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RELATIONSHIPS OF ELDERLY PEOPLE IN RESIDENTIAL CARE

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ABSTRACT

This study explores the nature of the relationships of elderly people in residential care with each other, with staff members, and with families and friends. Relationships are considered according to personal, social, and organisational dimensions. The life course perspective provides a framework for illuminating these dimensions. The research design uses participant observation, life histories and semi-structured interviews within an interpretive methodological approach. Three local authority residential homes, selected for contrasting size and design, provided the focus for the research.

The topic of relationships was chosen to enable the development of good practice in social care through improved strategies for training and education. Relationships provide a key to understanding residents' experiences within the context of professional values and regimes of care. Cognitive mapping and eco-systems analysis are used to interpret the data. The findings suggest that residents' identities, formed throughout their life courses, provide the basis for forming initial social relationships within the homes. Residents later adopt social roles as part of their social relationships with each other. Many (but not all) residents have moved to a Post-Attachment phase of relationships, in which social relationships are more important than new close personal relationships. The recommendations suggest ways of individualising care (and promoting relationships) through the development of integrated care practice.

A view of old age in residential care:

"And now she has sunk into the question of old age; she lives in a home..."

..."they seem to sit, constantly watching television in a large communal room - the images of war, death, rock music, soap opera and politics bathing them harmlessly from the giant TV in the 'day room'. There they sit, their knotted hands busy crocheting, their journey through this vale of tears not so much done as run out of steam. Nobody is interested in them any longer. Their options, like their lives, are now as significant as the sharp chirps of the budgerigar in the corner of the television room."

p. 25

(The two residents) "have formed an alliance. They have detected in each other a consanguinity which sets them apart from the other residents; they eat their meals together and sit next to one another watching television. A deep and immovable sense of unfulfilment binds them."

p. 26

Cartwright, Justin, (1988)
Interior ,
Hamish Hamilton,
London

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Chapter One

The Starting Point of the Research

1.1 The Focus of the Research: Why it was chosen

Relationships are an established part of the values system and skills repertoire of the caring professions (BASW, 1986; Timms, 1983; Halmos, 1965). For example, social workers are expected to establish and maintain relationships with their clients (Biestek, 1958, 1973; Perlman, 1957, 1979). Relationships have been little recognised as an aspect of residential life of elderly people. A study of relationships provides an opportunity to understand the experience of living in residential care from the clients' point of view. The clients in this instance are the elderly residents. Asking clients for their point of view is recognised now as intrinsic to good practice (Compton and Galaway, 1984; Whittaker and Tracy, 1989; Ahmad, 1990). Consultation and partnership in decision-making with 'consumers' or 'service users', as clients are now called, are expectations of professional values systems (Solomon, 1976; Devore and Schlesinger, 1991) and of the NHS and Community Care Act 1990.

Yet although elderly people are the largest group of consumers of social care and health provision (Tinker, 1992), they have not stimulated as much professional interest as have children and families (Stevenson and Parsloe, 1978). For example, fewer qualified social workers work with elderly people than with any other client group (Rowlings, 1981). The demand for residential care of elderly people rose sharply in the 1980s. It is now the largest sector of residential care provision. Yet only a minority of staff working in residential homes for elderly people have completed professional training, either in social work or in nursing (Willcocks et al, 1987). My own professional experience, first as a social worker and then as an educator, led me to believe that elderly peoples' relationships and their identities as individuals are often overlooked and ignored by professional workers and by residential staff. I became interested in finding out more about relationships and their importance in the context of residential care practice.

The research focuses on relationships of elderly people in residential care. The research took place in an East Anglian county beginning in 1989. As an educator employed in qualifying and post-qualifying programmes for professional social work and for health, I sought a relevant, relatively under-researched topic that could span social work practice and education and health. The topic, it was hoped, would shed fresh light on relevant concerns so that the research outcomes could lead to recommendations for the development of practice and for the curriculum. Relationships of elderly people in residential care provided a viable topic because the research could be completed within the constraints of the time and resources available. It promised to fulfil the criteria of an under-researched, values-related subject relevant to practice and education. This introductory Chapter outlines some of the reasons for selecting this topic. The Chapter explains why it is a little recognised subject area, its relevance to practice, and my motivations for exploring it. The topic's viability and possible areas of bias in attitude will be discussed. The Chapter discusses the issues explored by the research, and indicates how these issues will be developed in following Chapters.

The research topic will try to develop a consumer-focused approach. The value systems of the caring professions increasingly acknowledge the need to move away from an authoritarian 'expert' analysis of needs which does not consult the consumers of the service, towards a consumer-oriented approach which listens to consumers' views

(Solomon, 1976; Hadley et al, 1987). Knowledge of elderly residents' relationships provides a key to understanding what it is like to live in a residential home, and the emotions and feelings of individuals in that situation. The knowledge of relationships will provide a means of enabling the voice of the consumer, the elderly resident, to be heard. The impact of residential life on residents' relationships has been touched on in previous research (Townsend, 1962; Bury and Holme, 1991; Willcocks et al, 1987, discussed in Chapters Three and Four) but there have been few instances (Hockey, 1983; Noelker and Poulshock, 1984; Retsinas and Garrity, 1985; Tesch, Whitbourne, Nehrke, 1981), as far as is known, where relationships have been the primary focus of a research project. Academics, managers, and practitioners have studied the nature of residential life (Townsend, 1962; Sinclair, 1988; Ainsworth and Fulcher, 1981, 1985; Burton, 1989) rather than the persons who are at the centre of it all - the residents themselves (Phelan, 1984).

1.2 Personal Experience as a Motivation to Explore Relationships

As well as objective reasons for undertaking this research topic (e.g. the lack of knowledge of relationships of elderly people, and the relevance of relationships to practice, discussed below), there are other more subjective reasons. These are based on personal and professional experience. Each experience discussed below is a vivid recollection of an incident which made a strong impact. (Pseudonyms are used throughout rather than actual names.)

In the USA in the early 1970s I worked as the Director of a drop-in centre whose work was targeted at college students in the area. One of my staff was Bill Roberts, a young trainee psychologist. Bill discussed one of his clients, Mr. Jackson, a diabetic man in his 60s. Bill did not understand why Mr. Jackson was asking for help, and couldn't discover any problems apart from diabetes. I suggested that he explore (with the client's agreement) Mr. Jackson's feelings about having diabetes, and whether it had affected his relationships. After the second session, Bill reported that Mr. Jackson revealed anxiety over whether his illness might lead to sexual impotence. His marriage was under stress. Mr. Jackson welcomed the opportunity to share his feelings. I noted the surprise and disbelief of my colleague when he discovered that a couple in their 60s expected an active sexual relationship, and that marital problems could occur in a couple of this age. Bill had denied the existence of personal relationships and sexuality in older people. I learned from this experience that an elderly person seeking help may encounter barriers caused by the negative attitudes of younger people towards old age.

By the mid 1970s, still in the USA, I had become Director of an agency whose role was to mobilise and train volunteers. I was responsible for organising a monthly programme run by volunteers in a large county institution for elderly people. Residents who were physically active attended the activities programme in the auditorium. Volunteers visited each floor to make contact with the more disabled residents. I remember entering a room and seeing twelve wheelchairs each occupied by an elderly person dozing or staring with a glazed expression. It was all I could do to stop myself from turning around and walking out of that room. How could I make contact with those empty expressions? Were they capable of understanding? I forced myself to go to each person in turn, to crouch down to sitting level, to introduce myself, and begin a conversation. Because I as leader did this, the other volunteers followed my example. Trying to overcome deafness, loss of memory, and apathy was hard, but I found I could trigger a spark of interest more often than not by talking about the towns and farms where these old people had lived, the foods they liked, and the local traditions they valued. In time, I gained some understanding of each person's roots in a particular culture. This was relevant in that ethnically diverse area of the USA. From these interactions, I learned that forming an individual relationship is an essential first step for understanding an elderly person. My

personal fears of inadequacy and dismay in the face of institutionalised old age had to be overcome in order to reach the individual. My actions on these occasions were guided by professional values which assert the therapeutic importance of relationships (Perlman, 1979; BASW, 1986; CCETSW, 1989, discussed below).

Some years later, in the early 1980s, I returned to Britain and was working as a Senior Social Worker in an Outreach Centre in a rural area, where the public were invited to drop in to make self-referrals for social services intervention. Mr. Appleyard, a man of 75, came to the Centre. First he mentioned financial hardship. Then, after some hesitation, he told me that finances were only the tip of the iceberg. His real problem was conflict in his family relationships. Mr. Appleyard and his wife disagreed over whether they should continue to support their 36 year old unemployed son. He asked for counselling. Because he lived just outside the catchment area for the Outreach Centre, I referred his request for help to a neighbouring Social Services office. When I phoned, my call was re-routed to the Home Care Organiser for practical help as soon as I mentioned Mr. Appleyard's age. No social worker was prepared to listen to what the man had to say. His needs were pre-determined as practical. This experience taught me how undervalued elderly people are, and how difficult it may be for them to obtain a full professional assessment and subsequent help for situations which are centred on problems of relationships.

By the mid-1980s, my grandmother had reached the age of 93 and was living in a nursing home in the USA. I went to see my grandmother after two years' absence in Britain. I was saddened to see that her dentures were no longer in place. They had been lost and not replaced, so she could eat only strained food. She had been given a wheelchair to use, because it was 'easier', although she was able to walk. She asked her daughter (my mother) to take her out in the car. My mother refused. It was too much trouble and "too much of a worry". In a few days' time, it was my grandmother's sister's ninetieth birthday. My grandmother remembered this, but had no means of buying a birthday card and a stamp. I went to find a card and a stamp, and encouraged my grandmother to send the birthday greeting. My mother felt it was a waste of time. It did not matter - my grandmother was "too old". Later in the week, my great-aunt was pleased to receive my grandmother's card, but she marvelled that my grandmother was still able to write and remember who she was- after all, "she's in a home". I learned from this experience that entry into a residential institution can result in residents losing opportunities to express initiative, capability, and drive because of staff and relatives' low expectations. This is the 'living death' which Goffman (1961) describes.

By the end of the 1980s I had become a Senior Lecturer at a college of higher education, and was teaching a course primarily for Care Assistants working in residential homes for elderly people. I listened to them discuss the routines for toiletting and bathing residents. In one home, it was the custom to assign a number to each resident so that items of clothing and personal possessions were labelled with numbers, not names. In another home, an elderly resident with a learning disability was isolated from other residents and kept in her room because of fear of her behaviour. It was the practice in another home to remove the bodies of dead residents wrapped in a plastic bag, via the side door, in order "not to cause any bother". In another home, an activities session for the residents was always interrupted by an Officer paying the weekly pocket money to residents in the same room. I learned from listening to the Care Assistants that life in a residential home for elderly persons can be far removed from the values of professional practice. The residents were often powerless, and de-personalised. So, too, in their perceptions, were the Care Assistants. There was evidence of batch living (Goffman, 1961; discussed below and in Chapter Four). As an educator, I concluded that here was a tremendous challenge and opportunity to improve the level of practice.

These experiences, clearly recalled after so many years, stimulated my motivation to explore attitudes, opportunities, and practices towards elderly people, and especially towards elderly people in residential care.

1.3 Relationships: a Little Recognised Aspect of Residential Care.

Knowledge of the relationships of elderly people in residential care is a little recognised aspect of residential life. Relationships within the homes have received scant attention from professional staff involved in residential care - Care Assistants, managers, nurses, Officers-in-Charge, social workers, owners, inspectors, registration officers, and doctors - as well as from informal carers. People in these roles often face the difficult task of evaluating the benefits and drawbacks of residential care for an individual or for a group of elderly people. Operating within their powerful positions of responsibility, they are required to make decisions about admission, placement, and management structures. Aspects of care such as food, rooming arrangements, health care, activities, and daily routines, are given attention (Booth, 1985; Willcocks, et al, 1987) but the subjective experiences of elderly people within residential homes remain elusive (Booth, 1985).

The relative lack of interest in and knowledge of relationships in residential care stems from the way in which old age in general is studied and understood; from the historical development of residential homes; and from perceptions of death and bereavement. The next part of the Chapter discusses the lack of recognition of relationships from the perspective of each of these contributory factors.

1.4 Contributory Factors to the Lack of Recognition of Relationships: The Way in Which Old Age is Studied

Fennell, Phillipson and Evers (1988) discuss difficulties of studying old age which unwittingly trap the researcher into stereotypical negative frameworks of analysis. By implication, the stereotypes preclude recognising the value of relationships as a means of understanding the individual's own perspectives. One difficulty is the obsession with defining needs. Sykes (1985) argues that 'welfarisation' of old age includes focusing on action to meet need rather than trying to discover the social processes which create need; the establishment of agencies whose role is to define need and manage help for those in need, rather than tackle the causes of need; the production of statistics about need; and an assumption that giving help is the task of experts who are competent in their specialisms. Relationships have not been defined as 'needs' in the same way as other criteria. This is illustrated in a number of publications which attempt to classify need. A study (Fogarty, 1987) of public, private, and voluntary arrangements to improve the living conditions of elderly people in the member states of the European community, including Great Britain, identified income support, housing, environment, security, transportation access, help in illness and disability, contacts, activities, and capacity to cope as the primary needs of elderly people. Only in the reference to contact did these identified needs suggest a focus on relationships. The study states that it is important "to help old people to break out of over-dependence on family contacts and to ensure that they learn or re-learn how to form and develop relationships to non-family members" (Fogarty, 1987, p. 65).

Interestingly, the reference to contact is juxtaposed with loneliness (p. 63), which pathologises the nature and amount of relationships and contacts the elderly person is expected to find. The pathology model of the study of old age (discussed in Chapter Two) is defined by Johnson (1976) as seeing elderly people only in the context of problems and needs. By implication, they are worse off than the rest of the population. Fogarty's identification of the primary needs of elderly people falls into the trap of negative stereotyping (Goffman, 1963) which is part of the pathology model. The social

problem or pathology model (Johnson, 1976) typifies a frequent approach by the caring professions towards elderly people.

Wilkin and Thompson (1989) compare a variety of instruments and rating scales for measuring levels of dependency (a 'need') in old people. The six rating scales which are evaluated in their study assess performance in areas such as mobility, orientation, communication, co-operation, dressing, bathing, memory, etc. Only the Sheffield Joint Unit for Social Services Research (JUSSR) Assessment Schedule (Booth et al, 1983) includes a sub-section on 'forming stable relationships', under the general heading of 'social integration'. Because the questionnaire was designed to be completed as a postal questionnaire by Officers-in-Charge rather than through direct contact with elderly residents, its usefulness as a key to the consumers' view is limited. Wilkin and Thompson (1989) conclude that these instruments, which emphasise counting and measuring, should not comprise the sole focus of research. Numbering and counting should be complemented by other kinds of research which study the social construction (Berger and Luckmann, 1966) of dependency relationships, seek to understand the causes of dependency, and explore opportunities for reciprocity (Blau, 1964; Homans, 1958, discussed in Chapters Two and Three) in which old people contribute to society.

McClenahan et al (1987) propose a model for joint planning of the care of elderly people by local authorities and health services. This model uses classification factors (needs) of

physical disability,

incontinence,

mental disability,

social circumstance, and

housing conditions.

The factor of social circumstances approaches the concept of relationships but is defined in a utilitarian sense as the level of support from friends or relatives. This classification factor poses difficulties for the authors. They suggest that previous studies have not explored this issue sufficiently. These studies lead to the assumption that elderly people are not expected to 'need' relationships, except as a means of instrumental social support for solving problems. (This concept is explored in Chapter Three as the utility value orientation of relationships). These studies view elderly people as problems with many needs which are defined by experts. They are not concerned with reaching out to discover the consumers' own opinions. They do not perceive elderly people as individuals.

Fennell, Phillipson and Evers (1988) point to the tendency (illustrated by the preceding examples) of academics who study old age and staff who work with elderly people to base their views on medically oriented frameworks which give lesser consideration to social factors (of which relationships are a part). Although professional social work does consider social and environmental factors, it has not "built an independent knowledge base for work with this client group" (Fennell et al, 1988, p. 40). This argument provides one of the reasons for choosing this research topic: that knowledge of the relationships of elderly people in residential care will contribute to the development of professional practice.

The lack of attention to relationships in the study of elderly people is supported also by the influence of the theory of disengagement in old age (Cumming and Henry, 1961, discussed in Chapter Two). Disengagement theory argues that ageing results in mutual

disengagement or withdrawal from contact between elderly persons and others, resulting in more distant relationships. Although this theory has been attacked for its conclusions about the nature of ageing by, among others, Blau (1973) and Townsend (1973), it is not difficult to understand why disengagement theory reinforces the low level of recognition of relationships of elderly people. Disengagement theory resonates within the negative stereotypes, beliefs and traditions which shape understanding of the experiences of old age. By its nature, it does not promote the importance of relationships. There is, however, some research interest in relationships in old age, notably on friendship by Matthews (1983a, 1983b, 1979, discussed in Chapter Three) and by Jerrome, who explores friendship within social contexts of voluntary associations (1979, 1983b, 1985, 1986, 1989, 1992, also discussed in Chapter Three). Jerrome also has written about family life and intimacy across the life course (1990, 1993a, 1993b, also discussed in Chapter Three).

1.4.1 Contributory Factors to the Lack of Recognition of Relationships: The Historical Development of Residential Homes

Residential care represents disengagement (Cumming and Henry, 1961, discussed above and in Chapter Two) from everyday life, with its established family and social networks, because it involves a physical move into a new environment. Relationships were not considered important criteria of well-being within residential homes, not only because of this factor, but also because of the way residential care of elderly people developed from the punitive traditions of the workhouse. The Victorian Poor Law legislation (Poor Law Amendment Act, 1834) created institutions which stigmatised poor people (Longmate, 1974). Elderly poor people were subject to the same rigorous conditions of institutional life (which were designed to act as a deterrent to accepting charity) as the younger, more able-bodied inhabitants. To enter the workhouse was to be branded a failure in the eyes of society. Because of their dependence on charity, inmates of the workhouse were regarded as having lost any right to express dissatisfaction with the regime. The workhouse regime discouraged family relationships, separating spouses, parents and children, and siblings from one another. The individual in that situation could not expect very much - certainly not concern about feelings and relationships. Many people were forced to enter the workhouse in their old age because of poverty.

The present-day systems of residential care developed from workhouse traditions, which ended as recently as 1948. This is within the living memory of those elderly people presently resident in, or about to enter, residential care. Accordingly, there is an unrecognised collusion between residential staff and elderly people, in which both base their perceptions of residential care on the assumptions of the workhouse. Central to these assumptions is the power imbalance, in which the staff control decisions, and the residents respond passively. Consequently, relationships in residential care are undervalued, because active relationships might subvert the traditional power imbalance. Townsend (1952) argues that in any population (such as elderly people) where poverty and homelessness are widespread, a form of rationing or deterrence enters into the provision of care. According to this view, if residential care were made too attractive, it would destroy the motivation of individuals to provide for their old age (and avoid residential care). It would also destroy the motivation of unpaid carers (spouses and adult children, most typically) to go on caring for their elderly relatives so that the relatives can avoid entering residential care. This view also helps to explain the apparent listlessness and apathy observed in many residents of elderly persons' homes and the continued existence of institutional regimes (Booth, 1985; Fontana, 1977).

Townsend (1962) developed arguments from his classic research on residential homes for elderly people. He found that "in the institution people live communally with a minimum of privacy and yet their relationships with each other are slender. Many subsist in a kind of defensive shell of isolation. Their mobility is restricted, and they have little access to a general society. The social

experiences are limited and the staff lead a rather separate existence from them. They are deprived of intimate family relationships and can rarely find substitutes which seem to be more than a pale imitation of those enjoyed by most people in a general community" (pp 328-329).

A generation later, Fisk (1986) comments about the lack of progress in improving residential life of elderly people since Townsend's 1962 commentary. He suggests that success in the provision of residential care can be measured by looking at its aims and objectives. Davies and Knapp (1981; discussed in Chapter Four) list several objectives including reducing loneliness, boosting morale, and enhancing social interaction. The Department of Health and Social Security (1977) defined residential care as broadly equivalent to what is provided by a competent, caring relative responding to emotional as well as physical needs. Despite these attempts to incorporate an element of relationships into the aims of residential care, the descriptive imagery of Erving Goffman's study of the 'total institution' (1961) contributes to the perception that all residential institutions (no matter which groups of people are living within their walls) are detrimental to the well-being of residents.

Goffman identified the institutional processes of 'batch living' with regimented daily routines which stripped individuals of their identity by depriving them (for example) of their own clothes. He discussed the rigid separation of staff and residents - processes which he claimed could be found in all institutions. In Goffman's 'total institution', there is no room for personal relationships. Goffman's research (1961) is widely known to social workers and can stimulate change within residential care. As a social work lecturer, I observed that residential staff training to become professional social workers frequently react strongly to Goffman. Some are enlightened. Others perceive Goffman as mounting an exaggerated attack on residential care. They reject his analysis because Goffman's conclusions may lie too near the truth to be received comfortably. As institutions (such as residential homes for elderly people) move away from the Goffmanesque model, they seek to avoid inflicting dehumanising regimes on residents. Institutions could encourage relationships to develop and enhance residents' lives as part of changing the regime.

1.4.2 Contributory Factors to the Lack of Recognition of Relationships: Perceptions of Death and Bereavement in Elderly People

Another factor which helps to explain the lack of recognition of residents' relationships is the underlying fear that by so doing, the impact of death, loss, and bereavement on relationships will be exposed. Denial has been noted as a psychological reaction to impending death by Kubler-Ross (1973) and to bereavement by Parkes (1986). Stevenson (1989) discusses the lack of research into experiences of very old persons who have been bereaved. She also notes the denial of old peoples' social, emotional, and spiritual needs in some residential establishments, and the undue emphasis on their physical needs - "all they really need is to be warm, comfortable, and well fed." (Stevenson, 1989, p. 11).

All elderly residents have experienced loss. When they enter residential care, they lose their former home. They are unlikely to be given a key to the front door of the residential home or be able to lock the door of their own room in the home, despite the recommendations of the Wagner Report (1988) that they should have their own keys. Physical disability (including sensory loss) and mental infirmity can be experienced emotionally and expressed as forms of bereavement. Their parents have died. Many have outlived their siblings. Most are widows. Some very old residents have outlived their own children. Many of their friends and contemporaries are dead. Thoughts of their own impending death cannot be avoided. The outward denial and avoidance (Parkes, 1986) of discussing death and bereavement by those in contact with elderly people (observed whilst conducting the research) is often explained as arising from

concern for elderly persons' peace of mind. Denial is justified as a desire to protect elderly people from depression and emotional pain. Staff in residential homes adopt this attitude. They are reinforced in this behaviour by cultural traditions which deny feelings in favour of a stoic attitude towards suffering. Elderly residents themselves are part of this tradition and they collude in its perpetuation. Staff who deny the pain of death for residents depersonalise them as individuals and use a 'neutralisation technique' (Sykes and Matza, 1957, discussed in Chapter Two) as a form of self-armour so that they can carry on in their work roles. In this context, the subject of relationships with its connotations of loss and bereavement, is a verbal 'hot potato' which must be avoided, not always for the sake of the residents, but for the sake of the staff whose own feelings may be affected.

1.5 Exploring the Lack of Recognition

The lack of recognition of relationships, revealed by the way old age is studied, by the historical development of residential homes, and by perception of bereavement and loss, results in a lack of knowledge about relationships in residential care of elderly people. Probably, one suspects, there is little encouragement for relationships within residential homes. Professional staff may be reluctant or unable to value residents as individuals with feelings, wants, and relationships. Residents may be reluctant or unable to reveal themselves as individuals with the capacity for relationships. By choosing relationships as the focus of the research, the degree of reluctance, inability, and lack of interest on all sides will be explored in order to gain a fuller knowledge of relationships, and to explore assumptions about the nature of relationships. As well as the negative features, positive efforts towards valuing relationships within residential care may be discovered.

1.6 The Relevance of Relationships to Professional Practice in the Caring Professions

The preceding discussion argued that their is a tendency of those who work with elderly people to ignore or deny the importance of relationships of elderly people. Yet the importance of relationships is one of the highest tenets of professional social work practice. The research topic of relationships has been chosen for its relevance to practice of the caring professions. Social work is one of these professions. The issues for practice with elderly people surmounts any particular professional boundary. Examples drawn from social work literature, research, and practice wisdom are transferable to practice in the other caring professions, for example, nursing, occupational therapy, and in other developing areas of intervention, such as social housing, and private and voluntary residential care provision. The research is intended for a broad audience - the audience of professional workers, managers, and non-professional care staff involved in elderly persons' services.

The value systems of practice require professional workers to practice within the context of a therapeutic client-worker relationship. Different theories and models of professional practice promote the validity of this approach. For example, Biestek's classic text (1958, 1973) outlines seven principles which underpin good practice. These include

self determination,
confidentiality,
non-judgmental attitude,
acceptance,
individualisation,
controlled emotional involvement, and
purposeful expression of feelings.

The principles outline the nature of a professional relationship as a necessary tool for developing good practice. Perlman (1957), formerly Professor of Social Work at the University of Chicago, cited the importance of forming and working with relationships as the all-encompassing prerequisite for undertaking the problem-solving model of social work. She summed up her approach to practice by reasserting the primacy of relationships: "Universal and commonplace as it is, relationship, subjectively experienced, objectively elusive, is the mover and shaker and propulsion force in human life." (Perlman, 1979, p. 23).

An accepted belief within professional practice, as Perlman (1979) stresses, is that relationships are good and necessary for human existence. This argument asserts the importance of the research topic, and supports the optimistic view that relationships are no less important for elderly people than for younger people. In reference to elderly people, Perlman (1979, p. 25) states: "This hunger for emotional bonding is seen most pathetically among the lonely aged, whose loss of meaningful relations through sickness or health or through the indifference of others leaves them virtually starved for want of the input and exchanges of caring." Perlman's disappointingly patronising account of the relationship needs of elderly people indicates how professional practice and values fall short of their own aims, when considering elderly people. Although Perlman points out their need for relationships, she adopts the pathology model towards elderly people (Johnson, 1976; discussed above and in Chapter Two) which hinders accurate perceptions.

Relationships, particularly client-worker relationships, have been valued by Freudian-influenced professional workers (Freud, 1953, 1976, 1986 editions) for providing raw material for analysis of unconscious forces which trigger behaviour and of the defence mechanisms which ward off anxiety (Ferard and Hunnybun, 1962; Butrym, 1981). The psycho-social approach to social work practice (Hollis, 1972) developed from Freudian theory (Freud, 1953, 1976, 1986 editions). Typically, it makes use of the defence mechanisms of transference and counter-transference (when both client and worker transfer emotional reactions from previous relationships into present interpersonal relationships) as a means of bringing about change. The influence of Rogers' client-centred therapy (1957) also helps to explain the caring professions' continuing emphasis on relationships. Rogers (1957) defined the necessary conditions for therapeutic personality change. He identified congruence, unconditional positive self-regard, and empathetic understanding as the components of a helping relationship which must be established in order to bring about change.

Biestek (1958, 1973), Perlman (1957), and Hollis (1972) helped to define a method of professional practice in social work called casework, later portrayed by the Barclay Report (1982) as one-to-one counselling. The casework method, used by social workers based in fieldwork offices, clinics, or hospitals, dominated professional practice in social work until the 1970s (Barclay, 1982). During the years before the 1970s, residential work was not considered part of social work. It was viewed as 'tending work' (Parker, 1981) for which no particular training or method was needed. Because of residential work's exclusion from the mainstream of professional practice in social work, relationships did not receive a high profile in residential work. (It can be argued that nursing practice has always included 'tending' as part of professional practice). Despite (or perhaps because of) the traditional lack of over-all agreement on the definition of social work and its practice boundaries, since the 1970s professional practice moved away from a preoccupation with casework as the only possible approach for practising social work. Many social workers still remain ambivalent about the inclusion of residential work within professional practice. They argue against the tendency of social work to colonise many areas of activity (Pinker, 1982), but the colonialisation continues. For example, a major practice activity which had not been conceptualised previously nor recognised as a professional activity is defined in the Barclay Report (1982) as social care planning, to denote the service brokerage and service package planning undertaken by social workers with and for their clients. More recently, this has become known as care

management (Challis, 1994). Group care practice (Ainsworth and Fulcher, 1981, discussed in Chapter Four), a term which embraces residential work, day care, and domiciliary services, has made cogent claims to be viewed as part of professional practice. Group care practice characterises 'tending' (Parker, 1981) as the provision of 'nurturing care' (Ainsworth and Fulcher, 1981), thus highlighting the connotation with relationships.

At the present time, many residential workers seek to obtain professional qualifications. Students on professional social work courses undertake practice placements in residential establishments as well as in fieldwork settings (CCETSW, 1989, 1995). The Biestek principles (1958, 1973), Carl Rogers' client-centred therapy (1957), Perlman's problem-solving approach (1957), and Hollis' psycho-social method (1972) continue to be influential, but now these models of practice are taught not only to intending social workers doing casework in a fieldwork setting, but also to residential workers and managers in group care. Other practice models such as group work (Brown, 1986; Douglas, 1979), systems approach (Pincus and Minahan, 1973), community social work (Barclay, 1982), and behavioural methods (Hudson and Macdonald, 1986) rival the older approaches, and are also relevant to workers in group care establishments.

Forming and working with relationships as a prerequisite for professional practice appears to have expanded beyond an identification with only one or two particular practice methods, theories, or approaches. Working with relationships has linked itself firmly with the social work professional code of ethics (BASW, 1986), which is designed for professional practice with all client groups. The British Association of Social Workers Code of Ethics for Social Work (1986) established principles of recognising the value and dignity of every human being, regardless of age, and encouraging and facilitating the self-realisation of each individual. It states that professional workers will not reject their clients or lose concern for their suffering and should respect the privacy of clients in their relationships with them. Although recognising the difficulty of commenting on the worker-client relationship, the Code of Ethics is based on the premise that relationships are essential tools for developing value-based practice. The self-realisation (BASW, 1986) of the individual can be facilitated through the client-worker relationship.

The Central Council for Education and Training in Social Work specified in its Requirements and Guidelines for the Diploma in Social Work (CCETSW, Paper 30, 1989, revised 1995) the values, knowledge base, skills, and competences required of a social worker at point of qualification. The ability to communicate and engage with people to promote opportunities to function, participate and develop in society is identified as one of the six core competences of social work. Social workers need to form, develop, and sustain working and networking relationships with children, adults, families, carers, groups, agencies, community resources and other professionals. They must assist children and adults to express their emotional needs, and provide emotional support to sustain them through processes of change. This competence, with its supportive repertoire of values and interpersonal relationship skills, illustrates the importance of relationships for practice.

The applicability of this competence (comprising values, knowledge and skills) to residential work is most obvious in residential child care (Parker, 1988; Ainsworth and Fulcher, 1985) and in residential care of people with learning disabilities (Wolfensberger, 1972, 1982). The importance of relationships is acknowledged as part of day-to-day practice with these client groups, assisting in the aims of rehabilitation and improving the quality of life for residents. The practice model of social role valorisation or normalisation (Wolfensberger, 1982), intended to change practice with people with a learning disability, illustrates the importance of relationships in group care. In contrast,

residential work with elderly people emphasises the social care task of tending (Parker, 1981) and pays little regard to the possibility of rehabilitation or therapeutic intervention with residents.

Field social work with elderly people is dominated by resource provision, which the Barclay Report (1982, discussed above) designated as social care planning, rather than engaging with clients' relationships over a period of time. Despite professional emphasis on relationships, the reality of professional practice with elderly people increasingly involves crisis intervention (Golan, 1986), some social care planning (Barclay, 1982) usually in response to crisis, tending (Parker, 1981), and care management (Challis, 1994). How can relationships be formed, sustained, and valued, when practice is increasingly diverted into actions of social control? Practice is directed by statutory obligations, which threaten ongoing therapeutic interventions based on the use of relationships. Under Care in the Community legislation (NHS and Community Care Act, 1990), an assessment of need must precede the provision of services for elderly people. Case or care management (Challis, 1994), involving the planning and organising of care packages following the assessment of need, is an increasingly significant role for professional practitioners. If professional values are applied to practice, assessment and planning activities of care managers should be based on a therapeutic relationship between client and worker, so that needs may be identified and agreed more accurately.

1.7 Relationships, Professional Practice, and Elderly People

It is disappointing that establishing relationships as part of the professional help offered to elderly people seems to have diminished. Black et al (1983), Bowl (1986), and Marshall (1983) note that social workers primarily view old people as needing only practical help. Because old people are not seen as whole people, but are regarded as a social problem caused by the fact of being old (Fennell, et al, 1988, discussed in Chapter Two), their actual needs and problems are regarded as practical. Interacting with emotional needs is considered a more skilled, professional task than meeting practical needs. If emotional needs are not acknowledged, then non-professional workers will be assigned to visit old people, carrying out tasks in a routine manner by using checklists for detecting problems and 'needs'. They may not be encouraged to consider an elderly person as an individual with complex, inter-related needs, wants, and feelings, some of which may arise from present and past involvement in relationships. Checklists give little scope for engaging in, or valuing relationships.

How has this less than satisfactory approach to elderly people's relationships come about? The history of professional practice with elderly people provides some clues which help to explain the present situation. The workhouse tradition (Longmate, 1974, discussed above) is one cause. Social work with elderly people is a fairly recent development lagging behind other services. Services to children and families started in 1948, when newly established Children's Departments began to develop a professional social work service (Tinker, 1992). In contrast, it was not until the 1962 Amendment to the National Assistance Act 1948 (which enabled local authorities to provide meals and other domiciliary services intended to keep old people out of residential care) that local authorities employed Welfare Officers, who were largely unqualified, to carry out these duties (Tinker, 1992; Stevenson, 1989). In 1971, with the establishment of Social Services Departments to provide a unified social work service, the door was opened for the development of a professional and skilled social work service to old people. ('Social work' refers to a casework service in this context).

Stevenson and Parsloe (1978) and Goldberg and Warburton (1979) suggest that old people fall to the bottom of a hierarchy of client groups maintained by many Social Services Departments (Bowl, 1986). Historically, professional practice has been more

preoccupied with the needs of children and families than with elderly people (Stevenson and Parsloe, 1978). The Barclay Report (1982) criticised this practice, calling it rationing by age. Old people may be relatively neglected by social workers because the statutory obligations of social work towards children and families is extensive and clearly established whereas work with elderly people, particularly their protection from risk, is not required by statute (Stevenson, 1989). The increase in child and family oriented legislation and concern with child abuse have preoccupied professional workers to the exclusion of elderly people's concerns (Tinker, 1992).

Another explanation of the relative neglect of elderly people within professional practice is the belief that human development and the potential for change take place primarily within biological parameters of childhood and adolescence (Freud, 1953, 1976, 1986; Piaget, 1932; discussed in Chapter Two). Clinical and academic traditions view relationships as therapeutic change agents. Change may not appear to be likely or possible for people nearing the end of their lives, so that relationships seem to serve no purpose. There may be doubt whether elderly people have the ability to form new relationships. If it is believed that the only change possible in later years is deterioration, than why go to the trouble of offering professional intervention, particularly if that intervention consists of therapeutic interaction? Thus requests for help from elderly people receive a more superficial assessment than requests from other client groups. More unqualified workers undertake social work with elderly people than with other client groups. "It is rare.... for cases (involving elderly people) to be seen as being significantly complicated by interpersonal and emotional factors." (Black et al, 1983, p.196). Although loneliness is a reported factor, this social aspect is not seen as an issue to be considered, but simply as part of ageing (Bowl, 1986).

Turning to the situation within the residential care of elderly people, the picture regarding the value and importance attached to relationships looks even more bleak. The impact on residential care of professional social work training with its emphasis on the value of relationships in residential care is slight. As discussed above, the numbers of professionally qualified staff in residential work are low. Three quarters of the care staff and over a third (43%) of the senior staff have no relevant qualification. Of those who do possess a qualification, most have trained as nurses in institutions rather than in the community (Willcocks et al, 1987). Willcocks (1986) states:

"There is disturbing evidence of a general ambivalence towards the care task and the role of residential social work. It is lamentable that social work literature has traditionally neglected this area. Social work texts on the elderly tend to focus on skilled social work interventions from fieldworkers, backed up by a sensitive complex of domiciliary support schemes; and residential social work texts tend to focus on services for young people. Sadly, residential social work with old people combined the problem of a less popular client group, with the problems of a less popular form of intervention...there appears to be a conflict between social work values and a medical model of care." (p. 152)

It is this potential conflict between values and models of residential care which the research will attempt to explore. Exploring the nature of the relationships of elderly people in residential care, and the ways in which relationships are nurtured or discouraged may provide means of relating professional values to practice. Many claims have been made on behalf of relationships and their usefulness for achieving self-realisation (BASW, 1986, discussed above). Is professional practice, with its emphasis on the importance of relationships, able to exert an influence on residential life experienced by elderly residents? The research topic may provide some clues, and by so doing, demonstrate its relevance to practice.

1.8 The Viability of Relationships of Elderly People in Residential Care as a Research Topic

The choice of my topic was influenced also by practical considerations. I needed to be able to fit the research around a busy teaching schedule. Residential care provided an attractive venue for the research because residential homes are open twenty-four hours a day, and are located conveniently within a local area. Research could be undertaken early in the morning and in the evening as well as during office hours. Elderly residents and staff in the homes conduct much of their interactions and activities in a communal setting, so enabling participant observation.

My experience of interviewing and assessing situations as a professional social worker gave me confidence that I had the necessary skills to collect and analyse the data. My work role as a lecturer provided contacts and credibility to gain access. I had to consider whether the topic was an acceptable avenue of enquiry which could yield the desired information. Booth (1985) points to the difficulty of measuring the subjective well-being of residents in institutions. He casts doubt on whether residents really do mean what they say, and whether they say what they think, because of the "unthinking compliance" (Booth, 1985, p. 102) induced by the institutions and by feelings of indebtedness towards those who care for them. Relationships are indicators of subjective well-being in much the same way as morale and self-esteem. In asking residents to reveal their opinions and feelings about their relationships, the same kind of passive non-compliance which Booth (1985) describes could be triggered.

The topic had to be made comprehensible, clear, and non-threatening so that responses would be elicited. Although I wanted to learn whether professional values were being practised in the homes, a direct question about these might cause difficulties for staff and residents. The respondents might not be sure of the meaning of 'professional values'. The questions could be perceived as criticising the standards of the home. I learned from my teaching that residential staff are aware of criticisms about residential homes for elderly persons. They know that homes have faults and shortcomings. In the climate of privatisation, Care in the Community legislation, and inspection and registration requirements, critical enquiries from an outsider might be construed as a threat to their own livelihood. If the topic for research were to be perceived as threatening, managers could either refuse entry, or decline to answer questions. The same is true for the residents. They might be reluctant to make overtly critical comments on certain topics because of fear of the outcome - a backlash of adverse treatment from staff, or even worse, losing their bed in the home and becoming homeless.

By choosing relationships as the focus of the research, I could develop understanding about the links between values and professional practice, without being overtly threatening. 'Relationship' is a fairly neutral concept which can be interpreted and expanded in a number of ways. 'Friendship' or 'loneliness' are concepts which might incur resistance from elderly people who may not want to reveal themselves to a relative stranger. 'Relationships' provide a basis for enquiry which, if developed with appropriate strategies, could reveal sensitive information about transitions into residential care, institutional regimes, and self-realisation, without causing so much emotional pain that the topic would fail to elicit any response.

