long stay in hospital that she said made her more susceptible to residential care. She lacked a sense of attachment, trust, and security. The death of her mother at a young age destabilised her initially but made her fiercely independent (box 9). She had learnt to rely on herself but now was dependent on others. She had a stable married life but her son and daughter failed to provide support in later life. Her life situation changed when she went to live in sheltered housing. I observed when reviewing their moves to residential care, that the older people recalled their reactions to previous life issues and moves in their lives, including the death of a parent when they were children.

Catherine did not believe that residential care was the best move for her. Early and mid life moves had often been perceived as for the best, but her move to residential care was accompanied by uncertainty and fear. She said that this move had made her lose confidence in herself. She claimed that she did not react well to change, expressing this in Interview 2 (Box 66). Her fear of change and lack of security were exemplified in her attitude to the anticipated closure of the

residential home (Box 60). She did however have family contact within the home and this made *some* difference to her attitude and ability to sustain her within residential care. She did however only just cope with residential care rather than thrive in such an environment despite supportive influences from her social worker during the move and her daughter in the run up to and since relocation.

Box 60: Catherine: ‘Made do’ with change but did not accept it.

Catherine: “I make do, make the best of things, like you have to do. I have fitted in alright with everybody”. “It’s going to be closed this home you know. Mind you I think it’s going to be about two years before anything happens. A lot can happen in two years. We were only saying the other day ‘I hope I am up there when the change comes’” (Interview 2).

Edna experienced leaving sheltered housing and moving into residential care as a crisis. Edna saw the residential care home as a place where she would not be able to control her own life and expressed this rather graphically (box 61)

She could not accept that she was a resident. She was frustrated by a lack of opportunity to prepare her own meals, a facility that she had enjoyed in sheltered housing. She also disliked sleeping in a single bed because she had been used to a double. Living in one bedroom was experienced as highly restrictive.

Box 61 Edna: feeling trapped

“I need more room, this place will kill me. I feel like an animal being put in a shelter, wants letting out” (Interview 2).

The life Edna lived in the warden-aided sheltered housing was more like the independent life she had known. She felt that she could take risks and enjoy a certain amount of freedom, but the presence of the warden provided some feelings of security. She had always coped before, even as a fifteen-year-old without her mother. It seemed, however, that the circumstances of the move viewed within the context of her past life gave Edna’s outlook extra significance. She had been used to feeling in control of events. She felt powerless now, trying to maintain something of what she had, but failing. She resented that she could not make her own decisions about entering residential care.

Dora found the move to residential care extremely difficult. She never accepted the move. Owning her own home had always been important to Dora. She and her husband had invested much money, care and attention in their home. This was an important place for financial reasons, but it also symbolised continuity and stability. Losing it felt to her like losing part of her. She said that she could never accept the residential care home as her true home. The illness that sent her to hospital and then into residential care destabilised her. She had known very long periods of stability in her life and the move represented something that was relatively new to her. Her nephew provided some sense of guidance during the move, but Dora felt isolated and insecure (Box 55).

Five months after admission, **June** still felt uncomfortable in her residential care home. Her move had been sudden and traumatic. A panic attack precipitated her move to care and led to confusion and a lack of confidence. She did not have any key influences or attachments to support her (as a child, she had experienced the death of a parent and it was unclear who had brought her up.)

Elsie's early life was stable. She had lived within a mile or so of the residential care home all her life. She felt that her roots were in the locality of the residential care home but her acceptance of living in care was only partial because she knew that her stay was temporary. Her husband and son were distant influences and not perceived as particularly supportive. The death of her other son haunted her. This added to her sense of insecurity and vulnerability.

Events leading to **Mary's** move to care, a stroke and a fall, were very difficult for her. Her collapse was experienced as a trauma. She had lost control of events and was rushed into residential care. Mary was not happy that her husband was in a nearby nursing home away from her. Mary considered moving to the nursing home to be with her husband, although she did not have a physical need for nursing care. At one point she said that she did not care where she was, she just wanted to be with her husband. Subsequently her ability to cope in residential care was tested to a very large degree by the death of her husband. She found his loss very hard to cope with. Mary now felt isolated and could not accept the residential care home as her home (box 55).