1.9 Areas of Bias Against Elderly People, their Relationships, and Residential Care

The topic of relationships of elderly people in residential care compelled me to confront my own personal bias, arising from previous study, my experiences as a social worker and an educator (discussed above), and my acceptance of professional values as

guidelines for practice. One bias is the assumption that people are deprived of relationships in old age. Harris (1971) argued that ageing is a kind of deprivation in terms of income, employment, and in comparison to others in society and their own previous life experiences. Another personal bias is that residential homes are inevitably emotionally depriving institutions (Goffman, 1961; Townsend, 1962). A third bias is the argument (Perlman, 1979, discussed above) that relationships are intrinsically good and therefore necessary for the well-being of individuals. By identifying prejudices and attitudes at the outset, I hoped to avoid falling into the trap of collecting and analysing data on the basis of unspecified, submerged assumptions which might lead to superficial conclusions.

The assumption that professional values, with their emphasis on relationships and consumerism are useful determinants of good practice in residential care needed to be explored. The research advocates the importance of relationships as essential parts of human experience. It argues that elderly people need relationships, and possess relationship-forming skills developed over their life courses (Scrutton, 1989; Featherstone and Hepworth, 1990). In exploring this assumption, actual events and accounts must be perceived as clearly as possible. My personal bias about relationships of elderly people in residential care might be affirmed by the research findings, but I had to be prepared for the findings to fail to validate my assumptions. My belief in the power of education and training to develop good practice was another bias to be explored. I wanted to develop teaching, learning, and practice strategies from the findings of the research. At the conclusion of the research process, the findings might indicate that good practice in residential care cannot be defined, taught, or developed from this project.

A wider area of bias is ageism. Stevenson (1989) defines ageism as negative attitudes towards elderly people. Fennell et al (1988) define it as unwarranted application of negative stereotypes to older people. Townsend (1986, discussed in Chapter Two) attacks the negative stereotype which expects old people to become dependent as an inevitable outcome of ageing. The stereotype fails to take account of the processes of enforced retirement, inadequate pensions, and inappropriate placement in residential care, which structure the dependency. He attributes isolation and the lack of relationships of institutionalised elderly people to the processes of institutional life rather than to the individual attributes of elderly residents.

All the reasons for undertaking this research are to do with the need to counter the attitudes and practices which make up ageism: the lack of professional social work interest in elderly people, compared to children and families (Tinker, 1992; Stevenson and Parsloe, 1978); the lack of professionally trained staff working in residential care of elderly people (Rowlings, 1981); the ways in which old age is studied (Fennell et al, 1988); the institutionalisation of elderly people (Booth, 1985); attitudes towards death and bereavement (Parkes, 1986); a lack of interest by professionals in using professional values in their practice with elderly people (Stevenson, 1989); the observed actions of colleagues, relatives; and my own attitudes towards elderly people. The study of elderly persons' relationships in residential care will either confirm or dispel some of these ageist assumptions.

1.10 The Starting Point of the Research: Initial Questions

Having considered the reasons for the research, the issues it is intended to confront, and the purposes to which it will be put, the topic generates, at its starting point, the following questions:

Question One: What is the nature of the relationships of elderly people in residential care?

Question Two: How do elderly people perceive their participation in relationships within residential care?

Question Three: To what extent do the expectations and past experiences of the elderly residents themselves influence the development and maintenance of relationships?

Question Four: How do organisational factors, such as management policy and practice, design, and use of space and time, encourage or inhibit relationships?

Question Five: How do staff practices and attitudes encourage or inhibit the development and maintenance of relationships in the homes?

Question Six: How crucial are the presence and absence of relationships as indications of the well-being of elderly people in residential care?

Question Seven: When considering the aims of residential care for elderly people, how high a priority is given to the development and maintenance of relationships?

The sequence of the questions indicates the way the research topic will be developed. Starting with a general descriptive question "what is the nature of the relationships?", the emphasis is on exploration and discovery of what, to some extent, may be uncharted territory. It is acknowledged that no single discipline can cover all the relevant aspects (Hendrick, 1989; discussed in Chapter Three). The perspectives of different disciplines provide templates for structuring the investigation of relationships (Berscheid and Peplau, 1983).

For example, social geographers may be interested in investigating how relationships are shaped by social environments, and how the use of time and space can produce variation in relationships (Willcocks, Peace, and Kellaher, 1987). Anthropologists may be interested in exploring the cultural meaning of experiences of old age in a variety of contexts (Keith, 1982). Sociologists may approach the study of relationships from the perspective of primary group relationships (Cooley, 1909) and the role they play in maintaining a wider social system (Merton, 1957, 1968; Parsons and Bales, 1955). Social psychologists may seek to identify and understand individual human nature through study of close interpersonal relationships (Berscheid and Peplau, 1983). Developmental psychologists may choose to investigate the role relationships play in human growth and development (Bowlby, 1969, 1973).

The variety of approaches offered by different disciplines can result in conceptual bewilderment, a state of affairs which has been compared to a conceptual jungle with a capacity for choking the unwary explorer (Hinde, 1978). The rather general nature of Question One acknowledges the contributions of the various disciplines in conceptualising relationships. The breadth of meaning given to the term 'relationship' which includes 'friendship' (Matthews, 1979, 1983a, 1983b; Jerrome, 1979, 1986, 1990, 1993a; both discussed in Chapter Three) or 'attachment' (Bowlby, 1951, 1986; discussed in Chapter Two) needs to be sorted into conceptual dimensions for the research. Three dimensions of relationships are suggested. These are:

Personal relationships. Drawing on the contribution of social psychologists (Duck, 1986; Kelley et al, 1983; discussed in Chapter Three) who studied close interpersonal relationships, and the contribution of developmental psychologists (Bowlby, 1951, 1986; Parkes, 1986; discussed in Chapter Three) who studied the basis of attachment, characteristically important relationships are defined as close dyadic intimate relationships, usually long-standing, and involving kinship or deep friendship ties. The opposite of attachment is loss (Bowlby, 1973). In extreme old age in residential care, the

loss of close relationships through death and disability may be a significant aspect. Yet, this may prove to be an assumption which makes the researcher oblivious to different kinds of attachments which develop following losses of spouse, siblings, and friends.

Social relationships. Drawing largely on the contribution of sociology, relationships can be viewed as social networks which give valued social support especially in times of transition and stress (Brown and Harris, 1978; Berkman and Syme, 1979; Kahana, 1982; discussed in Chapter Three). Here, the perspective of developmental psychologists (Levinson, 1978; Erikson et al, 1986; discussed in Chapter Two) who study life events as transitional processes (Hopson and Scally, 1982) provides insight.

Organisational relationships. The contributions of anthropologists (Jerrome, 1979, 1981, 1983b, 1985, 1986, 1989, 1992; Hockey, 1983; Keith, 1982; discussed in Chapter Three) concerned with the meaning of cultural contexts suggest a focus on the way organisational regimes operate, particularly with regard to their use of power. As noted previously, social geographers' interest in the design and management of environmental life space (Willcocks, Peace, Kellaher, 1987; discussed in Chapter Four) leads them to consider the interconnection of organisational relationships with personal and social relationships. Sociologists (Goffman, 1961; Townsend, 1962; discussed in Chapter Four) who research institutional practices also explore how organisational structures affect relationships.

Question One emphasises finding out the nature of relationships within the context of residential homes for elderly people. Once the term relationship has been analysed into conceptual dimensions, and the stages of the research result in the collection of data, the data will be analysed. Because there are many independent and dependent variables in the study of relationships which interact with each other, it is difficult to determine causes for the presence or absence of relationships. Berscheid and Peplau (1983) warn against rushing too soon into causal analysis. The goal, instead, is to identify and understand the relationships which exist in particular situations with particular individuals in particular groupings. Descriptive analysis can serve as a building block for further research which may explore causes (Harvey, Christensen, and McClintock, 1983).

The next Questions move the research into a more specific framework. Questions Two and Three are linked, in that they seek to discover the consumer's point of view. Question Two asks how elderly people themselves perceive their relationships in residential care. It suggests use of participant reports which involves the subjects of the research as equal partners, by asking for their opinions and ideas, rather than relying on the views of experts, or on observation. Listening to the views of elderly people is a form of empowerment - sharing power and decision-making with groups of people who hold relatively powerless positions within society because of the pervasiveness of structural oppression (Solomon, 1976). Ageism (discussed above) is a form of structural oppression which is doubly pervasive within the context of residential settings (Townsend, 1962). Listening counterbalances ageism (Fennell et al, 1988; Stevenson, 1989; discussed above).

Asking Question Two pushes the researcher to choose a method which encourages self-determination and self-definition. Johnson (1976, p. 106) suggests the use of the life biography as a means of countering ageism by "facilitating joint decision-making about outcomes" based on "the value judgement that older people are entitled to select their own destiny within certain limits". Johnson views the state of being old as "the present manifestation of past experience and processes" (1976, p. 106). To understand the needs of elderly people within a present-day context, the circumstances of an individual's life history must be considered.

This leads to research Question Three, which considers how relationships are influenced by elderly people's expectations and past experiences. The life-course, defined by Runyan (1978, p. 570) as "the sequence of events and experiences in a life from birth until death, and the chain of personal states and encountered situations which influence, and are influenced by this sequence of events" is an important theoretical orientation which, like the study of relationships, is based on multidisciplinary perspectives. To gain the understanding of relationships sought by Question One, the researcher needs to learn how each individual developed, changed, managed, and made sense of particular life events. The concept of the life course (discussed in Chapter Two) draws on the disciplines of sociology, psychology, anthropology, demography, and history. It provides a broad framework for developing the research topic; a framework which supplies an over-arching unity to the three separate components (relationships, elderly people, residential care) of the research. Viewed through the life course perspective, the research explores the significance of personal, social, and organisational relationships as keys to understanding the final years of the life span, the Fourth Age (Laslett, 1989), as lived by very old people who have made a transition into institutional care.

The life course can be criticised for being a "motley and monolithic movement" (Kaplan, 1983, in Sugarman, 1986, p. 193) which is all things to all people. Many theoretical orientations on adult development are contained within its framework. Its comprehensive nature makes it suitable for a study of extreme old age. There is general agreement that ageing is a complex phenomenon which is multi-determined and which cannot be understood within one single disciplinary approach (Silverman, 1987). The proposed research is concerned with particular aspects of the ageing experience (very old people in residential care) which will gain coherence (Silverman, 1987) from the use of the life course perspective. The life course perspective is significant beyond the specificity of Question Three. All the questions which the research asks can be placed within this perspective, but Question Three becomes the pivotal question of the research, providing an organising framework for the other Questions.

Moving down the list of Questions, the next area of specificity is organisational relationships. These are addressed by the linked Questions Four and Five which ask how management and staff practices influence relationships. The underlying theme is that of power within the environment. Earlier, the theme of empowerment (Solomon, 1976) was discussed within the context of seeking the views of the residents. Residential care takes place within institutional environments (discussed above) which have been portrayed by, among others, Goffman (1961); Miller and Gwynne (1972); and Townsend (1962) as depriving individuals of basic human rights and making them powerless.

Another important theme suggested by the linked Questions Four and Five is the interplay of environmental influences on the individual and the individual's corresponding influences on the environment. The 'goodness of fit' between the individual and the environment is a theme of the ecological paradigm of human development (Bronfenbrenner, 1979, after Lewin, 1948; discussed in Chapter Two). The ecological paradigm provides an apt tool for analysing the inter-relationships of elderly residents and the environments of the residential homes.

Questions Six and Seven are linked, but are intended to cover different aspects. These Questions raise issues about the importance of relationships for the well-being of elderly people in residential care, and the priority of relationships within residential care. They define relationships as valued components of residential care practice. They assert the utility of relationships for developing professional standards of care. In asking these Questions, there is the risk of falling into a rhetorical trap inspired by idealism, and creating artificial or unrealistic standards for judging the meaning or value of relationships

(Tunstall, 1968). Because elderly people have been studied traditionally in terms of dependence, independence, need, and problems, rather than as rounded individuals (Johnson, 1993), overcompensation may lead to equating certain types of relationships with standards of well-being. This occurs when professional workers draw on a value base which views relationships as generally beneficial. Before reaching conclusions about the benefits of particular relationships, the concept of 'good' relationships needs to be developed.

1.11 Summary of the Chapter

To sum up the Questions which trigger the research, relationships will be explored from aspects of residents' views, organisational features, and standards of professional practice. The life course perspective (Blaikie, 1992) provides a unifying concept which links the components of relationships, elderly people, and residential care within a multi-disciplinary framework. Relationships will be considered as personal, social, and organisational in their dimensions, drawing on multi-disciplinary approaches for the research design and methodology.

In Chapters Two, Three, and Four, the topic of the research will be developed through a review of the literature. The themes which help to explain the choice of the topic will be elaborated as a basis for the research design. In Chapter Two, concepts of ageing and the life course perspective will be explored. In Chapter Three, dimensions of relationships will be discussed. Chapter Four considers residential care. The remaining Chapters construct the research design, and gather, present, and analyse data. Chapter Five develops methodology. Chapter Six operationalises the design. Chapters Seven, Eight, and Nine present the data. Chapter Ten argues the conclusions of the findings, and Chapter Eleven makes recommendations arising from the research.

Relationships of Elderly People in Residential Care

Chapter Two

Overview of Theoretical Concepts of Ageing

2.1 Introduction and Structure of the Overview

An understanding of ageing and how ageing processes affect relationships in old age is needed to develop the topic of relationships of elderly people in residential care. This Chapter reviews theoretical concepts which contribute to an understanding of ageing. It places these concepts within the general framework of the life course perspective. The significance of these perspectives as an organising principle for the theoretical concepts will be explored. Social gerontology provides a basis for examining individual experiences and social contexts of ageing. Gerontology, the study of ageing, developed as a multi-disciplinary field of study (Hendrick, 1989, discussed in Chapters One and Three). It argues that ageing is comprised of three inter-active processes, biological, social, and psychological (Silverman, 1987; Victor, 1987, 1994; Fischer, 1978). Social gerontology includes contributions not only from sociology, but also from psychology, anthropology, social geography, psychiatry, history, and demography. Each of these disciplines has its own distinctive theoretical underpinnings and methodological approaches, including a variety of often opposed 'world views' of how ageing is to be studied (Bond, Briggs, and Coleman, 1990; Overton and Reese, 1973). This diversity of views is appropriate for the research topic and its intended application to practice, because practice itself draws on diverse academic contributions and is multi-faceted in its approach.

There are difficulties in proposing a conceptual scheme to explain adult development and the processes of ageing. Old people are diverse and heterogeneous. Theories share over-lapping concerns. Some address particular aspects of ageing which others do not. Others explore the same aspects using substantially different questions. Conclusions vary, reflecting the parameters of disciplines and different methodologies. Theories of ageing change and adapt in response to an expanding knowledge base which the theories help to generate. Changing societal values, influenced by political and historical events, shape the selection of issues to be researched. For example, the choice of the present research topic owes much to the current demographic concern about increasing numbers of very old people surviving in the late twentieth century (CSO, 1983; OPCS, 1990, 1991, 1992) and the political decision to implement Care in the Community policies (Audit Commission, 1986; National Health Service and Community Care Act, 1990) for elderly people, as well as the values orientation discussed in Chapter One and subsequent Chapters. The omission from many exisiting studies of considerations of how gender, class, and race influence processes of ageing is now being recognised increasingly in the present day. This omission means that any conclusions to be drawn from these studies necessarily will be limited in their potential application.

Certain theories about aspects of ageing should be called 'theoretical models' or 'perspectives' because their frameworks are loosely structured and untested. The starting point in considering specific theories and concepts relevant to a study of ageing is to look at the different ways they define and perceive the processes of ageing, and how these contribute to an understanding of relationships in old age. There are two broadly contrasting approaches to the study of ageing. One is the macroscopic approach to ageing, where the life course is considered in outline, contrasted with the microscopic approach (Buhler and Masserik, 1968), which looks closely at particular aspects of behaviour at specific moments in time. Bertaux (1982) refers to these contrasting approaches as diachronic, studying processes across time, and synchronic, studying processes linked to a particular moment in time. For the purposes of this study, Bertaux's phraseology will be used to define the two approaches. Theories

based on biological and psychological perspectives tend to take a diachronic view. These will be considered first before discussing the synchronic approaches which tend to be based on sociological perspectives.

In the next section, biological perspectives of ageing are discussed as part of the diachronic approach.

2.2 Diachronic Views of Ageing: Biological Perspectives

Biological perspectives are important for furthering understanding of the topic. Mayer (1987) argues that biological theories of ageing are indicative of both the nature of ageing and the state of biological gerontology. Although physiological evidence of ageing is visible in human beings with the onset of changes in the skin, hair, muscles, eyesight, hearing, and agility, there is no universally agreed biological theory to explain the processes of ageing. Ageing can be explained as resulting from wear and tear on body mechanisms, from chemical reactions caused by the cross-linkage of molecular structures, from a depleted store of energy, from the programming of genes, from error and mutation of cells, or from auto-immune reactions. This is not an exhaustive list, but it indicates the diverse theoretical approaches within one discipline. To explore these further is beyond the scope and focus of the present research.

Biological definitions of ageing have dominated conceptual thinking about the experiences of adult life, and in particular, the capacity for change and development in adult life. Ageing takes place throughout life, but in infancy and childhood the evident outcomes of the ageing process are biological growth leading to physical maturity. Because these processes are perceived as beneficial, they are called development. In adult life, in contrast to the biological growth of childhood, the processes of biological change are called senescence, indicating the physical deterioration and decline which end in death (Bond et al, 1990, 1993). The biological definition of development, as being limited to physiological processes, precludes the possibility of development occurring in adult life, and denies recognition of possible psychological, cognitive, and social changes. Since relationships in old age depend on the possibility of change and development to facilitate replacement of lost relationships with new ones, the biological perspective suggests that relationships in old age will be, at best, a continuation of earlier relationships.

Biological ageing, according to Strehler (1977), has four criteria which differentiate it from other biological processes:

1. it is universal, occurring to everyone in the population;

2. it is progressive, occurring gradually over time with cumulative effects;

3. it is intrinsic and internal, occurring from within the organism and not caused by outside factors such as lifestyles and environmental factors; and

4. it is degenerative, having a harmful effect on an organism.

Biological change represents 'strong' development (Baltes, 1979) because it unfolds in a uni-directional, sequential, and irreversible pattern, as portrayed above. Biological change, 'strong' development, and the ageing process are inter-twined and share the same characteristics. In contrast, behavioural change resulting from psychological, cognitive, and social development represents development in its 'weak' form. In this case, behavioural change is not intrinsic, but is influenced by environmental factors. It is not necessarily progressive, and although probably universal, it is difficult to identify one commonly experienced behavioural change. Behavioural change is not necessarily degenerative. It is not uni-directional, sequential, and irreversible. Social

gerontologists claim, however, that behavioural change takes place across the life course (Silverman, 1987).

2.3 Summary of Discussion of Biological Perspectives of Ageing: Their Relevance to Relationships

Biological perspectives of ageing have influenced psychological and sociological theories of ageing. Relationships in old age are dependent on the possibility of change and development in old age. Theories of ageing which are influenced by biological perspectives undervalue the possibility of development in old age. Biological perspectives, interpreted in a rigid manner, close off the possibility of a theoretical recognition of development and change in adult life, other than degeneration. The diverse rates of chronological ageing and the variety of theories of biological ageing leave open the possibility of adult development, giving some hope that new relationships in old age may be possible. A conclusion which may be drawn from biological perspectives is that the rate and pace of ageing varies from individual to individual. Chronological age cannot be used as a rigid boundary to determine the onset of old age. Chronological age, related to the age of compulsory retirement, is often used in Western societies to define the beginning of old age. This is a socially determined definition rather than a biological one (Silverman, 1987, Holmes, 1980).

The next section discusses cognitive psychological processes of ageing as part of the diachronic approach.

2.4 Psychological Studies of Ageing: Cognitive Processes

Experimental psychology (which studies cognitive processes such as perception, memory, learning, and thinking) developed in the nineteenth century as a laboratory-based science concerned with human intellectual functioning. It is influenced by biological perspectives of ageing. A biologically determined model of ageing describes a period of growth and development in childhood, followed by a relatively stable period in adulthood, and then a long decline in late adulthood and old age. The study of cognitive ageing has not excited a great deal of research interest because ageing was viewed as cognitive disorganisation, following a reverse order of development (Bond, et al 1990, 1993).

For example, the creation and widespread use of the IQ (Intelligence-Quotient) test failed to take account of the influence of social factors on intelligence measurement. Since older people performed less well on the psychological tests, their poor results were interpreted as evidence (and the result) of biological decline. Schaie (1977, 1978) argues that adults learn to think in a more integrative way than young people, and that standard I. Q. tests do not test this ability. Old people may perform better at tasks involving remembering meaningful information (Cohen and Faulkner, 1984). This approach supports a values orientation which rejects negative stereotyping (Goffman, 1963), and which emphasises the importance of environmental contexts (Bronfenbrenner, 1979; discussed in Chapters One, Three, and below). It can be argued that I. Q. tests are inadequate for measuring the application of intelligence which draws on years of experience, and is demonstrated by the ability to make decisions in complex, ambiguous situations (Dittman-Kohli and Baltes, 1990).

Development of intelligence can be affected by social factors, such as poverty, isolation, and lack of stimulation. For many people, old age is a time of social and economic disadvantage. There is now thought to be a connection between these factors (Labouvie-Vief et al 1974). Intellectual functioning in later life is influenced adversely by the presence of disease, rather than solely by the effects of chronological age (Siegler, 1980). Institutional care is recognised as a disadvantaged social climate which affects residents' cognitive functioning. Experiments in old peoples' homes in the

U. S. A. by Rodin (1986), and Langer and Rodin (1976) report a reversal of cognitive decline following the introduction of improved practices which give residents more control and initiative. These studies are relevant to the research topic, and they also support the influence of environmental contexts (Bronfenbrenner, 1979, discussed above).

Biological ageing does affect performance on cognitive tasks, mainly on non-verbal and speed-related tasks (Hooper et al, 1984). Deterioration is more pronounced after the age of 70, and there are considerable differences in ability in cohort groups. Recently, a recognition that individuals' abilities need to be studied outside the confines of the laboratory (Neisser, 1982) has counteracted much of the influence of the 'rise and fall' theories of cognitive ageing (Coleman, 1990). Old people perform better on tests with socially relevant tasks in a naturalistic setting than on tests in a laboratory setting. They attach a greater importance to accuracy than speed, and respond well to compensatory strategies designed to make up for their lesser speed (Gottsdanker, 1982; Rabbitt, 1982). These findings also support the importance of environmental contexts (Bronfenbrenner, 1979; discussed in Chapter One and below) as influences on individual functioning.

2.5 Summary of the Discussion of Cognitive Processes of Ageing: the Influence of Environmental Factors

Kramer (1987) contrasts the traditional linear approach of experimental psychology with the non-linear approach. The traditional approach, which tests behaviour in a laboratory, is mechanistic, viewing human behaviour like parts of a machine studied separately in isolation from each other and from the influences of the environment. The newer, adult-centred approach is 'organismic' and non-linear, viewing cognition processes as inseparable from the influences of the environment. In adult life, cognitive tasks are geared to practical problem-solving tasks in the real world. Research must move out of the laboratory into the real world and use relevant problem-solving tasks as the basis for research with adults. These two traditions of experimental psychology represent different world views (Overton and Reese, 1973), which use different research questions, methodology, and produce different results, an example of the sometimes conflicting nature of theories. These views are incompatible; the non-linear view is criticised for being too imprecise, and producing an over-optimistic view of ageing cognition; the linear view is criticised for being too precise, and producing an unnecessarily pessimistic view.

The non-linear approach incorporates one of the views of the life course perspective (Blaikie, 1992; discussed below), that the environment influences development. Traditional experimental psychology remains rooted in biologically influenced linear 'senescence' views of ageing. The non-linear view is important for the research since it suggests that environmental contexts of residential care will influence residents' cognitive abilities. Elderly peoples' potential for forming and maintaining relationships may also be related to their levels of cognitive functioning.

The next section discusses developmental psychology perspectives as part of the diachronic approach to ageing.

2.6 Diachronic Views of Ageing: the Contribution of Developmental Psychology and its Understanding of Relationships

In this section, Piaget's cognitive development theory (1932) and its subsequent applications are presented. Then, psycho-social theories of development are reviewed, including Freud (1953 edition), Bowlby (1951, 1986), Jung (1969, 1982, 1989 editions), Gutmann (1964), Erikson et al (1986), Gilligan (1982), and Havighurst (1948, 1972).

Developmental psychology contains contrasting theories which are useful for furthering understanding about ageing. Their preoccupation with cognitive and psycho-social development in infancy and childhood means that they do not contribute as much understanding of adult ageing processes as one might hope. Developmental psychology's theoretical perspectives draw on biological processes, and this accounts for their limited view of adult development. Although many psychological theories of development tend to be theories of child development rather than life span/life course theories, they provide an important base for understanding adult experience. Wordsworth's poetic phrase written in the nineteenth century, "The child is father of the man", highlights the need to take past experiences into account for understanding the person of the present.

Piaget (1932) established the importance of environmental contexts for child development. He argued that children develop through four different stages and levels of reasoning (the sensori-motor, pre-operational, concrete operational, and formal operational periods) in response to their interaction with the environment. Piaget viewed intelligence as a process of adaptation to the environment. In seeking to adapt, the child uses two interrelated processes: assimilation, in which the individual adapts the environment to his or her own needs, and accommodation, in which the individual accepts and incorporate the demands of the environment into his or her own existence. Implied in Piaget's theory is the need for balance and reciprocity in making and resolving demands on or from the environment if satisfactory social relationships are to be achieved (Herbert, 1981).

Kramer (1983) recognises that Piaget stopped short of developing the stages beyond the point of biological maturity, because of the influence of biological perspectives on his thinking. Labouvie-Vief (1977, 1982, 1985) proposes a post-Piaget model of adult cognition called post-formal operations which seeks to establish the notion of cognitive development throughout the adult life course. Kramer (1983) suggests that the common features of post-formal operations are relativism and dialecticism. Relativism is the awareness that the different contexts in which phenomena are perceived produce different, contradictory, yet equally valid information. Contradiction is a constant feature of reality, and reality is constantly changing. Dialecticism emphasises change in a more orderly, systematic progression. At each stage of the dialectic approach there is a need to achieve a synthesis of the contradictions that arise, through finding solutions or redefining situations before encountering the contradictions of the next stage. Tolerance and co-operation, both socially useful skills in adult life, are particularly evident in the process of dialecticism. These kinds of thinking draw on past experience, and are concerned, like the earlier stages, with adaptation to the environment. Kramer (1983) warns of her own and others' doubts that the proposed post-formal stage might not be qualitatively distinct from the stage of formal operations (Commons, Richards, and Armon, 1982). This extension of Piaget's classic theory emphasises the influence of environmental contexts on performance, and continuing development throughout the life course.

Psycho-social theories of development contribute substantially to the understanding of ageing from the perspective of 'soft development' (Baltes, 1979). Freud's influential theories (1953, 1976, 1986 editions) also stop short of considering adult development because of the influence of biological perspectives. Freud suggested that human behaviour is shaped by unconscious motivations. The oral, anal, and phallic developmental stages of early childhood up to the ages of five or six years determine much of the nature of the adult personality. The most important relationships in infancy and childhood are those which are formed with the parents. Through these relationships, sexual instincts and aggressive drives are expressed. As the child develops, frustrations and conflicts arising from these relationships are resolved through identification with another person, and displacement of the original identification onto another person or object. Defence mechanisms are processes of reactions to excessive anxiety, which attempt to distort or deny on an unconscious level

the anxiety-provoking aspects of reality. They include projection of one's own feelings onto another person, and transference, the substitution of the characteristics of a previous relationship into a present relationship.

Freud made an important contribution to understanding the dynamics underlying close personal relationships, but was criticised for claiming aggression and sexuality as human drives which exist even in childhood. Feminists criticise Freud for attributing penis envy to women, and for his denial of child sexual abuse (Mitchell, 1975). Freud's theories have crept into popular understanding of personal relationships, with the concept of the unconscious widely accepted. Relationships are interpreted as indicative of unresolved conflicts arising from the infant's identification with the parents. Relationships are likely to be permeated with one or more defence mechanisms. Freud has suggested that in order to understand the adult, one must first understand the child that the adult once was. Relationships, according to Freud (1953, 1976, 1986 editions), represent more than rational exchanges between people. They provide a means for a re-play, on an unconscious level, of previous powerful anxiety-provoking relationships. Freud suggests that relationships are established as a result of powerful drives in infancy and childhood. The environmental context (Bronfenbrenner, 1979; discussed above and below), other than the presence of close parental figures, is less important as an influence on relationships. Relationships formed in adult life are seen as echoes and re-workings of early childhood relationships. Freud's theory devalues the significance of adult relationships as important in their own right. Freud's contribution is important, yet limited for understanding relationships in old age because of the lack of consideration of adult development. Gergen (1978) suggests that Freud's developmental theory blinds scholars to the importance of the adult years, and argues that no theory should be taken as a complete account, but should be evaluated for its potential for generating new ideas and new questions.

John Bowlby's research on maternal deprivation enlarges on aspects of Freud's work. Like Freud, he emphasises childhood development and relationships. Bowlby (1951) highlights the importance of the attachment between mother and child (discussed in Chapter Three for its importance as a personal relationship occurring throughout the life course; Weiss, 1973, 1975, 1978, 1979, 1982; Kalish and Knudtson, 1976). The mother-child relationship needs to be established in early infancy and maintained in order to ensure psychological well-being. Rutter (1972) later modified Bowlby's findings, including Bowlby's insistence on the mother as the sole constant nurturing figure necessary for the infant's optimum development. Bowlby (1986) argued that attachment in old age is important for helping individuals to face death. He distinguished between friendship and attachment relationships, asserting that friendship could not be a substitute for attachment. He viewed friendships as centred on common interests and activities, but attachment relationships, with their emotional intensity, as existing independent of any activity. Breaking an attachment relationship triggers strong bereavement reactions, in contrast to the break-up of a friendship. Attachment is viewed as part of being a healthy adult. In old age, mutual assistance is an important part of attachment relationships. Old people who have attachment relationships with children and grandchildren are happier than those who do not. Bowlby wrote these observations in his own old age. It is clear that he valued dyadic intimate relationships based within the family much more than social relationships, including friendship. The existence of attachment within old age is accepted, but as part of the continuance of earlier patterns. He says little about the capacity of old people to develop new attachments, except to base the capacity on the individual's psychological experience of attachment in childhood.

Jung, unlike Freud, saw development as ongoing into the adult years. Jung (1969, 1982, 1989 editions) suggested that the goal of development is self-actualisation, through the individuation process towards the establishment of the transcendent self. As part of the individuation process, as individuals approach middle age, a re-

evaluation of previous interests and priorities takes place. The individual undergoes a significant transition at this stage. Until then, the individual has been concerned with fulfilling the biologically determined roles of reproduction, child-rearing, and the socially determined roles of establishing a place in society. Jung draws attention to the one-sided nature of this development, in which men are dominated by the animus archetype, and women by the anima archetype. In cultures with sharply defined gender roles, men strive for achievement and status, and women strive for expressive relationships, each thus denying the other archetype within their personality. But in mid-life transition, men may develop the anima archetype, and therefore become more expressive, and women may develop the animus archetype and strive for outward achievement.

Jung's theories contribute an important understanding of development in middle age and beyond. He viewed the individual personality as a product and embodiment of a collective cultural history. Environmental contexts therefore are important in his thinking about relationships. Jung emphasises the importance of reflection and introspection as personality characteristics of later life which assist in developing the transcendent self. The individuation process with its need to integrate both the animus and anima archetypes in the drive towards the transcendent self suggests a changing emphasis on the nature of relationships sought by men and women as they grow older.

Gutmann (1964, 1979, 1987) elaborated some of Jung's themes of ageing and gender differences, studying middle-aged and elderly people of different nationalities, cultures, and societies with projective tests, interviews and analysis of dreams. He identified three ego mastery styles:

active mastery, in which individuals seek to change conditions in the world in an assertive way;

passive mastery, in which people give in to situations, and rather than seeking to change the world, seek to change themselves; and

magical mastery, in which individuals cope with situations by denial of reality or by reframing their perceptions.

Gutmann (1987) argues for an almost universal progression from one ego mastery style to another. Men move from active to passive mastery in later years, while women move from passive to active mastery. Gutmann reinforces Jung's ideas of the integration of the animus and anima. Gutmann (1987) also asserts the importance of social situations and obligations arising from the family as influences on gender roles and mastery styles. Magical mastery is more common in extreme old age, and mastery styles are also age-related. The implications for relationships are that women in extreme old age may be more assertive than men; and both women and men in extreme old age may deny the reality of their losses of physical fitness and close relationships. Coleman (1994) suggests that Gutmann puts disengagement theory into the context of elderly people assuming new roles as guardians of cultural values.

Erikson (1950, 1986) based his theory of ageing on Freudian principles of psycho-sexual development but extended the stages of development into adult life. He suggested that development continues throughout the life course. It takes the form of transactions between individuals and their societal contexts in the form of eight developmental crises. Individuals may resolve each crisis through a polaristic choice involving orientation towards either psycho-social growth or decline. The stages occur in an ordered sequence, which Erikson et al (1986) call epigenetic, indicating that the way each crisis is resolved lays the groundwork for resolution of the next crisis. Like Piaget (1932, discussed above), Erikson's theory is dialectical and organismic (Kramer, 1983, 1987). This is illustrated in the diagram below.

FIG 1 **Eight Ages of Man: Developmental Crises and Favourable Outcomes** (Erikson et al, 1986)

Age	Developmental Crisis	Favourable Outcome
Infancy	Basic trust vs. basic mistrust	HOPE
Early Childhood	Autonomy vs. shame, doubt	WILL
Play Age	Initiative vs. guilt	PURPOSE
School Age	Industry vs. inferiority	COMPETENCE
Adolescence	Identity vs. confusion	FIDELITY
Young Adulthood	Intimacy vs. isolation	LOVE
Adulthood	Generativity vs. self-absorption	CARE
Old Age	Integrity vs. despair	WISDOM

Erikson was interested primarily in the earlier stages, but as he grew older, he devoted more attention to the later stages. He gave greater emphasis to the last stage of life as a search for coherence, not just in close relationships but with the wider world and the environment in which the individual lives. Erikson's theory becomes more relativistic in its acknowledgement of the importance of the environment on development and relationships. In the last stages of maturity and old age, the individual is concerned to achieve a balance between integrity and despair, at the same time re-working some of the earlier themes of previous stages. The favourable outcome of the last stage is wisdom, which Erikson defines as "truly involved disinvolvement" (Erikson et al, 1986, p. 51).

Essential to Erikson's view of development in old age is the need to remember and review earlier life experiences in order to develop heightened awareness of individual identity. The heightened awareness helps individuals come to terms with their impending death. Increased tolerance of individual differences and others' points of view is a favourable outcome of old age development. He notes a tendency in elderly people towards pseudo-integration, the deliberate omission from life reviews of earlier discontent in an attempt to construct a satisfactory view of the life cycle. Gutmann's discussion of magical mastery (1987, discussed above) echoes this tendency. Erikson's observations affirm the difficulty noted by Booth, (1985, discussed in Chapter One and below) and others of gathering an accurate picture of elderly persons' views. Erikson suggests that the conscious decision to preserve privacy from researchers is accompanied by the unconscious need for integration.

Erikson argues that the adult struggle to achieve a balance between generativity and self-absorption, with the favourable outcome seen as care, is reworked in old age. This can be expressed as a grand-generativity which moves beyond middle age's direct responsibility for maintaining the world. The elderly person continues to show concern for and involvement in relationships and roles as parent, grandparent, friend, adviser. These roles become less controlling and intermingle with the need to accept care from others in a way which is caring in itself. Erikson views grandparenting as one of the most satisfying relationships of old age. Exchange of advice on an intergenerational basis is also accompanied by exchange of assistance. Elderly people should be involved in giving concern and contributing to others' well-being without being responsible for them.

The process of selective remembering and reworking earlier struggles in order to recast previous relationships in a more satisfying mould is most intense in old age. Changes in social roles and dependence require a different balance in intimate relationships. Coming to terms with isolation in old age can include developing new kinds of mutuality with friends and activities. Erikson views intimacy in old age as an outcome of attachments formed in youth, brought to fruition in marriage, and continuing in widowhood. Second marriages are based on companionship rather than intimacy. Friendships are viewed as having developed over decades. Old friendships, rather than new friendships, also can give a measure of intimacy. Relationships in old age with new friends are divergent. Some old people become involved with other people in mutuality and companionships and others disclaim relationships in a tendency towards isolation. Erikson echoes Bowlby (1986) in valuing the intimacy of marriage, parenting, and grandparenting above other kinds of relationships. To enter into his concept of old age development, it is necessary to have been married and to have had children. His focus excludes from consideration single old people, childless old people, and homosexual old people. Like Bowlby, he discounts friendship as an intimate relationship. Unlike Jung (1969, 1982, 1989 editions) and Gutmann (1987, discussed above), Erikson does not differentiate between gender roles. Buss (1979) criticises Erikson for naiveté in his acceptance of the conventional family, and for suggesting that psychological well-being is possible only when an individual is conforming to the conventional expectations of society.

Erikson takes account of the cultural contexts of each stage, including the impact of historical events and the particular environments which affect individuals. With his extension of the developmental stages into maturity and old age, and the importance he attaches to environmental factors, Erikson provides a promising theoretical basis for understanding the significance of relationships of elderly people within the context of residential care, except for the conventional naiveté discussed above. Based on Erikson's model, one would expect to discover some examples of relationships (although not strong attachment) in residential care, in which environmental contexts influence the relationships. Elderly people who experienced emotionally satisfying intimate family relationships in the past might be more likely to achieve integrity rather than despair, provided that they can overcome the bereavement reactions (Bowlby, 1951, 1986) which are likely to result from the deaths of parents and spouse.

The final Eriksonian stage, for which the favourable outcome is wisdom, suggests that reflective detachment will be the dominant feature of old age relationships. This echoes Maslow's study (1954, 1970, 1987, discussed in Chapter Four) of the needs which shape human motivation. Maslow suggests that motivational needs exist in a hierarchy, with self-actualisation (echoing Jung, 1969, 1982, 1989 editions, discussed above) or self-fulfilment at the top of the hierarchy. Self-fulfilment is embodied in the notion of the autonomous individual, rather than the social being. Carl Rogers (1961) also places a high value on the concept of achieving a sense of one's own personhood. He emphasises reaching a state of reflective wisdom, slightly detached from, but not isolated from, the rest of humankind. Kohlberg's theory (1969) of moral development also suggested a rather similar final stage to be achieved, in which the highest morality is that of independent behaviour and views, when the individual is able to take a moral stand which is different from that expressed by the crowd. These similar theoretical concepts are rooted in Western culture which emphasises individual choice rather than family and social cohesion. They support the view that relationships in old age are characterised by detachment and reflection which are determined by psychological need rather than by pragmatic considerations of having outlived contemporaries with whom attachments were previously formed.

Gilligan (1982) criticises Kohlberg's assumptions that moral values are equated with autonomy. She identifies a gender difference in moral development, with women valuing the connectedness of relationships above the predominantly male value of autonomy. She acknowledges Jung's view (1969, 1982, 1989 editions) of a change in

mid-life, with men gaining more awareness of the importance of relationships at this stage. Her views are consonant with Gutmann's findings (1987). Gilligan suggests three stages of development for caring relationships:

1. the individual cares for his or her own survival, and seeks relationships in which being cared for is paramount;

2. the individual cares for others, assuming nurturing responsibilities;

3. the individual cares for his or her own integrity, recognising the need to balance care for self and others.

She accepts that social contexts affect the stages of development but maintains that these stages are characteristic of women's development. Theories which promote the importance of autonomy were written by men about an essentially male characteristic. Gilligan derives much of her thinking from Jung's ideas (1969, 1982, 1989 editions), maintaining that both men and women need to integrate caring and self-expression in the later stages of life when maturity is attained. The importance of Gilligan's views, like those of Jung (1969, 1982, 1989 editions) and Gutmann (1987), both discussed above, is that the researcher is alerted to the likelihood of gender differences in the kinds of relationships which men and women have developed throughout the life course, and of different gender-based expectations of relationships. The need for integration suggests that the unfulfilled aspects of relationships which were denied in earlier years must be expressed in the relationships of old age. Men may seek to develop more nurturing relationships, and women more assertive, self-expressive ones. A further application of Gilligan's theory could be projected: that old age, and particularly advanced old age, moves beyond the integration stage which may be a driving force in mid-life, to a reprise of the first stage of self-survival. Physical dependency in advanced old age may of necessity make self-centredness the motivating force in relationships, with remnants of the second stage and possibly the third still evident.

Havighurst (1948, 1972) proposed a different view of adult development and ageing, suggesting developmental tasks as the keynote of personality formation. His model consists of six age periods with up to nine developmental tasks identified for each period. The tasks of old age describe the culturally specific roles which elderly people assume in Western society. The emphasis is on adjustment to losses of various kinds in the first three tasks. The latter tasks suggest the establishment of different kinds of relationships, influenced by the need to find satisfactory care for physical dependence and the fact of approaching death. Havighurst does not offer any gender variation in the tasks outlined. Chiriboga (1987) comments that Havighurst provides a useful set of guidelines which merit further investigation, but the considerable cultural and societal change which has taken place since Havighurst proposed the tasks means that his model is best used for general guidance rather than as a specific blueprint. Like Erikson, Havighurst's ideas are dialectical and reflect societal contexts. Development is seen as inter-active. Inner and outer influences affect the outcomes of the developmental tasks, the resolutions of which are crucial for ongoing developmental stages and tasks.

2.7 Summary of the Discussion of Developmental Psychology's Views of Ageing and its Influence on Relationships

The preceding discussion reveals developmental psychology's pre-occupation with childhood development (Freud, 1953, 1976, 1986 editions; Piaget, 1932) at the expense of adult development because of the influence of biological developmental processes. The importance of early childhood experiences in shaping adult personality is clear. This suggests that to understand the present-day relationships of elderly people, it will be necessary to learn about their past relationships over the life course.

Piaget (1932) and Jung (1969, 1982, 1989 editions) emphasise the importance of environmental contexts in shaping development. Unlike Freud, Jung (1969, 1982, 1989 editions) and Erikson et al (1986) extended the stages of development into adulthood and old age. Like Maslow (1954, 1970, 1987), they suggest that the reflective detachment of self-actualisation, rather than intimate attachment (Bowlby, 1951,1986, discussed above), is the characteristic psycho-social process of the years of maturity . Erikson's eight ages are dialectical, indicating that adults need to think through and resolve recurring conflicts and dilemmas as they move through the stages to old age. Erikson mentions pseudo-integration, the deliberate omission of past painful events from life reviews, as characteristic. This may be significant when seeking to discover elderly people's past and present relationships. Residents may present a view of themselves which omits significant but disturbing events. Gilligan (1982), echoing Jung (1969, 1982, 1989 editions), develops a view of gender differences in relationships in adult life. Jung argued that gender-related styles of relationships undergo a change in middle life.

In the next section, Levinson's view of ageing (1978) is presented as a perspective which bridges the synchronic and diachronic approaches of ageing (Bertaux, 1982).

2.8 A Process Oriented View of Ageing and its Perspective of Relationships

Daniel Levinson and his associates (1978) developed a bridging theory between psychology and sociology, taking both a diachronic and a synchronic approach to ageing (Bertaux, 1982). Instead of stages, Levinson describes eras (a diachronic approach) of the life span, ranging from childhood and adolescence to late late adulthood. The late adulthood era begins at age 60 and continues to 85 years. The late late adulthood era begins at age 80 and continues till death. Within each era, an individual builds a life structure (the synchronic approach) based on societal context, social inter-action, and personality. Transition periods lasting up to five years bridge the eras. These are: early adult transition, mid-life transition, and late life transition.

Levinson balances the stable eras with volatile transitions which mark the beginning and ending of the move from one era into another. He is influenced by Freud (1953 edition), and more particularly by Jung (1969, 1982, 1989 editions) and Erikson (1950, 1986). Levinson studied mid-life rather than old age, so his views on the later eras of late and late late old age remain speculative. He saw late adulthood as a distinctive and fulfilling era, in which individuals assume the identity of being old. He suggests that individuals need to keep the drive of their youth within the new structure, by finding a balance of involvement between the self and the demands of society. He promotes Erikson et al's dialectic (1986) of integrity versus despair as a task within the structure.

In late late adulthood, he suggests that individuals will need to deal with a number of infirmities, with the result that the life structure territory will be small, with a few significant relationships. Individuals' overwhelming pre-occupation in old age will centre on meeting needs for bodily comfort. Under conditions which are unfavourable, life may become meaningless, but development can occur as the individual comes to terms with approaching death. The most significant relationship is with the self.

Levinson studied men and much of what he says is gender specific. He describes the central components of a man's life as occupation, marriage and family, friendship and peer relationships, ethnicity, religion, and leisure. He acknowledges the importance of relationships, but they are very different relationships from those which Gilligan (1982) describes. For example, he identifies the mentor relationship as a significant relationship within early adulthood, in which a young man is guided and inspired by an older man, often in the work setting. Levinson claims that it is not usual for women to have a mentor. Levinson bases his theories on the social context of the particular

society and historical era which he studied. More women have moved into full-time and part-time careers since the 1970s, so it is probable that relatively more women will now have a mentor in the workplace.

Levinson, like Gutmann (1987), describes his eras as universal rather than culture specific, although his discussion of men seeking to attain 'the dream' is grounded in American values. The eras are based on a view of humankind which integrates the contributions of biology, psychology, and sociology. Levinson recommends changes for the institutions of society, including government, industry, education, religion, and the family. Adult development is possible, but can be undermined by poverty and despair. His conclusion criticises the excessive masculinity of men, and suggests that there should be more flexible patterns of work and leisure.

The next sections discuss synchronic perspectives on ageing, including old age as a social problem. The political economy of old age, activity and disengagement theories, age stratification, socialisation, sub-culture, labelling, and ageing as a minority group are reviewed briefly. Then, ageing as reciprocity and exchange and as continuity are discussed.

2.9 Synchronic Perspectives on Ageing and Their Views of Relationships

So far, theoretical perspectives which adopt the diachronic approach (Bertaux, 1982), in which ageing is considered as development over time have been discussed, with Levinson's study (1978) noted as an attempt to bridge the two approaches. Other theories adopt a synchronic approach (Bertaux, 1982) to ageing, studying its social processes. These synchronic perspectives will be considered in the light of their relevance for understanding relationships. Attempting to fit the synchronic explanations of ageing into a linked pattern is difficult. There are many explanations which are derived from a sociological base but which do not fit precisely, or fall outside the boundaries of any one academic discipline. Sociology has stimulated different approaches which contribute to an understanding of ageing, but there is no over-arching sociological orientation which provides a comprehensive explanation of ageing. One of the reasons for the relative lack of interest in a sociology of ageing in Britain is sociology's brief history as an academic subject, and its preoccupation with power, conflict, and social structure at the expense of interests in issues of welfare, well-being, and adjustment. Another view is that the majority of elderly people are women whose lives do not fit so easily into the male-dominated sociological concerns of class, occupational careers, and conflict (Fennell, Phillipson, and Evers, 1987).

A comprehensive sociology of ageing is viewed by di Gregorio (1986b) as necessary for a sociology of old age, and for social gerontology itself. Synchronic theories of ageing, although deriving from sociology, owe much to social psychology, anthropology, and the general orientation of social gerontology as a multi-disciplinary field of study. Some synchronic perspectives lack a sense of historical and situational context (Crawford, 1971). Fennell et al (1987) argue that social theory has not been applied systematically to a study of ageing. Studies are largely descriptive, and research has been normative, with certain untested *apriori* opinions formed about the nature of ageing. The following overview makes certain choices about where to place particular theoretical perspectives, at the same time recognising realistically the untidiness of the overview.

The overview suggests two dominant themes which influence synchronic theoretical perspectives: old age as a social problem (a pessimistic view of ageing) and old age as discovery (an optimistic view). The first theme, old age as a social problem, includes discussion of activity theory (Havighurst, 1948, 1972), which is really an optimistic view, illustrating the untidiness of categories; disengagement theory (Cumming and Henry, 1961), age stratification (Riley, 1976, Riley et al, 1972), socialisation (Rosow,

1974) and the political economy of old age (Walker, 1980, 1983). The second theme, old age as discovery, includes discussion of age as continuity (Victor, 1987, 1994) and as reciprocity and exchange (Homans, 1958; Dowd, 1975). Again, illustrating the untidiness of categories, a third grouping comprised of labelling theory (Becker, 1963; Berger and Berger, 1976), the sub-culture (Rose, 1965) and minority group view (Palmore and Whittington, 1965; Breen, 1960) of old age shares characteristics of the social problem view, but is broader in intention. Each of these views of ageing will be discussed and considered for their relevance to understanding the relationships of elderly people in residential care.

2.10 Synchronic Perspectives: Old Age as a Social Problem, and the Political Economy of Old Age as Influences on Relationships

The theme of ageing as a social problem (MacIntyre, 1977) or pathology (Johnson, 1978, discussed in Chapter One) permeates synchronic theories of ageing. For example, a 1978 British social policy discussion document on ageing was titled A Happier Old Age (DHSS, 1978) and by implication, suggests that old age is not normally a happy period of life (Coleman, 1990, 1993). Concern with social needs arising from the problems of old age is relatively recent. Three factors led to awareness in the 1890s of the particular situation of elderly people (Thane, 1987):

first, growing understanding of the complex causes of poverty brought about in part by the social surveys of Booth (1892, 1894, 1899) and Rowntree (1980 edition) which attributed destitution to inadequate wages and ill health rather than shiftlessness;

second, the difficulties older workers began to have in remaining in employment due to recession and technological change, linked with the recognition of the concept of retirement; and

third, the geographical concentration of greater than usual numbers of old people in certain areas due to migration of young people in search of work.

The theme of old age as a social problem is sometimes interpreted on an individual basis, resulting in concern for the individual old person within society, and how best to help individuals overcome their problems (MacIntyre, 1977). The individual approach to the problem of old age is broadly analogous to the biological approach to ageing (Strehler, 1977, discussed above) which emphasises deterioration and decline. Each takes a unilateral and one-sided view of ageing. Victor (1987, 1994) comments that medical and health concerns dominate this approach, and that the differences between elderly people and the rest of the population have been emphasised at the expense of studying the similarities of their experiences, and the differences between different groups of elderly people.

Alternatively, ageing as a social problem can be interpreted as a collective issue, leading to a consideration of the problems society as a whole faces as a result of the numbers of old people within it (MacIntyre, 1977). The collective approach to old age as a social problem is less humanitarian, in that it focuses on the 'burden' (Townsend, 1986) of old age on the political and economic resources of society, rather than on concern for elderly individuals. Although not concerned *per se* with the study of relationships of individuals, its pessimistic approach to old age supports ageist attitudes (Townsend, 1986), which in turn have a negative effect on perceptions of relationships. The concept of the burden of old age (Townsend, 1986; Uhlenberg, 1987) results from demographic trends in the 1930s of low birth rates and greater longevity. These trends led to predictions of economic disaster, when the increased number of dependent old people would create a drain on tax revenues needed for pensions and health care, while fewer workers would contribute to government tax revenues needed to finance the extra amounts needed for elderly people. Concerns about levels of government spending in the 1980s, linked with the growing numbers of very old people (Coleman and Bond,

1990, 1993), led to a revival of this prediction. Changes in demography modified this forecast. Cowgill (1984) countered the burden prophecy by arguing that the growing numbers of dependent elderly people are balanced by decreasing numbers of dependent children in the population, therefore ensuring that the balance of dependency remains the same.

Johnson (1978) identified five dominant areas of research on the social problems of old age, including morbidity, quality of life, use of services, retirement, and relationships. The social problem approach to ageing often makes value judgements about what constitutes 'successful ageing' relative to the problems of old age. The social problem approach usually studies relationships for their utility in alleviating the problems of old age (the utility value orientation to relationships, discussed in Chapter Three and below). Relationships are viewed often as problematic, because of loss through death and ill health of many contemporaries, and the fear that families will not wish to shoulder the burden (Townsend, 1986; Uhlenberg, 1987) of a caring relationship with a dependent elderly relative. Research on friendships as social support (Matthews, 1979, 1983 a and b; Jerrome, 1979, 1983b, 1990, 1993a, discussed in Chapter Three) draws some of its thinking from the social problem perspective of old age. Relationships, it is hoped, will provide a means of addressing the problems of loneliness, isolation, and despair, which are thought more likely in old age. Victor (1987, 1994) comments that little attention is given in these studies to the positive contributions elderly people themselves could make through their relationships. These studies on relationships will be reviewed at greater length in Chapter Three.

The political economy approach (Victor, 1987, 1994; Walker, 1980, 1983) to ageing also is linked to the theme of ageing as a social problem. The political economy approach is primarily a macro-level approach (Bronfenbrenner, 1979, discussed in Chapter One and below), concerned with the effect of economic and political policies on cohorts rather than on individuals. It appears to offer little understanding of relationships, except indirectly. Political economy refers to the study of the inter-relationships of governments, economies, and socially defined groups, in this instance, elderly people (Victor, 1987, 1994). Elderly people are viewed as disempowered and structurally dependent because of their limited access to resources, particularly income. This Marxist influenced understanding of power illustrates how old age can become a time of increased exploitation because of enforced exclusion from the labour market. Old age is socially constructed (Berger and Luckmann, 1966) by setting arbitrary ages for retirement. Chronology or biological functioning is not as important as the political-economic agenda (Estes, 1979; Olson, 1982; Walker, 1983). Relationships between elderly poor people and better-off younger people are perceived as antagonistic. Perceptions of shared adversity in old age could stimulate solidarity of group and individual relationships, resulting in more cohesive personal and social relationships amongst old people. Alternatively, the effects of class structures and the stratification of society (Riley et al, 1972), based on economic wealth, may lead to a corresponding imposition of power and domination within the social settings of old age. Elderly people and their carers may replicate the political economy within their retirement communities, social clubs, or residential homes.

Criticisms of the political economy approach have been slow to emerge because of the obvious existence of poverty in old age. Johnson (1978) criticises the universal application of structured dependency (discussed in Chapter Four) to all elderly people as a result of retirement, because most studies have been conducted with groups of institutionalised elderly people whose dependency, though obvious, may have occurred for reasons other than poverty. Johnson (1978) argues that pensions have given many old people a range of economic choice and security. Dant (1988) criticises Townsend's condemnation (1962) of institutions for elderly people, maintaining that some elderly people may enjoy the freedom from daily household chores which residential care provides. He also dismisses Townsend's assumptions of disempowerment (Solomon, 1976) of all old people as a result of losing wage earner roles. Wilkin (1987) suggests

that a more sophisticated measurement of powerlessness and dependency in old age, based on the contexts of environment and relationships, could counter the macro-level assumptions of the political economy approach. When one examines particular situations, contextual social and personal relationships emerge as significant factors in the lives of elderly people. For example, Phillipson (1982) comments that retirement, which is central to the political economy approach, restricts the availability of social relationships because it causes the individual to withdraw from established social networks at work.

2.11 Summary of the Discussion of Ageing as a Social Problem, the Political Economy of Ageing, and Their Influence on Relationships

Ageing as a social problem and the political economy of ageing are two perspectives which argue that organisational relationships and structures shape the lives of elderly individuals. They are more concerned with collective causes and solutions for problems rather than studying individual differences. They argue that the ageing experience is in part biologically determined but also is socially determined by compulsory retirement and inadequate income leading to poverty. These two approaches are pessimistic and emphasise deterioration in old age. They tacitly support ageist attitudes (Townsend, 1986). Relationships usually are viewed as having a utility value orientation (discussed in Chapter Three), intended to provide necessary social support for the problems of old age. The conclusions of the social problem and political economy views of ageing may be modified if research took account of differences in environmental contexts, and how these affect individual experiences of relationships.

In the next section, activity theory and disengagement theory and their contribution to an understanding of relationships are discussed.

2.12 Synchronic Approaches: Activity Theory and Disengagement Theory

Activity theory (Havighurst, 1963) and disengagement theory (Cumming and Henry, 1961) both emphasise the adjustment or adaptation which each individual makes to the onset of old age. They owe much to a social psychology perspective. Activity theory (Havighurst, 1963) developed first in the 1950s. It suggests that well-being in old age depends on continuing involvement in activities which are part of social roles in middle age. The loss of functional social roles signals the advance of old age. Role exits, such as retirement, or widowhood, create identity crises because of the loss of social contacts and relationships (Parsons, 1942; Blau, 1973). When roles are lost in old age, other activities need to be substituted to compensate for the lost roles. Activity theory was promoted by role theorists, who emphasise the influence of social roles on behaviour. Instead of viewing retirement as the end of social functioning and social relationships, elderly people's use of leisure confirms researchers' arguments (Cavan et al, 1949; Havighurst and Albrecht, 1963) that activities are necessary to happiness and social well-being. Activity theory asserts the importance of activities for defeating the social problem of old age, thus enabling a happy old age, and with it, the well-being of society as a whole.

Guillemard's study La Retraite-une Mort Sociale? (as discussed by Fogarty, 1987) which examined living patterns of French pensioners, established several categories of activity involvement. 'Third Age' people (37%) were lively and active, challenging the stereotypes of ageing; 'family and leisure centred' people (36%) were primarily interested in families and hobbies and had networks of social support; 'spectators' (13%) were people who although not unhappy, tended to be preoccupied with household routines rather than social contacts; and 'withdrawn' people (14%) had little purpose or satisfaction, and low levels of contact or activity beyond waiting for death. The explanation for these different levels of involvement, according to Guillemard, lies

in the diversity of previous life course experience. Old people come from different social classes, have different income levels and interests, as well as experiencing different levels of health. Most people lay the groundwork for their retirement through their life course interests and hobbies. The better off, better educated, and healthier ones are apt to make more use of activities in retirement. Guillemard (1987) blends the diachronic and synchronic approaches (Bertaux, 1982) illustrating the impracticality of establishing rigid boundaries around theoretical perspectives. The hopeful aspect of Guillemard's study is the finding that only a minority of old people are disengaged, lonely, and withdrawn from meaningful activities and relationships.

Activity theory is attractive for a study of relationships, because it seeks to establish a clear connection between social relationships which arise out of, and are maintained through, the shared pursuit of activities in old age. The positive values orientation of activity theory should not preclude a critical appraisal of its perceptions of ageing. Acceptance of activity theory depends on whether one believes that activity is really necessary for well-being (Victor, 1987, 1994). Guillemard's study shows that activity takes place within a life course continuum of involvement, and that there may be danger of oversimplifying the concept of activity. Lemon et al (1972) do not support the assumptions of activity theory, though Stanger (1988, discussed in Chapter Three) shows some evidence to support its claims. Bond, Briggs, and Coleman (1990, 1993) criticise the idealism of activity theory, viewing it as unrealistic to expect elderly people to ignore growing physical frailty and maintain their middle-aged life styles. They point out that activity theory is naive in its denial of the influence of economic, social, and cultural factors on the activity choices of many elderly people.

Disengagement theory (Cumming and Henry, 1961), which developed later than activity theory, exerts a powerful and controversial influence on how ageing is perceived. It fits much more readily into the ageing as a social problem approach. Cumming and Henry (1961) concluded that the ageing process results in a mutual disengagement or withdrawal from contact between the elderly person and others in his or her social system, resulting in greater distance and altered relationships. This withdrawal is seen as inevitable, and independent of variables such as poverty or illness. Disengagement from the social world serves as a preparation for death. Before the ultimate disengagement of death, the individual gives up many of the relationships, both personal and social, which have made up the fabric of individual life. The theory implies that withdrawal is not enforced. Individuals may relinquish their roles voluntarily. Disengagement benefits society as a whole, because room is made for younger people to assume responsible social roles, and ageing people are freed from stress.

Disengagement theory has been criticised for its simplicity (Victor, 1987, 1994). It fails to account for ambivalence in human motivation, or for the possible substitution of different kinds of involvement as withdrawal from other activities takes place. Rose (1965) argues that Cumming and Henry (1961) fail to take account of cultural values and economic conditions which determine the extent of disengagement in old age. It also seems contradictory to assume that disengagement takes place both inevitably and voluntarily. Although these aspects of the process may be true for some individuals, the social pressures of ageism (Townsend, 1986, discussed above) must be taken into account when deciding whether the process is voluntary or involuntary. Disengagement theory is unpopular because it offends value orientations, including empowerment (Solomon, 1976, discussed in Chapter One and below) which seek to challenge ageism (Townsend, 1986, discussed above) and reverse the powerlessness and segregation of many elderly people (Shanas et al, 1968; Fisk, 1986; Estes et al, 1982; Blau, 1973; Townsend, 1973). It is criticised for being too synchronic, and ignoring the diachronic nature of loss, which occurs in various forms throughout the life course (Victor, 1987, 1994). Disengagement theory does not support the importance of relationships as ongoing elements in the lives of elderly people. It suggests that elderly people, as they age, will participate in fewer and fewer

relationships, and that this withdrawal is a normal chain of events. Relationships are viewed in the context of loss and bereavement (Kubler-Ross, 1973; Parkes, 1986, discussed in Chapter Three). Taking a somewhat different view, Coleman (1994) suggests that a little recognised positive contribution of disengagement theory is its respect for reminiscence as an activity of old age, and its attention to the changes in personality in mid life.

2.13 Summary of the Discussion of Activity and Disengagement Theories

Activity and disengagement theories both emphasise adjustment to ageing. Activity theory, which suggests that successful ageing is based on involvement in activities, has important implications for promoting social relationships and the use of leisure. Disengagement theory, which suggests that withdrawal from social roles and relationships is natural and desirable in old age, has been criticised for its pessimistic outlook on ageing. Its argument is consonant with the social problem and political economy views of ageing (MacIntyre, 1977; Johnson, 1978; Walker, 1980, 1983), discussed above). Both theories are generalist in approach and fail to take account of individual differences in elderly people.

The next section discusses age stratification and socialisation.

2.14 Synchronic Approaches: Age Stratification and Socialisation and Their Perspective on Relationships

Age stratification (Riley et al, 1972; Neugarten and Neugarten, 1986, discussed below) divides society into dimensions according to the boundaries of age, and is linked with other systems of stratification such as social class, ethnicity, and race. It is a dynamic theory which takes account of changes in society and how these influence the lives and roles of individuals. Social roles (both formal and informal), status, power, and the various meanings attached to the social definitions of age are important concepts. This approach is not limited to a study of older people, but can be applied across the life course. It is significant because it was the first sociological theory to consider specifically the implications of age.

Age strata within society differ from each other according to two dimensions of time, the life-course dimension and the historical dimension. Individuals within the same segment of the life course tend to share common social roles. The historical dimension refers to the period of history through which a particular age cohort lives, creating shared perceptions, norms, and values which may differ from preceding and successive age cohorts. Age stratification is one system of stratification within complex social structures, and therefore is not a sufficient explanation of ageing when considered alone. It is unique because unlike social class stratification, age stratification is unidirectional, irreversible, and universal. It resembles strong development (Baltes, 1979; discussed above) and raises the issue of the integration and segregation of different age strata in their social relationships with each other. Age stratification emphasises the relationships between individuals and society and how these relationships are defined by the particular age cohort to which the individual belongs. Social change can sharpen the difference between age strata and create more affinity for each other within the age strata. This implies that a particular generation of elderly people will prefer relationships with each other not simply because of their chronological age similarity but because of shared commonality of values and experience across the years.

Age stratification theory owes much to socialisation theory (Rosow, 1974, discussed below). Socialisation is the process through which individuals learn the values, customs, roles, and skills expected within their culture. Socialisation is an important factor within the life course perspective (Clausen, 1986; Blaikie, 1992, discussed

below). Studies of socialisation (Rosow, 1974) are concerned with the initial process of socialisation in infancy and childhood rather than its ongoing process throughout adulthood. Ageing is viewed as a time of discontinuity and ambiguity, when loss of established roles occurs and few clear guidelines point the way for re-socialisation into the roles of old age (Rosow, 1974). Elderly people reach old age with negative attitudes towards growing old which they learned as young people. These attitudes do not provide good preparation for transitions into old age. Rosow (1974) suggests that elderly people's opportunities for socialisation into old age are poor unless they are insulated from other age groups and form associations with peers who are going through the same experiences. The implications for relationships are that there is little opportunity for relationships across age barriers, and more opportunity within similar groups of elderly people. This suggests that residential homes might provide fruitful opportunities for developing new relationships.

2.15 Summary of the Discussion of Age Stratification and Socialisation and Their Perspectives on Relationships

Age stratification (Riley et al, 1972) is important because it was the first sociological theory to consider the implications of age. It argues that like the factors of race, class, and gender, age determines social roles, power, and status within society. It draws attention to the life course dimension of time (discussed below), by suggesting that individuals within the same age strata will have affinity for each other because they share common expectations and roles. It also takes note of the historical dimension of time, noting the influence of social change on the expectations and experiences of particular age cohorts who move through the age strata. Socialisation (Rosow, 1974), the process through which individuals learn the social expectations of their society, supports age stratification. There are no clear patterns for socialisation into ageing. Suggestions that ageing socialisation might be more positive in separate age-segregated groups implies that residential homes can provide opportunities for relationships through application of age stratification.

2.16 Synchronic Approaches: Ageing as Sub-Culture, Labelling and a Minority Group

Rose (1965) argues the sub-culture theory of ageing. He suggests that some elderly people are beginning to form a distinct, although limited, sub-culture within society because they interact more with each other than with other groups, experience similar problems, and are excluded from full participation in society. Demographic, ecological and social organisational factors support the formation of a sub-culture of ageing. These include the increased longevity of older people, the postponement of frailty to advanced old age, compulsory retirement, and the growth of retirement communities. Rose argues that old people form into a sub-culture because they develop a positive affinity for each other based on their shared experiences of old age, and share an ageing group consciousness, which can lead to forming pressure groups and other activity. This also supports the view that relationships amongst elderly people should flourish particularly in closed settings (like residential communities) where the population is comprised exclusively of older people with common interests. There are also clear links with activity theory (Havighurst, 1963). Sub-culture theory does not assume a negative connotation. It can be both positive and negative. It takes into account the differences of class, race, and poverty within an age cohort which might splinter a sub-culture based on age, but argues that age cuts across the other potential sub-cultures. Physical and mental health, and social activity are key factors in conferring status within the sub-culture. Different social settings influence the interactions and relationships within the subculture (Kleemeier, 1961).

Labelling theory (Becker, 1963; Berger and Berger, 1976) suggests that certain groups of people in society are perceived as different or deviant. Because of this perception, they are subjected to negative interactions and expectations, with deviant outcomes as a

result. Elderly people are labelled as deviant (Berger and Berger, 1976) because of the connotation of age with unattractiveness, decrepitude, dependency, and death, setting up chain reactions of decreased self-esteem and de-humanisation (Johnson, 1993, 1994). This process of negative stereotyping (Goffman, 1963) affects the quality of relationships, often erecting a barrier between individuals and groups of people which is hard to break down (Kuypers and Bengtson, 1983). The remedy for this reaction, according to Kuypers and Bengtson (1983), is to re-define the status of old people by giving them a more positive economic position and to improve services and environments for old people. They also suggest giving old people more self-determination in defining the nature of social organisations and programmes designed for their benefit so that the power relationship between service providers and service consumers is balanced more evenly. Labelling theory is criticised (Taylor et al, 1973) for being too simple. The consequences of labelling are not always uniform, so that the predicted chain-reactions sometimes fail to occur.

The sub-culture view (Rose, 1965) stopped short of characterising old people as a minority group. The minority group perspective (Palmore and Whittington, 1965; Breen, 1960) extends Rose's argument by suggesting that elderly people form a minority group because they are subject to discrimination, similar to that experienced by certain racial groups, as a result of the negative experiences of ageing within Western society. Although minority group and sub-culture perspectives may be characteristic of the experiences of many elderly people, it is not possible to argue that they are true for all elderly people because of differences in individual life styles. The experience of ageing is more heterogeneous than these approaches suggest.

2.17 Summary of Discussion of Ageing as a Sub-Culture, Labelling, and Minority Group and Their Influence on Relationships

These three approaches share one characteristic. They treat elderly people as a group set apart from others, with distinctive characteristics of their own. Because they base their conclusions on shared group characteristics, they may not be useful for understanding individual differences within a group. The approaches are not necessarily negative towards ageing, but they often have this connotation. The sub-culture theory of ageing (Rose, 1965) is linked to socialisation (Rosow, 1974), activity theory (Havighurst, 1948, 1972), and age stratification (Riley, 1987). It explains the motivation for forming relationships in old age by arguing that shared positive affinity in old age will lead to shared group consciousness and shared activity.

The next section discusses ageing as discovery (Fennell et al, 1987), and reciprocity and exchange (Dowd, 1975; Homans, 1958, 1974).

2.18 Synchronic Approaches: Ageing as Discovery, and Reciprocity and Exchange

Ageing as discovery is a distinctive thematic approach to ageing which emerged during the late 1960s and 1970s in an attempt to contextualise the ageing process (Fennell, Phillipson, and Evers, 1987) by redressing some of the extremes of the social problem approach to ageing. It is both a reaction to the research on ageing as a social problem, and a proposed re-formulation of the meaning of old age which challenges the negative stereotypes of old age (Coleman and Bond, 1990, 1993). Discovery takes place on two levels. First, it provides a means of discovering more about the experience of old age, in recognition that elderly people have very different experiences of old age, and that they as individuals are very different from one another, and should not be lumped together as merely old. Research methodologies, such as life histories (Plummer, 1983, discussed in Chapters Five and Six), support the discovery approach.

The second level of the discovery approach is its emphasis on old age as non-pathological for the majority of elderly people. Old age is viewed not as a necessary

adjustment to social problems caused by ageing, but as a time of discovery of new experience, potential, and meaning. Shanas (1980), Keith (1982), and Silverman (1987) view old age as pioneer territory, and elderly people as new pioneers, in support of the discovery theme. Ageing is viewed as a process of positive growth which takes place throughout the life course (Oppenheimer, 1991). The developmental psychology approach (Piaget, 1932; Freud, 1953, 1976, 1986 editions; Jung 1969, 1982, 1989 editions) supports the discovery theme. Key concepts of the discovery theme include:

1. re-configuring the social and economic environment in which change affects older people;

2. understanding the complexities of the ageing process without falling into the trap of relying on stereotypical mythology;

3. disseminating research as a means of advocacy, so that the general public may discover a new concept of old age; and

4. concern with quality through empowerment of elderly people themselves as consumers of services, so that their opinions and views are sought and discovered (Willcocks, 1992).

The discovery theme promotes the importance of relationships within old age. Individual relationships are viewed in a positive light, not simply as an instrumental means of social support (Cobb, 1976; Hobfoil, 1985, discussed in Chapter Three) or as loss and bereavement (Parkes, 1986; Kubler-Ross, 1973). Empowerment (Solomon, 1976) of elderly people suggests that relationships in old age can develop through the initiative of elderly people. The potential of elderly people to discover and maintain new relationships in old age is advocated by the discovery approach to ageing.

Exchange theory (Dowd, 1975, discussed in Chapter Three with regard to its applicability to relationships) and reciprocity (Homans, 1958, 1974) are concerned with relationship dynamics. Simmons (1945) suggests that older people preserve their status in society to the extent of their ability to continue reciprocal relationships with others, in which power is more or less evenly balanced. Mauss (1925, 1965) suggests that social interaction is based on an exchange of tangible and non-tangible goods and services. Blau (1964) argues for the reciprocal nature of social exchanges, where the roles of giver and receiver alternate. Homans (1958, 1974) discusses the nature of social interaction as economic costs and rewards, so that participants in the exchange seek to maximise profit in their exchanges with each other. Dowd (1975, discussed in Chapter Three) argues that as people become older they lose more and more of their reciprocal power as their social roles diminish, so that at the last they have only the power to decide whether to comply with others' wishes. This suggests a framework for interpreting the dynamics of relationships within institutional settings. Matthews (1979) in her research on relationships of old women (discussed in Chapter Three) draws on this theoretical perspective.

2.19 Summary of the Discussion of Ageing as Discovery and Reciprocity and Exchange, and Their Understanding of Relationships

Ageing as discovery regards old age as a time of discovery of the self and new experiences, and avoids labelling ageing as a social problem. Exchange and reciprocity (Dowd, 1975; Homans, 1958, 1974, discussed also in Chapter Three) provide insight into the relationship dynamics in old age: that power and status are balanced between giver and receiver, but in old age the balance is disrupted with the elderly person in a receiving role rather than a giving one. This helps to explain why some elderly people may disengage from relationships. They may not wish to do so, but the exchange mechanism ceases to work satisfactorily.

2.20 Continuity Perspectives on Ageing

Psychological theories of ageing (discussed above) emphasise individual development, and take the diachronic approach (Bertaux, 1982). Sociological theories tend to emphasise processual aspects of ageing but not the developmental factors which affect the ageing experience. A synchronic (Bertaux, 1982) counterpart to developmental theory is the continuity perspective (Victor, 1987, 1994), which recognises that the roles and issues experienced by people at earlier points in their lives contribute to their ability to deal with ongoing and future roles and issues. Some of the sociological perspectives of ageing, discussed above, emphasise continuity within life experiences. For example, the continuity perspective promotes the concept of the socialisation process which enables people to carry forward reflections drawn from their personal histories into future happenings. Unlike disengagement theory (Havighurst, 1963), which emphasises discontinuity, the discovery approach places greater emphasis on continuity (Fennell, Phillipson, Evers, 1987).

Continuity theory emphasises stability in personality and life style. It maintains that as individuals become old, they remain essentially the same kind of people they always were. They respond to old age by attempting to preserve their previous personality and life style patterns. This approach to ageing is attractive because of its flexibility. It does not impose a uni-directional course of action for achieving 'successful ageing', as do disengagement and activity theories (Victor, 1987, 1994). At one level, as a means of insight into the experience of ageing, it dispenses with moralistic judgements about what constitutes 'successful ageing' (Hughes, 1990). At another level of analysis, it falls into the trap of measuring individuals' 'adjustment' to old age, according to the level of continuity in life style achieved in old age (Victor, 1987, 1994). Advocates of the continuity perspective assume that adjustment, or a successful old age, may depend on preserving continuity. Accordingly, any individual whose life exhibits a marked degree of discontinuity may be said to have failed to achieve a successful old age.

The continuity perspective does not take into account the necessary changes caused by retirement and the loss of close relationships through bereavement. These are factors which make it difficult if not impossible for individuals to preserve their earlier lifestyles. Yet this outlook on old age does suggest that individuals' behaviour and choices may be based on a continuum deriving from their experience of the past. Not all of this experience is based on personality. It is based also on cultural and class factors. The continuity perspective recognises that people are heterogeneous. There are differences of social class, gender, ethnicity, health status, sexuality, religious and spiritual beliefs, and income within the population of elderly people, just as there are in the younger population. The cohort effect (Elder, 1974; Riley, 1976, discussed above in the section on age stratification) is important for continuity, because it recognises that people born at a certain period in time experience the effects of, and in turn influence, the historical social and economic events of their lifetimes. For example, the Depression and World War II in the 1930s and 1940s affected the lives of cohorts who lived through these decades (Elder, 1974, Riley, 1987). The continuity perspective does not deny the existence of relationships in the lives of old people. Because it emphasises individual, heterogeneous pathways towards old age, relationships assume a necessary place in its schema. It suggests that people's relationships in old age will tend to replicate their relationship patterns of the past. To understand their present relationships, one must first recognise and learn about the continuity of their relationships across the years.

2.21 Summary of the Discussion of the Continuity Perspective and its Perspective on Relationships

The continuity approach (Victor, 1987, 1994) emphasises continuity of identity and relationships across the life course. It has less to say about the relationships of elderly individuals whose lives have been marked by discontinuity. Many of the aspects of the

continuity approach are consonant with the ideas of the ecological perspective (Bronfenbrenner, 1979) and the life course perspective (Blaikie, 1992).

In the final sections, the life course perspective is discussed as an organising principle for the separate approaches covered so far.

2.22 The Life Course Perspective as an Organising Principle for the Different Perspectives on Ageing

Each approach to ageing is useful but limited. The many-faceted discussion of ageing would remain disjointed without an over-arching perspective. Current theoretical perspectives on ageing share a growing interest in the life course perspective, whose potential for providing a framework for the proposed research was discussed in Chapter One. Use of the term life course indicates concepts constructed from a sociological framework, while psychologists are more likely to use the term life span (Silverman, 1987). For the purposes of this research, life course will be used. Sugarman (1986) suggests that the life course represents a general orientation, rather than an articulated theory. By comparing her summary of views of the life course from a psychological perspective with a summary by Riley (1979) from a sociological perspective, it is possible to see some of the similarities and differences in interpretation. The commonly held views are:

(i) the potential for development extends throughout the life span (Sugarman, 1986); ageing is a life-long process, from birth to death; therefore understanding of any component of the life course can only be achieved by understanding what has come before and what is to follow (Riley, 1979);

(ii) development can occur on different fronts, including intellectual, physical, and social (Sugarman, 1986); ageing is comprised of three inter-active processes, biological, social, and psychological (Riley, 1979);

(iii) development tends to favour a reciprocal influence model of the relationship between a person and the environment (Sugarman, 1986); the life course of any individual or cohorts of individuals is affected by social, environmental, and historical change, and new patterns of ageing experienced by a cohort can influence social change (Riley, 1979);

(iv) there is no specific route that the development should or must take; development is multi-directional (Sugarman, 1986).

Although similarities outweigh differences, the preceding summaries reveal the characteristic approaches of psychology and sociology. The life cycle concept of development has been supplanted to some degree by the more flexible approach of the life course. The concepts of development, process, time, and context are identified as important. Sugarman (1986) refers to development throughout, while Riley (1979) refers to processes. Psychology's emphasis on development leads to ideas about individual behaviour unfolding in sequences of events and in predictable patterns. Bryman et al (1987) criticise the life cycle for its inadequacy in coping with transitions (Parkes, 1971; Hopson, 1981; discussed below and in Chapter Three). It implies a deterministic normality about stages of development (even though its advocates with their different versions of the life cycle are unable to agree on a definitive list of stages).

The significance of the concepts of development, process, time, and context within the life course are discussed in the next sections.