Resilience

Seven of the eight older people who did not feel a sense of homeostasis within residential care still had enough reserve to show resilience to cope with the setting. Although lacking reserve in their lack of consistent family support, practitioner help or social networks they found some resilience to cope. They found resilience in the way they found coping strategies to help them respond effectively to change, an important feature of resilience (Stewart, Reid and Mangham 1997). They did this by deploying various strategies. Their strategies included the ability to be selective with their memories.

Remembering and forgetting

Memory strategies, forgetting and/or remembering aspects of the past were elements in older people's abilities to make sense of their moves and to show resilience in the face of change. With the exception of **Barbara**, they all managed to develop coping strategies. Many of them had noticeably inconsistent memories, embodied in the words of **Mary** (Box 62). **Edna** said that she was 'resigned' to a life in care residential care (interview 2). She coped by forgetting or denying the anger she held inside. **Elsie** coped mainly by thinking of returning to her home. She said that all she wanted to do was 'go home'. All other thoughts were subjugated to this one. The one interview I had with her was fragmented. She repeated her wish to go home. Unhappy memories were left to one side, including the death of her son. **Dora** also coped by focusing on one thought: the sale of her house. She coped in the first few months with the knowledge that the house would be sold. She was noticeably more relaxed after the sale.

Box 62 Remembering to forget: Mary and her selective memory.

Mary

"No good thinking about all that has gone. I mean I don't want to go back "(Interview 3).

Bernard showed this resilience in the way he used his life outside the residential care home to switch his focus of attention from the home. He said that "it is good

to get out this place sometimes and it keeps me going to be honest going to band practice, kind of helps (Interview 8)” He also coped by repressing some of his memories. For example, the death of his father and his own relocation to a children’s home had a marked effect on Bernard who felt a sense of shock and bewilderment. He was unable or unwilling to recall too much detail. He instead focused on the importance of meeting his wife and adopting a child. This switch of attention from issues surrounding the death of his father and relocation to a children’s home towards more comforting memories showed an ability to deploy diversion tactics. Bernard was actively deploying the compensatory strategy outlined by De Muth (2004) by stressing positives over negatives.

Trapped, alone and in crisis

The older people who did not experience homeostasis experienced disruptive, unsettled emotions. The disruptive episodes that led these older people to residential care lowered their threshold of coping. This low threshold of coping led them to a state of vulnerability (Grundy 2006), affecting their quality of life. The way events were interpreted was important. Older people who felt secure did not experience disruptive events as crises. One older person, **Barbara**, did not develop any apparent coping strategies and her move to residential care became a crisis. She recalled the moment where she felt out of control with her situation. This was on holiday with her daughter (Box 63). One moment she was with her daughter enjoying a holiday, safe and secure. The next moment she was out of control, her body ailing and her mental state vulnerable.

Box 63 A crisis for Barbara: reliving the moments when she felt unable to cope.

“We were away on holiday and my legs just went. They had a job taking me to the toilet. I couldn’t walk. The toilets were not ever so big. It made it ever so inconvenient taking me to the toilets. I said look this is going to be a holiday and I am not going to go away again because I didn’t want to spoil their holiday you see. Well, we came back on the night we should have done. That was on the Thursday. On the Friday night I vomited blood and I also vomited blood the following morning. Well, my son-in-law is worried and he sent for the ambulance. He took me to the hospital and I was in there about a fortnight. They then sent me to the hospital and I was in there about six weeks. Then I had physiotherapy and injections in my knees, but it was no good” (Interview 1)

Barbara was a private person and her hospital stay was much the harder because of her dislike of communal areas. She could not tolerate being in an open ward. She felt she could not really accept residential care.

Barbara had many interests prior to entering residential care but could not find any continuing enthusiasm for them. She said that her illness and the events that led to residential care had upset her deeply. Her life situation felt completely different now. A state of grief and sadness had enveloped her. She had lost her home and her independence. Her daughter and son lived a few miles away. She felt cut off and deeply unsettled. This was confirmed by her subsequent move to nursing care, to be near her daughter. Barbara's lack of confidence was evident in her reluctance to walk and in the tears she shed, ironically, on leaving residential care for nursing care. She did not want to continue the interviews in the nursing home. Her only interest was in being close to her family, and to cling to the only people that now mattered. The changes had been too drastic for her, with no obvious support from either family or practitioners and no social networks from which to draw.