2.23 Development and Change in the Life Course

The life course characterises development in a flexible way. The earlier part of the Chapter established that because developmental psychology grew from a biological view of development (Strehler, 1977, discussed above), the criteria for determining what was or was not development were conservative. The characteristics of biological development (discussed above) were defined as strong development: change in a sequential, universal, uni-directional, end-goal directed, and irreversible pattern (Baltes, 1979, discussed above). As we have seen, many life cycle theories try to fit this view, and consequently neglect the study of cognitive and social development in adult life, because behavioural changes in these areas do not support the strong view of development (Baltes, 1979, discussed above). The life course perspective maintains that development in its weak form takes place throughout life (Baltes, 1979). Sugarman (1986) warns about the dangers of assuming that any change of any amount over any period of time is development. The concept of development is linked with the idea of improvement, requiring a values statement. It is a process of movement towards the ideal (Kaplan, 1983). If everything or anything that happens is development, then the values assumptions are missing. With regard to the life course perspective, Sugarman (1986) qualifies and expands her statement on development in (i) above with a further statement in (iv) above about the multi-directional nature of development. This counterbalances the assumptions of certain psychological theories which do not account sufficiently for individual variations (Rosenmayr, 1982).

Sociological contributions are more apt to discuss development as a process of change and transition, as in (iii) above, and to be less concerned with achieving an ideal end goal as an outcome of development. Change, used in a processual manner, is substituted more often than not for the word development within the sociologically defined life course. Baltes et al (1980) attempted to integrate the concepts of development and change within a structural framework, proposing three different types of influences on the life course to account for both ordered and random change. These are:

1. normative age-graded influences, such as those associated with biological maturity and chronological age, for example, starting school or reaching retirement;

2. normative history-graded influences associated with historical time, for example, austerity, depression, war; and

3. non-normative influences, based on biological or environmental factors which are individual, random, or atypical, for example the death of a child in a road accident. (An example of a non-normative influence which became a normative influence in the post-war years is the employment of married women). Non-normative influences become more frequent as individuals move through the life course, having already achieved the more predictable aspects of change which are linked to biological maturity.

Pearlin (1982, discussed in Chapter Three) views the life course as a whole, and ageing in particular, as involving change. The study of ageing is the study of change and its consequences, including the individual's coping skills to counteract the stresses caused by changes. Hareven (1982) defines the life course perspective as a way of examining both individual and collective development as transitions and timing of life events, including changes in status. Plath (1982) discusses life course change as cultural pathways, divided into three domains of labour (or activity); love; and work. Plath argues that transitions (Parkes, 1971; Hopson, 1981, discussed below and in Chapter Three) are strategic points of analysis in the life course, and can be regarded as thresholds of change. Any event can become a threshold, but it is not clear where to place thresholds within the life course. Tornstam (1981) suggests that processes of change occur at three inter-connected levels: individual ageing, the new cohorts of ageing populations, and historical and social aspects. Elder (1982) identifies two types

of change within the life course: transition, which is change over short time spans and specific life events; and trajectory, which is longer term changes in which transitions are embedded.

2.24 The Concept of Process in the Life Course

Sociological contributions to the life course (Hareven et al, 1982; Bryman et al, 1987, among others), emphasise process rather than development. They take a cross-sectional, segmented view rather than a longitudinal view of change over the life course. The weakness of the sociological view is its tendency to explain and elaborate variety at the expense of continuity (Rosenmayr, 1982). If the sociological contribution is one which emphasises process, then how will process be characterised within the context of the life course perspective? Clausen (1986) identifies three characteristics:

1. development, the typical processes of growth of the individual's biological, social, and cognitive potential;

2. socialisation, the ways individuals learn to function in society; and

3. adaptation, the responses of the individual to the physical and social environment by modifications in behaviour.

Clausen's identification of development as a sociological process represents an attempt to incorporate the psychological concept of development within a sociological framework. The strengths of the sociological view are its willingness to consider the divergence of individuals from the norm as a valid part of the ageing experience, and its placement of the experience of ageing within an environmental context. Socialisation (Rosow, 1974, discussed above) is a concept which is important within the ageing process. The sociological contribution emphasises the reciprocal nature (Homans, 1958, 1974; Dowd, 1975; discussed above and in Chapter Three) of the relationship between individuals and environments. Its emphasis on the individual's processual relationships with the environment draws on the ecological perspective (Bronfenbrenner, 1979, discussed above and in subsequent Chapters).

2.25 The Concept of Time in the Life Course

Time is an underlying concept implicit in theories of development and social processes. Blaikie (1992) suggests that an inter-disciplinary design for the study of ageing can be achieved only through a re-evaluation of the way boundaries are placed around the concept of time. The longer period of adult life needs to be taken into account as a basis for understanding old age. Neugarten and Datan (1973) distinguish between three different dimensions of time:

life time, or individual time, which is the chronological age of an individual, closely linked to biological changes;

social time, which is the age grading and age expectations established by social systems, including the social system of the family; and

historical time, which is the succession of social, political, economic and environmental events which transpire during the lifetimes of individuals and cohorts of individuals.

Hareven et al (1982), expanding the same theme, argue that the time perspective is crucial for understanding adult development, which takes place over individual, social, and historical time. The timing of life events within the life course perspective is not dictated by rigid stages, but unfolds with more individual variations. According to this view, the study of ageing cannot be limited to old age, but will include personal

experiences drawn from the past, and the wider social conditions which affect individual experiences.

Bertaux (1982) criticises sociology for detaching logic from history, and ignoring the influence of history on social processes and social change. The dimension of historical time (Neugarten and Datan, 1973; Hareven et al, 1982, discussed above) is useful for understanding the social processes of ageing. The life course consists of a point of intersection between personal time and historical time. Historical time provides an anchor for the individual life experience.

Harris (1983) warns against too facile a matching of personal time with historical time to form stages of the life course, preferring instead to discuss individual transitions (Parkes, 1971; Levinson, 1978, Hopson, 1981; discussed above and in Chapter Three). Transitions occur within cohorts conditioned by the interaction of individual life courses with historic events, leading to clusters of transitions within cohorts which in turn affect the socio-historical process. Earlier events shape later events; the life course perspective studies sequences of events which are both intended and unintended. Personal time is, like history, linear not cyclical; the concept of a cycle is inappropriate as a theoretical tool.

Neugarten and Neugarten (1986) incorporate the dimension of time into the discussion of age stratification (Riley, 1976; Riley et al, 1972; discussed above) of society. In this view, an individual's lifetime is divided into socially relevant units, with the result that the process of biological time is translated into social time with socially defined roles, rights, and responsibilities. Riley and Riley (1986) discuss the impact of increased longevity on the life course with regard to personal, social, and historical time, arguing the need to redefine age-related social norms. For example, the emergence of the 'young-old' (Neugarten, 1974) who lead energetic lives in retirement defies previous age-related behavioural norms.

Time as a dimension within the life course moves the study of ageing away from its connotation with social problems (MacIntyre, 1977; Johnson, 1978; discussed above). The time dimension requires that the individual person is understood within the context of societal change and within an age cohort as part of historical time. The ageing individual is perceived as a whole person not just as a segment of a structural process.

2.26 The Use of Context in the Life Course

Linked with the concept of time is a concern with context in the life course. Time itself may be perceived as a context within which to view the individual, and as part of the environment in which individuals live out their life course. The individual is not seen in isolation from the wider social and physical environment. The individual is affected by this environment, and in turn, the environment is affected by the actions of a cohort of individuals moving throughout the life course at a particular moment in historical time.

Characteristic of the interpretations of development as change and transition is their contextual depth. Most interpretations discuss change as occurring on more than one level. The individual is viewed as inextricably intertwined with the influence of the environment (Bronfenbrenner, 1979, discussed above and below). Sociologists are reluctant to link the process of change to a predictable pattern which could be called development. Lerner and Busch-Rossnagel (1981) suggest that individuals produce their own development by the reciprocal relationship existing between active persons and active contexts. In much the same spirit, Bohannon (1980) discusses the life course as consisting of the rhythms of our own bodies, communities, and environments, which may accelerate or decline over time. The changing pace of the rhythms in their inter-actions with each other form the transitions of the life course.

Kurt Lewin (1936, 1948) influenced this contextual view of development. The person and the environment are interdependent areas of what Lewin called 'the life space'. To understand how such a situation came about, he proposed an analysis of the history of the individual and the environment. Lewin was criticised for ignoring the objective environment in favour of the psychological environment (Tolman, 1948), and for not appreciating fully the influence of the individual's past history (Leeper, 1943), but he succeeded in encouraging a multi-dimensional view of human development. Bronfenbrenner (1979, discussed above, below, and in Chapter Three), using Lewin's concepts (1936) and Brim's terminology (1975), presents a model of the ecological view of development, called the ecological paradigm. This is described as the configuration of the person-in-environment; each influencing the other and each an important determinant of human well-being. The environment is portrayed as existing in four inter-related dimensions:

first, the micro-system of dyadic and family relationships and social networks;

second, the meso-system of relationships between an individual and institutions, functioning as a system of microsystems;

third, the exo-system, which is the influential relationship of an individual with concrete, distant organisations with which there may be no direct contact; and

fourth, the macro-system, the over-arching cultural institutions of a society. The inter-relationships of the systems are described using an analogy of a set of nested Russian dolls.

Riegal (1975), and Baltes et al (1980) also adopted an ecological approach. Ageing is a complex series of processes, in which the individual life course is influenced by extrinsic environmental factors (physical and social), intrinsic factors related to human biology, each person's unique individuality, and by what and how the individual learns in a particular cultural setting.

2.27 The Life Course as a Theoretical Orientation

The life course perspective is not a theory. It represents a general orientation of generally accepted views which attracts contributions from many disciplines. Sugarman (1986) suggests that more synthesising frameworks for theoretical concepts need to be developed. Kohli (1986) contributes an interpretation, based on historical analysis, of the life course as a social institution of modern society, which complements the concepts of the life course discussed above. Kohli's interpretation uses historical change to explain the growing importance of individual life time, arguing that the social institution of the life course emphasises the importance of life time, or temporalisation, linked to chronologisation (chronical age). Increased longevity in a wider proportion of the population has led to predictability and uniformity in the stages of life, so that age boundaries have become important markers. Individualisation, the process through which individuals free themselves from the restrictions of status, locality and family, is important in the life course. In modern society, work has replaced the family as an organising principle. The modern organisation of work gives rise to the welfare state, which rationalises recruitment to the work force and receipt of benefits through chronological age boundaries. Increased individualisation leads to individuals controlling their own behaviour rather than being subject to external constraints. The individual plans his or her life course through individual goal setting and planning. The individual life course needs to integrate the conflicting demands of work and the family. This then supports the concept of life-long development and growth. (Kohli acknowledges that chronologisation of the life course may have halted because of diverse patterns of family life, discussed above, and of employment in the post-modern society).

In considering the interactions of individuals, environments, and historical events as a framework of development, the life course perspective asserts a dialectical model of development (Reese, 1976), assuming a continuous state of change both in the individual and in the environment. Reese (1976) considers the dialectical model as a super-ordinate model with the capacity to include many models and theories. The emphasis of life span psychology on personal development (Sugarman, 1976, discussed above) and the life course perspective on social processes (Riley, 1979, discussed above) pose a challenge for those who wish to incorporate both approaches into a study of ageing and yet remain within the boundaries of their academic discipline. The insights of both psychology and sociology are needed in pursuing the approach of the life course perspective. Each in its traditional areas of concern seems too narrow a focus for the life course.

Rosenmayr (1982) claims that the search for a sociological personality theory is growing, because developmental psychology does not account sufficiently for individual variations. Sociology, although elaborating individual variety, also does not provide a sufficient over-all structure. He urges sociologists to identify the socio-structural determinants of the life phases. Clausen (1986, discussed above) synthesises the contribution of psychology into a sociological framework for the life course perspective, when he identifies development as an essential process of the life course. Blaikie (1992) points out that gerontologists tend to ignore theory or borrow according to whatever concepts seemed suitable for a current argument. He suggests exploring the validity of combining the psychological and sociological approaches into life course development, a synthesis which could provide an analytical tool as well as a basis for intervention. This would involve linking the essential aspects of life span psychology (e.g. personal interaction) with life course analysis developed by sociologists (wider social experience). Thus Blaikie (1992) advocates stitching together ideas from social and behavioural sciences into an inter-disciplinary design for the study of ageing. Although there has not been much generation of verifable hypotheses (Silverman 1987), the life course perspective asks relevant questions, suggests certain methodology, and establishes ways to interpret findings (Abeles and Riley, 1976-77).

2.28 Summary of the Chapter on Ageing: Usefulness of the Life Course Perspective for the Study of Relationships

The life course perspective makes it easier to sift through different theoretical concepts in order to develop understanding of ageing. The life course perspective warns against taking a narrow one-sided view. Ageing has many facets and directions. Social contexts and processes, change and development are essential concepts which the life course perspective incorporates so that its vision of ageing is broad and includes different viewpoints. The importance of these concepts in the life course perspective leads to a re-examination of the way theories (discussed above) take account of these themes.

For example, when cognitive psychology (Neisser, 1982; Kramer, 1987; Labouvie-Vief, 1977, 1982, 1985; discussed above) tests cognitive abilities in real life situations with contextualised tasks rather than in laboratory conditions, more positive views of cognitive abilities in old age may result. Biological views of development (Strehler, 1977, discussed above) which regard ageing as senescence have dominated developmental psychology to the extent that few theories look beyond adolescence and show little interest in the possibility of growth and change in adult life. Jung (1969, 1982, 1989 editions), Erikson et al (1986), and Gilligan (1982), among others discussed above, help to remedy this imbalance by emphasising the on-going nature of psycho-social development in adulthood and old age. Jung (1969, 1982, 1989 editions) and Gilligan (1982) draw attention to gender differences in how adult relationships are formed, although Erikson et al (1986) avoid this issue. Erikson et al (1986) and Bowlby (1986) view attachment in old age only as a continuation of earlier attachments to parents and spouses which inevitably diminishes in old age because of

bereavement. Weiss (1975, 1978, 1979, 1982) and Kalish and Knudtson (1976), each discussed in Chapter Three, accept the possibility of other forms of adult attachment, because they also accept that change and development take place in adulthood. Theories and approaches which are strongly oriented towards historical and social contexts are so culture-specific that they rapidly become out-dated. For example, Havighurst's tasks of middle age and later years (1948, 1972), are specific to Western society at a particular historical time and therefore have limited applicability. Levinson's eras of the life span (1978) are limited to American men, and they do not take account of later re-thinking of gender roles (Gilligan, 1982). Kohli's historical analysis (1986) of the importance of chronologisation, temporalisation, work, and individualisation in the life course is based on modern industrial organisational structures rather than the changes in the post-modern society.

The life course perspective's priorities of process, time, and context can work together unwittingly to emphasise the adjustment which individuals make to society's demands at the expense of recognising individual differences. For example, age stratification (Riley et al, 1972; Neugarten and Neugarten, 1986) suggests that elderly individuals on the one hand form a recognisable social group in society, and on the other hand that there is a recognisable process of socialisation (Rosow, 1974) in which individuals learn appropriate behaviours for the status of old age. Gutmann's magical mastery (1987) also suggests a psychological process of adjustment by reframing perceptions of reality, perhaps echoing Erikson et al's pseudo-integration (1986) in which individuals omit painful experiences in their integration of experience.

The approaches to ageing as a social problem (Townsend, 1986) and as political economy (Walker, 1980, 1983) are so rooted in context that they emphasise group adjustment to poverty and discrimination in old age at the expense of noting individual differences. The social problem and political economy views of old age (MacIntyre, 1977) raise issues about the strain on relationships between elderly people and their carers. Other theories of ageing, for example, activity theory (Havighurst, 1963) and disengagement theory (Cumming and Henry, 1961) tend to generalise and ignore context rather than take note of individual circumstances. Jung (1969, 1982, 1989 editions), Maslow (1954, 1970, 1987), and Erikson et al (1986) suggest that the meaning of old age is expressed through the achievement of self-actualisation - a philosophical, self-aware, detached relationship with others which replaces attachment to a large extent. If this is so, different kinds of relationships may be sought by elderly people in residential care. Personal relationships may be less intense and social relationships more highly valued.

The over-arching nature of the life course perspective, drawing on inter-disciplinary and multi-faceted approaches, provides a tool for understanding and assessing the significance of relationships (of various kinds) of old people within particular settings of residential care. It supplies a framework which bridges the different disciplines concerned with the study of ageing. The life course perspective provides a means of linking together the research topic's components of relationships, elderly people, and residential care. It acts as an organising principle for discussions of the three separate components. This organisational principle for the research topic operates like a funnel, sifting the concepts which elaborate the questions asked at the beginning of the research.

To conclude, the life course perspective facilitates study of the personal, social, and organisational relationships within residential care, so that consumers' views, organisational features, and values of professional practice are taken into account. It stimulates consideration of historic, organisational, and practice dimensions of residential care experiences. The next Chapter expands understanding of the research topic by exploring the different aspects of relationships.

Relationships of Elderly People in Residential Care

Chapter Three

Conceptualisations of Relationships

3.1 Introduction: Outline of Chapter Format: Personal, Social, and Organisational Relationships

Chapter One established the importance of the research topic, and discussed the questions posed by the research. Chapter Two presented an overview of theories of ageing and their contributions to an understanding of relationships, and introduced the life course (Riley, 1979; Hareven, 1982; Bryman et al, 1987; Blaikie, 1992) as a unifying perspective. This Chapter draws on Chapter Two's review of ageing with regard to the implications for relationships. It considers contributions to the study of relationships from the dimension of personal relationships, which includes attachment, marriage, intimacy, family relationships, and inter-generational relationships; from the dimension of social relationships, including frameworks of social networks, support networks, social support, as well as processes and factors of life events, transitions, stress, and coping responses; and from the dimension of organisational relationships, involving the interface between individuals and organisational structures.

The study of relationships, like the gerontological study of ageing and the life course perspective (Kohli, 1986; Blaikie, 1992; discussed in Chapter Two) is inter-disciplinary (Hendrick, 1989). Psychology, sociology, and anthropology are the main contributors. The approach, language, and focus for explaining relationships differ according to the academic tradition of the particular study. Constructing a framework for the study of relationships is not easy. Conceptual complexity creates disagreement about definitions and makes it difficult to compare studies. Antonucci (1990) criticises previous research for taking too simple a view of the structure and nature of relationships, arguing that researchers work in parallel on different aspects of relationships without a unifying conceptual base, and that much research is opportunistic rather than pursuing a conceptual formulation. For example, relationships have been studied as:

social support	morale	well-being	social integration
intimacy	attachment	contacts	social circumstances
social interactions	emotional needs	sociability	emotional bonding
friendship	social exchange	transactions	emotional support
emotional care	social roles		

Many research findings are based on American studies of relationships. Streib and Binstock (1990) doubt whether conclusions derived from different social patterns and cultural expectations are transferable. Alternatively, it can be argued that a knowledge base should draw on a wide perspective, and that research on ageing in other societies is an important consideration. For pragmatic reasons concerning the availability of research studies, this discussion is based primarily on British and American studies, with some contributions from Australian research.

Two orientations underpin the conceptualisations of relationships:

1. relationships are essential components of human existence, necessary for the development of the self and for self-fulfilment;

2. relationships have a utility value in maintaining the individual within a social structure.

The self-fulfilment orientation, with its roots in developmental and social psychology, is consonant with the developmental diachronic perspectives (Bertaux, 1982, discussed in Chapter Two). The utility value orientation, consonant with synchronic perspectives (Bertaux, 1982, discussed in Chapter Two), is grounded in sociology and anthropology, as well as in social psychology. Personal relationships provide a focus for studies based on the self-fulfilment orientation, and social and organisational relationships provide a focus for studies based on the utility value orientation, but the alternative orientation cannot be excluded from each dimension of relationships. These relationship dimensions correspond to the systems of the ecological perspective (Bronfenbrenner, 1979, discussed in Chapter Two). These are illustrated in Figure 2, below, which draws on Gottlieb's adaptation of Bronfenbrenner (1981, 1985, showing correspondence with social support and social networks, but ignoring the exo-system level which relates to the dimension of organisational relationships):

FIG 2

Correspondence of the Ecological Perspective (Bronfenbrenner, 1979) with Relationship Dimensions, including Gottlieb's adaptation (1985)

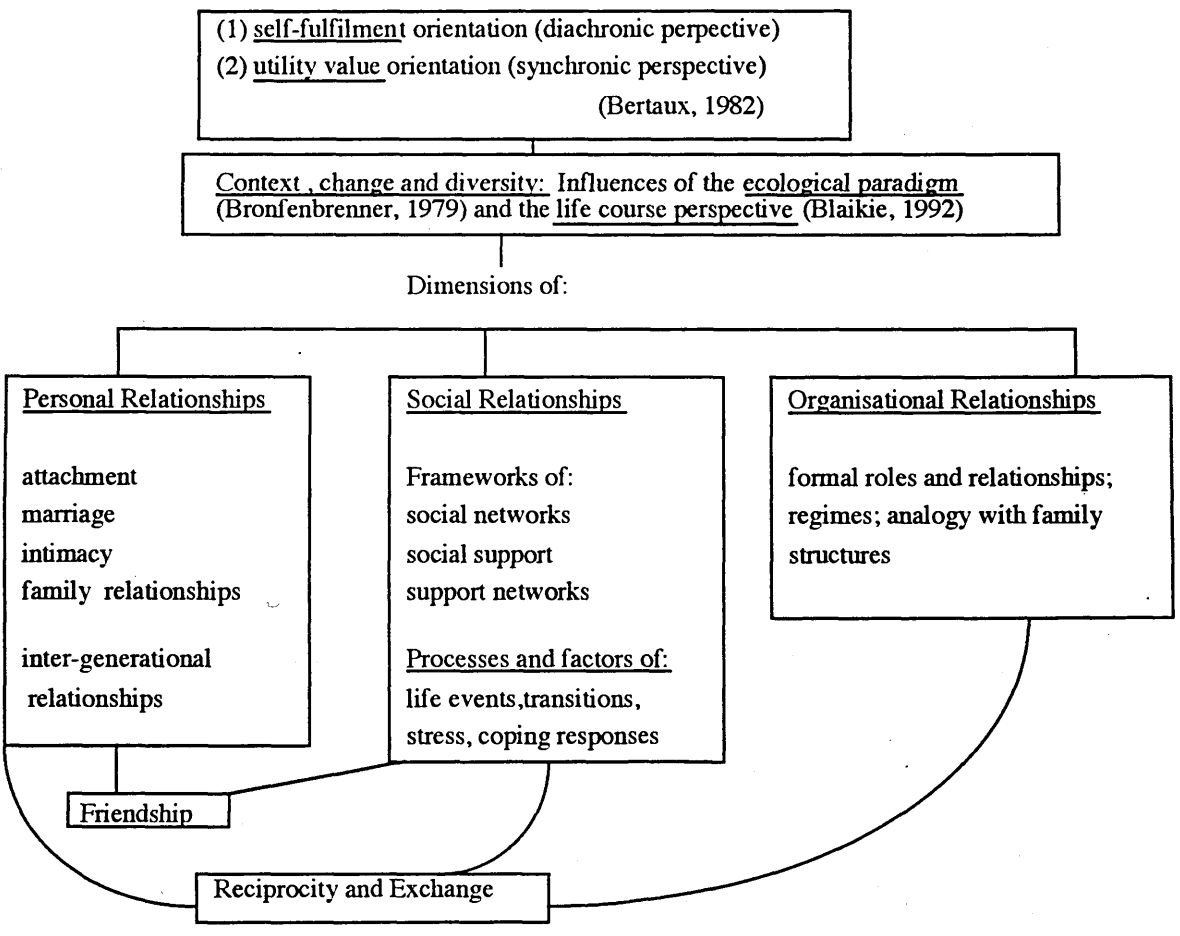
Micro-system level Dyadic and family relationships	->	Personal relationships and certain social relationships *Processes of interactions and affect;* *Resources within relationships;* *Intimacy.*
Meso-system level Relationships between individuals and institutions of society	->	Social relationships and certain organisational relationships *Concern with analysis of individuals' social worlds in networks.* *Different ways of accessing and using social support;* *Social networks.*
Exo-system level Relationship of individuals to distant organisational decisions	->	Organisational relationships
Macro-system level Individuals' relationships to cultures and influences of society	->	Personal, social, and organisational relationships. *Concern with social integration and participation in institutions, voluntary organisations;* *Informal community social life;* *Social support.*

The ecological paradigm (Bronfenbrenner, 1979, discussed in Chapters One, Two, and below) influences the discussion of personal, social, and organisational relationships because these relationships take place within different contexts, between different people.

and in changing situations. The ecological paradigm values not only close, intimate personal relationships but also social and organisational relationships. It takes into account the dynamic nature of different kinds of relationships and their interactions with different kinds of environments. These ideas resonate within the life course perspective (Kohli, 1986; Blaikie, 1992; discussed in Chapter Two) and its characteristic features of context, change, and diversity.

Throughout this overview, the relationships of elderly people are viewed as part of a continuum of relationships established during the life course (Blaikie, 1992, discussed in Chapter Two), particularly in the context of family relationships. Changes in relationships arising from ageing experiences in particular contexts will be explored within this continuum. Reciprocity and exchange are processes embedded in all three dimensions of relationships. These will be discussed in a separate section. Friendship will be discussed as a relationship bridging the dimensions of personal and social relationships. Discussion of organisational relationships will follow. Finally, some specific studies which discuss elderly people's relationships in the context of residential care will be considered. Figure 3, below, illustrates the discussion to follow.

FIG 3 Conceptualisation of Relationships



3.2 Summarising Conceptual Considerations of Relationships

Two orientations underpin the dimensions of personal, social, and organisational relationships: self-fulfilment and utility value. Conceptual complexity arises from the nature of the topic and the number of academic disciplines contributing to its study. Although some caution is indicated in applying American research findings to the British situation, common socio-economic and demographic trends facilitate the transferability of research. The ecological paradigm (Bronfenbrenner, 1979) provides a useful organising concept, as does the life course perspective (Blaikie, 1992, discussed in Chapter Two). Both take account of conceptual complexities. These concepts of relationships will be considered within the context of residential care for elderly people.

3.3 Personal Relationships

This section explores conceptualisations of personal relationships, and the issues identified by researchers from different disciplines. It considers aspects of attachment, marriage, intimacy, family relationships, and inter-generational relationships.

Bowlby (1982) comments that research on personal relationships is extremely time-consuming due to the diversity of disciplines and approaches represented. The field of relationships is a sensitive and difficult one. No single research method can shed more than a narrow beam of light onto any area, but there is a chance that the strengths of one method may balance the weaknesses of another (Bowlby, 1982). Jerrome (1990, 1993a) draws attention to methodological problems. Some psychologists stress the importance of a scientific approach to account for different forms of relationships, so that forces which shape and are shaped by personal relationships can be identified (Berschied and Peplau, 1983). Most studies are cross sectional rather than longitudinal, so that differences in satisfaction may be related to changing social *mores*, expressed across time and therefore affecting different age cohorts differently. Statistics may be based on evidence which tell little about the subjective experience of family life, and the range of difference in family patterns. Psychological research has tended to focus on individuals' responses to stimuli, and to neglect environmental factors which influence individuals' reactions. For example, research on interpersonal attraction was dominated by American social psychologists who conducted much of their research in laboratory conditions on young students, which is not particularly relevant to the relationships of elderly people. Currently there is more interest in studying processes of relationships in real-life situations than in laboratories (Duck and Pond, 1989).

Collecting data systematically (a requirement of the scientific approach) can be sabotaged by cultural taboos (Bochner, 1982; Argyle and Henderson, 1985) about revealing personal feelings. Jerrome (1990, 1993a) points to the possibility that elderly peoples' responses to researchers' questions may be based on family expectations. What actually happens, and what elderly people say outside the family, may be rather different (Booth, 1985, discussed in Chapter One and below). Marris (1982) challenges the scientific approach, arguing that attachment relationships are unique. Special relationships are irreplaceable, and give meaning to people's lives. Love and grief are incompatible with scientific mechanisms and the utility values orientation (discussed above). Marris recognises that uniqueness is a paradox for theory, suggesting that generalising relationships into needs should be resisted. Although accepting the need for classification and causality, Marris argues the unique experience of individual personal relationships.

Jerrome (1990, 1993a) provides a working definition of personal relationships as intimate relationships characterised by emotional intensity, high personal involvement, and self-disclosure. Psychologists and sociologists who study the significance of personal

relationships offer similar value-laden definitions in which personal relationships are viewed positively. For example, Berschied and Peplau (1983) argue that relationships with others are part of the core of human existence. Freedman et al (1981) suggest that a satisfying, intimate relationship is the crucial factor in determining personal happiness. Hendrick (1989) considers relationships to be the wellsprings which drive much of our human lives. Sociologists study personal relationships characterised by intimacy as primary group ties (Cooley, 1909), which are informal, personal, and negotiable, and which meet needs for support and sociability as well as intimacy (Creech and Babchuk, 1985). Society values sociability and successful relationships and stigmatises loneliness and isolation (Jerrome, 1990, 1993a).

In contrast, the relationships of elderly people are viewed negatively. Elderly people are perceived as losing social roles, economic status, relatives, and friends through retirement, illness, death, and institutionalisation. The loss of personal relationships in old age becomes a factor in the stigmatisation (Goffman, 1963) of the experience of old age.

Attachment and intimacy are the most important aspects of personal relationships. As we have seen, human development studies, including Freud (1953, 1976, 1986 editions) and Erikson et al (1986) among others discussed in Chapter Two, emphasise the importance of childhood relationships, including attachment and intimacy, for fulfilling human potential. In later life, a more objective and broadly based view of personal relationships emerges. For example, Maslow's hierarchy of needs (1954, 1970, 1987, discussed in Chapter Two) suggests that the self-actualising person is accepting of self and others, and sustains close inter-personal relations with a few carefully chosen people. Allport (1964), drawing on the work of Maslow (1954) and Erikson (1950, discussed in Chapter Two), developed six dimensions of maturity, of which two apply directly to relationships. These are: an extension of the sense of self through active participation in family, or work, or leisure interest; and a warm relating of the self to others in intimacy and compassion.

In an elaboration of Erikson (1950), Peck (1968) identifies major challenges or tasks in middle age, of which two are specifically directed towards relationships: to develop flexibility towards new people and activities, and to re-define relationships as broader and less sexual. Echoing the work of Jung (1969, 1982, 1989 editions, discussed in Chapter Two), Gutmann (1975, 1987, also discussed in Chapter Two) notes the gender differences in relationships likely to emerge as people age, with men changing from an active to a more passive approach, and women becoming more assertive. Similar findings are also reported by Neugarten (1968).

3.4 Summarising the Discussion on Personal Relationships: the Implications for Elderly Peoples' Relationships in Residential Care

So far, the discussion has explored the problem of establishing a precise definition for personal relationships, and established attachment and intimacy as key concepts in early life. Society values close personal relationships for their utility value orientation. Close personal relationships are viewed also as a source of self-fulfilment. Developmental psychology (discussed in Chapter Two) places a high value on personal relationships. Social psychologists (Berschied and Peplau, 1983) have attempted to establish a science of close relationships, but there is a growing recognition that relationships cannot be studied satisfactorily within a laboratory. The context (Bronfenbrenner, 1979, discussed above) of the environment must be considered as well. Much of the research has been biased towards young persons. In later life, intimacy is balanced by more objective personal relationships involving a wider circle of people. Gender differences in forming relationships, and how these change over time, are noted. According to the views of developmental psychologists, personal relationships in old age will be more detached and

philosophical than the close intimate attachments of childhood. Consideration of elderly peoples' relationships in residential care represents a shift of emphasis from the familiar contexts of youth and young adulthood in which relationships are usually studied, to a less familiar context which arouses negative stereotypes of ageing. These negative images (as well as the areas of bias discussed in Chapter One) may prevent the researcher from seeing the personal relationships of elderly people clearly.

3.5 Personal Relationships: Attachment across the Life Course, including the Context of Residential Care

Advocates of attachment regard it as the personal relationship, different from other close relationships which are formed during a life course. Bowlby (1969, discussed in Chapter Two) portrays attachment as a lifelong process influencing the number and quality of all interpersonal relationships, both sexual and non-sexual. The three criteria of infant attachment are:

1. association of the attachment figure with security feelings;

2. increased likelihood of attachment behaviour when threats are perceived;

3. the tendency to try to end or prevent separation by calling or crying for the attachment figure (Bowlby, 1969, 1973, 1980).

Adolescence brings the experience of loneliness, and separation distress without an object (Sullivan, 1953; Weiss, 1982). Attachment to parents is replaced by attachment to the peer group. With age, the nature of attachment changes. The issue becomes one of finding meaning and attachment within adult life (Brodzinsky, Gormly, Ambron, 1982). Cicirelli (1983b) defines attachment in adult life as the emotional bond between two people, including being identified with, in love with, and wishing to be with another person. Because the childhood attachment experience is so powerful, new relationships with peers and elders become possible only when adults have freed themselves, or re-defined their childhood attachments. Weiss (1975, 1978, 1979) argued that adults display attachment criteria in the following situations:

a well-functioning marriage;

in some cases, a not so well-functioning marriage;

in committed non-marital relationships;

in lone parent-child relationships;

in male buddy relationships;

and in single woman-sibling, parent, friend relationships

The differences between adult attachment and infant attachment are: first, that adults bond with peers of special importance, who provide support or help in mastering challenge (see also Levinson's 1978 account of the mentor relationship in males, discussed in Chapter Two); second, that adults are more resilient in their coping ability even when experiencing loss; third, adults can tolerate temporary separations better; and fourth, attachment in adults is usually directed to a sexual relationship.

Studies of attachments within adult life have focused on the family life cycle (Nock, 1979, Duvall, 1977), portraying a stereotypical, culturally specific family life style which tends to ignore the incidence of divorce, single parenthood, and the overlap of generations (Brodzinsky, Gormly, Ambron, 1982). When adults form attachments to groups, ideas, or objects, the critical factor is the degree of strong emotional involvement invested in the relationship (Kalish and Knudtson, 1976). Weiss (1982, discussed below), argues that attachment is not the only form of close relationships among adults, nor the only bond of emotional significance.

Research findings on attachment appear to have little to say about the experience of attachment in old age. One might suggest the following applications of these findings: that elderly people, especially those in residential care, will lose their primary attachment figures of parents and spouses through death, and will need to make sense of these losses. They will need to free themselves psychologically from these attachments before they are able to form any new attachments. They will need to find new relationships within residential life if they are to form any attachments. The most likely targets of attachment for elderly people in residential care will be other residents, staff members, or a close relative who remains in touch, such as a sibling or adult child. A resident, relative, or staff member who acts as a mentor may become an attachment figure. Attachment will be influenced by the cultural influences arising from their life course experiences (Blaikie, 1992). Opportunities for sexual relationships may be limited because of institutional regulations and ill health. The gender imbalance may result in a lack of possible partners for women who predominate due to their greater longevity (Phillipson, 1982). Attachment may be possible in other forms, as Weiss (1982) suggests. Just as adolescents become attached to a peer group, adults in residential care may become attached to the group of residents, to the home itself, or to an idea or activity. Signs of attachment may be revealed by the amount of emotional intensity invested in the relationships and activities. Attachment activity which people show towards elderly people includes residential proximity, frequent visits, writing letters, and giving care (Cicirelli, 1983b). The same activity may be true of the attachment behaviours of elderly people to others.

3.6 Personal Relationships: Marriage across the Life Course

Most elderly people in residential care look back in reminiscence to their experience of marriage. Marital relationships in late adulthood have been presented sometimes as pessimistic, loveless, and unexciting relationships, but, more often than not, they are reported as good (Stinnett, Carter, and Montgomery, 1972). Nowadays most married couples can expect to live together on their own without dependent children for many years. Freedom from child-rearing and employment gives couples more time for each other (Adams, 1975). Older married people are less likely than older single people to feel depressed or develop mental illnesses. Married couples live longer, stay healthier, and feel better (Hess and Soldo, 1985). Older married couples are likely to rate emotional security as the most valued aspect of their relationship (Reedy, Birren, and Schaie, 1981).

Ade-Ridder and Brubaker (1983) show that there are distinct periods of greater and lesser satisfaction with the marital relationship. Three main patterns occur:

first, satisfaction increases in the later stages after child-rearing but never reaches the level of the pre-children stage;

second, there is a gradual decline in satisfaction;

third, satisfaction remains unchanged after retirement.

Adopting flexible rather than rigid family roles helps prepare for the marital transitions and crises likely to be encountered in old age. Failing mental and physical health of one or more of the partners affects the quality of marital relationships. Spouses care for each other when one of them experiences physical decline, and are just as much 'carers' (discussed below) as the younger generation within the family. The experience of many elderly people prior to entering residential care is one of caring for a spouse, or being cared for by a close relative, until a crisis of ill health or death occurs which disrupts the caring relationship and leads to admission to care. Most residents have been widowed and some need still to resolve their feelings of bereavement.

3.7 Personal Relationships: Intimacy across the Life Course

Intimacy may be lacking for elderly people, due in part to gradual losses of both personal and social relationships through death and role change, and to negative socialisation. As noted by Booth (1985) and Jerrome (1990, 1993a, b), this is a difficult area to research as people are reluctant to discuss such a sensitive matter. In residential care, one might expect to find barriers to sexual intimacy caused by institutional regimes, cultural taboos, bereavement reactions, and lack of privacy.

Lowenthal and Haven (1968) argue that having the experience of one intimate relationship is more closely linked with high morale than high levels of general social interaction. Intimate relationships in old age, as well as meeting dependency needs (the utility value orientation), also satisfy needs for personal support, aid, sociability, self-worth and stimulation (the self-fulfilment orientation). Personal support is largely supplied by close kin. Sociability and stimulation are met largely by a peer group, but a sexual partner is the primary source of intimacy (Jerrome, 1990, 1993a, b). Sexuality is a part of intimacy which is often viewed as a problem for elderly people. Society's negative view of sexuality in older people (Belsky, 1984; Dailey, 1981) may create problems where none might exist if there were different social perceptions of the implications of old age. The youth culture surrounding sexual activity acts as a negative incentive for the expression of elderly peoples' sexuality. Social attitudes influence the actual level of sexual activity in old age (Hendricks and Hendricks, 1977). Sviland (1975) argues that adult children and institutions exert negative influences on expressions of older persons' sexuality, ignoring the problems of frustration, depression, and loneliness which result. Sexual intercourse does not necessarily cease in old age. Again, this depends on earlier patterns and the quality of the relationship.

Not all elderly people are married. Some have never been married. Relatively little is known about lesbian relationships in older women because of cultural inhibitions of perceived danger in openly acknowledging this kind of intimate relationships. Jerrome (1993b) provides an over-view of lesbianism in old age, asserting that most older lesbians are in couple relationships and are sustained by friendships. An increasing number of elderly people are divorced, and many are widowed. Gubrium (1975) finds that single elderly people are not particularly lonely, but it is not clear whether this is because they are natural isolates or because they make use of other emotional resources (Shanas et al, 1968). Single elderly persons often are closest to their siblings. In a study of single, never-married working class elderly women and their widowed counterparts in the USA, Allen (1989) found that despite stereotypical views about the relationships of the 'old maid', single women's lives were intertwined with their families, and they assumed a myriad of caretaking roles, chiefly of their parents, but often of siblings. In later life, they enjoyed close relationships with their nieces and nephews.

Concern with intimacy leads to a consideration of its opposite, the loss of close personal relationships. Widowhood is an example of such loss, acknowledged as the greatest

emotional and social loss (Parkes, 1970) causing depression and low morale (Atchley, 1975; Shanas et al, 1968). Morgan (1976) challenges this view of the normal reaction to widowhood, arguing that changes in life style, reduced income, and status trigger depression, rather than the fact of being widowed itself. Increasing numbers of elderly people in Britain are widows, including two thirds of women over 80. Nearly all widows never remarry. Most women reach the end of their lives as widows. Men usually remain married until they die unless the marriage ends in divorce, since women outlive men, and men usually marry younger women. Men generally experience more distress than women when they are widowed, gaining less social support and having more difficulty in managing their roles (Stroebe and Stroebe, 1983). Lopata (1979) suggests that widows have three options: to continue their old life style, to develop new friends, or to become isolates. Lopata's study indicated that most widows felt the pain of loss and bereavement, the degree of which depended on the quality of the previous relationship with the dead spouse, but most did not plan to remarry. However, the re-marriage rate is slowly increasing for older people because of their rising longevity, and growing acceptability of sexuality in later years. Dono et al (1979) suggest that when relationships are lost, as in the death of a spouse, a system of functional interchangeability operates within primary groups, with same-sex friendships and kin networks replacing the lost intimate relationships. Hochschild (1973), Litwak and Szelenyi (1969), and Dono et al (1979) indicate that primary group ties are not interchangeable for meeting personal needs for intimacy. Relationships are task-specific, which may explain the increase in remarriage and intimate relationships in old age.

In the proposed research, it might be possible to explore whether there are differences in the relationships formed in residential care by those who have been widowed and those formed by never married residents. Widowed elderly people in residential care may seek out others to replace the lost partner in a sexual relationship or a close friendship, or become isolates. The never-married residents may seek similar kinds of friendship relationships or try to continue their relationships with surviving siblings outside the home.

3.8 The Change in Personal Relationships within the Family

Personal relationships have been considered so far mainly as part of the self-fulfilment orientation within attachment relationships, marriage, and intimacy. Most close personal relationships are located within the family. When considering personal relationships within the family, the utility value orientation of relationships becomes more evident. The family provides care and socialises its members. The majority (97%) of elderly people say they have a close relative (Wenger, 1984). This indicates the high value placed on family relationships by elderly people. Nevertheless, a substantial minority of elderly people lack close family relationships. 30% of elderly people who are 75 years +, and 7.5% of those who are 65 years+ had outlived their children (Abrams, 1980 b). 1.6 % of elderly men and 2.2 % of elderly women in 1981 (expected to rise to 3.6 % and 7.2% respectively by 2019) are divorced (Henwood and Wicks, 1985). 8 % of men and 11.2 % of women 65 years+ have never married (Jerrome, 1990, 1993a). 5% of people of retirement age have no relatives or have lost contact with their relatives (Hunt, 1978).

The family is of strong ideological interest to economists and politicians in the UK and the USA. They fear that the demise of the family as an institution signals the break-up of society, and will result in excessive demands on state welfare systems to care for its dependent members, including the growing numbers of elderly people (Qureshi and Walker, 1987; Fennell et al, 1987). Feminists (Dex, 1985) argue that tasks which have fallen largely to female family members limit the potential of women. The pre-industrial family unit has been portrayed idealistically as an extended family offering care and support to its members within a close network of relationships. Modernist theory (Cowgill, 1972;

Cowgill, 1974) saw this pattern of family life being destroyed by industrialisation, and the extended family replaced by the highly mobile nuclear family centred on the employment of the male, and specialised roles within the family. More recently Nussbaum, Thompson and Robinson (1989) among others queried the extent of the historical existence of the extended family, and described it as a myth.

Jerrome (1990, 1993a) argues that British family structure has changed with regard to the following factors: demography, with falling fertility and mortality; technology, with more women in the work force and more aids for the domestic household; legal constraints, with divorce, abortion, and birth control more easily obtainable; ideology, with more emphasis on personal choice, egalitarianism, and shared family roles and the provision of community care; and economic opportunities, with more affluence and state welfare provision increasing choices. Social policies which affect family relationships tend to reflect one or other ideological view about the extent to which the family's caretaking role should be supplemented or supplanted by state welfare intervention. Under Care in the Community legislation, the caretaking role is viewed as a partnership between the family and the state.

3.9 Inter-Generational Personal Relationships

Inter-generational personal relationships are important to elderly people. Jerrome (1990, 1993a) provides a useful over-view of the literature. She is critical of the cross-sectional nature of much of the research, which ignores historical dimensions of family relationships. Most studies focus on one aspect of family life at a particular point in time, and neglect changes which take place over time. Wenger's research (discussed below) is an exception to this trend. The principle areas of concern with regard to inter-generational relationships are the changes in family structures, changing roles of family members, the resulting effects on family care of elderly people, and the extent of conflict between younger and older generations. Each of these concerns will be discussed.

The structure of the ageing family is a complex system comprised of interdependent relationships. Because of increased longevity, men and women can form 'crescive' bonds - family bonds which are forged by accumulated shared experience over time (Turner, 1970). For example, Watkins et al (1987), in a study of US census statistics, showed that women live more years of their lives in a relationship with an over-65 parent than with their own children under 18. It is now not unusual to be part of a four-generation family, but with fewer members in each generation (Hagestad, 1986; Shanas, 1980) - the tall and lean beanpole family structure (Bengtson, Rosenthal, and Burton, 1990), which is also called verticalisation (Hagestad, 1986; Knipscheer, 1988).

Grandparenthood is a family relationship which has become more significant as longevity has increased (Hagestad, 1988). Most grandparents now have the opportunity to relate to adult grandchildren (Cherlin and Furstenberg, 1985). Many people experience a renewal of close family emotional ties when they become grandparents. Jerrome (1990, 1993a) argues that grandparenthood in British and American society tends to be characterised by emphasis on independence, choice, structural separation from adult children, and a lack of clarity about explicit rights and expectations between generations. It is important to note cultural differences. In Asian culture in Britain, there may be more positive acceptance by Asian elders of dependence on adult children (Jerrome, 1993b). Afro-Caribbean elders may assume a more formally organised grandparenting role. Bengtson et al (1976), based on research in California, suggest that grandparenthood is a relationship which provides continuity, stability, and an interpretation of the past. Kornhaber (1985) suggests the opposite, that American grandparents are not interested in ties with their grandchildren. This is detrimental to the development of the grandchildren, who then adopt stereotypical negative views of ageing. Neugarten (1964) noted five classic styles of interaction in the

relationship. These are: the formal, in which the parenting role is left to the parents; the surrogate parent, who assumes much of the parenting; the funseeker, who seeks to gain enjoyment from the relationship; the reservoir of family wisdom, who takes on an authoritarian, teaching role, and the distant figure, who is little involved. In effect, grandparenting may involve a shift from one to another of these styles according to the particular relationships and situations encountered.

A significant minority of elderly people has no children. Childlessness may be chosen or involuntary, with a resulting importance given to spouse, extended family, or fictive kin relationships in place of the missing parent-child relationships (Parke, 1988). Childless elderly people are most likely to have contact with siblings, nieces, nephews and cousins. In a survey of a thousand elderly people, Singh and Williams (1982) found that the 20% who were childless were much less satisfied with their family life. Beckman and Houser (1982) also found that childless widows had lower levels of well-being.

As well as the traditional paternalistic family structure, more matrilineal inter-generational structures may develop as the numbers of births to unmarried women rise (Burton, 1990). The rising incidence of divorce and re-marriage increases the importance of the roles of step-parent and step-grandparent, with implications for the inter-generational relationships of elderly people (Aldous, 1987; Hagestad, 1986). It remains to be seen whether family ties in old age will remain the same when increased numbers of those who are currently experiencing changing, diverse family structures (divorce, single parenthood) reach old age. The cohort effect (Riley, 1976, discussed in Chapter Two) within different age strata may well result in changed expectations and behaviour when the present middle-aged cohort reaches old age. Age-condensed inter-generational patterns, typified by teen-aged pregnancies (Burton, 1985), with a blurring of caregiving roles between mother and grandmother; and age-gapped inter-generational patterns, typified by delayed childbearing, may result in a simultaneous strain of double responsibility for aged parents and dependent young children (Rossi, 1985). Crises which threaten family relationships include independence of adult children, retirement, illness, death, and divorce. These crises could affect the relationships expected in old age. Where elderly people have formed crescive bonds across generations, they may be less likely to enter residential care. Elderly people whose family life has been disrupted in earlier years may be more likely to become residents.

The changing nature of adult-child relationships as children themselves reach adulthood has created research interest (discussed above), often because of the concern that adult children will no longer care for the 'burden' of aged parents (MacIntyre, 1977; Cowgill, 1984; Coleman and Bond, 1990, 1993; discussed in Chapter Two), and that family life is collapsing. The utility value orientation underpins this concern. Rosow (1974) suggests that roles and responsibilities for kin will be rather vague and undefined in a diverse society which has different religions and ethical codes rather than a commonly agreed moral code for all. The result may be discrepancies in expectations of reciprocal giving and receiving of care and support in old age (Gouldner, 1960; Cairns, 1979; Kelley, 1983; discussed below).

Alpert and Richardson (1980) suggest that parenting is a five stage process. In the final parent-adult child stage, contrary to popular myth and certain research (Bart, 1970), parents relinquish their responsibility for dependent children with relief (Lowenthal and Chiriboga, 1973). At this stage, the responsibility for aged parents becomes more pressing. Optimistic views of family life emerged from some research, asserting that families still care for their dependent elderly relatives (Hagestad, 1988; Shanas, 1979). In general, adult children (usually the daughter) do provide help (Cicirelli, 1983b; Fisher, 1982; Litwak,

1985; Shanas, 1979). The mother-daughter dyad is the most significant relationship (Cicirelli, 1983b; Shanas, 1979).

Old people may also wish to be independent of their adult children (Atchley, 1976). The present generation of middle-aged adults may be the first cohort who feel themselves relatively free of having to provide the basic maintenance of food and shelter to their aged parents (Hess and Markson, 1980). Troll, Miller, and Atchley, (1979) find that old people are not abandoned by their adult children, but that they prefer to live on their own within reach of the children. Older people tend to live independently, but to become more involved with their families than with other activities (Sussman and Burchinal, 1962). Relationships between generations are marked by continuous feedback and mutual moral influence (Bengtson and Troll, 1978; Riley and Foner, 1968; Cicirelli, 1983 a, b). Reciprocity as a key concept in inter-generational relationships has become important throughout the 1980s (Jerrome, 1993b). Even when family members live apart, the influence of family structures remains strong (Nussbaum, Thompson, and Robinson, 1989). Contact with adult children is found to be important and beneficial to many older people (Alpert and Richardson, 1980).

When illness or other crises occur, elderly people turn to their adult children for help. More than 70% of older people in Britain see a relative at least once a week. Those with adult children tend to see them regularly. More than half of very old people are in daily contact with a relative. This pattern is replicated in both rural and urban areas, although people who move away from their local area on retirement tend to have less contact. Most elderly people are satisfied with their contact with adult children, and about a quarter say they would like more contact with grandchildren. Over two thirds of elderly people with children live within a few miles of at least one adult child. This proximity increases with illness and widowhood (Warnes et al, 1985). The frequency of contact drops between the ages of 65 to 86, after which it increases. When parents are between 65 and 70 years, the adult children leave home or are occupied with their own families, and the very aged parents (grandparents) die, so this is the period of sharpest decline in contact between generations (Jerrome, 1990, 1993a).

Mutual aid tends to be the pattern until the increased dependence of the elderly family members creates an imbalance in demand. The most significant role undertaken by a family member is as a carer, or 'tending' (Parker, 1981, discussed in Chapter Four), providing physical care for disabilities, as well as assisting with household tasks. This role usually is undertaken by a daughter for a mother. More elderly women than men need care, owing to demographic patterns of mortality (Tinker, 1992). When no daughter is available, a son might be called upon before outside carers are approached. Daughters also care for their male relatives. Substantial spouse-to-spouse tending takes place (Wenger, 1984, 1986, 1992). Increased longevity may result in a female family member, herself over retirement age, providing care for very frail old parents. Middle-aged adults form the link between young and old family members, but the relationship between middle-aged children and aged parents undergoes a power shift (echoing the argument of exchange theory, Dowd, 1975, discussed in Chapter Two) as parents become more physically dependent (Hess and Waring, 1978). It is in these kinds of situations that elderly people may enter residential care, not because the younger generation is less caring in intention, but because of the excess strain on the carers who are themselves growing older. As elderly parents need more support, conflict can affect the parent-child relationship (Brody, 1985; Cicirelli, 1983a). Sometimes the caring relationship can be harmful, and actual abuse of the elderly people can take place (Eastman, 1984). The amount and kinds of help given are affected by proximity, attachment, economic status, other caring obligations towards the primary family, and the health of the caregiver.

During elderly people's life courses, social change has resulted in increased educational and leisure opportunities and patterns of consumption, growing media influence, decline of organised religion, and shifting international political roles, together with a general growth in prosperity. Technological improvements benefit domestic households by reducing the time and effort needed to run a household, so that individuals have more choices, but also, as discussed above, agreement on values may be less likely within the family. The role of women has changed. More women plan the size of their families and continue to work following marriage and children. Increasing numbers of lone parents (usually women) are responsible for bringing up children. British society is now multi-racial, multi-ethnic, and more European in culture. Although these factors may lead to inter-generational conflicts and feelings of uneasiness in elderly people about the rate of change, people who are old in the 1990s lived through the social upheavals of the 1930s Depression and World War II in the 1940s. They were in the vanguard of a changing society. For example, many married women now in their 70s and 80s returned to work during World War II. Many travelled abroad for holidays. Their lives were different from those of their mothers, illustrating the age cohort effect of age strata (Riley et al, 1972, discussed above and in Chapter Two). The generation gap caused by lack of agreement about social values may be an expression of a power shift, a disguised envy, and a waning sphere of influence of the older generation on the younger generation, rather than disagreement about specific issues (Jerrome, 1990, 1993a).

3.10 Summary of the Discussion of Attachment, Marriage, Intimacy, Family and Inter-generational Personal Relationships: Their Significance to the Relationships of Elderly People in Residential Care

Changed structures, contexts, and diversity need to be taken into account in studying personal relationships. The cross-sectional nature of much of the research ignores historical contexts and how changes may occur over time. Attachment in adulthood is generally linked to a sexual relationship, but it is possible to form attachments to a close friend or relative of the same gender. Marital relationships in later life undergo changes but generally are reported as satisfactory. The potential of grandparenthood as a close personal relationship has not been researched extensively. Opportunities for sexual intimacy in old age may be limited because of the death of spouses, gender imbalance, ageist attitudes (Townsend, 1986), and discouragement by institutions and adult children. Loss of close personal relationships, and the resulting emotional impact, is a common feature of old age. This loss will have been experienced by elderly people in residential care, most of whom are widowed or never married.

Unlike studies of attachment and intimacy which are based on the self-fulfilment orientation, studies of family relationships are based on the utility value orientation. The utility value orientation arises from the fear that families will no longer accept responsibility for their dependent members, including the increasing numbers of very old people. Research has sought to disprove this fear. Family structures are changing, along with changing social and economic roles. Most elderly people live alone by preference but are in contact with their adult children. The increased longevity of elderly people may have created more strain on the adult children or spouses who become carers. Elderly people needing care are most typically women who have been widowed. Much of the research is reassuring about family bonds, but the bonds of elderly people in residential care may be disrupted. Residents may be geographically distant from relatives, or have no relatives left. Alternatively, family bonds may be strong, but the carers in the family might have experienced ill health and stress resulting in admission to care.

3.11 Social Relationships: Definitions, Importance, and Concepts

In the next part of the Chapter, social relationships are explored. The discussion considers research which argues for the importance of social relationships. The discussion uses three different conceptual frameworks: social networks, support networks, and social support. Processes and factors associated with the frameworks, including life events, transitions, stress, and coping responses, also are included in the discussion.

Edwards and Klemmack (1973), Graney (1975), Okun et al (1984), and Tate (1982) indicate that a high level of social relationships is associated with greater well-being. The utility value orientation is emphasised in the study of social relationships, although the self-fulfilment orientation is important too. Cassel (1974) researched the increased prevalence of strokes in groups of people who lack social support (a form of social relationship), and argued that social support acts as a 'buffer' or cushioning agent against health-destroying stress. Loss of relationships is central to the research on stress and life events by Holmes and Rahe (1967) and Paykel, Prusoff, and Ulenhuth (1971). All the events listed in their life events typologies are actual or threatened losses of social relationships (Henderson, 1983).

Some research is more cautious. Although links are found between well-being and social relationships, an over-all connection between the two factors is doubted by Conner et al (1979), Lemon et al (1972), and Strain and Chappell (1982). Wellman and Hall (1986) argue that if questions about support (the utility value orientation) are the only questions asked, then data about the full range of relationships, some of which may be non-supportive or neutral (the self-fulfilment orientation), may not be obtained. Social support focuses on relationships which confirm identity and self-worth and tends to ignore family relationships which can be destructive (Gibson and Mugford, 1986). Henderson et al's study (1980) concludes that lack of social relationships contributes to the onset of neurosis, but a person's belief that his or her relationships are adequate is more important than their actual availability. When a person perceives a lack of support and then is faced with environmental adversity, the risk of neurosis is increased.

The discussion in Chapter Two on the life course perspective (Kohli, 1986; Blaikie, 1992) argued that relationships and social environments are interlinked, and influence each other, as well as being influenced by environmental contexts. The ecological paradigm (Bronfenbrenner, 1979, discussed above and in Chapter Two), makes the same point. Interactions between people are important because they form the basis of social relationships. They comprise ways in which people respond to social cues and produce environmental events. Influences extend from the individual to society, when many relationships of a certain sort occur, and their effects on the people involved and on the environment are consonant with each other. Certain relationships may provide building blocks for social organisations, for example, when family groups and individuals meet together to form a religious congregation, which in turn exerts influence on the members (Kelley, 1983).

Concepts used in the study of social relationships, as in the study of personal relationships (discussed above) are value-laden. Most imply that social relationships are synonymous with social support, and fail to take account of more negative aspects of relationships. Gottlieb's discussion (1981) of social support and social networks provides an analytical template which adapts the ecological paradigm (Bronfenbrenner, 1979, discussed in Chapter Two and above) of three levels, (micro, meso, and macro) of the environment (but leaving out the exo-level) into which various social support constructs can be placed. This corresponds to the dimensions of personal, social, and organisational relationships, discussed earlier in this Chapter and in Chapter One. This template, illustrated in Fig. 2,

above, suggests a greater complexity of levels and contexts in social relationships than in personal relationships.

Aspects of social relationships are not entirely interchangeable with each other. For example, Moos and Mitchell (1982) argue that there are three components of the concept of social support:

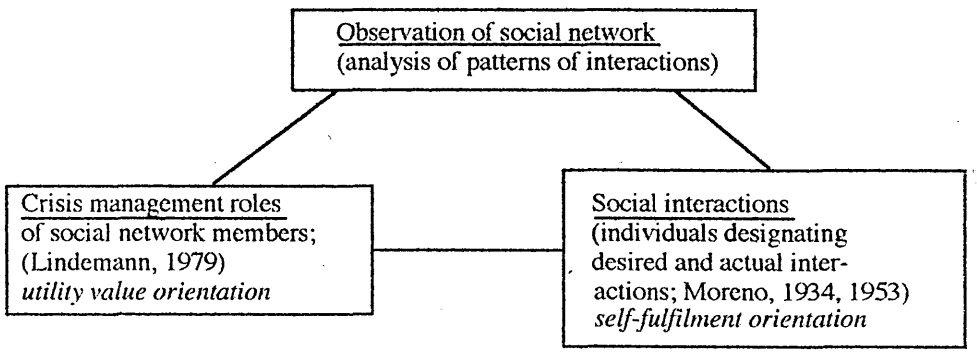
1. a social network analysis of patterns of interactions;

2. crisis management roles of members of social networks, based on crisis theory (Lindemann, 1979);

3. social interactions, portrayed through Moreno's sociometric analysis (1934, 1953) in which individuals were asked to plot their desired and actual social interactions.

The three components are illustrated below:

FIG 4 Social Support Components (Moos and Mitchell, 1982)



The term 'social support' is used generically, placing social networks, social interaction, crisis management, and transition within its boundaries. One of the components, crisis management, noted above, is consonant with the utility value orientation, and one, desired social interactions, with the self-fulfilment orientation.

Others consider social support as a function of social networks, by outlining the provisions of social relationships within the networks. For example, Weiss (1973, 1974) proposes six provisions of social relationships which are supplied by others:

1. attachment, provided by relationships which give a sense of security, place and emotional comfort. Individuals experience loneliness, listlessness, and distress when loss of them occurs.

2. social integration, based on relationships involving shared concerns which provide companionship, and social activities. They include the development of networks with common concerns, and pooled information, ideas, and shared interpretations of experiences.

3. opportunity for nurturing others, which is the satisfaction adults get from being responsible for a child or other person. This provides motivation to persevere through adverse times.

4. reassurance of worth, which promotes self-esteem, competence in social roles, and the development of social roles with colleagues and family.

5. a sense of reliable alliance, which stems mainly from relatives. The decreased level of contact with relatives in modern life may lead to this being in short supply (unless substitutes are found).

6. obtaining of guidance, which is important when individuals face adversity. Individuals need access to someone trustworthy and authoritative, who gives emotional support as well as the chance to develop plans to overcome adversity.

Weiss' provisions (1974) overlap with some of the aspects of attachment and nurturing in personal relationships. They are useful particularly for considering relationships of elderly people in residential care, because of their applicability to old age and to the context of residential care. Other similar contributions include those of Henderson, Duncan-Jones, Byrne, and Scott (1980) and Thoits (1982). All of these inventories or provisions take account of both the self-fulfilment orientation and the utility value orientation. Henderson (1983) suggests a typology based on the commodities provided by relationships, rather than on the persons who are the sources of the relationships. He bridges the categories of personal and social relationships when he argues that social relationships may serve as a vehicle for a range of commodities which are usually specific to a particular relationship: intimacy gives an opportunity to express painful feelings in a close relationship; friendships and work-based relationships provide confirmation of socially appropriate behaviour or endorsement of personal worth; the social environment acts as a source of psychological supplies necessary to find the inner resources for coping.

3.12 Summarising the Point Reached in Discussion of Social Relationships

Social relationships are studied in a number of different ways, influenced both by the utility value orientation of relationships and the self-fulfilment orientation. Issues of complexity create difficulties in researching the topic. The link between social relationships and health is a frequent utility values theme. Social relationships are comprised of six provisions (Weiss, 1973, 1974): attachment, social integration, nurturing opportunity, reassurance of worth, a sense of reliable assistance, and obtaining of guidance. Some of the provisions overlap with important aspects of personal relationships. The influence of the ecological paradigm (Bronfenbrenner, 1979; Gottlieb, 1981, 1985) is evident in the frameworks of social relationships - social networks, support networks, and social support - and in their processes and factors, which include crisis, transitions, life events, stress and coping responses. The next sections discuss these frameworks and processes.

3.13 Social Networks: Definitions and Classifications

This section begins with different yet similar definitions of social networks as aspects of social relationships. A social network is a group of persons with whom a person is involved. Relationships are the significant structural interactions which hold a network together and give meaning to it. Any disrupted relationship within a network reveals the loss of practical help and emotional help (Duck, 1986, 1991). A social network is a set of people with whom one maintains contact and has some form of social bonds (Adams, 1967); a social connection (Wellman, 1981); and social ties (Berkman and Syme, 1979).

Homans (1958, 1974) defines formal or structural components of networks (the interactions or amount and type of contacts) more explicitly. Ward (1985), for example, lists family, friends, neighbours, and professionals as the components of networks. Some of these network characteristics are morphological, based on the number of people in the

network and their dominant characteristics. Others are interactional (Heller and Swindle, 1983).

Analysts argue the utility value of different types of networks. For example, Boissevain (1972) claims that multi-plexity, the diversity of links within a network, provides support in a greater range rather than a greater intensity. Kahana (1982) argues that the greater the extent of a person's network of interpersonal activities and participation in organisational activities, the greater the degree of social support obtained from it. Hobfoil and Stokes (1988) call this the model of conservation of resources, as the wider the pool of resources, the more the existing resources will be reinforced. Granovetter (1973) argues the effectiveness of large, diffuse networks for seeking information. Stokes (1983) argues the effectiveness of small and dense networks for maintaining identity in times of stress.

Different structural classifications unravel and make sense of social networks. These classifications emphasise slightly different aspects. Moos and Mitchell (1982, in Fig 5 below) take a more dynamic, processual stance than Marsella and Snyder (1981, in Fig 5 below) by considering the individual's contribution to the network. Both share characteristics. Also contributing to the understanding of social networks is Schlossberg's identification (1981) of personal resources. These classifications are set out in Figure 5, below, which shows their correspondence to each other and to the dimensions of personal, social, and organisational relationships.

FIG 5 Social Network Classifications

	Influences on Social Network Resources (Moos and Mitchell, 1982)	Dimensions of Social Networks (Marsella and Snyder, 1981)
Personal and Social Relationships	*personal factors (age, class, gender; role, life stage, health, values, racial and ethnic identity, previous experience, etc.; Schlossberg, 1981)*	*interaction (relationships between people, reciprocity, intensity, and frequency of contact)* *quality (degree of friendliness and affection)*
Social Relationships	*coping responses (interaction of personal skills and emotional responses)*	*function (including purpose)*
Organisational Relationships	*environmental factors (geography, social expectations)* *life events (schedules of random markers and transitions shaped by cultural mores)*	*structure (including size, density, connectedness, stability)*

Sugarman (1986) suggests that the function of social networks is to provide relationships of a particular quality or emotional intensity - a function consonant with the self-fulfilment orientation (discussed above). Moos and Mitchell (1982) argue that the function of social networks is social regulation or control to ensure that individual behaviour remains within the bounds of social acceptability, according to class, ethnic, racial, and age stratified expectations. This view is consonant with the utility value orientation of social relationships (discussed above).

Croog (1970), Minuchin (1974), and Rook (1984) argue that social networks have negative as well as positive effects when, for example, a sense of security turns to a sense of being trapped. One must distinguish between the function of social integration which is belonging, and social interaction which establishes social identity and roles (Antonucci and Depner, 1982). Each does not necessarily relate to the other. If a person is a member of a social network, support is not automatically available or obtained. The quality of the interaction, and the exchange of feelings are important factors in determining support. The term social integration has a subjective meaning (Liang, Dvorkin, Kahana, and Mazian, 1980). Measuring only the frequency of social interaction is not a good indicator of the quality of relationships. Measuring does not take into account mediating factors (Lemon, Bengtson, Peterson, 1972) of, for example, the amount of choice which determines interactions and involvement, and personal preferences for withdrawing from involvement (Kahana, 1982; Lowenthal and Boler, 1975). Again, these distinctions relate to the difference between the utility value orientation and the self-fulfilment orientation of social relationships.

Explorations of social networks have been used to show a positive link between networks and health and well-being (Wenger, 1984; Hall and Wellman, 1985). Because most people form networks with their peers, elderly people experience a contraction of their networks when their contemporaries die (Kendig, 1986).

3.14 A Summary of the Discussion of Social Networks: The Implication for Elderly People in Residential Care

Social networks may or may not provide social support, depending on the different influences arising from within the person and from the environment. Networks provide both utility value and self-fulfilment orientations for individuals. Personal, social, and organisational relationships are essential for the maintenance of the network. Elderly people's networks are likely to contract due to deaths of contemporaries, with a corresponding decrease in the self-fulfilment orientation of networks. Consequently elderly people's networks may be regarded by professionals simply as vehicles for the provision of social support (the utility value orientation) rather than providing self-fulfilling relationships. Elderly people in residential care will probably experience contracted, changing networks because of their institutional isolation. Networks based on institutional regimes may be regarded as supplying a utility value only.

3.15 Social Support

Social support is an important concept of social relationships, referring to the help a social network provides, or is assumed to provide, to an individual within the network. Wood and Robertson (1978) argue that good relationships with family and friends, as part of social support, heighten feelings of life satisfaction for elderly people (the self-fulfilment orientation of relationships). Psychological personality characteristics, such as self-esteem, mastery, and internal locus of control are associated with positive social support (Pearlin and Schooler, 1978). Other advocates of the social support concept (Cassel, 1974; Cobb, 1976; Caplan, 1974) take a broader, ecological paradigm view (Bronfenbrenner, 1979, discussed above) of the individual inter-acting with environmental factors, and being both influenced by, and influencing the environment. Hobfoil (1985) states that support must be considered in the context of its ecological congruence, or how it matches what is needed at a particular time and circumstance. Therefore the needs for social support must always be considered within the context of the environment before it can be offered. For example, factors which limit the availability of aid from sources of social support include:

situational factors, including event characteristics, expectations of socially acceptable reactions, stressful transition periods, multiple events and effects, and groups which affect individuals negatively;

limiting personality factors such as lack of diplomacy, and particular social roles; and

stigmatised events, such as negative interactions of individuals and events (Hobfoil and Stokes, 1988).

Different, yet similar definitions of social support abound. Social support is defined as:

(a) information leading the person to believe that he or she is cared for, esteemed, or valued, and belongs to a network of communication and mutual obligation (Cobb, 1976, emphasising the self-fulfilment orientation); (b) social interactions or relationships that provide individuals with actual assistance or which embed individuals in a social system believed to provide love, caring, or a sense of attachment to a valued social group or dyad (Hobfoil and Stokes, 1988, emphasising the utility value orientation); (c) both the number and quality of interpersonal relationships and the specific interactional events required for them to be supportive (Rook and Peplau, 1982); (d) emotionally sustaining behaviour, problem solving behaviour, indirect personal influence (the belief that someone would help); and environmental action (Gottlieb, 1978); (e) both a property of a person, and a property of personal relationships; both felt and actual support; positive belief about the availability of support (Gottlieb, 1985); and (f) not just what actually happens but also confidence, trust, and belief that support will be offered (Henderson et al, 1980, discussed above).

The most apt definition is offered by Kahn and Antonucci (1981), who define social support as interpersonal transactions that include one or more of the following key elements: aid, affect, and affirmation. These key elements characterise the essence of the two orientations of self-fulfilment (affect) and utility value (aid) found in personal, social, and organisational relationships. Affirmation accords with the self-fulfilment orientation but also the utility value orientation because it enhances the individual's role in society. Cobb and Jones (1984), Broverman et al, 1970, and Duck (1986) have each identified similar components of social support. Kahn and Antonucci's elements are set out in Figure 6, below.

FIG 6 Social Support for Elderly People
(Kahn and Antonucci, 1981)

Inter-personal Transactions
with Key Elements of:

AID =	*direct assistance (things, money, information, time)* (utility value orientation)
AFFIRMATION =	*expressions of agreement and approval of something a person says or does* (utility value, self-fulfilment orientation)
AFFECT =	*liking, admiration, respect, love* (self-fulfilment orientation)

3.16 Summarising the Views of Social Support: Their Significance for Relationships of Elderly People in Residential Care

Views of social support identify a range of different elements of social support and go beyond counting the number of interactions. Of these, Kahn and Antonucci (1981) suggest the most relevant key components: aid, affirmation, and affect. Both the utility value and self-fulfilment orientations figure in these components. One of the most distinctive components of social support is its role in affirming status (or affirmation). This is more characteristic of social relationships than close personal relationships but plays a part in both. Social relationships may lack intimacy, but they enhance the social image of individuals in their social world. The belief that social support is available is an important factor. Negative factors within the self and the environment may limit the availability of social support. Elderly people in residential care may have lost many of their close personal relationships through death of their contemporaries and spouses. Their social networks may have contracted for the same reasons and also because of their entry to residential care. They will find aid within residential care. They may be able to find affirmation of their status, but probably only to a limited degree, depending on the opportunities provided by the regime and by their own resourcefulness. The availability of affect in residential care will be explored. Residents may be living apart from their relatives and former social networks, but their belief that these relationships continue may be an important source of social support.

3.17 Support Networks in Old Age

The study of support networks in Britain began around 1980, building on earlier American research. The term 'support network' is analogous in most instances to 'social network' but Wenger (1989) uses 'support network' purposefully to match aspects of networks with social intervention needs. Wenger's summary (1989) of the main trends of research into support networks of elderly people provides a useful introduction to a discussion of her own longitudinal research on support networks.

A significant feature of a network is its density. The density of a network refers to the proportion of people in the network who are well known to each other. A small but dense network provides strong emotional support, but its small size may hinder the spread of knowledge and therefore the availability of a greater level of resources (d'Abbs, 1982). A low density network may provide better access to help. Although Wenger (1989) is cautious about comparing the USA with Britain (Jerrome, 1990, 1993a, discussed above), a review of earlier research in Britain, the USA, and Australia on the provision of social support through social networks suggests that on average elderly people have five to seven people in their social support network (Mugford and Kendig, 1986; Wenger, 1984). The linkages of a network can be either uni-plex, providing only one kind of support; or multi-plex, providing many kinds of support (Boissevain, 1972, discussed above). Multiple linkages are stronger and are reciprocal (Dowd, 1975, discussed in Chapter Two and above) in nature.

The same factors noted earlier in this Chapter in the discussion of aid, affection, and consensus in inter-generational personal relationships are relevant. The stronger the ties, the more likely they will be supportive. The closer the relationship, the more likely support will be asked for (Wellman, 1981). Most members of elderly peoples' support networks are family members who are middle-aged or older. The network of kin provides aid and support, with the important relationships (as discussed above) being those of siblings and children (Mugford and Kendig, 1986; Wenger, 1986). Gender, class, and attitude (Schlossberg, 1981, discussed above) affect the support network. Women have larger networks with multi-plex ties, including more bonds with friends and siblings (Mugford

and Kendig, 1986). Men's networks are more limited, centred on children and their immediate neighbourhood. Being married makes a difference for men, resulting in larger networks. These networks shrink when men are widowed (Wenger, 1984). Network size tends to be smaller for married women. Single women who have never been married are less likely to have close relatives and their support networks are smaller in old age (Mugford and Kendig, 1986). Middle class elderly people are more likely to have extensive mutual aid and support (d'Abbs, 1982). Their support is dispersed because they probably have moved away from their original neighbourhoods, but they have more access to transport and telephone as means of keeping in touch with their networks (Bulmer, 1987). They are apt to establish relationships quickly, and are more inclined to turn to friends for help. Working class elderly people tend to rely more on a small, kin-based network (Mugford and Kendig, 1986), with the mother-daughter link especially strong (d'Abbs, 1982). They have more ties with neighbours and will delay seeking help from outside their immediate network. Elderly people (no matter what their class and gender) whose attitudes are positive seek and receive more support than those with negative attitudes (Mugford and Kendig, 1986). There are fewer attitudinal constraints on help-seeking for the very young, and conversely, for the very old.

Wenger's own British-based longitudinal research relates support networks to intervention strategies designed to promote community care. Her work is community-based, rather than focused on the experiences of elderly people in residential care, but provides a view of the probable life courses of those who enter residential care. Its findings on the varieties of networks, the different types of support available, and personal and environmental factors affecting resources in the networks echo findings of similar research in the USA and Australia. Wenger's research consists of several surveys, beginning in 1979, and again in 1983, 1987, and 1992, in which she identified the following typologies of networks, with matching suggestions for intervention. These are broadly consistent with earlier typologies of Bott (1957).

(1) a local integrated network, with close relationships with family, neighbours and the community; service intervention suggested: partnerships between formal, statutory services and informal, non-statutory support, with intervention taking place at an early point when need is first identified.

(2) a local self-contained support network, in which people rely mainly on neighbours, community involvement is low, and relatives are at arm's length; these tend to be private, retiring types, or childless people who are more likely to enter residential care (Wenger, 1986); service intervention suggested: the neighbours may be the first to ask for help, which may be resisted, and social isolation may be encountered.

(3) a wider, community-focused, support network, with distant kin, but friendships and community involvement. These are mostly middle class people with high morale; service intervention suggested: a broker role, offering help in finding private services.

(4) a family-dependent support network, which has close local family ties, with few friends or neighbourhood ties, often based on a shared household with the daughter. These people have a high expectation of being cared for by kin; service intervention suggested: assessments need to focus on the mental health needs of the elderly people and their carers, and to be aware of people's expectations; peer contact may be lacking, and there may be loneliness.

(5) a private, restricted support network, with an absence of kin (other than, in some cases, a spouse), with limited community contact, no friends, and only superficial contact with neighbours. These people are heavily reliant on statutory services and are vulnerable,

in that they are most likely to have to change their life style or lose their independence; service intervention suggested: emergency help is often needed for help with loneliness and depression.

Elderly people in networks (2) and (5) appear to be most vulnerable for admission to residential care. Members of network (4) could also be vulnerable because of over-reliance on family carers. Wenger found that the ageing process may cause a shift from one type of network to another. A hierarchy of relationships within the networks reflects the importance of the category of relationship (whether kin or non-kin), and also the amount of contacts, the salience of the relationship, commitment, and involvement. One third of the respondents had tenuous support networks which left them vulnerable, especially men and the unmarried. Changes in the support networks were related to the incidence of death, frailty, and the ageing process in the carers as well as the respondents. When elderly people are lonely, the family is seen as having to meet this need, but most lonely old people complain of lack of friendship (Blau, 1973). Professionals should pay attention to the larger social networks which may supply friendships (Wenger, 1983). Wenger's research calls attention to the need for social relationships which supply the self-fulfilment orientation as well as the utility values orientation.

3.18 Summary of the Discussion on Frameworks of Social Relationships: The Implications for Elderly People in Residential Care

In the preceding sections, social relationships were discussed within the frameworks of social networks, support networks, and social support. The complex study of social relationships is influenced by the utility value orientation, the ecological paradigm (Bronfenbrenner, 1979), and the life course perspective (Blaikie, 1992), all of which emphasise the importance of context in determining levels and content of relationships. Social networks may or may not provide social support depending on environmental factors. Elderly people's networks tend to contract due to deaths of contemporaries. Evaluating measures of social support involves more than simply counting numbers of interactions. The meaning and quality of the interactions to the individuals involved in them must be taken into account, in recognition of the self-fulfilment orientation of social relationships. The key elements of social support are aid, affirmation, and affect (Kahn and Antonucci, 1981). Social support is especially important for affirming the status of an individual within social settings, thus providing both utility value and self-fulfilment. Wenger's research on support networks in old age (1979, 1983, 1987, 1992) identifies the practice interventions suitable for each type of support network.

The next sections discuss the processes and factors of social relationships, including life events, transitions, stress, and coping responses.