She could not deploy any successful coping strategies such as deflection of her thoughts or memories and instead focused exclusively on her deep sense of unhappiness in residential care. This was an acute disruption in her psychological homeostasis and with her coping strategies failing she was in crisis in that she was now unable to cope (Roberts 2000).

Practitioners' Views of outcomes of moves

Practitioners' understanding of why older people did not want to be in residential care contrasted with the older people's accounts of their experiences. Seventeen of the twenty-nine practitioners interviewed said that older people were discontent in care as a direct result of the circumstances of their admission. Practitioners claimed that relationships with family carers had broken down, leading to crisis admissions to residential care. Crisis was not defined.

Practitioners were unaware of the complex ways in which these older people responded to life in residential care. There were individual differences in the ways these older people responded to their moves, but practitioners identified singular rather than complex reasons for residential care. Practitioners thought that sharing of consistent, accurate information was essential and that social care practitioners should work together to manage a 'successful' move. All practitioners thought that the internal worlds of older people mattered to some extent. Practitioners considered that 'knowing about' the residents was important for building relationships. They emphasised practical explanations for 'successful' moves. Practitioners thought that older people's ability to adapt to residential care was based on the suitability and adequacy of their immediate situations and their support systems rather than their family histories, dynamics, and patterns of trust or attachment.

Three practitioners defined a 'successful' move as one in which the older person feels safe in residential care. Alison, a deputy residential care home manager said, "They are stuck in four walls, never seeing a soul, they become frightened. Then they come in here. It is nice for them to know that they can have twenty-four hour care".

The look of the building was cited as important, as well as personal privacy, space and a sense of territory. Jim, a community psychiatric nurse said, "most people like their own space, their own rooms. They can accept a certain amount of restriction, but they do like their own space".

Social worker Dawn said, "You have to find out about a person's lifestyle and see if you can find a solution that allows them to hold on to their identity".

The residential care staff rationalised the new residents' feelings of distress, expressing the view that it is quite usual for residents to feel unsettled and resentful at this early stage, and stating that older people often had difficulty accepting the move to residential care in the early stages.

Discussion

The older people that were able to find homeostasis within residential care were the ones who had been able to sustain emotional bonds with people. These were often with family members although practitioners and wider social networks provided important attachments. Continuity of these relationships was vital. Lack of support made their turning points critical incidents in their journey to residential care. Those that had the support of others during these moves were more likely to have successful outcomes to their moves in terms of achieving homeostasis. Continuity in terms of attachment to key individuals was linked to a sense of continuity in their outlook. Social networks formed around their religious faith provided an ongoing sense of support, through pen friends and the local church also fostered resilience.

This resilience for those that achieved homeostasis manifested in an acceptance of their lives and how they were progressing and an acceptance of residential care as a part of their life course. Their lives had developed in ways that developmental theorists may support (Erikson 1965, 1980, 1986 et al, Guttman 1987, Kirkwood 2001) but this development was not always ordered and straight forward but chaotic, supporting Crain's (2005) criticism of such theories. The chaos was supported by the experiences of those that did not find a sense of homeostasis. These older people did not have consistent and supportive family relationships, lacked social networks but also felt a lack of acceptance of residential care or the events in their lives leading up to it. The one exception, Catherine, did have a supportive practitioner (social worker) and daughter but these older people did not feel any sense of attachment (Bowlby 1988) or belonging. Consistent family or practitioner support was important to those that achieved homeostasis but continuity of support mattered and Catherine's support was not ongoing or sustaining.

None of these older people felt any sense of contentment. They certainly did not feel any sense of ego integrity in the way that Freud and Jung talked of as a last stage in adult development (Baumeister et al 1988, Casement 2001). Instead they had unsettled and chaotic emotional responses to their lives and relocations to residential care. They felt vulnerable (Grundy 2006) and their lack of support

from individuals or networks added to their sense of discontent. Most of these older people looked back on their early and mid lives with unease and their turning points to residential care were then experienced as more critical to them than the ones who experienced homeostasis.