3.19 Processes and Factors of Social Relationships: Life Events, Transitions, Stress, and Coping Responses.

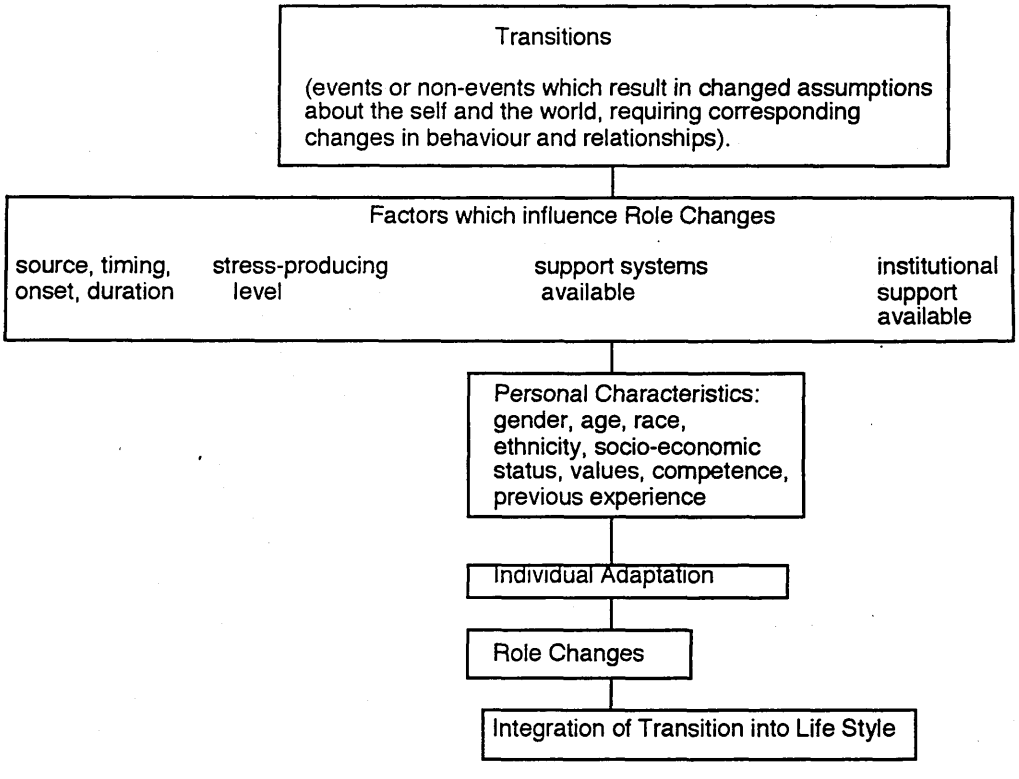
Life events are important influences on individuals' life courses and their relationships. They are defined as: processes which have antecedents, durations, contexts, and outcomes (Reese and Smyer, 1983); and benchmarks, milestones, and transitions which give shape and direction to individual lives (Danish et al, 1980).

Significant life events have been classified into taxonomies, whose common feature is the loss of relationships (Henderson, 1983, discussed above; Hopson, 1981, discussed below). Perhaps the most well-known taxonomy of life events is Holmes and Rahe's one-dimensional study (1967) of the relation of life events to stress. They list 43 stress-inducing life events in order of degree of stress. The death of a spouse is most stressful.

Pearlin (1982) criticises Holmes and Rahe's life events (1967) for being unrelated to each other, arguing for a schema to indicate how experience is organised through the dimensions of time and space. He maintains that understanding the economic and social events accompanying transitions is important, if coping responses are to be encouraged. This, too, echoes the importance of context proposed by the ecological paradigm (Bronfenbrenner, 1979, discussed above) and the life course (Blaikie, 1992, discussed above). Other taxonomies of life events include Brim and Ryff's three-dimensional life event taxonomy (1980) of probability, age-relatedness, and prevalence; and Reese and Smyer's identification (1983) of 35 dimensions of life events, in which events fell into two broad categories of event contexts, and event types. 'Friendship' and 'community' are social relationship contexts which they use less often in their classification than personal relationship contexts of family, health, and love.

Life events are processes in which the dynamics of psycho-social transitions play a prominent part (echoing the work of Levinson, 1978, discussed in Chapter Two). Parkes (1971) describes transitions as major changes in life space (defined as the parts of the environment with which the individual interacts and in relation to which behaviour is organised, for example, persons, possessions, and residential settings) whose effects are lasting, and which occur over a relatively short time frame, affecting areas of the assumptive world. Schlossberg (1981, discussed above and below) devised a model for analysing transitions by examining each transition in respect to the role changes it involves, and the factors which influence the role changes. These contribute to individual adaptation, and the eventual move from being occupied with the transition to integrating it into the individual life style. This model is presented in Figure 7 below.

FIG 7 Analysis of Process of Transitions and Role Changes Schlossberg, 1981



Hopson (1981) suggests a transitional cycle of seven stages:

immobilisation,
reaction,
self-doubt,
letting go of the past,
testing,
the search for meaning, and
integration,

which is similar to Parkes' bereavement stages (1986) and Kubler-Ross' stages (1973) of death and dying. Since the lives of elderly people in residential care have included many significant transitions, including the loss of close relatives, retirement, and the actual move into residential care, the transition model is useful for understanding relationships in residential care in response to life events (as Levinson, 1978, discussed). Transition theory assumes that life events give rise to stress or crisis. Relationships are affected by stress but also function as coping responses in response to stress. This leads next to a discussion of stress and how it features in the study of social relationships.

Stress can be understood as an organism's state of existence when reacting to new circumstances (DiMatteo and Friedman, 1982); and the manifestation of responses to environmental changes (Selye, 1956). Dohrenwend (1973) argues that change is a stressor, particularly if it involves major psychological re-adjustment or the need to re-shape personal identity. The three stages of adaptation to stress are alarm; resistance, including alertness to danger; and exhaustion (Selye, 1956). Pearlin (1982) argues that the study of ageing is the study of change and its consequences. (The link between development and change was noted in Chapter Two). One of the consequences is stress, but it is wrong to assume that ageing causes more stress than the stresses encountered in youth. Similar circumstances may affect different individuals differently. Some 'hardy personalities' (Kobasa, 1982), who regard stress as a challenge, do not exhibit the usual expected responses of distress in reaction to life events and transitions. Segerberg's study (1982) of centenarians in the USA supports this view, by suggesting that a common element in the lives of those who survive to 100 years of age is their ability to control their stress levels, largely through a regime of hard work, activity, positive attitudes, and successful handling of angry feelings.

Hopson (1981) argues that as well as resulting from change, stress can be caused by undesirable life events, or by under-utilisation of an individual's skill and time. Pearlin (1982) claims that it is the social and economic contexts which accompany transitions (such as, for example, divorce) rather than the transitions themselves which determine the extent of the stress encountered. This argument lends weight to the ecological paradigm (Bronfenbrenner, 1979, discussed above and in Chapters One and Two) and the life course perspective (Kohli, 1986; Blaikie, 1992; discussed above and in Chapters One and Two) with their emphasis on environmental contexts as influences on relationships.

Stress reveals itself through physical and mental reactions, and in the coping responses which individuals develop. Coping responses are responses which modify demands or seek to change situations, or modify or re-shape the meaning of situations confronting individuals. They are responses which modify the individual's ability to handle the demands, by devising ways to live with distress, or by using coping activities and responses to control situations rather than change them. Coping responses are self-esteem resources in the personality which establish and maintain social support networks (Pearlin and Schooler, 1978; Pearlin, 1982). They consist of efforts to manage, master, tolerate,

reduce, or minimise environmental and internal demands, and conflicts among them which tax or exceed a person's resources (Lazarus and Launier, 1978).

The utility value orientation (discussed above) is evident in the way researchers link social support, stress, and coping responses. For example, Cobb (1976) argues that social support has an effect on the stress levels encountered by individuals, and that people can cope with stressful life changes better if they have social support. Pearlin (1982) suggests that coping with stress requires a support system. At times of unexpected events or crisis when their own inner coping mechanisms are over-loaded, people often cope by turning to social support. French (1974) argues that the degree of social support moderates the correlation between external stress and health.

People use coping strategies selectively (Pearlin, 1982). Pearlin and Schooler (1978) distinguish between coping resources (the social and psychological resources available to a person) and coping responses (the use a person actually makes of the resources). The greater the range and options of coping skills available to people as part of their coping responses, the more likely they are to be effective (Hopson and Scally, 1981, 1982). Coping skills can be taught. The process of empowerment (Solomon, 1976, discussed above) through which individuals increasingly take greater charge of themselves and their lives (Hopson and Scally, 1981, 1982) is an important aspect of this premise.

Cassel (1974), Antonucci and Depner (1982) and Gottlieb (1981) argue that social support acts as a 'buffer' or cushioning agent against health-destroying stress. Cohen and Wills (1985) suggest that social support is most likely to act as a buffer in relation to crisis situations. Another interesting recurring theme of understanding how social support operates in relation to stress (Henderson, 1983, discussed above; Gottlieb, 1985; discussed above) is the belief that support is available. Coping depends on getting support, but also on believing that one can get it (Gottlieb, 1985). People's belief in their own ability to resolve difficulties helps to resolve stress (Bandura, 1977). When there is no assurance that efforts made to cope will meet with success, family problems are likely to receive priority for resolution in preference to employment, social or economic problems (Pearlin, 1982).

3.20 Summarising the Importance of Transitions, Crises, Life Events, and Coping Responses for Elderly People in Residential Care

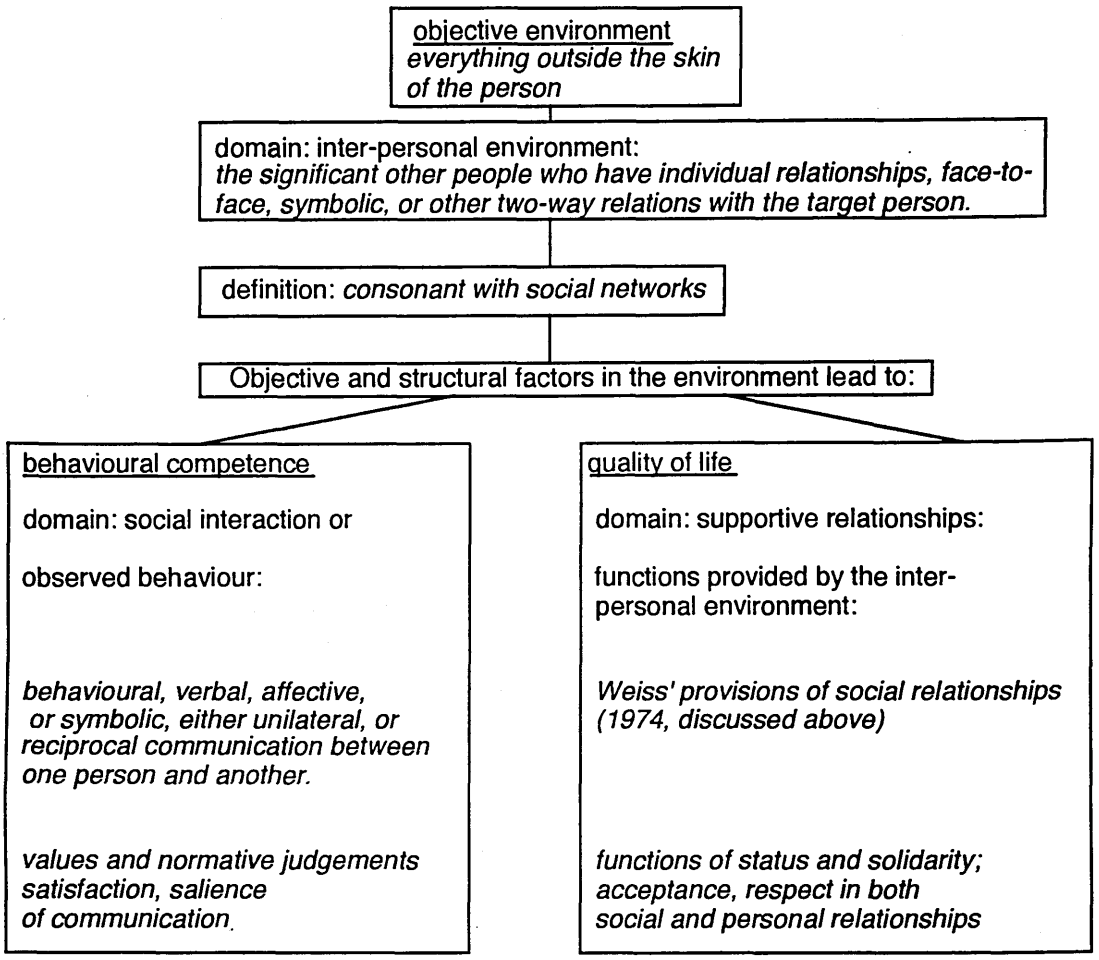
Research findings concerned with these processes emphasise the utility value orientation of social relationships. Social relationships are viewed as helpful in situations of transition and crisis, and as an important component of people's coping responses for stressful life events. Of the various findings, the 'buffering effect' of social support (Cassel, 1974; Gottlieb, 1981; Antonucci and Depner, 1982; Cohen and Wills, 1985), which is found in social relationships, makes realistic claims for its utility. This does not promise a cure-all, but suggests that relationships provide a cushion and mitigation against stress. Equally important is the suggestion that an individual's belief in the availability of helpful social relationships may be as supportive as that which is actually available (Henderson et al, 1980; Gottlieb, 1985). Little attention is paid to the possible negative aspects of social relationships evoked by processes of life events, transitions, crisis, and stress. These processes provide an insightful but limited view of the role of social relationships. For elderly people, entry into residential care is an important transition which causes stress and requires coping responses. Their coping responses will involve changes in their social relationships. Elderly peoples' response to residential care, including their social relationships, will arise from their life course experiences, their previous patterns of relationships, and environmental contexts. In the next section, two frameworks which attempt to integrate the related yet disparate concepts of social relationships are discussed.

3.21 Two Integrative Frameworks for the Concepts of Social Relationships

Different concepts (discussed above) with their own terminologies, internal systems, and sub-classes try to distinguish between different types of social relationships. None of these is entirely successful, although they provide useful insights. Two attempts to integrate related concepts will be discussed next. The first was developed by Lawton and Moss (1987) who anchor concepts of social relationships within a framework of the good life. The good life uses the objective environment, behavioural competence, and the perceived quality of life as its subclasses.

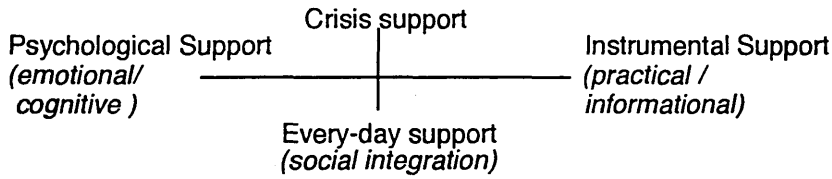
Several useful points are made. First, social competence is based on the quality of an individual's behaviour towards others. Second, the perceived quality of the interpersonal environment depends on distinguishing between the quantity and quality of interaction. Counting interactions cannot measure the valued attributes of social competence such as conversational skill (Heller and Swindle, 1983). Third, the salience of a social relationship, network, or interaction is an aspect of quality which is independent of satisfaction. An individual might rate many people highly on 'liking' but only one of the mentioned relationships may be important to the respondent. Therefore satisfaction and salience should be considered separately. Fourth, the functions provided by the inter-personal environment, including status and solidarity and Weiss' provisions (1974, discussed above) are aspects of the perceived quality of social relationships. Acceptance and respect appear to be common functions of both close intimate relationships and social relationships. Many of these functions are defined in an *a priori* fashion, have not been operationalised, repeat components, do not compare the functions of family and friends, and do not ask whether the functions of supportive relationships differ from other kinds of relationships. Figure 8 overleaf illustrates these points:

FIG 8. The Good Life (adapted from Lawton and Moss, 1987)



In the second example, illustrated in Figures 9 and 10 below, Veiel (1985) constructs an integrative framework for research on social support, using House's question (1981) about social support: who gives what to whom regarding which problems? Veiel's structure is concerned primarily with dyadic relationships, and therefore is more limited in scope than the ecological paradigm (Bronfenbrenner, 1979; Gottlieb, 1985; discussed above). Veiel distinguishes between crisis and every-day support, and emotional and practical support, but not the specific roles of support providers, except to suggest that there is a difference between professional and non-professional providers.

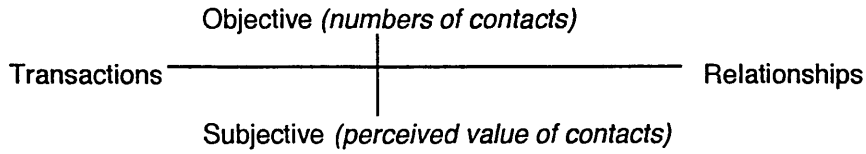
FIG 9. Social Support: Dimensions of Assessment (Veiel, 1985)



Veiel's criteria for measuring social support are expressed in the diagram below. It takes into account objective measures such as numbers of contacts, and subjective measures of quality; and the need to distinguish between close relationships and the actual transactions

which take place. Veiel does not include intimacy but notes Brown and Harris' view (1978) that intimacy is a valuable social support, and Granovetter's contrasting claim (1973) that more superficial relationships in certain circumstances can be just as supportive.

FIG 10 Criteria for Measuring Social Support (Veiel, 1985)



3.22 Summarising the Integrative Frameworks and Their Significance for the Relationships of Elderly People in Residential Care

Lawton and Moss (1987) affirm the importance of environmental contexts as influences on social relationships, echoing the views of the ecological paradigm (Bronfenbrenner, 1979, discussed above) and the life course (Blaikie, 1992, discussed above). The distinction between salience and satisfaction within relationships is a useful concept to be applied within residential care. Their framework validates Brown's (1974) assertion that status and solidarity are the basic material from which social relationships are constructed. A satisfying social life requires both status and solidarity, in varying mixes at different times (and probably in different relationships). Lawton and Moss (1987) conclude that over-all psychological well-being is a mix of both pleasant feelings and an absence of negative feelings, the latter enabling a person to behave competently.

Veiel's framework (1985) draws on and integrates previous research in a clearer and more satisfying manner than Lawton and Moss (1987), but is disappointingly silent on sources of relationships. Both frameworks link the different concepts of relationships, but with only partial success. They try too hard to anchor each concept at a particular point in a framework when in reality the relationships on which these concepts are based are elusive, changing, and shifting from one category or dimension to another, rather than remaining fixed at a particular point in a framework. Applying this to the relationships of elderly people in residential care, one might expect a change in the nature of relationships because of entry to care. Status and solidarity may ensue from social relationships as much as from close intimate personal relationships. The boundaries between social relationships and personal relationships become less distinct in later years. Relationships become more broadly based and self-actualising (Maslow, 1954, 1970, 1987, discussed above) because of life course experience (Kohli, 1986; Blaikie, 1992, discussed in Chapter Two). They are less dependent on intimacy for self-fulfilment although this remains important.

The next sections discuss reciprocity and exchange, processes of both personal and social relationships, and friendship, belonging to frameworks of both personal and social relationships.

3.23 Reciprocity and Exchange

Reciprocity (discussed in Chapter Two as a perspective of ageing) is considered separately from the three-fold dimensions of personal, social, and organisational relationships, because it cannot be contained within any one of the dimensions. It is discussed in this Chapter because it provides understanding of the ageing process and the nature of relationships. The following definition of reciprocal relationships, devised as a working guide during the research, is suggested:

Relationship between people is characterised by a process of reciprocal sharing, on a voluntary basis, of personal experiences, opinions, emotions, and needs, with another person who is perceived as supportive, understanding, and trustworthy. The reciprocity of sharing will be most significant in personal relationships, and a less significant factor within professional relationships.

This definition expresses valued qualities of relationships. The theme of reciprocity is emphasised because it suggests a balanced power relationship which supports the professional goal of empowerment (Solomon, 1976, discussed above). Gouldner (1960) explains social reciprocity as a generalised moral norm of reciprocity which defines certain actions and obligations as repayments for benefits received. Cairns (1979) argues that reciprocity occurs when the actions of two or more persons support each other in a relationship and their actions become similar to each other. These can be either positive or negative in their counterparts, for example the *lex talionis* as a negative matching of actions. Social cohesion and equilibrium depend on positive reciprocity (Kelley, 1983). There is a mutual benefit in helping each other. When people decline to help each other, the reasons may include a lack of expertise, being confronted with problems which make people uncomfortable, and misconceptions about what would be the right response.

Social reciprocity is concerned with recognising the consequences of behaviour and is linked to the development of maturity (Kelley, 1983). There are early signs of reciprocity in mother-child relationships (Brazelton, Koslowski, and Main, 1974), but socialisation, the process which develops reciprocity, does not end after the childhood years. Peer groups become important sources of socialisation (Rosow, 1974, discussed in Chapter Two). People tend to reciprocate actions of others and to realise that actions they direct towards others are likely to be reciprocated. Antonucci and Israel (1986) studied veridicality, the degree to which respondents agree on reciprocity between themselves, and found that it was highest between spouses, but was not related to well-being.

A linked concept is exchange. Wellman and Hall (1986) argue that there are three types of exchange: exchange of goods and services; exchange of equal value commodities; and a balance of reciprocity, in which one member of a social network may receive services from an individual in the network, and reciprocate to another member of the network, so that over time a balance is achieved. Clark, Mills, and Powell (1986) suggest that the amount of reciprocity is determined by the nature of relationships. Close and long-lasting relationships do not need immediate reciprocity because of the continuity in the relationship. In the othe exchange relationships, immediate reciprocity is the rule.

In family life, as the status and roles of elderly people change in relation to their adult children, the exchange relationship continues to exist, but it is subject to re-negotiation. The relationships between elderly people and their adult children are reciprocal ones, in which they give as well as receive services, such as emotional support, money, and baby-sitting help. These patterns tend to continue as long as the health and financial resources of elderly people are maintained. When these decline, a role reversal occurs (Riley et al, 1972; Troll et al, 1979, discussed above). Dowd (1975, discussed in Chapter Two) argues that elderly people cannot maintain reciprocity because they lose control over available exchange commodities.

Townsend's classic British study (1957) on the family life of old people found that old people often lived with their relatives but preferred a supported independence; that help was reciprocated, and that a segregation of roles and individual contact with relatives reduced the possibility of conflict. Many old people denied they were lonely. Townsend distinguishes between isolates and desolates. Missing members of the family who might have been expected to fulfil certain roles were replaced by others, for example, nieces and

nephews. Cantor (1979, 1980) calls this the hierarchical compensation model (echoing Dono et al, 1979, discussed above in the section on personal relationships), when more distant bonds become important in circumstances when the closest bonds are unavailable.

Timms (1989) argues for the importance of recognising the implications of social exchange and reciprocity in social support networks. Elderly people may not recognise or acknowledge these. For many elderly people, the indebtedness implied in receiving a service is disempowering. Carers do not always perceive the flow of support which they give as one-way; the person cared for participates in a relationship which can lead to greater closeness with the carer, and vice versa (Parker, 1990; Qureshi and Walker, 1987). Elderly people may be concerned about being a burden to their relatives, and may find greater equality of relationships and reciprocity with close friends. Bereaved people may find peer relationships a greater source of support (Ishii-Kuntz, 1990). Jerrome (1993b, discussed above), however, argues that reciprocity in inter-generational relationships in the family has emerged as a key concept during the 1980s.

3.24 Summary of the Discussion of Reciprocity and Exchange: Their Importance to Elderly People in Residential Care

The concept of reciprocity generates value-based statements urging the reciprocity of relationships. Even the most frail of elderly people have the potential to be participants in society through their relationships. For example, the Jubilee Policy Group (1992) argues that the positive contribution of elderly people is to be valued, as human flourishing is not found in isolation. Dependent people not only provide a test of the moral structure of society, but they have a significant, indispensable contribution to make to the health and flourishing of the community (Forrester, 1988). In a more dispassionate tone, Antonucci (1990) concludes that the concept of reciprocity is not understood clearly. She suggests that individuals build a support bank throughout their lives, on which to draw in times of need. Antonucci and Jackson (1989) suggest that belief in reciprocity is important for successful ageing, echoing Henderson (1983), and Gottlieb (1985), discussed above. In residential care, elderly people may need to search for relationships in which reciprocity and exchange are possible. It is likely that residents will be viewed as receiving help rather than giving help or services. Perhaps only in a befriending or helping relationship with another resident will they be able to develop a reciprocal relationship.

Next, the important relationship of friendship is discussed.

3.25 Friendship

Friendship is a bridging topic contributing to a consideration of both social and personal relationships. It does not fit neatly into the categorisation of personal, social, and organisational relationships. It can be conceptualised as either a social relationship with informal ties providing levels of social support (Allen, 1989); or as a personal relationship with close intimate bonds bordering on attachment (Bowlby, 1951, discussed above). In the discussion which follows, acknowledgement is made of its links with both these aspects of relationships.

Friendship is voluntary. Because of this, it differs from non-voluntary relationships with family, neighbours and work colleagues, even though factors of class, gender, age, socio-economic status and race may limit the choice of friends (Adams and Blieszner, 1989). Underlying constraints, based on patterns of attachment and developmental transitions which have developed throughout the life course, of which retirement is one example, may affect friendship choice in middle and late adulthood. For example, male friendships in old age tend to be more curtailed than those of women (Wright, 1989), because the typical

nature of men's friendships which develop over the years are agentic relationships, based on camaraderie with work colleagues, rather than the communal relationships (Bakan, 1966) formed by women, based on intimacy or community involvement. Agentic relationships are vulnerable to the role changes imposed by compulsory retirement.

Kin relationships, although based on positive concern, physical caring, practical aid, and socialising together, may lack a sense of shared values and provide less self-affirmation than friendships (Blau, 1973; Wood and Robertson, 1978). Relationships between siblings, who have lived throughout much of the same life course, are the exception to this, because they are more likely to share a common world view, and be able to provide a source of friendship in old age (Chappell, 1983). Although friendship in old age may provide a greater boost to morale, elderly people tend to see its function not so much as competing with the functions of family members, than as complementary to them (Jerrome, 1990, 1993a). Friendship is viewed as important in old age as a means of social support, integration, and therefore psychological well-being (Wood and Robertson, 1978; Adams, 1986). It provides a means of socialisation to the roles of old age (Hess, 1972), a tool for adjustment through mutual help, and an indication of self identity and worth. It fulfils both the utility value orientation and the self-fulfilment orientation.

The study of friendship in old age provides an opportunity to explore and perhaps challenge the commonly held view that people's social horizons, integration, and participation diminish with the onset of old age, because of the socialisation patterns characteristic of old age (Allan, 1989). Research on friendship in old age has been carried out in the USA by Adams, (1985, 1986, 1987); Hess, (1972); Blieszner, (1989); Matthews (1979, 1983 a and b, 1986); and Rosow (1967, 1974) among others, and in Britain primarily by Jerrome (1979, 1981, 1983b, 1985, 1986, 1989, 1992) and Allen (1979, 1986, 1989). The American research on friendship is largely based on survey research methods, with some emphasis on guided conversations, participant observation, and semi-structured interviews (Matthews, 1983a). Friendship literature is criticised for being cross-sectional, and lacking a historical approach (Matthews, 1986; Armstrong, 1988). Most studies are small-scale, based on mainly female, middle class, white respondents. Economic factors influencing friendships are rather neglected, but attention is paid to the influence of social circumstances on friendships, and the social significance of friendship (Allan, 1989).

Research is based primarily on community groups and individuals living in the community rather than on elderly people in a residential setting. The issue arises whether the findings may be transferred to the institutional setting. Also there is the issue of deciding whether or not American research is relevant for British settings (Streib and Binstock, 1990, discussed above). For example, Allan and Adams (1989) argue that American women of all ages find opportunities for friendships from their memberships of a wide range of organisations which fulfil different purposes, but in Britain there are fewer opportunities for leisure-based organisational memberships. The process of defining friendship is an issue. Adams (1989) suggests that if the definition is left to the respondents, findings are difficult to interpret and compare. If friendship is given an *a priori* definition, then a sub-type of friendship, rather than a general concept of friendship, is studied. Inductive qualitative methods, which are helpful for arriving at a typology, are very expensive and time-consuming, and therefore, by implication, not very feasible. Matthews (1983b) opts for leaving the definition of friendship to the respondents. She defines 'friends' as people for whom an individual has feeling or emotional attachment which only he or she can know. Having suggested this definition, which is left open for respondents to fill in the gaps, Matthews (1983b) acknowledges and analyses the difficulties of defining and measuring friendship in a logical consistent way: 'friendship' is not a categorical label, and it is based

on individual definitions rather than agreed criteria. She suggests three frameworks of analysis:

the cultural perspective which views friendships as being influenced by social rules, rewards, and expectations;

the life course perspective, (Blaikie, 1992, discussed above) which views friendship as resulting from the turning points and critical incidents of the stages of development; and

the social-psychological perspective, which views friendships as resulting from the initiatives and actions of social actors rather than from passive forces, an approach which owes much to symbolic interactionism (Mead, 1934; Stryker, 1980).

Matthews (1979) argues that old people are actors, not passive beings and that studies which investigate friendship as a source of social support miss the complexity of meanings attached to and derived from friendships. If one interprets friendships as part of the dynamic of elderly people discovering a new phase of life (the discovery approach to ageing, Fennell et al, 1987, discussed in Chapter Two), rather than seeing them as ill and needy (the social problem approach to ageing, MacIntyre, 1977, discussed in Chapter Two), then the study of friendship must adopt a different perspective, and look for meaning and dynamism in friendships.

Matthews (1983b) defines three styles of friendship in old age:

the independent, based on friendly relations, not intimacy;

the discerning, based on singling out a handful of individuals; and

the acquisitive, based on holding onto old friends and gathering new ones.

Matthews (1983b) also distinguishes between friends as

individuals, those who are acquaintances over a long period of time with whom shared life experience has taken place; and friends as

relationships, those who know and understand one's points of view.

By implication, individuals who make friends on the basis of relationships would be more likely to make new friends than those who value friends as individuals in the context of shared experience over time. Adams (1986) makes a similar distinction between a primary orientation to friendship, in which an individual forms exclusive relationships with relatively few people, and a secondary orientation to friendship, in which little distinction is made between acquaintances and friends.

Litwak (1989) views friendship in a utility value orientation, providing psychological, social, and practical services which are matched to individuals' particular social roles and status. Due to the complexity of roles in modern society, three types of friendships are likely to emerge: long term, intermediate term, and short term. Long term friends are those who are known throughout most of the life course, often going back to childhood. Intermediate term friends are those whose roles are based on a fairly lengthy shared experience, such as employment. Short term friends are those who become friends as a result of moves, crisis, and transitions causing a change in life style.

In old age, short term friends may become the only friends possible following geographical moves, loss and bereavement, and on a practical level, the death of many long term friends. The role of short term friends, because of their proximity, includes providing practical help. Litwak's study is based on the lifestyles of a mobile group of elderly Americans, so that proximity of long term friends is assumed to be unusual. This may not always be the case in British society, particularly for working class people.

Friendships are often based on peer relationships which are important in old age as a means of socialisation. Jerrome (1986) defines friendships as peer relationships for articulating common interests. Research on peer relationships include studies of friendships and social networks by Francis (1981, 1984); Hess, (1972); Rosow, (1974); Jerrome, (1983b, 1985, 1986, 1989, 1992); and studies of elderly persons' homes (Keith Ross, 1977; Hochschild, 1973; Gubrium, 1975; and Hockey, 1983). Elderly people are more likely to seek out peer group relationships in old age and to form friendships with their peers (Harris, 1983). Harris (1983) suggests that working class women find more support in formal associations like old peoples' clubs. They have been most deprived and are less likely to have had the leisure, income, or cultural values to enable them to develop informal peer group relationships until old age (Wenger, 1984; Abrams, 1980; Unruh, 1983). Widows are more likely to join clubs or associations (Jerrome, 1989). Middle class elderly people tend to join heterogeneous clubs and associations (Harris, 1983; Rosow, 1967) as a means of primary group relationships (Cooley, 1909) to compensate for the social and economic losses of old age, as well as the loss though death of their contemporaries. The leisure afforded by retirement makes this possible.

Jerrome (1979), in an early British anthropological study of elderly women in a social club, noted four strategies for making friends in old age:

recultivating and building on old relationships;

becoming 'good neighbours' and helping others;

intensifying relationships with siblings and children ; and

making new friends.

She distinguishes between the relationships which result from these strategies: the exclusive relationship, which aims to replace the closeness of the marital relationship, but which tends not to succeed; the altruistic, giving relationship, and the receiving relationship. Her findings suggest that loneliness is detrimental in old age and that men are less likely to have a confidante than women. In comparing these relationships to those in a nursing home, Jerrome concludes that proximity in an institution creates opportunities for helpfulness but not friendships. The close friends of residents were previously known individuals who lived outside the institution. Jerrome's continuing research on relationships of old people in club cultures (1986, 1992, 1993b) argues that club activity does not necessarily provide opportunities for new friendships. People are more likely to attend clubs with existing friends than to use clubs as a source for making new friendships. My proposed research hopes to illuminate these issues further in the context of residential care.

Adams (1987) studied friendship patterns of middle class elderly women in a suburban area of the USA. She discovered, like Jerrome, a considerable amount of change (growth as well as attrition) in the friendship networks of the women when she re-interviewed her sample three years after her initial study. The women she characterised as members of high society reported a dropping away of casual acquaintances and deeper friendships with few

people. This was perhaps a reflection of a pattern of social interaction imposed by husbands' occupations which no longer needed to be maintained. Pillars of the community women tended to have lived a long time in a local community and to be actively involved. In retirement they expanded their non-local friendships, either through broader new interests or through taking up old friends who lived at a distance. Marginal women tended to have less money, to move more often, but to have developed a wider circle of casual friends as a result of memberships in social organisations in retirement.

3.26 Summary of the Discussion of Friendship: the Implications for Elderly People in Residential Care

Friendship is an ambiguous multi-disciplinary concept. Studies of friendship in old age illustrate the dynamic changing nature of friendships, their variety, and heterogeneity (Allan, 1989). This is perhaps to be expected, since elderly people are not a homogeneous group. Friendship serves a variety of purposes for individuals. It can provide emotional support and affirm personal identity, as well as being a means of exercising power and status. Friendship can be studied from the utility value orientation, as social support, or from the self-fulfilment orientation as a close personal relationship. It differs from kin relationships because it is a voluntary relationship. Friendships, once formed, may be subject to strains and conflicts and either a sudden cessation of the relationship or a gradual withering away. Friendships in elderly people are more likely to end through gradual neglect or death. In general elderly people express a high degree of satisfaction with their friendships.

Opportunities and limitations for friendship are strongly connected to the context of the social setting and circumstances of the individuals concerned. One must speculate, therefore, that opportunities for friendships in residential care will be shaped by the particular circumstances operating for a particular individual in a particular setting, and that it would be a mistake to expect uniformity. In particular, geographical proximity and mobility play a large part in maintaining old friendships on an active basis (Allen, 1989). It is old friends who may be able to see beneath the veneer of age and share experiences with an elderly person. If residential homes are geographically distant from the communities where residents used to live, and if transport and physical energy are lacking, then it may be difficult to retain old friendships when living in residential care. The existence of a circle of potential friends with whom there are opportunities to share a variety of experiences, rather than just a few intimate friends, may be more significant. New acquaintances may assist in achieving social integration and well-being in old age more than the exclusivity of close, attachment-like friendships (Allen, 1989; Adams, 1986). In residential care, this has implications for the ways in which elderly residents relate to each other within the home and the opportunities for involvement provided. Those residents who are able to adopt a helping role with others and become good neighbours may develop successful friendships (Jerrome, 1990, 1993a). Residents whose friendships are independent, based on friendly relations rather than intimacy, and who make friends on the basis of the relationship itself rather than shared experience over the years, may be more likely to develop friendships in residential care (Matthews 1983b).

In the next section, organisational relationships are discussed. It is in this section that the importance of context as an influence on relationships (Bronfenbrenner, 1979, discussed above) becomes most evident.

3.27 Organisational Relationships

Organisational relationships are relationships which are shaped and guided by organisational imperatives and structures. Although there is a body of literature on

management relationships within formal organisations, management relationships are more concerned with implementing the production goals of the organisation than with the views of the consumers. The concern of this research is to learn, through the views and interactions of residents, how relationships in residential care are shaped by organisational demands.

Previous discussion established that individual relationships (personal and social relationships, including friendship relationships) depend on a range of available opportunities; that most researchers regard relationships as good and necessary; and that different concepts seek to explain the nature of relationships, but no single conceptual framework is sufficient on its own. Exploring the nature of relationships of elderly people in residential care makes it necessary to move outside the framework of personal and social relationships and consider the importance of organisational relationships. The ecological paradigm (Bronfenbrenner, 1979, discussed above) places personal and social relationships within a wider context of environmental influences, which includes organisational structures.

Whether these organisational structures are self-supporting and independent, as in the case of many private residential homes; or part of a network of homes, as in the case of Social Services homes and some private and voluntary associations, residential homes are institutional organisations which have needs, specific characteristics, and relationships. Templates which seek to conceptualise the difference between personal and social relationships and organisational relationships have been developed. For example, the structural difference between an intimate close personal relationship based within a family structure, and an organisational relationship between a staff member and a resident of a home can be analysed by using the seven role dimensions developed by Katz (1984) . Katz adapted these from Getzels (1974) to show the distinctions between mothering and teaching. A further adaptation of the dimensions to the research topic suggests the following comparison:

FIG 11 Intimate Personal Relationships Compared to Organisational Relationships
(adaptation of Katz' seven role dimensions, 1984; from Getzels, 1974)

Role Dimension	**Intimate Personal Relationship**	**Organisational Relationship**
1. Scope of functions	Diffuse and limitless	Specific and limited
	There is a taken-for-granted expectation that intimate relationships will be able to take on a range of responsibilities and functions which are potentially limitless, whereas the organisational relationship is limited to particular duties which are specified.	
2. Intensity of affect	High	Low
	Intense feeling accompanies actions in intimate relationships, but feelings are kept in check in the ideal organisational relationship.	
3. Attachment	Optimum attachment	Optimum detachment
	Attachment is viewed as a desirable aspect of intimate relationships, but detached concern is viewed as ideal within an organisational relationship.	
4. Rationality	Optimum irrationality	Optimum rationality
	The commitment within an intimate relationship defies rational judgement at times, but cool, reasoned judgements remain the ideal within an organisational relationship.	
5. Spontaneity	Optimum spontaneity	Optimum intentionality
	Flexible spontaneous diversions in interactions, often centred on leisure or play activities, characterise intimate relationships, but predictability and logical process are emphasised in organisational relationships.	

Role Dimension	**Intimate Personal Relationship**	**Organisational Relationship**
6. Partiality	Partial	Impartial
	Intimate relationships indicate to tindividuals that they are special people, and stand out from the crowd; organisational relationships are intentionally impartial in the interests of fairness to the group.	
7. Scope of responsibility	Individual	Whole group
	Intimate relationships enable a special case to be made for the needs of an individual, but the organisational relationship can never exclude the needs of other group members from consideration.	