Their unease was often related to the lack of secure and ongoing attachments which made the events of their early and mid life seem more painful to recall. It was not the frequent house moves or the death of a parent in early life that was damaging, in fact these events in themselves made little impact, but the lack of ongoing attachments or social support.

They did not have enough reserve in terms of social networks or support of family to achieve homeostasis but did have enough resilience to avoid crisis. They developed coping strategies, usually by 'forgetting' unpleasant memories. One older person, Bernard, found some ability to cope or show resilience through social networks but these were only compensatory tactics (De Muth 2004) to help them adjust to change. The only person who failed to display resilience, Barbara, lurched into crisis as she failed to utilise coping strategies.

Practitioners did not recognise the complexities of older people's conceptual worlds and in particular the distinctions to me made between those that experienced homeostasis and those that did not. They did not have a notion of a successful relocation. Residential care was seen as being somewhere not suited to the wants and needs of older people regardless of their life histories or levels of reserve and regardless of how 'home' was seen in relation to 'care'. They did not recognise how the support of family, occasionally practitioners and often social networks could shape responses to residential care.

Chapter Eight: Concluding reflections, analysis

This final chapter reviews the evidence from this thesis and considers how it informs the four research questions that guided the work. I conclude by identifying evidence to confirm existing findings on the subject and also the evidence that suggests new knowledge. I consider the significance of the findings for policy and practice and identify further research that needs to be done to consider these questions further. The chapter is divided into four sections with the first section reviewing the research questions. Section two identifies new knowledge, section three considers the significance of the findings for practice and a final section four reflects on how research might develop understanding.

Section one: Review of the research questions

- **How are older people's experiences in moving to residential care to be understood?**

My research supports earlier work (Townsend 1962, Leeson 2005, Morgan et al 2006) that suggests that residential care can be a negative experience in that older people can experience disruption and an inability to feel part of the life of the residential care home. The eight older people that did not experience homeostasis knew much isolation within the home and the circumstances of their admissions contributed to feelings of disruption with little support as they relocated and since the move. Family and practitioners often influenced older people's moves in ways that accorded with Reed et al's (2005) 'push' factors with older people's autonomy in decision making eroded.

Whilst residential care was not necessarily the default choice talked about in earlier work (Townsend 1962, Clark, Dwyer and Horwood 1998) there were circumstances leading older people there that made it a negative 'choice' or one that may not have arisen had some circumstances not arose. Incidents of stroke, heart attack and illness (reported in Wright's 2003 and Morgan et al's 2006

studies) together with family and practitioner involvement proved catalysts and made the experience of relocation negative. Interviewed practitioners thought that finance or lack of it played a significant role in leading people to residential care. The interviews with older people revealed that many owned their own homes and had affluent backgrounds but that did not prevent their admission. Practitioners in my research cited lack of suitable alternative housing as one factor affecting understanding of how and indeed why older people move to residential care.

My research found that older people experienced moves to residential care as emotional experiences and fear was prevalent in the older people's accounts as it was in Wright's (2003) work. Older people often cited fear as a factor, fear or a feeling of vulnerability (Morgan et al 2006) in one's own home and also in residential care was a significant feature of their experiences. The restrictions of home in terms of services limiting older people's choices of when to receive services have been documented (Hooyman and Kayak 1996, Tinker et al 2001, Raithby 2001) but not in terms of comparisons of home and residential care. My research offered contrasts that suggest that for some older people the private home was regarded as much more fearful than residential care and somewhere that some older people were less likely to feel 'at home'.

Interviewed practitioners also referred to fear and older people finding solace from the fear of living in their own home when they enter residential care. In that sense residential care was seen as something positive but only as a refuge from the isolation of home, according in that sense with Townsend. My research departs from earlier research in finding that for some older people residential care was a more positive experience. Older people with more reserve (Grundy 2006) were not so much vulnerable as they moved into residential care but thrived with social networks and the supportive presence of a key family member to make residential care less of a default choice and more of a positive one.

- **How do older people's perspectives on residential care compare to those of practitioners?**

My research has reflected on how older people and practitioner have conceptualised issues of relocation and done so in a way that earlier research has not done so. My research found that practitioners had a detached view of the issues and concerns felt by older people and were unaware of the complexities of older people's responses. Their geographical proximity to residential care homes, their age, social class or any other dimension of difference had little or no impact on this feeling of 'distance'. Some older people felt social class, gender or ethnicity were important differences amongst older people that defined their experiences of residential living but they tended to not reflect these ideas in their perceptions of older people's moves. This detachment was not surprising in many ways as their experience of relocation was not personal or emotional but based on their role. Their lack of recognition of the complexity of the relationship between older people and residential care was however strikingly apparent. They were not aware of older people's strengths, their possibilities for development as well as decline in the way they may respond to change (Grundy 2006 Vandsberger et al 2005).

Practitioners were aware of how older people's relocations were partly shaped by their responses to key 'events' such as stroke or heart attack but were not aware of how patterns within older people's life course shaped their responses to those events and their subsequent outcomes of their relocations. Practitioners understood older people's vulnerability not in terms of them lacking reserve (Grundy 2006) but as an indication that they were susceptible to residential care. Practitioners saw older people as vulnerable in ways similar to other research from Townsend (1964) to Liu and Tinker (2003). They were seen as in deficit or deficient in a physical sense. Older people on the other hand expressed their vulnerability in the way they lacked social networks or support. Practitioners did not emphasise how older people may have compensatory supports (Baltes 1997, De Muth 2004) or at least resilience to deal with change. Practitioners did not differentiate between those that were more or less 'successful' in achieving

homeostasis. They assumed as has much of the earlier research that residential care is essentially a negative experience, that family and/or practitioners 'pushed' older people into care homes and that it was by definition a 'last refuge' for older people.

- **How is older people's experience of moving to residential care affected by past life events, significant others, personal choice and other factors?**

Earlier research shows some recognition of how older people's life histories may shape or help to shape events leading them to residential care. Morgan et al (2006) and to some extent Townsend (1962) recognised how the events of people's life times can impact on late life including moves to residential care. The earlier research did however emphasise how these events had a negative impact on this subsequent move and placed less emphasis on how for some older people the past acted as a source of reserve (Grundy 2006) and resilience. My research found that older people engaged with their pasts much more than earlier research has done. Past associations with church and wider social networks helped sustain them and even if those past social networks were no longer active in their lives they were still sustained by memories. Some retreated into a moral siege (McCulloch 1985) helping them to sustain themselves in the present (Baumeister). Attachments (Bowlby 1988, Yelloly 1980) mattered and the continuity of attachment, even to the past as a conceptual space was valued.

It was those patterns of resiliency (Vandsberger et al 2005) and attachments that were important to understanding older people's relocations, affecting attitudes including their levels of acceptance of their situation and how they made sense of residential care within the terms of their life course. My research did confirm how housing histories, identified in Morgan et al's (2006) research played a part in developing older people's understanding of their relocation but not in isolation from other changes. Incidents of stroke, heart attack, bereavement and other events gave meaning to their settings. Their personal homes were often interpreted as places where they could not find homeostasis and they contrasted residential care and the private home in many different ways. Life histories were

bound up with housing and other histories as part of 'careers' of moves (Jamieson et al 1997).

With residential care assumed as a default choice practitioners were not aware of the reciprocity (Kelly 1995, Pyke 1998) between older people and their relatives and how there was 'pull' as well as 'push' (Reed et al 2003) in these relationships. They had some awareness of how practitioners and family may sometimes 'push' older people into residential care but were not aware of how powerful sons and powerful daughters supported influential and at times relatively autonomous older people. Practitioners assumed, like much of the earlier literature, that older people were passive in the process of relocation and would not actively seek the support of family in their desire to move to residential care.