Katz (1984) suggests that these dimensions help to identify sources of role strain and suggest ways in which the boundaries of the roles may be made more diffuse in the interests of good practice. White (1984) argues that residential care, by modeling itself on the ideal of family life, tends to ape family structure rather than use sociological analysis as a conceptual model. No residential establishment can perform the functions of the family in entirety, but if they do not perform any of the family functions, they will fail to meet residents' needs. Six features of family structure are identified, which have implications for the provision of residential care. White (1984) specifies these as :

FIG 12 Six Features of Family Structure Contrasted to Residential Care Structure (White, 1984)

1. Maximum independence, yet part of a range of networks, such as education, health, etc. *In contrast, residential care is part of a large organisation, with rules imposed on establishments, such as fire regulations and staffing levels, so that independence is sacrificed; the individual establishment is not free to make its own rules, which a family can do more easily.*

2. Small simple organisation. *The family is able to develop within it spontaneous, personal, reciprocal relationships, but these are almost impossible in a large, complex organisation which determines the policy of an establishment.*

3. Dynamic roles. *The family is able to change and develop new roles in response to time-related cycles of its members' life courses, but residential homes tend to have prescribed rigid roles.*

4. Permeable boundaries. *The family is able to interlock and interweave with a number of other networks and institutions of society (employment, education) in accordance with the ecological paradigm (Bronfenbrenner, 1979, discussed above), but the residential home tends to turn its attention inwards on its resident individuals rather than becoming aware of, and interacting with, its outer environment.*

5. Unconditional commitment. *Family life has the potential to provide this to its members, despite the fact that some families are dysfunctional; but residential care does not encourage this kind of commitment.*

6. A mixture of types and ages. *The family contains within it a diverse range of ages, but residential care tends to be segregated.by age or disability.*

Both of these templates use as a comparison the projected qualities of a family-based, close relationship. They both argue that organisational relationships in a residential home are influenced by the rules and restraints imposed from outside the establishment itself, by the large size of establishments, and by the inflexibility of staff roles. These arguments will be explored in the proposed research.

Raynes, Pratt, and Roses (1979) did not use family patterns when they identified four bureaucratic dimensions which characterise organisational relationships, but their dimensions are consonant with the two previous templates. These are:

1. centralisation the extent of delegation of authority;

2. formalisation — how rules influence the roles of workers;

3. communication — the contact staff have with other professional networks outside the institution; and

4. specialisation — the extent to which tasks are divided or shared by staff.

Studies by Raynes et al (1979) and Evers (1982) show an association between the levels of these dimensions and the levels of personalised concern (Booth and Phillips, 1987) within a residential establishment. They affirm Merton's view (1957, 1968) that formal organisations create formal social relationships, in which people focus on roles rather than personal relationships. Reiterating the same points, Phelan (1984) argues that residential care is subject to a framework of legislation which imposes rules and structures upon both workers and residents. There are more workers within residential homes than are involved directly in giving care, so that care provision has to be negotiated within the organisation. The rules which are supposed to be in the residents' interests are really for the benefit of the workers. This argument provides another insight into the nature of organisational relationships. Douglas (1986) developed the theme of 'embeddedness' of group living within institutions, warning that any group of individuals must be considered as one of several sub-groups, affected by the overall 'embedded' nature of organisational systems. Bond and Bond (1987) assert that the social environment of institutions is embedded in and influenced by organisational relationships. They identify as important the issues of

teamwork,

centralisation,

communication,

specialisation, and

staff functions.

A number of anthropological studies illuminate the nature of organisational relationships in residential settings and in group settings of clubs for elderly people. Their conclusions may not be entirely applicable, because much of this research (Keith Ross, 1977; Keith, 1980, 1982, 1990; Jerrome, 1989, 1992) took place in somewhat different settings of American residential communities and British elderly persons' clubs. Hockey (1983), however, conducted her research within a British Social Services home. Keith (1980, 1982) carried out anthropological research which examines relationships in elderly peer groups. Keith's qualitative studies explored the subjective reality of an old peoples' home and day centre through insiders' views about the quality of life, and sought their own perceptions of wherethey belonged in the organisational structure. Individuals become a community and develop organisational relationships when they have shared symbols, a degree of interdependence, and a sense of threat from outside. The issues of meaning through time, and establishing identity were significant. Keith (1990) elaborates the theme of community formation in age-homogeneous communities in her discussion of the conditions which promote a sense of community in residential care. These conditions are a perceived homogeneity of social characteristics, a lack of alternative living arrangements, and a minimisation of exclusive ties. Positive feeling about being part of such a community can promote positive behaviours of mutual aid which are viewed as reciprocal and non-stigmatising. On the other hand, Francis (1984) discusses a negative example of a

community failing to develop because of the influence of a controlling manager, and the residents' previous weak sociability levels.

A high level of conflict is said to exist in residential care communities (Fry, 1979) because of the newness of the residents to the setting, the lack of any alternative to 'being in the same boat' and the uncharted social territory. Keith (1990) suggests that egalitarianism is a prominent feature of residential relationships, because the group as a whole is outside the power systems of society. The shared experience of liminality, of being in limbo between the culturally defined roles of middle age and extreme old age, binds people together. Liminality suggests a process of transition from life outside into the community of institutional residential care, from independence to dependence, and from living to death (Turner, 1969). Keith (1990) suggests that elderly peoples' individual disagreements about norms and life styles can be transferred to a formal, collective conflict between residents and managers. These formal disagreements may serve the purpose of protecting intimate relationships with families and friends from deterioration due to conflicts (Kandel and Heider, 1979). Displacement of conflict is more likely to occur when the situations causing concern are difficult to resolve.

Jerrome's British-based accounts (1983b, 1986, 1989, 1992) of clubs for elderly people note that peer groups become important for elderly people as sources of moral and practical support for their state of liminality (Keith, 1982; Myerhoff, 1984). In the face of social discontinuity brought about by the ageing process, the collective rituals of the club help members to impose order on their social world and cope with uncertainty. 'Ageing well' in the world of the club means social participation. The virtues of coping, struggle, stoicism, resignation and acceptance are strategies reinforced by the collective gathering together. Moral virtue is associated with struggle and resistance against ill health, thus postponing the designation of the status of 'old', which is based not on chronology, but on health. This resistance strategy has been noted by Williams (1986) as more typical of middle class elderly people than of working class elderly people. Resistance to growing old can backfire on the leaders and members of clubs. Leaders find it psychologically impossible to relinquish their roles, as this would be construed as moral weakness and surrender to old age. Resultingly, clubs are age-graded associations (Fennell, 1981; Unruh, 1983). Club culture provides a means of socialisation (Rosow, 1974, discussed in Chapter Two) into becoming old. Club relationships are supportive social relationships with codes and rituals. The club itself is a means of empowering elderly people, as they themselves are in charge of the club. The organisational relationships within the club, and the relationships of individual members to the club's structural norms are important aspects of the club experience. The ritual enhances identities. In contrast, Hockey (1983) suggests that peer group ritual in residential care is controlled by the staff, and that different strategies are used. In both contexts, leadership and helping are important examples of organisational relationships, but residential care provides fewer opportunities because residents are likely to be older and more frail than elderly people living in the community.

3.28 Summary of the Discussion of Organisational Relationships: the Significance for Elderly People in Residential Care

Organisational relationships are likely to be influenced by organisational demands, in consonance with the ecological paradigm's view (Bronfenbrenner, 1979, discussed above) of environmental context. Unlike close personal relationships, organisational relationships are limited in scope because of outside constraints and formal roles and regimes. Another constraint is the ageism of old people (Townsend, 1986, discussed above). They all too easily fulfil the stereotypical role (Goffman, 1963; Bowl, 1986) of old age.

The embeddedness of organisational relationships in social environments is a useful concept (Bond and Bond, 1987; Douglas, 1986). Some studies of organisational relationships focus on how residents build a power base in contrast to the power base of the staff. They suggest that the positive aspect of organisational relationships for residents may be the sense of community which results from the perception of shared problems. Dealing with shared problems can lead to subsequent galvanisation towards leadership, power, affirmation, and in some instances, protest. They suggest that residents' organisational relationships are expressed though group action rather than individual acts. I suspect that it may be difficult for elderly people in residential care to devise, on a conscious level, a strategy for taking control of their organisational relationships. As Midwinter (1991) suggests, there are covert cultural obstacles against such participation. For example, when work and parenting are removed, the lack of structure may cause people to lose life's organisational skeleton. Their strategy may be to adopt embedded roles within the home which provide aid and affirmation (Kahn and Antonucci, 1981, discussed above) of their status. These could be roles in which they help other residents and staff, or passive, help-receiving roles. Organisational relationships can also trigger personal and social relationships based on protest or alliance against the institutional regime (Hockey, 1989, discussed below).

The next section discusses specific studies about the relationships of elderly people in residential care, before the Chapter draws to a close.

3.29 Studies of Relationships of Elderly People in Residential Care

Relatively few studies are concerned specifically with relationships of elderly people in residential care. Because they are concerned with evaluating care regimes or residents' well being, they discuss relationships only tangentially. Existing small scale studies are narrowly focused and do not take account of the complexity of the many variables and a lack of agreed outcomes of care (Bond and Bond, 1987). Because of the narrow focus of each study, a collective and comparative overview is needed to gain a more balanced view. This section considers British and Australian studies first, starting with small scale studies and then moving on to discuss two larger studies, after which a number of American studies are reviewed.

In the first to be considered, Minichiello (1986) studied the social processes of entering nursing homes in Australia, interviewing 96 residents. This research is important because it draws attention to the way in which events and processes of admission to care are significant for the relationships which follow. Reasons for entry were identified as crisis situations combined with inadequate resources to resolve the crisis satisfactorily (Anderson and Newman, 1973). Usually the family made the decision about entering the nursing home and the elderly individual was only a minor participant in the decision, but over time residents tended to shift their stories from saying they were coerced into the home, to claiming it was their own idea (Tobin and Lieberman, 1976). This resonates with the view of pseudo-integration developed by Erikson et al (1986, discussed in Chapter Two). In an example of learned helplessness (Seligman, 1974, discussed above) and structured dependency (Townsend, 1986; Bowl, 1986, discussed above), many residents began to believe that they could not manage 'outside' and developed a fear of going out. Only a few residents, who lacked informal support and used residential care as a substitute for family care, had actively planned their entry to care. Both residents and their relatives held negative stereotypical views of nursing homes. Some relatives felt so disturbed and guilty at their elderly relative's entry into residential care, that they tried to compensate by strengthening family bonds. Others felt so guilty that they were not be able to face their relative in the home (Minichiello, 1986).

In a study of the role of nursing homes and residential care homes in the last year of life of residents, Cartwright (1991) emphasises the importance of support from relatives and friends especially around the stressful time of admission to care. He conducted 639 interviews with surviving families in ten areas of England. The survey included relatives whose deceased relatives had died in residential care and relatives of those who had died living in the community. In the former instance, just over one third reported the care in residential homes as good. In the last twelve months of life, 7% of residents had no visits, 52% one to four visits, 33% five to nine visits, and 8% ten or more visits. The visits were from relatives and friends.

Hockey (1983, 1989, 1990) studied the concerns and roles of elderly people in residential care. Her findings are important for the proposed research as they suggest patterns of relationships likely to be found in residential care. Hockey (1983) analysed the concerns of a small group of residents articulated in a song of entertainment and moral uplift which they wrote and performed in the home. Their philosophy expressed values of acceptance of present hardships in the form of rules and hierarchy, as well as loss of their past, but also retention of their identities, and hope and trust in a wider pattern of meaning. She noted that residents who adopted the role of articulating these needs were the more able and less dependent residents. These residents had a continuing ability for sociability, were known to staff, and enjoyed friendships with each other. Some of their friendships pre-dated their entry to the home.

Hockey (1989) studied transitions to institutional life in a residential home for elderly people in the north of England. The 46 residents were heterogeneous in age, class, range of fitness, and social status. They held in common the experience of living together in an institutional, restricted space, with reminders of death and deterioration through enforced eating together. The result was a threatened sense of personal identity, as they were cut off from their past, and experienced institutional reminders of death. Residents made sense of the transition to residential care by referring to earlier transitions in their lives, such as going to war, and going to work. The men who were interviewed gave chronological accounts of their lives, emphasising social roles and positions of influence, while the women gave more fragmented accounts of personal interactions and relationships which involved giving care. The women lost more in the transition, as they lost their caring role. The men experienced some continuity as they had been used to being cared for by women. That was still the case at the residential home, because the care assistants were women. Hockey (1989) noted the need of residents to create space for themselves away from those they perceived as being less able and more dependent than themselves. Some women found fulfilment in assuming a caring role with another less able resident, but needed to choose a responsive recipient. The men assumed organisational roles on the residents' committee. Identity was sought through reminiscence. Stoicism and determined independence were strategies for survival.

Middleton's study (1983) of friendship and isolation in sheltered housing units noted that tenants' patterns of friendship and interaction were shaped by social class, cultural expectations, and previous life styles. (Although sheltered housing, discussed in Chapter One and Chapter Four, lies outside this research's definition of residential care, many elderly people live in sheltered housing units for some years before they enter residential homes). This study draws attention to the importance of reciprocity as a basis for social relationships which affirm the individual's status. Most elderly people in the unit seemed more at ease with casual social relationships than with close personal friendships. Those who had always been friendly to others continued making and sustaining friendships in the same way. A general problem which reinforced the difficulty of forming new relationships was the recognition of each other's frailty and age, with the risk of bereavement and loss if a close relationship was formed. Over time, as spouses died, individuals became more

isolated. The desire for friendship was carefully disguised, not only because of social traditions of privacy and closed family groups, but also from fear of rejection and possible loss. Working class cultural traditions led to a reluctance to visit each others' flats, but tenants were willing to shop together. Male-female friendships were also frowned upon. Helping relationships were rare unless they were based on kinship or previous acquaintance. Contacts were made with former acquaintances, those next door, and those who shared mutual concerns. The communal lounge in the sheltered housing unit was regarded with ambivalence. Some people avoided using it because they associated it with charity or dependence, or because of pressure to participate. Formal activities were less threatening to attend than informal ones. Group memberships were easier for many people than close relationships, and groups tended to be dominated by the personalities of the leaders. Helping each other in a community role was acceptable as a means of developing relationships.

Within Essex Social Services Department, Stanger (1988) conducted experimental research on the resourcing levels needed to maintain a good quality of life within elderly persons' residential homes. The aim was to achieve a clear understanding of the basic principles of emotional care and to seek and identify appropriate models of care which include emotional and social care as part of the process. Seven residential homes were chosen on the basis of diversity of design and location. In four of the homes, enhanced staff hours were provided so that activities programmes could be introduced. Three homes were designated as the controls and continued with their usual patterns of care. Using the Philadelphia Geriatric Center Morale Scale, the morale of residents was tested before and after the activities programmes. The result was a 12% rise in morale over 14 weeks in the experimental homes and a 1% drop in morale in the control homes. The implications are that activities (Havighurst, 1963, discussed in Chapter Two) provide meaningful relationships and enhance morale. The design and methods of this experiment were criticised informally on ethical grounds by another Essex employee who claimed that the clinical approach to interviewing was upsetting to residents. Many of the residents were unsure of the purpose of the interviews and feared eviction from the home if the 'right' answers were not supplied.

Lansley and Whittaker (1992) studied a volunteer befriending scheme in a residential home which sought to combine befriending (the self-fulfilment orientation) with advocacy (the utility value orientation). They concluded that the two roles were not entirely compatible. Residents and volunteers both wanted to gain self-fulfilment and enhancement of the self-worth of residents. Residents did not want to be seen as objects of charity. A reciprocal relationship changed volunteer participants' perceptions of their activities from merely duty to friendship.

Two larger British studies of elderly people are those of Bury and Holme (1991) and Willcocks, Peace, and Kellaher (1987). These did not focus exclusively on relationships, but relationships are important within the questions they ask and in their findings. The aim of Bury and Holme's study (1991) of very old people aged over 90 was to discover the quality of life for these survivors of old age, and to examine the relationship between their subjective views and their objective circumstances. 47% of the respondents lived in residential homes, mostly in the private sector. About 25% of the respondents were unable or unwilling to participate in the survey because of confusion or dementia. On the whole, appropriate social and emotional support was given in the residential homes and acknowledged appreciatively by the residents. Those in residential care criticised their living arrangements more than those living in the community, with 23% of the residents critical of staff shortages, inflexible routines, and the limited autonomy allowed them, but not reporting serious abuse or neglect. The most frequent complaints concerned relationships with other residents. The authors call this the unacceptable face of communal

living, because of lack of space and privacy. Although the majority of residents reported favourably on staff-resident relationships, for a significant minority the relationships between the staff and the residents were criticised as inadequate or non-existent. The rapid rate of staff turnover meant that the stability of relationships suffered. Good caring was noted favourably, but the demands of other duties on overly-busy staff were given as reasons for off-hand and unconcerned behaviour by staff. The authors comment that these relationships may have been reported inaccurately, either exaggerating the criticisms or the praise. Like Booth (1985, discussed above) they state that it is difficult to determine the true state of resident satisfaction in residential homes. Residents were reluctant to complain. Personal relationships which were available through regular contact meant a great deal to the old people. When asked what gave pleasure and support, 40% said personal relationships. Other responses included activities, food, smoking, pets, and sunshine. Those who lived in residential homes were visited by their relatives, and to a lesser extent, their friends. Examples of reciprocity (Gouldner, 1960; Cairns, 1979; discussed above) in relationships were noted, with some residents taking responsibility for tasks in the homes, which gave them a sense of independence. Little opportunity was given to residents to participate in the running of the residential homes.

In a study of 100 old age homes, Willcocks, Peace, and Kellaher (1983, 1987) used questionnaires, interviews, visual games, observation, and location studies to determine social interaction patterns and daily routines. They found that organisational arrangements and the physical design and characteristics of the homes could either promote or constrain the development of interpersonal relationships. When homes were small, organised on a group living basis, or where there was a plentiful supply of single rooms, with ample private as well as public space, new friendships occurred more readily. Some residents preferred the anonymity of larger groups with greater numbers to the physical design of small Unit-based group living. The authors noted that staff were untrained in group work. Problems tended to occur in small groups because of dominance by cliques or individuals, personality clashes, relatives' participation, and general misunderstandings. They conclude that because of the organisational and structural constraints, small group living does not offer an alternative life style. Most residents want more control over their physical environment rather than increased activities. For many of the women residents, the nature of the social relationships available in the homes may not meet their needs for friendships. Insufficient space in the homes means that visits from relative and friends are not as satisfying as they could be, because of the lack of privacy. There was much confusion about the degree and amount of time which staff could or should give to develop supportive social relationships with the residents. Willcocks et al (1987) recommend that the provision of more private space might enable more frequent visiting by relatives, and the possibility of forming meaningful friendships within the home. If homes were more attractive, visitors would come more frequently, including organisers of group activities as well as individuals. The authors viewed the presence of day care clients attending the homes on a daily basis as an impediment to the residents' sense of belonging which is necessary in a residential home. There is little possibility of fruitful relationships arising between residents and day care clients, because the day care clients pity and fear the more dependent residents, and the residents resent the day care clients for their independence. Willcocks et al conclude that design is a significant factor in promoting or impeding residents' relationships and well-being.

These British and Australian studies discussed the pervading influences of institutional regimes on the strategies adopted by residents to form relationships. Organisational relationships and spatial designs can be re-organised to promote personal and social relationships. Negative cultural attitudes towards ageing and dependence which are shared by both staff and residents reduce the potential for the development of these relationships. The success of research in finding out the true opinions of elderly residents is doubtful.

American studies on relationships of elderly people in residential care echo the same findings. They report that the effects of institutionalisation are negative, because of social losses as well as physical deterioration. Entering an institution can cause stress, upsetting a delicate equilibrium of health and social roles, with a resulting decline in health on admission (Lieberman, 1961). A change of room or a room mate can also cause this decline. Enforced relocation can be a negative experience for older people in poor health who are vulnerable for this reason. Minichiello (1986, discussed above) found that if admission to care is voluntary and the prospective resident plans it, then the adjustment to residential living is relatively without problems. Preparatory pre-entry programmes for future residents may reduce stress and negative effects on health.

Tobin and Lieberman (1976) argue that there is scant physical, social, or psychological difference between elderly people who are institutionalised and those who are not. Both have experienced loss, and are likely to have a confidante. Life in an institution (e.g. a nursing home) presents problems, such as lack of privacy. Residents encounter staff who are strangers or who may be members of racial groups whom residents fear and dislike because of long-held prejudices and racism. Residents need to find a new identity because of loss of previous roles. Two topics of conversation amongst residents are health and the institution itself (echoing Hockey, 1989, discussed above), with the underlying fear that if complaints are too frequent, relatives might cease to visit. Noelker and Poulshock (1984) studied the factors affecting the development of intimacy in an elderly persons' home in the USA. They chose an un-Goffmanesque home and used interview methods which drew on interpersonal perceptions of the meaning of intimacy. Nine out of ten residents reported at least one intimate contact mainly external to the home: 33% reported children, 12% other relatives, 23% external friends, and 32% other residents. Two out of three residents admitted feeling lonely, but more admitted that death was a concern. Staff, who held a negative cultural image of old age, did not confide or interact with the residents. By taking total responsibility for the residents' needs, the staff deprived residents of the opportunity to develop roles of reciprocity and exchange (Wellman and Hall, 1986, discussed above) of services.

Retsinas and Garrity (1985) undertook research with an *a priori* view of the nursing home as a lively social world with its own friendship patterns, in which social class and ethnicity are less significant than in the world outside, and where the fear of death may unite residents but also discourage intimacy. This study is important for noting how sensory deprivation and confusion affect relationships negatively. Using methods of observation and charting patterns of contact, they concluded that 33% were loners, that lucidity, speech and sight were key requirements for having friends, and that the long term residents tended to have fewer friends even when allowing for increasing disability. They noted the formation of dyads based on room location, and of cliques. They concluded that there was no difference in sociability between women and men, and that residents with frequent visitors socialised with other residents as frequently as those with fewer visitors.

Fontana (1977) studied a nursing home in the USA, using participant observation in order to understand life within an institution from the viewpoint of the patients and the staff. He concluded that patient-to-patient relationships were negative or lacking. Individual patients denied any similarity between themselves and the perceived inferior status of other patients who were more confused, disabled or mentally ill. Similarly, staff ignored the attempts of individual patients to build relationships because they perceived the patients as inferior. Tesch, Whitbourne, and Nehrke (1981) studied the friendships (which were not defined in their research), social interactions, and subjective well-being of older men living in an institution in the USA. They used the Philadelphia Geriatric Center Morale Scale and sociometric interviews. The men studied had little privacy, because they shared five-bedded rooms. The researchers found that the residents whose previous lives had been

relatively isolated were better adjusted to institutional life. The men valued outside relationships. They had negative perceptions of each other (echoing Fontana, 1977, discussed above). Within the institution, the men desired privacy and independence above contact with each other. Both Fontana (1977) and Tesch et al (1981) established that fear and dislike of other residents' disability (perhaps seeing their own future mirrored in others) may prevent residents from forming relationships with those perceived as less able.

Langer and Rodin's study (1976) was designed to test the concept of learned helplessness (Seligman, 1975). One group of elderly nursing home residents in the U. S. A. was encouraged to take decisions for themselves. Others, in a separate group, were not encouraged to do this, but were offered a high level of concern and care in which decisions were made by the staff. It was found that the group which made their own decisions felt more in control of their destinies, with an internal locus of control (Kuypers, 1972), rather than control ensuing from external forces. The well-being, morale, and adjustment of the residents was enhanced, as they were happier, more mentally alert, and showed long term positive responses.

3. 30 Summary of the Discussion of Specific Studies of Relationships of Elderly People in Residential Care

Bond and Bond (1987) provide a useful analysis of some of the major aspects of residential care for elderly people and raise issues pertinent to relationships. Dependency, which implies subordinate relationships, is present in the relationships between residents and staff. A number of studies examine the relationship between individualised regimes and the degree of institutionally induced dependency (Miller, 1985; Townsend and Kimbell, 1975 ; Booth, 1985), but the many factors involved in the process of determining the level of dependency make a direct cause-effect link unlikely. The significance of organisational relationships on staff practices and residents' behaviour is demonstrated (Bond and Bond, 1987). Staff practices in carrying out certain regular tasks such as mealtimes and bathing can either reinforce dependence or foster independence (Barton, Baltes, and Orzech, 1980). Bond and Bond (1987) note the importance of design and spatial arrangements, including placing of furniture, for promoting sociability as well as independence (Lipman and Slater, 1977, discussed in Chapter Four; Willcocks et al, 1987, discussed above). The organisational relationship of each residential home with its local community is important for the residents. Ideally, homes should be providing visual contact with the world outside as well as opportunities for participation.

Sinclair (1988), in a review of the research on elderly people's residential care, provides the following overview of aspects of relationships. Elderly people see the disadvantages of residential care as the loss of independence, privacy, and the need to mix with other elderly people who may be uncongenial. They see the advantages of residential care as the provision of comfort, physical care, and the reduction of loneliness. Most residents want the freedom of privacy in their own room and the choice of companions. They value company and interesting activities of their own choice. Many are said to be lonely, but have few ideas for overcoming this aspect of their lives. Sinclair (1988) presents additional evidence that group living is less successful in reducing loneliness than is intended (Booth and Phillips, 1987). Although the majority of residents state that they get along well with each other and make new friends, most research notes the low level of contacts in residential homes.

Sinclair (1988) states that residents make acquaintances, not friends: e.g. social relationships, not personal relationships. The staff of the homes are praised for their efforts to develop relationships. Visitors are important, and 66% to 88% of residents receive visits. Although volunteers are appreciated, they make little difference to residents'

over-all satisfaction with residential life. Negative attitudes about ageing, cultural attitudes about privacy, and fear of death and being associated with extreme levels of dependency may prevent elderly people from developing close relationships (Sinclair, 1988). The reason for low sociability is suggested to be the high turnover, not of the staff, but of the residents, as 20-30% die or enter hospital within one year of admission to care. Staff attitudes are important for determining the day-to-day experience of the residents. Care assistants exercise formal and informal power and determine the unwritten rules of the establishment; but the Officer-in-Charge has the greatest power. Most staff are unqualified. There is no evidence that trained staff function better than others. One of the reasons why staff are attracted to the job is their sense of altruism and interest in elderly people. Most residents and staff think that confused residents should be segregated from other residents, as their behaviour is viewed as objectionable.

Sinclair's overview (1988) is supported by the specific studies reviewed in the preceding section. Organisational relationships are influenced by rules and restraints imposed from outside the home, an example of the exo-system (Bronfenbrenner, 1979, discussed above and in Chapter Two) of the ecological perspective. Many variables influence relationships. One significant factor is the central role of staff, not as a source of significant relationships for residents, but for setting boundaries around opportunities for activities, and limiting or extending contact with other residents and with the outside world. Staff hold the key to organisational relationships which in turn determine the levels of institutionalised dependency (Bond and Bond, 1987). However, the lack of agreement about the optimum level of staff-resident relationships is noted (Willcocks et al, 1987). Most elderly people in residential care say they value personal relationships, and appreciate visits. Residents are ambivalent about the kinds of relationships they want, entering care partly because they are lonely, but at the same time disliking the loss of privacy and the enforced intimacy of communal living. Social relationships are needed for self-fulfilment, not just for utility. Reciprocity in social relationships provides a means of avoiding the stigma of charity.

British research reiterates the view that a true account of elderly people's opinions about residential care, including their relationships, may not be possible. The difficulty of gaining an accurate picture of residents' views (Booth, 1985, discussed above) is due to the compliance and powerlessness which are features of institutionalisation. Sinclair (1988) reinforces the frequently made statement (Booth, 1985, discussed above) of how difficult it is to gather residents' views. Residents fear the consequences of complaining. They are unable to think of any alternative residential provision which would improve what is currently being provided.

3.31 Overall Conclusions arising from the Chapter and Implications for the Research Design

In the extensive preceding discussion, personal, social, and organisational relationships were examined from different perspectives. The following reflections emerge:

1. The research discussed in this Chapter studies relationships both for their self-fulfilment orientation in promoting personal satisfaction, and for their utility value orientation in preserving health and maintenance of a chosen lifestyle. It could be argued that the utility value of a relationship which supplies practical aid to a dependent elderly person, but which does not affirm the individual's identity and self-respect, is diminished because of its neglect of the second orientation of self-fulfilment. Kahn and Antonucci's identification (1981) of aid, affirmation, and affect as the essential categories of social support is a characteristic conceptualisation of the roles and purposes of relationships. This trio of categories is effective because of its simplicity. It is applicable to personal, social, and organisational relationships, reciprocity and exchange, friendship, life events, transitions,

stress, and coping responses - the aspects of relationships explored in this Chapter. Organisational relationships must supply aid; social relationships must supply affirmation (of status and identity); and personal relationships might be expected to supply all three, but especially affect. It is likely that elderly people's relationships in residential care will need to include aspects of aid, affirmation, and affect, and residents will need to develop roles which fulfil these categories.

Weiss' provisions (1973, 1974) of social support (attachment, social integration, opportunity for nurturing others, reassurance of worth, a sense of reliable alliance, obtaining guidance) are also particularly relevant for evaluating elderly peoples' relationships because they take social and organisational relationships into account as well as personal relationships. They include the utility value orientation and the self-fulfilment orientation. There are no hard and fast boundaries between the categories of personal and social relationships, reciprocity, and friendships in these studies. The status of a particular relationship can shift from one category to another. Therefore the attempt to categorise is at best an imposition of imperfect analytical frameworks on a variety of relationships.

2. Ideologies of ageing permeate the research and influence research findings. The study of elderly people's relationships within residential care is inspired by a professional value base, which seeks to empower those who become consumers of residential services. Empowerment (Solomon, 1976) is a guiding principle which includes the need to discover the individuality and diversity of elderly people, to attack the bias of ageism (Townsend, 1986), and to establish a more positive image of old age. The extent to which elderly people themselves have internalised the negative stereotype (Townsend, 1986; Bowl, 1986) of old age can affect their potential for forming relationships, and is an important issue emerging from these studies. Elderly people's belief (Henderson, 1983; Gottlieb, 1985) that they do have social and personal relationships affirms their individual morale and status and is also an important consideration.

3. The exploration of so many different strands of current concerns and research about ageing, elderly people, relationships, and residential care raises issues for the research design. Most of the research is cross-sectional and lacks historical perspective (Jerrome, 1993a). The life course perspective (Blaikie, 1992, discussed above and in Chapter Two) provides a conceptual basis for the separate strands. The life course perspective emphasises context and continuity as influences on relationships in old age. Discovering the relationships of elderly people means taking past experiences and relationships into account. This personal continuity is grounded within historical and environmental contexts in which individuals influence, and are influenced by the different levels of the environment, as portrayed in the ecological paradigm (Bronfenbrenner, 1979, discussed above). The setting and regimes of residential homes, as well as residents' personal histories and styles of relationship-making, influence their relationships.

4. The subjects of this research are the very old, hardy survivors of the life course (Blaikie, 1992, discussed above and in Chapter Two), for whom dependency and death are more imminent than in the early years of old age. Some research discusses the social problem view of old age (Townsend, 1986, discussed in Chapter Two) in reference to a somewhat younger cohort of elderly people who are still living in the community. Therefore one must question to some extent the transferability of those conclusions for this research.

5. Conclusions drawn from the discussion of specific studies about relationships in residential care include the following reflections. Formal organisations facilitate formal social relationships (Merton, 1957, 1968; Raynes et al, 1979). The social environment of a residential home is embedded in organisational relationships (Bond and Bond, 1987).

Organisational relationships are influenced by rules and restraints imposed from outside the setting, by the large size of homes, and by inflexible staff roles. They need to develop more diffuse boundaries and adopt more of the flexible characteristics of family life (Katz, 1984; White, 1984). Individuals develop their own organisational relationships and form a community through a shared sense of identity. This can promote positive aid (Keith, 1990) and provide protest against liminality (Williams, 1986). Social groups of individuals become important as sources of moral practical support for ageing (Jerrome, 1989). The design of homes is important for achieving a higher standard of care (Lipman and Slater, 1977), but group living in residential homes is not successful in reducing loneliness (Sinclair, 1988). Activities improve morale (Stanger, 1988). Volunteers in residential care are motivated by the need for self-fulfilment in their relationships with residents (Lansley and Whittaker, 1992). Giving support to carers and residents through the admission process is important for sustaining their inter-relationships (Cartwright, 1991). Resident leaders who articulate the needs of their fellow residents are more able, sociable, get along with staff, and have had long-term friendships, as well as being known and respected in their communities (Hockey, 1983). When residents need to make new transitions, they refer to earlier transitions in their lives. The kinds of leadership relationships formed reflect a gender difference, with male residents assuming a leadership role on committees, and women becoming leaders in caring for others (Hockey, 1989; Jerrome, 1993a, b).

6. This study of relationships will be undertaken within a context which accepts the possibility of psycho-social growth and development (discussed in Chapter Two) in old age, and which values both social and personal relationships. Evidence from Chapter Two suggests that a different kind of relationship - more detached and philosophical (Erikson et al, 1986; Maslow, 1954, 1970, 1987; Jung, 1969. 1982, 1989 editions) - will be developed in later years and will replace to some extent the expectations of attachment and intimacy within personal relationships. Organisational relationships within residential settings will be recognised as powerful influences on individual relationships. Throughout these stated implications for the research design lies the evidence of the influence of professional values, which in theory would seem to lead the research towards optimistic and idealistic expectations of relationships. Yet, as discussed above, the research may result in findings which fail to fulfil expectations. Individuality and diversity of relationships may not be demonstrated. Ageism may not be challenged. Factors which may impede the development of relationships include loss of contemporaries from death, sensory loss, frailty and confusion, the transition to residential care, and fear and loathing of others' disabilities. Good practice, or any link between practice and relationships, may not be discovered. These issues will be explored because of their centrality to personal and professional values.

The next Chapter discusses the history, ideologies, and practices which shape residential care for elderly people. .

Chapter Four

A Review of Residential Care

4.1 Perspectives of Residential Care within a Climate of Change

This Chapter reviews the historical traditions, structures, issues, and different types of provision which characterise residential care. Residential care of elderly people has changed in the past, is currently changing, and will continue to change in the future. The continuing existence of residential care under the NHS and Community Care Act 1990 depends on collaborative organisational relationships between purchasers and providers of care. The purchasers are care managers whose role is to assess needs, plan, and purchase care packages from statutory and independent providers on behalf of potential consumers of residential care (Audit Commission, 1992). The providers are the agencies which offer service provision, including residential care. Organisational relationships within residential care affect life style choices, and ultimately the social and personal relationships (discussed in Chapter Three) of elderly people. These organisational relationships now are mediated by the requirements of the Community Care policy, which include financial assessments designed to reduce the numbers of elderly people living in institutions, along with attempts to professionalise care practice.

Relationships are valued components of professional care practice (discussed in Chapter One). Attempts to professionalise residential care may lead to a greater recognition of the importance of relationships of elderly people in residential care, but motives for professionalisation are not entirely altruistic. Self interest, and the desire to preserve the enterprise (Estes, 1979) of residential care may provide more potent motives than the desire to empower residents (Solomon, 1976, discussed in previous Chapters and below) and defeat the stigma (Goffman, 1963) of institutionalisation (Townsend, 1962, discussed in previous Chapters and below).

The first sections of Chapter Four discuss different types of residential care, their statutory base, historical development, and how these factors influence relationships.

4.2 Different Types of Residential Care

The starting point is to explore the range and breadth of residential care. As was made clear in Chapter One, my own professional area of interest is in social work and social care. Arising from this interest, the focus of this research is on residential homes, (traditionally viewed as part of social welfare provision) rather than on sheltered housing or nursing homes which relate to different professional fields of interest in housing and health.

The Registered Homes Act, 1984, defines a residential home as "any establishment which provides or is intended to provide, whether for reward or not, residential accommodation with both board and personal care for four or more persons in need of personal care by reasons of old age, disablement, past or present dependence on alcohol or drugs, or present mental disorder."

Residential homes are part of the social care provision of local authority Social Services Departments, private or voluntary organisations, and individual private proprietors. Fennell et al (1987) conclude that there is no 'typical' residential home because of diversity of size, internal design, philosophy, staffing, activities, and routines. The most frequently encountered Social Services-run home was purpose-built in the 1960s for an ambulant population of approximately sixty elderly residents, with mainly double rooms, some single rooms, and a few four-bedded rooms.

Nursing homes are similar to residential homes except that they provide skilled nursing and personal care. They employ qualified nurses as well as unqualified nursing assistants (Wilkin and Hughes, 1987). The Health and Social Services and Social Security Adjudications Act 1983 classified residential homes which do not provide nursing care separately from nursing homes (Tinker, 1992).

Sheltered housing schemes are different from residential homes and nursing homes. Sheltered housing schemes are not classified as a 'social service'. They are administered by local authority Housing Departments, or by private or voluntary housing associations and other providers, rather than by Social Services Departments. Sheltered housing occupants live independently as tenants with keys to their own front doors, in contrast to residential homes and nursing homes where elderly people are designated as residents or patients without tenancy rights to a particular room or bed (Wagner, 1988).

The distinction between these three types of provision is becoming less clear (Tinker, 1992). Some sheltered housing schemes also provide a team of Care Assistants and domestic staff who supply services to individual tenants. Some residential homes have dual registration (Tinker, 1992) under the Nursing Homes Act, 1975, where part of the home is designated to provide nursing care.

The fourth type of provision is long term geriatric nursing care in a hospital ward, and psycho-geriatric wards in mental hospitals run by the National Health Service. The trend in Health Service provision is to provide rehabilitation rather than long-term care (Wilkin and Hughes, 1987; Tinker, 1992). The hospital image of dormitory style beds predominates, but day rooms, occupational therapy, and rehabilitation facilities are provided. Unlike other types of residential care, NHS hospital care is provided without cost to the consumer. Despite the emerging trend of restricting Health Service care to the more acute cases and to rehabilitation, long term bed occupancy by elderly people continues in the Health Service, with a resulting outcry against 'blocking' expensive hospital beds by elderly people (Willcocks, 1986; Victor, 1990, 1994; Tinker, 1992). More recently the extent of the responsibility of the National Health Service for providing ongoing long term care to elderly people has come under scrutiny, with the intention of shifting much of the responsibility to social care provision.

4.3 Historical Development and Statutory Base of Residential Care

The historical development and statutory base of residential care influence the nature of relationships in residential care (discussed in Chapter Three). Organisational relationships predominate over personal and social relationships because the organisational regimes which determine the routine of daily living in residential homes were not intended to enhance residents' well-being, but to provide subsistence level care. In 1946 there were almost 63,000 elderly people in institutions and local government homes (Rowntree, 1980 edition). The homes were located for the most part in large residential premises which had evolved from the nineteenth century workhouses (Townsend, 1962; Means, 1986). Improvement in workhouse standards did not occur quickly enough in the 1930s and 1940s to prevent the public from becoming aware of residents' lack of personal possessions, personal items of clothing, comfortable chairs, and meaningful activities. When the opportunity arose in the post-war years to create a Welfare State, the priority was to reform existing services for elderly people (e.g. residential care) rather than to create alternative systems based on community care.

The National Assistance Act 1948 (discussed above) provided the legislative basis for the post-World War Two developments in residential services for elderly people. Part III (Section 21) of the Act states: "It shall be the duty...of every local authority... to provide residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them."

Means and Smith (1985) and Townsend (1962) criticise the failure to provide any general power to develop a wider range of services to benefit old people. The Act failed to give local authorities the power to provide domiciliary (home care) services, meals on wheels, counselling, or day care (Means, 1986). The Act expressed a firm belief in the benefits of residential care as the form of welfare provision appropriate for elderly people. The new residential homes were to be smaller and pleasanter. The stigma of accepting relief was to be abolished by introducing the 'hotel' concept (House of Commons, 1947; Means, 1986). Residents would pay for their board, lodgings, and care just as if they were living in a hotel. This idealistic view assumed that the stigma (Goffman, 1963) of institutionalisation, which had been instilled in the minds of elderly people over generations, would vanish overnight. The statutory provision for service development designated by the Act was limited, without the scope for developing the complex organisational relationships between providers of services which would have enabled more diverse services to develop. It was not until 1962 (Bowl, 1986, discussed in Chapter One) that the National Assistance Act was amended to enable local authorities to provide domiciliary services to old people.