Wright (2003) noted the influence of carers whilst Brierley (2003) mentioned how hospital doctors played a significant part in older people's relocations. Earlier research did not however identify how relationships with 'significant others' supported and encouraged the development of reserve and from it resilience. My research found that social actors, mainly family, often supported, rather than undermined older people in their efforts to manage change. Older people's active rather than passive involvement in relocation was identified by Sandberg, Lundh and Nolan (2002) although their research did not identify how family involvement was critical to the outcome of their moves. Their research, along with much other research, did not discuss outcomes or refer to how families or significant others played a part in helping the older people to negotiate their internal needs with the external environment. My research, by contrast found that the involvement of 'significant others' was critical on many levels. Their involvement *made* the events of their relocation (the turning points) critical for their involvement, critical to their development and critical to the outcome of their move.

- **To what extent can we talk of ‘successful’ moves to residential care and how is success to be conceptualised, measured and explained?**

Previous research has not evaluated relocations to residential care in terms of whether or not they were successful but my research conceptualises success in terms of homeostasis. This is not to justify residential care (a point made earlier in the thesis). Whilst the potentially oppressive nature of residential care as an institution is recognised my research has sought to develop such understandings and show the many ways in which it may be experienced.

Previous research has identified different phases to relocation. Davis and Nolan’s (2003) study identified three different phases to the moves as did Reed and Morgan et al (2006). These studies discuss factors shaping the process of relocation without consideration of the outcomes. They did not have any concept of a ‘successful’ relocation. My research has taken research forward by discussing and evaluating outcomes and has identified how reserve (Grundy 2006) contributes to older people’s homeostasis. This reserve was found in the way older people deployed family during the process of relocation and used social networks (including faith based networks) along with family to help them adapt to residential care. These sustained vital feelings of attachment (Bowlby 1988; Yelloly 1980) and trust. The less resilient older people found acceptance and ‘forgot’ more painful memories in order to cope. The one older person who did not cope moved into crisis (Roberts 2000).

Relocation in earlier life did not for the majority of the older people have a significant impact on their responses to late life relocation to residential care. Many of the older people experienced many relocations in earlier life (as was shown in chapter four) but it was the quality of ongoing attachments to people that were more significant to later adaptation to residential care more than the experience or frequency of house moves in early or mid-life.

My research developed understanding of relocation by employing a resiliency framework (Vandsberger et al 2005) and in doing so recognised older peoples' capacity for change and development as they moved to and beyond the move to residential care. The 'compensatory' strategies (Baltes 1997) for dealing with change, employing their strengths to cope with deficits (Grundy 2006) were important features of their experiences. My research has also highlighted how practitioners can be unaware of these strengths and of the variation between older people in how they respond to and make sense of residential care. It has highlighted the differences between this group of older people and practitioners.

Section two: New Knowledge

This research discovers new knowledge in that it finds that for some older people residential care was less a default choice and more of an active choice for older people who are able to express their internal worlds within this setting. My research finds that older people can find active expression of themselves through their social networks and through relations with key social actors within the setting of residential care. It identifies how homeostasis is achieved for some and not for others and how patterns of experience from a life time can contribute to these outcomes. The findings, outside the conceptual worlds of the interviewed practitioners, challenge any presumption that community based living is always preferable or desirable for older people.

My research also adds to understanding of relocation to residential care by highlighting how older people who do not express themselves in residential care and achieve homeostasis find enough reserve through resilience to help them adapt to these settings. Whilst resilience has been shown to be present in those living within community settings this research shows how those same qualities can sustain older people within residential care. It is not however the settings themselves that encourage less adaptation or crisis but the relationship between the older person and his or her environment. It has affirmed older people's capacity for responding effectively to change and also identified how older people who do not utilise these strategies can move into crisis.

Section Three: significance of the findings for practice

Social and health care practice towards older people has seen various developments since my fieldwork was undertaken. It would be inappropriate to try to understand these people's experiences of relocation undertaken some ten years ago within contemporary contexts. The older people in my research simply did not have certain options open to them as policy and practice had not developed in such ways. We can however speculate on how far these subsequent developments may have theoretically influenced these cohorts of older people had they been available to them. We can also discuss the significance of the findings for practice and speculate on how far the knowledge of how older people experience relocation could inform policy makers and influence practice.

The introduction of the National Service Framework for older with the single assessment process, the introduction of intermediate care and initiatives such as the NHS have sought to expand options for older people. The emphasis has been on so called person centred care. These services and this policy framework may have widened older people's choices and encouraged joint working. They may have helped these older people to avoid the perceived need for residential care and allowed for better management of their moves so that older people did not have to draw upon their reserve or show resilience.

The older people may have found homeostasis in other settings had they been available and single assessment processes might have encouraged more holistic information to be gathered and more 'joined up' responses to their psychological as well as physiological needs. Older people could have been given a 'right to request' not to live in residential care, as promoted in the 2005 Green and White paper *Our Health, Our Care, Our Say: A new direction for community Services (SEU/ODPM)*. Direct payments Act would have given them more choice, at least in theory, to buy in services that they considered appropriate to their needs. These older people may or may not have used these options and it is difficult to speculate on what sort of impact they may have made on the older people's decision making process. The 2003 Hospital Discharge Act may have speeded up or sought to speed up the process of discharge from hospital and had a potential

effect on options and choices, reducing perhaps the negative consequences of too long hospital stays.

These older people had different levels of income, wealth and different housing circumstances (outlined in chapter four) and also different levels of reserve expressed in their health, family relationships, social networks and coping strategies. They had wants and needs in terms of support that may or may not have been addressed in these policy developments. We must also not assume that these older people that did or did not achieve homeostasis in residential care would have been helped by issues related to the quality of care given to them in the homes. The Care Standards Act 2000, adopted since the fieldwork was undertaken, may have been concerned with establishing good quality care but for this group of older people it was the interaction between them and the home and how this fitted with the patterns of their lives that was the key to their adaptation or otherwise. The detail of the homes and how far care standards were met were of less significance to them.

We must also be careful not to assume that for these older people residential care was a default choice and had they, driven by various policy and practice agendas, had wider choices they would have declined to choose residential care. My findings suggest that older people were much more active in their decision making and that they are capable of understanding their own needs and how to sustain them within settings. Their social networks, their belief structures and their capacity for resilience sustained them as they made difficult decisions and services need to understand choice and what it means to older people rather than assume that older people will necessarily *choose* direct payments or intermediate care.

Single assessment processes may need to understand how services need to not only work together on commissioning services but need to work together to produce assessments that understand choice from older people's point of view. Individual choice has to mean active choices but an acceptance that community based living regardless of how it is organised may not always be the preferred choice of older people. We also need to understand how people's capacity for resilience and reserve and for achieving homeostasis will depend not only on the

choices available to people but on their life time of experience and on the quality of their relationships with others as much as the suitability of the setting.

Social work and social care practice can be developed by understanding much more about how older people respond to moving to and living within residential care. Those involved in older people's relocation to residential care need to know how and why some older people may be more successful in adapting to residential care and why others seem to 'fail'. Practitioners working in various capacities need to understand how older people relate to family and practitioners, how they evaluate their interventions, which ones they value and why. Practice needs to be aware of issues of reciprocity, power and control and to ask about and know of the significance of social networks, belief structures and coping strategies. Those involved in all settings need to assume less about residential care and about its capacity for meeting need. Residential care does not have to be a default choice, it can be a positive one and seen in that way by older people. Practice needs to understand that any setting can be potentially responsive to need. Those involved in health and social care settings need to know how older people are evaluating change and making sense of settings.

Practice also needs to understand that older people are as capable of being resilient as those in earlier stages of life. My research into issues related to residential care supports Blane's (2008) findings and recommendations for helping older people to enhance resilience through good interpersonal relationships and social networks. Interventions to help older people find homeostasis and show resilience need to be targeted at those not already exposed to adversity so that change is managed effectively and so that turning points do not have critical and negative outcomes for older people. This knowledge develops understanding by helping practitioners understand the complex relationships between older people and other social actors and between older people and their living environments. They need to know about patterns of resilience within people in order to respond to people before any events become critical ones in their journey to residential care.

Section four: Further research

This was a small scale piece of interpretive research that sought explanations of the 'lived experience' (Von Manan 1990, Denzin and Lincoln 1998) of moving into residential care. It is indicative of other older people's experiences although not necessarily representative as it was a small sample and further research needs to test the findings with larger groups of older people in different settings.

Further research also needs to test the findings amongst more diverse groups including older people from a wider diversity of ethnic groups, cultures and geographical locations. The research was also carried out in the late 1990s and further research is needed in a more contemporary context to understand the effect of various policy and practice developments. These will affect choices and may also affect outcomes of placement in residential care. Further research also needs to examine in more detail the relationship between poverty, income and wealth and if or to what extent lack of income leads people towards residential care in later life.

Townsend's study was undertaken within different social and economic contexts but also before numerous policy developments that have served to affect choices and outcomes. Whilst these are difficult and complex relationships further research could test my data against wider populations of older people to see to if or to what extent my findings were replicated. Homeostasis, resilience and reserve may or may not be found to be crucial indicators within other populations or may be less vital but there is a need to know how far these concepts serve understanding of other populations of older people. There is a need to discover the degree to which other older people are 'successful' in managing relocation to residential care or indeed other settings and to what extent these qualities are central to this process.

Further research could also examine how far or to what degree social workers and other practitioners were influential in shaping outcomes. I did not, as indicated earlier, interview the specific practitioners involved in these specific older people's lives and this could be undertaken, subject to the various ethical and practical dilemmas of doing so outlined in this thesis. Greater involvement in

the interface between social workers and those undertaking moves could reveal more insight into the relationships between practitioners and their service users.

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Appendices

Appendix 1: Letter to staff asking for cooperation in the research.

Appendix 2: Questionnaire for interviews with practitioners.

Appendix 3: Themed interview guides for interviews with older people.

Appendix 1: Letter to staff asking for cooperation in the research

Dear

I am a student of Nottingham Trent University and I am asking for your cooperation in a research project. I am embarking on a PhD in which I want to find out what shapes or influences older people's move to residential care. The project will involve interviewing older people at various stage of their move to residential care. I also want to interview a cross section of practitioners who may have some involvement with older people making the move. These will be practitioners based in community settings as well as residential care. I am asking for your cooperation in this.

The interviews will focus on the different roles of practitioners like yourself as well as your ideas and feelings over what you feel are the important factors leading older people to care and their subsequent reactions to life in a home once the move has been made. I will use a questionnaire for the interviews but you will be free to talk about the issues which you feel are important. It is important firstly to stress that the findings will be used solely by me and for my research at Nottingham Trent University. They will not be circulated elsewhere and will be used in the strictest confidence. The project has absolutely nothing to do with any audit of staff competence or any review. I am independent of Nottinghamshire County Council or any other body other than Nottingham Trent University. It is also important for me to stress that you may withdraw from the interview or the research project at any point. It would though be very appreciated if you could spare me some time to be interviewed. We could arrange a time and place for your interview at your convenience.

Look forward to hearing from you.

Chris Towers

Appendix 2: Questionnaire for interviews with practitioners

1. Describe your role and tasks with older people?
2. Do you have much contact with friends and families during older people's move to residential care?
3. What are the reasons older people move to residential care?
4. Does an older person's previous life experience affect their move to care?
5. Are there any people, professional, carers or perhaps family that you would regard as having particular influence on older people moving to residential care?
6. Are there any aspects of your own role with older people that you would recognise as particularly important to older people as they move to care?
7. To what extent does social class, gender and ethnicity influence relocation to residential care?
8. How would you define a successful move?
9. What is your understanding of crisis?
10. Have you any other comments to make on the moves, on your role or on how older people may experience moves?

Appendix 3: Themed interview guides for interviews with older people.

THEME ONE	SUBJECTS
The role and tasks of practitioners with older people moving into care.	<p>Assessments.</p> <p>Co-ordination of services.</p> <p>Contact with friends and families of the older person.</p> <p>Accompanying older people to hospital.</p> <p>Perceptions of power and influence as persons move to residential care.</p> <p>Advice giving.</p> <p>Information giving.</p> <p>Emotional support.</p>
THEME TWO	SUBJECT
Understanding move and the nature of crisis.	<p>Reasons for going into care.</p> <p>What people in care need in order to feel settled.</p> <p>Admission to care: planned or crisis?</p> <p>Definitions of crisis.</p> <p>Change and development of older people in care.</p> <p>Previous life experience and the move to care.</p> <p>What defines a 'successful' move to care?</p>

1.