4.4 The Enterprise of Residential Care

The post-World War Two emphasis on residential care rather than on domiciliary care was prompted in part by guilt about the low standards of the workhouse. This resulted in organisational relationships having to meet the personal and social relationship needs of elderly people. Political pressures and the existence of a considerable enterprise (Estes, 1979) and industry (Townsend, 1981; Challis, 1990) of Public Assistance Institutions (PAI), the former workhouses, also influenced the decision to retain residential care. Estes (1979, p. 2) defines the 'enterprise' as "the congerie of programs, organisations, bureaucracies, interest groups, trade associations, providers, industries, and professionals that serve the aged in one capacity or another."

Although Estes portrayed 1970s USA-based enterprises, the same features were present in Britain in the 1940s and in successive decades up to the 1990s. Self-interest motivated trade unionists and professional workers to retain ownership of residential homes so that managers' and care workers' jobs could continue. Concerns about the cost of hospital care and the traditional roles of residential homes as alternatives to hospital care, both aspects of organisational relationships, converged to create a powerful lobby for retaining residential care as a social policy priority (Townsend, 1986).

4.5 Summary of the Discussion of Types and Development of Residential Care

The generic definition of residential care includes residential homes, nursing homes, sheltered housing, and geriatric nursing care. This research is concerned with residential homes. Their post World War Two provision is founded on the 1948 National Assistance Act which emphasised residential care for elderly people instead of domiciliary services in the community, thus preserving the existing residential homes which had developed from the legacy of the Poor Law (discussed in Chapter One). With the introduction of the 1948 Act, it was hoped that the stigma (Goffman, 1963) of institutionalisation would disappear with the creation of homes like hotels.

The next Section of the Chapter discusses the influence on relationships in residential care of the literature of dysfunction, the increasing provision of residential care, including private care, and Care in the Community policies.

4.6 Anti-Institutional Attacks: The Literature of Dysfunction

The anti-institution movement drew attention to the continuing stigma of residential care in the early 1960s by arguing that residential care is detrimental to the well-being of residents. Goffman (1961) portrayed the 'total institution' as a regime with rigid procedures, rules, block treatments, and batch living, which met the needs of the administration, not the residents. Opponents of residential care made no distinction between the former workhouses, with their institutional character, and the newer, smaller residential homes built in the 1950s and 1960s. All were viewed as equally detrimental to elderly people's relationships. Each generation of politicians and social planners was criticised for not challenging the underlying ethics and effects of residential care on residents (Fennell et al, 1987). Research and publications of the literature of dysfunction raised doubts about the value of residential care for all client groups, including children (Bowlby, 1951), people with a mental handicap (Morris, 1969), mental illness (Goffman, 1961; Jones, 1967), physical disability (Miller and Gwynne, 1972), and elderly people (Townsend, 1962).

Townsend's The Last Refuge (1962), based on research conducted in old people's homes, exposed the extent to which the legacy of the workhouse lived on in local authority-run residential homes. Many residential homes were located in former workhouses. Rigid rules and humiliating procedures were not unusual. Residential homes had not succeeded in becoming like hotels. Townsend recommended ending the widespread use of residential homes for elderly people, and in their place, providing more sheltered housing, community-based services, and better financial benefits. Those who, like Townsend, attacked old people's institutions, argued that residential homes imposed a loss of privacy and identity on residents, so that residents "failed to make new relationships" (Means, 1986, p. 92) because they were isolated from friends, relatives and their own community. Despite the improvements in residential care, the stigma of residential care did not vanish altogether. Organisational regimes and relationships (Goffman, 1961; Townsend, 1962; discussed above and in Chapter Three) continued to exert a negative influence over the development of personal and social relationships.

4.7 Increasing Provision of Residential Care

In the years following The Last Refuge (Townsend, 1962), the numbers of residential homes increased, despite the impact of the anti-institution lobby (Sinclair, 1988). Although a programme of capital building in the 1950s and 1960s replaced many of the former workhouse buildings, some of these remained in use as old people's homes, and some former hotels were converted for residential care (Willcocks et al, 1987). Many of the 1960s local authority homes, built in the 'communal' style (discussed below), were adapted in the 1980s to Unit living style homes. Those homes which proved too costly to bring up to new higher standards were closed or sold to the private independent sector (Wilding, 1992, discussed below). The demand and take-up rose, although it still represents very small proportions of elderly people: about 5% of those 60+ and 8% of those 75+ (Stevenson, 1989).

The reasons which account for the growth of residential care fall into three broad categories:

i.) reasons to do with elderly people and their carers;

ii.) reasons to do with the organisation and delivery of services for elderly people; and

iii.) the traditional image of residential care as a solution for frailty and dependence.

Reasons which are concerned with elderly people and their carers include the demographic rise in the numbers of elderly people who survive to a very old age (CSO,

1991; OPCS, 1992). The increase in the numbers of very old people (85 + years) many of whom are physically and mentally frail, has placed a resulting strain on their carers - chiefly female family members (Wright, 1986; Thornton, 1989). Contrary to popular fears that levels of care provided by family members might decrease because of the availability of the welfare state's provisions (Moroney, 1976; Hagestad, 1988; Shanas, 1979; and Bengtson, Rosenthal, and Burton, 1990, discussed in Chapter Three), studies indicate that most elderly people do receive support from their families. Some elderly people are not so fortunate, because they either have no relatives, live at a distance from their close relatives, are estranged through divorce, other circumstances, or their children or spouses are themselves incapacitated through age or disability (Warnes et al, 1985; Jerrome, 1990, 1993, discussed in Chapter Three). A rising incidence of elderly people live alone at a distance from their families who might not be available to provide help in a crisis (CSO, 1989; OPCS, 1989; Bulmer, 1987). Stress on carers increases as elderly people live longer (Wright, 1986; Thornton, 1989). The poverty of many elderly people causes some to become homeless (Drake et al, 1981; CSO, 1992). Entry to residential care may be prompted by the inability of family members, for a variety of reasons, to provide a caring relationship at a time of crisis.

Reasons associated with the organisation and delivery of services include the high cost of providing care for elderly people in hospital beds (Tinker, 1992), with the accompanying fear that elderly people were 'blocking' acute care beds (Victor, 1990, 1994, discussed above). Most importantly, the lack of comprehensive and integrated community-based services (House of Commons, 1985; Audit Commission, 1986) has created a pressure for more residential places. Insufficient community-based programmes such as cleaning and shopping services, day centres, transport, medical care, home-based nursing and personal care available twenty-four hours a day, together with counselling and supportive relationships, adequate housing, and pensions to support frail elderly people in the community, pushed elderly people into residential care (Townsend, 1962; Wade et al, 1983; Sinclair, 1988). Means (1987) argues that the lack of community-based services keeps women in their roles as unpaid carers, thus explaining the low commitment on the part of social policy planners to develop more supportive services which would enable elderly people to live in the community.

Other powerful organisational reasons for the growth in residential care include a lack of consensus amongst social policy makers about how to meet the needs of elderly persons (DHSS and Welsh Office, 1978; DHSS, 1981); and difficulty in agreeing the best mix of community-based and institutional care to be delivered by a range of different professional and non-professional staff. Professionally qualified and other staff responsible for the provision of services are divided between Health Service programmes, Social Services Department programmes based in local authorities, and private and voluntary services. Co-ordination and collaboration on a large scale needed different forms of legislation and funding (DHSS, 1985; Audit Commission, 1986) and led to the introduction of the NHS and Community Care Act 1990, implemented in 1993. The over-all picture is of a lack of sufficiently sophisticated organisational relationships, resulting in a piecemeal growth and delivery of residential care and other services.

The third reason for the increasing provision of residential care is the tradition of turning to residential care as a solution for increased dependency. The image of the residential home as a solution to the need for care, although historically negative, remains powerful. Elderly people, when facing increased dependency, still think about 'going into a home' as an inevitable step, perhaps because they are not given sufficient information about alternatives (Sinclair, 1988). Sinclair (1987) argues that most elderly people who enter residential care do so reluctantly. They would rather remain in their own homes (Bowl, 1986; Townsend, 1981). The actual moment of admission to care is often precipitated by a crisis, involving a combination of the reasons discussed above: a fall requiring hospitalisation, together with a breakdown in the health of the

carer, linked to insufficient availability of community based services (Minichiello, 1986, discussed in Chapter Three).

4.8 The Complexity of Organisational Relationships in Residential Care and the Development of Private Care

The independent sector of private residential homes provided the greatest increase in admissions to residential care in the 1980s. In 1986 about 56% of elderly residents were in statutory local government-run establishments; 20% in voluntary homes, and 24% in privately-run homes (Means, 1986). Over double the number of residents were in private care (Audit Commission, 1986) in 1984 (55,000) compared to 1979 (26,800). The expansion in private care was funded by a change in the Supplementary Benefit Regulations (now Income Support) in 1979 which enabled residents in private care to apply for and receive state financial support for residential care from board and lodgings allowances (Bond, 1987; Peaker, 1988; Tinker, 1992). The changes in legislation made it possible for the care industry to become profit making (Tinker, 1992; DHSS, 1987; National Audit Office, 1987). Elderly people from a wide socio-economic range were able to enter residential care without requiring prior assessment of their actual need for care, or considering community-based alternatives. The amount of social security funding for private care of elderly people was over £1.1 billion a year in 1989 (Heptinstall, 1990). The Audit Commission (1986) argued that the social security payments spent on funding private care diverted money from developing community-based services which might provide alternatives to residential care.

Before the 1993 implementation of the NHS and Community Care Act, 1990, many social workers, managers, and residential care staff employed by local authorities criticised the growth of private care (Phillips and McCoy, 1990). One reason for this criticism was self-interest in the 'enterprise' of care (Estes, 1979, discussed above; Townsend, 1981). Some local authority residential homes transferred to private independent ownership because central government funding was made available for private care. This was an attractive option for cash-limited local authorities. Some local government staff were made redundant when homes closed or transferred to private ownership (Peterborough Citizen, 3 December, 1992). A more idealistic reason for opposing private residential care is the belief that the ideology underpinning private care is incompatible with the aims of social welfare intervention (Mendelson, 1974; Weaver et al, 1985; Willcocks, 1986). Another critical view of private care is the belief that local authority owned homes are forced to admit the more dependent elderly residents, with private care taking the more able residents, and rejecting the truly frail and dependent applicants (Willcocks, 1986; Townsend, 1986). This fear has not been proven conclusively so far. Some studies suggest that similar dependency levels exist in private and statutory residential homes (Wade et al, 1983); while other studies find lower dependency levels in private care (Tibbenham, 1985).

The rise of private independent care introduced another organisational structure into the already complex mix of residential care organisations. Creating systems of collaborative and co-ordinated organisational relationships for Care in the Community became necessary but was difficult to achieve. The NHS and Community Care Act 1990 was intended to create better systems, and these are now developing.

In contrast, organisational strategies for children's services are markedly different from those for elderly people. Even as local authorities built more residential homes for elderly people (Sinclair, 1988), they closed many of their existing children's homes (Parker, 1988). Social services for children were increasingly diverted to community-based intervention with the declared aim of preventing children from being taken into care. This change was promoted by new legislation and enabled by financing measures (Wagner, 1988). Professionally trained staff in the Children's Departments, established in 1948, were able to meet the increased demands for counselling and preventive intervention (Parker, 1988). Unlike the changes taking place in children's

services, large scale closures of old people's homes and the substitution of community-based services in their place did not occur, despite developments in domiciliary care.

The combination of ageism (Comfort, 1977; Townsend, 1986; Phillipson, 1982; Itzin, 1986), the tradition of institutionalisation (Goffman, 1961; Townsend, 1962, 1986), the increasing pressures for admission of more elderly people (DOH, 1989; Audit Commission, 1986), the absence of alternative programmes supported by specific legislation and financing, and the lack of professionally trained workers who could develop community based services as an alternative (Martin et al, 1988; NAO, 1987; Tinker, 1992), meant that residential care of elderly people continued as an industry and growing enterprise (Estes, 1979, discussed above) for local authority Social Services (Wagner, 1988). The enterprise grew to include the independent private sector of residential care providers, which has a profit motive and probably an ideological motive for preserving its business. One part (residential child care) of the residential enterprise (Estes, 1979) diminished, but another (residential care of elderly persons) increased. Organisational relationships continued to predominate over personal and social relationships because of the legacy of the past. Organisational relationships grew more complex yet remained uncoordinated.

4.9 Care in the Community Policies and Residential Care

The National Health Service and Community Care Act 1990 was implemented in 1993. Care in the Community aims to return institutionalised people to the community, and to prevent or postpone the admission of vulnerable people to institutional care. The NHS and Community Care Act requires prior assessments of people seeking to enter residential care. In theory, these enable the most suitable decision to be made for meeting clients' needs. Assessment also controls the level of central government spending which funds individuals in private residential homes. A proportion of the Income Support payments made by central government for residential care is set aside to enable community-based services to develop.

The reasons (Tinker, 1992) for the popularity of Community Care include generally held beliefs backed up by the literature of dysfunction (Townsend, 1962, discussed above) about the importance of personal and social relationships: that it is more beneficial for an individual to live in the community than in an institution; and that institutionalised people are human beings who have basic rights to live as ordinary people in the community. More pragmatic reasons (discussed above) emerge from the contexts of organisational relationships - the diminishing need to institutionalise people because of the development of drugs and other methods of controlling disturbed behaviour, the escalating cost of residential care, and the difficulty of recruiting and retaining adequate staff for the residential institutions. Interpretations of how Community Care should be implemented are diverse (Tinker, 1992), ranging from substitution of domiciliary services for residential care, to more sophisticated concepts of networks of social relationships involving family members, friends, and neighbours providing informal care (Seebohm, 1968; Wenger, 1984, discussed in Chapter Three).

The Griffiths Report (1988) recommended that local authorities manage the over-all delivery of Care in the Community, but not as sole providers of services. Local authorities now are required to develop organisational relationships with providers of health care, housing, and private and voluntary social care. Residential care is at the heart of discussions about Care in the Community, with organisational relationships an important issue. Henwood (1992) criticised Care in the Community plans, voicing concerns about assumptions that residential care is unacceptable, and that Community Care will be less expensive and reduce the demand for residential care. Although politically unpopular at the time of its publication (Eaton, 1992), the Henwood report drew attention to the withdrawal of NHS long stay beds for elderly people, and the lack of funding for appropriate alternatives (e.g. residential beds) to be purchased in the community. Grundy and Arie (1982) and Sinclair (1988) advocate an expansion of

residential care because of demographic trends suggesting an increase in the numbers of very old dependent people.

Local authorities must now think through the implications of their industries and enterprises of social care (Estes, 1979), including their residential homes. In view of the arguments voiced by Henwood (1992), it seems unlikely that residential care will disappear. It may be used more purposefully in the future to provide support for carers through the use of short-term respite care, thereby helping more elderly people to remain in the community (Sinclair and Williams, 1990). Organisational relationships may not become less complex, but the intention of Care in the Community legislation is that they become better co-ordinated. Residents' well-being can be promoted by providing more than a subsistence level existence. Improving residential care standards may facilitate personal and social relationships within the context of the organisational relationships of residential care.

4.10 Summary of the Discussion of the Literature of Dysfunction and the Growth in Residential Care

The literature of dysfunction (Goffman, 1961; Townsend, 1962; discussed above) attacked residential institutions for de-humanising residents, making no distinction between former workhouses and the modern smaller homes. Townsend (1962) recommended the closure of residential homes for elderly people. Despite this, as we have seen, residential care grew rapidly because of the increased numbers of elderly people, the ease of funding through private care, the high cost of hospital care, and lack of sufficient community-based services. Most elderly people enter residential care reluctantly. The biggest increase in residential care was in the private independent sector due to easily obtained government funding. Care in the Community legislation is designed to reduce the numbers of elderly people in residential care, but Henwood (1992) suggests that the need for residential care will continue. Organisational relationships and structures continue to influence the lives of residents, but with the development of Community Care, organisational relationships may become more supportive of personal and social relationships.

Having traced factors which explain the growth of residential care for elderly people, and its current changes, the next sections outline present characteristics of residential homes, their populations, and care practices, and how these affect the relationships of elderly people.

4.11 Dependency Levels and Their Effects on Relationships

Different types of generic residential provision (residential homes, sheltered housing, nursing homes, and geriatric hospital care, discussed above) are designed for different levels of frailty and dependence. Decisions about who goes into which type of residential provision are not based usually on concerns about relationships but on disability levels. Sheltered housing is intended for the most active, residential homes for more dependent, and nursing homes and hospitals for the most dependent elderly people.

The interpretation of 'needing care and attention' (National Assistance Act, 1948) which determines eligibility for residential care has now expanded to include confused, incontinent elderly people whose mobility may also be limited. The received wisdom of residential care staff is that they are looking after a more dependent group of people then they used to (Stevenson, 1989). It is a widely held but not entirely proven belief that elderly people who seek to enter residential homes are increasingly dependent compared with the resident population of homes a generation ago. The Officer-in-Charge of one of the homes visited for the research commented: "Twenty years ago, the new admissions to care had to be able to make their own beds. Now we get them unable to walk, doubly incontinent, not aware of their own identity."

The 'increased dependency' belief is based on several factors: the reduction in the number of long term geriatric hospital beds; the development of community services which enable individuals to postpone entry into residential care, individuals' own wish to remain in the community as long as possible, and increased longevity (Sinclair, 1990). These have created a trend for later entry into residential care, when physical and mental frailty are more likely to occur. The average age of residents in residential homes is higher than it was in the 1950s. In 1982 it was estimated as 85.1 years for women and 83.2 years for men (Willcocks et al, 1982). Three times as many women as men live in elderly persons' homes (Willcocks, 1986) due to the increased longevity of women compared to men.

There is no conclusive evidence of widespread heavy dependency levels amongst residents. Some research (Booth, 1985; Townsend, 1986, discussed above) supports the increased dependency view, but only for certain residents. Townsend (1986) analyses studies of dependency levels in residential homes for elderly people from 1958 to 1982, and concurs with Booth (1985) that the incidence of dependency levels in residential homes has not increased markedly over the years, that as many as two-fifths of residents can perform all or nearly all of their self-care tasks, and that residential staff, because of their caring roles, tend to take a pessimistic view of residents' capabilities, and therefore assist in the structuring of dependency. These arguments ignore the three-fifths of the residents needing help and attention of varying levels for their personal care. Townsend's arguments also pre-date the introduction of the NHS and Community Care Act 1990 which is designed to prevent or postpone admission to care. More recent data support the view that residents are not only older on admission, but are more frail and confused (Tinker, 1992).

Phillipson (1982), and Townsend (1986) argue that structured dependency contributes to the growth of residential care. For example, the perceived need to minimise risk of accidents leads relatives and social workers to pressure elderly people to trade independence for the safety of residential care. They argue that institutional care, along with compulsory retirement and inadequate pensions, are key components of structured dependency. Booth (1985) suggests that increased dependency dominates professional thinking to the extent of creating a new stereotype of the general care population based on the characteristics of a minority of residents. In reality there is an overlap in characteristics of the residents of the differing types of care provision (Bond and Bond, 1987). When surveys of residents' dependence levels have been undertaken (Townsend, 1962; Gilleard, 1980; Bond and Carstairs, 1982; OPCS, 1991), a wide range of dependence is shown to exist within each type of care.

Although categorisation according to dependency levels is an accepted principle of managing residential care and establishing organisational relationships, each type of provision contains examples of multiple regimes (Booth, 1985) co-existing within individual establishments. Multiple regimes are intended to meet differing needs of residents, but in some homes they exist simply because of staff attitudes. The differing levels of physical and mental frailty within residential care sparked a debate about the desirability of segregation according to disability level and types within and between homes. Some planners favour establishing specialist Units within homes (Pettit, 1984). Unit-based residents would have to meet certain types of disability criteria. Others argue that integration of different abilities within homes would not be detrimental to the majority of residents, provided resources are adequate (Meacher, 1972; Wilkin, 1983). Keeping residents close to their neighbourhood and family, rather than segregating them in specialist units, is the most important placement criterion for many professionals (Willcocks, 1986). The issue of increased dependency leading to multiple regimes highlights the importance of effective organisational relationships which can manage the diversity of dependency so that individuals' personal and social relationships thrive. Placement on the basis of dependency levels

creates a greater responsibility to ensure that personal and social relationships of the residents are not forgotten.

The postponement of entry to residential care leads to a high turnover of residents due to death and hospital admissions (a turnover of two-thirds over two years in Booth's 1985 study). These factors may contribute to the stress felt by staff (Willcocks et al, 1987) and a possible reluctance to involve themselves in anything other than superficial personal and social relationships with the residents. Care staff provide intimate physical care and interact with groups of very old individuals on a day-to-day basis. When one of the group dies, another elderly person takes up the vacancy of the empty bed within a matter of days. In a home of sixty residents, forty will die within two years. Few of the staff receive training in strategies for countering the effects of loss and bereavement on residents or on themselves (Tinker, 1992; Willcocks et al, 1987). Residents also may be reluctant to form new relationships with others for the same reasons.

4.12 Aims of Residential Homes: Care and Control and Their Influence on Relationships

The aims of residential homes for elderly persons are only implicitly understood and defined (Willcocks, 1986, discussed above). The provision of care and control is central to every definition. Activities concerned with care and control take place on a day-to-day basis as part of the homes' organisational relationships, which in turn influence the social and personal relationships of the residents. The declared aim of the 1948 Act of providing 'care and attention' is ambiguous because 'care' can be interpreted in many different ways. The variety of conditions requiring care and attention are now interpreted as physical and mental disability of a severity never dreamed of in 1948, when people with such conditions would have been allocated to hospital care. Does providing 'care' mean that no hope of change or rehabilitation is possible or desirable? The care provided by residential homes can include rehabilitation, development of skills, or providing a therapeutic community. None of these aspects of care have been promoted widely as part of the provision of residential homes for elderly persons (Townsend, 1986). There is some evidence of rehabilitation (Williams, 1980) in the use of short term admissions for crises involving poor housing and self-neglect, followed by re-housing and the introduction of a package of community based services.

In both social work and the health professions, 'care' is undervalued as a professional intervention (Walton and Elliott, 1980). 'Care' has been regarded traditionally as requiring fewer professional skills. Its outcomes are less dramatic than acute care. It is viewed as maintenance, rather than bringing about change (Willcocks, 1986; CCETSW Expert Group, 1992). Professional social work developed a body of practice theory intended to bring about change rather than providing care (Compton and Galaway, 1984; Pincus and Minahan, 1973; Ahmad, 1990). The medical profession concentrates its efforts traditionally on curing patients, sometimes to the detriment of elderly people who have been perceived as needing care rather than cure (Tinker, 1992; MOH, 1956; Wilkin and Hughes, 1987). The relegation of 'care' to the bottom of the professional stockpile of skills, knowledge, and competences is evidence of the values of society which reserves its highest level of intervention for groups of people who have the potential to become economically productive (e.g., children, discussed above). Society penalises old people and others who are not economically useful (Bowl, 1986; Key, 1989; Fennell et al, 1988). The tendency to value economically productive people may also be noted in the speed with which residential care for children declined in response to findings about the harm caused by institutionalisation (Bowlby, 1951, discussed in Chapter Three). In contrast, residential care for elderly people continued to expand in the years following the literature of dysfunction's revelations (Goffman, 1961; Townsend, 1962, discussed above).

Taking an alternative view, Townsend (1986) argues that residential homes for elderly people continue to have an implicit aim of social control (discussed in Chapter One). In the nineteenth century, the spectre of the workhouse (Longmate, 1974) served as a deterrent to people who sought relief. In the latter part of the twentieth century, admission to a residential home can be used to deter demand for a higher level of more expensive community-based service. The aim of 'care' can be interpreted as looking after helpless people who cannot be expected to do anything for themselves. The resulting pitfall is the creation of structured dependency and with it, social control (Townsend, 1986, discussed above) by smothering residents with too much help (Ward, 1980). For example, one of my students revealed her underlying assumption of care and control when she described a residential home for elderly persons as "a place for them to end their days." This assumption was challenged, and she was asked why the home could not be a place for residents "to live their lives".

Her comments indicate the widely held ageist view of elderly people and the role of residential homes in structuring dependency (Townsend, 1986). By implication, personal and social relationships will be undervalued, unrecognised, and subsumed by the organisational relationships which maintain structured dependency. Care, interpreted narrowly, leads to control and then to structured dependency.

The next section explores how the lack of specific aims for residential homes inhibits the development of strategies for good care practice and the evaluation of residential care practices. The 'good care practice' movement pushes the aims of care towards higher levels of specificity, so that they can be used as tools for practice which promotes the value of personal and social relationships.

4.13 Good Care Practice as a Mitigating Factor for Institutionalisation

The caring professions of nursing and social work defend the continuing existence of residential homes with an argument based on the need for good care practice. Good care practice is promoted as a mitigating factor (Atherton, 1989) for the damage caused by institutional regimes. Many professional social workers (Atherton, 1989; Brearley, 1990) believe it is possible to create 'good' institutions out of 'bad' institutions. If so, the continuing existence of institutions and the need for professional training of residential workers is justified. The argument's assumption is that residential homes will continue to exist as enterprises (Estes, 1979; CCETSW Expert Group, 1992); and that criticisms made by the anti-institution movement (Townsend, 1962; Bowlby, 1951; Miller and Gwynne, 1972; Goffman, 1961) can be countered by developing good care practice.

The negative effects of institutionalisation may be attributable to the regimes and interactions within care, rather than to the existence of institutionalisation itself (Booth, 1985). Booth (1985) balances discussion of the intrinsic harm caused by institutions (the view of the literature of dysfunction, discussed above) with an overview of the 'good care practice' approach, which apportions blame for the poor quality of life within institutions to poor care practices. If care practices and philosophies were more supportive and enabling, then residential life would improve in quality and personal and social relationships would be enhanced. Unlike Townsend's recommendations (1962, discussed above), the good care practice approach does not conclude that residential homes should be replaced. The care 'enterprise' (Estes, 1979) and 'industry' (Challis, 1990) find good care practice an attractive justification for retaining residential homes rather than developing community-based alternatives.

Those who promote the 'good care practice' approach are interested in expanding the aims (discussed above) of residential homes to include more than care and control. For example, in the 1970s, the Personal Social Services Council defined the policies (or aims) of residential homes which should determine care practices. Physical care or 'tending' (Parker, 1981) was not enough; giving food, shelter, warmth, and keeping

people from harm needed to be matched by policies of fulfilling individual needs, including personal identity, making decisions, participation in daily life, and forming relationships (Booth, 1985). These aims support the trend (Sinclair, 1988, discussed above) of establishing good care practices as an alternative to addressing the underlying issue of whether the provision of residential homes is desirable, practical, and effective social policy. Good care practices promote the importance of personal and social relationships for residents, but nevertheless need to be viewed critically.

The 'good care practice' approach is used to support the need for more training for residential staff and for professional social work's colonialisation of residential care. More and more guidelines, theories, and models of care practices have been developed (Ainsworth and Fulcher, 1985; CCETSW Expert Group, 1992; CPA, 1984; Goldberg and Connelly, 1982; Barrowclough and Fleming, 1986). The Certificate in Social Service Scheme (CSS), introduced by the Central Council for Education and Training in Social Work (CCETSW) in 1975 as a part-time qualifying course for residential workers, promoted models of care practices (CCETSW, 1974). The CSS qualification had been designed originally in 1975 as a separate qualification for residential care workers, but not as a professional social work qualification. In 1988, CCETSW agreed that the Certificate in Social Service Scheme was to be recognised as a professional social work qualification. This decision helped to promote the professionalisation of residential care.

With the move towards a more professionally trained staff, residential care of elderly people now shifted its interpretation of 'care' increasingly towards a therapeutic intervention. By implication, residential homes are viewed increasingly as therapeutic communities and centres for rehabilitation. Yet the aims of residential homes remain implicit rather than explicit in the new literature which is emerging. The tacit acceptance of residential homes as potential forces for good supports the criticisms of Townsend (1962), Goffman (1961) and others from the traditions of the literature of dysfunction that residential homes continue to provide a means of social control (Willcocks et al, 1987, discussed above). Residential care, in their view, marginalises people whom society rejects as unfit, disturbing, and economically unproductive (Sinclair, 1988; Evers, 1984; Ford and Sinclair, 1987; Townsend, 1986). Introducing 'good care practices' and professionalising residential work provides a means of retaining control and authority in the hand of professionals. Professional staff may assuage their guilt feelings by promoting good practice, while at the same time continuing to support the enterprise (Estes, 1979) of residential homes. As stated earlier in this Chapter, the belief in institutional care practices as a force for good is not based entirely on altruistic concern for the recipients of care. Planners, organisers, and academics whose field of interest is the enterprise of residential care benefit as well by retaining their professional roles.

The subject of this research, and my own professional role, are part of the movement to raise the standards of, and therefore justify, the enterprise (Estes, 1979; Townsend, 1981) of residential homes. As an educator involved in professional social work education, I occupy a place within the network of self-interest (Townsend, 1981) which seeks to preserve residential homes because of my interest in educating social workers for practice in residential settings. The research will need to take account of this purpose and possible bias on my part in the way information on relationships is gathered and analysed.

4.14 Summary of the Discussion on Diversity of Residential Homes' Population, the Aims of Care, and the Development of Good Care Practice

The population of residential homes is diverse and heterogeneous (Fennell et al, 1988, discussed above). Women predominate for demographic reasons, and the average age of admission has been increasing due to improvement in community-based services.

The turnover in the residents is rapid. Two-thirds of the population changes in two years, due to death and hospital admissions (Booth, 1985). This inhibits the development of personal and social relationships because of constant losses. Despite a general perception that residents are now more dependent than they used to be, Townsend (1986) disputes the greater proportion of dependency levels. He attributes rises in admissions levels to structured dependency caused by compulsory retirement and inadequate pensions, resulting in forced admission to residential care. Dependency levels overlap in all kinds of residential care, raising issues about whether placement policies should segregate residents on the basis of disability, or place a mixed range of dependency together in one home or in Units within a home. Placements based on dependency levels and which ignore individual characteristics and attachments will not enhance personal and social relationships. The aims of residential care for elderly people are articulated only implicitly. They include both care and control. Direct care giving is an undervalued professional intervention. The development of good care practice is promoted as a mitigating factor against institutionalisation, and as a means of professionalising residential work. The professionalisation of residential work includes the promotion of personal and social relationships.

The next sections review a number of models and frameworks of good care practice which promote relationships.

4.15 Models of Care and Good Care Practice in Residential Homes for Elderly People and Their Views of Relationships

The movement towards developing models of good care practice gained its initial impetus from the literature of dysfunction (Jones, 1967; Goffman, 1961; Townsend, 1962; discussed above). Analytical frameworks for evaluating residential care first identified the features of institutionalisation present in an establishment. These were contrasted with features intended to counter the effects of institutionalisation. Miller and Gwynne's study (1972) of a home for adults with physical disabilities identified two models of care. The warehouse model emphasises physical care and dependence, and consequently denies individual social and emotional needs. The horticultural model enables the development of potential by encouraging choice and emphasising independence. Miller and Gwynne (1972) call attention to the dangers inherent in each model in that the one (warehouse) denies the need for independence while the other (horticultural) denies the reality of dependence. Some workers adopt the horticultural model as a guideline for practice, neglecting to develop an eclectic model which might take more account of the individual's actual situation. The extremes of each model lend themselves to a particular type of relationship. The warehouse model minimises the importance of personal and social relationships in favour of predominantly managerial and hierarchical organisational relationships. The horticultural model facilitates the dominance of personal and social relationships. In reality, a mixture of personal, social, and organisational relationships is needed within residential care.

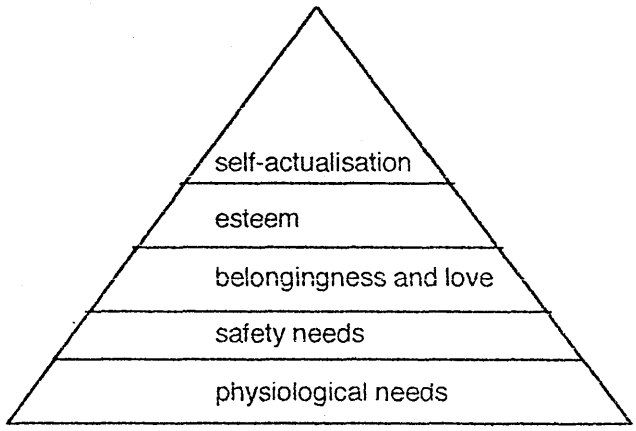
The activity theory of ageing (Havighurst, 1948, 1960, 1972, discussed in Chapter Two) contrasted with disengagement theory (Cumming and Henry, 1961, discussed in Chapter Two), can lead to overly simple paradigms for care practice. These theories can be used mistakenly to promote polarised extremes as strategies for good practice. They suggest a view of elderly people as homogeneous stereotypes, rather than as complex, diverse individuals. They may support unwittingly the development of rigid regimes based on one or other of the polarities. The application of these contrasting theories to practice leads to different evaluations of relationships. Activity theory enhances the importance of personal, social, and organisational relationships, while disengagement theory tends to undervalue all three kinds of relationships.

Wolfensberger's normalisation or social role valorisation model (1972, 1982), developed initially in the context of people with learning difficulties, influences residential care for elderly people. Normalisation promotes a culturally valued life style

for devalued groups in society. Elderly people, as far as possible, should be enabled to lead a 'normal' life according to the standards which are considered satisfactory by the mainstream of society (Wolfensberger, 1982). Normalisation leads to the promotion of community-based services rather than residential care. When applied to residential care, it mitigates some of the negative effects of institutionalisation. Normalisation may be threatening to existing residential staff within the industry (Challis, 1990) and enterprise (Estes, 1979) of residential care. It alters the power balance in the relationships between staff and residents. It promotes empowerment (Solomon, 1976) of residents, and delivery of different kinds of services in different ways. Normalisation leads to an analysis of existing personal, social, and organisational relationships so that they facilitate structural changes in service delivery.

Maslow's hierarchy of needs (1954, 1970, 1987, discussed in Chapter Two) provides a framework for promoting and evaluating good practice within residential care (Ward, 1980). Five steps on the hierarchy are identified, each one of which is a need which must be satisfied before proceeding to the next step.

FIG 13 Maslow's Hierarchy of Needs (1987 edition)



Maslow's interpretation of needs promotes the development of personal relationships and social relationships, but rather neglects organisational relationships. Social workers use Maslow's hierarchy of needs as a tool for developing practice in residential care establishments. Atherton (1989) criticises Maslow's model for being individualistic and not accounting for possible conflicts in the needs of residents.

Davis' model (1981) for developing residential care practice compares residential regimes with aspects of family life and relationships. Family relationships can provide fulfilling personal relationships, as well as social relationships within the wider extended family (discussed in Chapter Three). Complex networks of family relationships share some of the characteristics of organisational relationships. Davis identified family substitutes (small informal units), or family complements (assisting families by providing respite, refuge and rehabilitation) as comparative paradigms. The flaw in these analogies is their assumption of a view of family life as ultimately 'good'. Davis' model fails to take account of the high prestige and status attached to public boarding schools, which are residential establishments characterised as family alternatives because they are not based on patterns of family life. Residential homes for elderly persons also are based on a family alternative model but lack the high status of the public school. Residential homes which provide short-term respite care to relieve the family carers of elderly people living in the community function as family complements. The family analogy for residential care probably works best in relation to children's homes because the pattern of a desired family life for children is clearer, even in the current climate which recognises alternative family life styles (Martin and Martin, 1978; Thorne, 1982; Allen, 1979). When trying to specify a desired family life style for elderly people, there is less agreement about the patterns of family life for

elderly people (Featherstone and Hepworth, 1990; Qureshi and Walker, 1987). Most elderly people live alone or with their spouses. Assumptions that elderly people as a whole prefer to live with their adult children are not substantiated in existing research (Tinker, 1992; Bond, 1990, 1993; Laslett, 1989; discussed in Chapter Three).

The use of space and design within residential homes has been an influential approach for developing good care practice. It promotes organisational design as a facilitator of personal and social relationships. Harris, Lipman, and Slater (1977, discussed in Chapter Three) argued against the use of the hotel-type communal design (discussed above) with its large communal dining rooms and lounges because this design encourages disorientation, dependency, and demeans the residents. This argument was influential in changing the design of residential homes. Unit-based living, in which residents live in small group clusters of 6 to 8 people with single or double bedrooms, sharing a kitchenette, dining area, and lounge, has become more prevalent. Many communally designed homes were converted to Unit living in the 1980s (Barrett, 1976; Lipman and Slater, 1977, discussed above). Although group living is intended to break down the effect of institutionalisation by providing opportunities for relationships between residents, there is evidence that staff find group living Units stressful. Residents in small Units do not necessarily develop close relationships with each other. Rather, they find it more difficult to maintain privacy in the close quarters of group Units (Willcocks et al, 1987, discussed in Chapter Three). Booth and Phillips (1987) argue that problems of group living arise from flaws in implementation rather than being an intrinsic weakness. Positive staff attitudes, good staffing levels, and the leadership of the Officer-in-Charge are identified by Johnson (1993) as some of the factors necessary for successful group living. Significantly, in the successful instances of group living detailed by Johnson (1993), the more able residents were placed with the less able residents in Units, and they contributed to the care of their frailer co-residents in an example of reciprocity.

Willcocks, Peace and Kellaher (1987, discussed in Chapter Three) undertook a study of a hundred old people's homes which criticised both Unit and communal designs. They recommended the residential flatlet in which each resident has his or her own bed-sitting room with private facilities, but also access to a communal lounge and dining room as desired. Relationships, they argued, will flourish in a normal manner if residents have more choices over the people with whom they interact. Rather than enforcing companionship, the residential flatlet facilitates privacy. Because privacy is available, both personal relationships and social relationships will result.

Davis (1981), Maslow (1954, 1970, 1987), Goffman (1961), Cumming and Henry (1961), Havighurst (1948, 1960, 1972), and Lipman and Slater (1977), although illuminating particular aspects of residential practice, present one-dimensional frameworks which focus on a dominant issue. Each argues an enlightened point of view for implementing values into practice. The analogies of Davis (1981) and Miller and Gwynne (1972) are liable to be misinterpreted and used in too simplistic a manner. Relationships figure both explicitly and implicitly in these frameworks, with personal and social relationships emphasised more than organisational relationships. Instead of recognising that certain types of organisational relationships are necessary within residential care to enable the growth of personal and social relationships of residents, organisational aspects are ignored. Lipman and Slater (1977) and Willcocks et al (1987) do address the inter-relationship between organisational design and residents' personal and social relationships.

4.16 More Complex Frameworks for Developing Practice Within Residential Homes

The more satisfactory frameworks for developing practice take account of the complexity of organisational relationships and environmental contexts of residential homes. Davies and Knapp (1981) characterised life and events within residential care as consisting of processual relationships between

inputs of resources; non-resource inputs from the social environment; quasi-inputs of the characteristics of individual residents; and outputs of well-being, morbidity, mortality, and the impact of residential care on the residents' significant others.

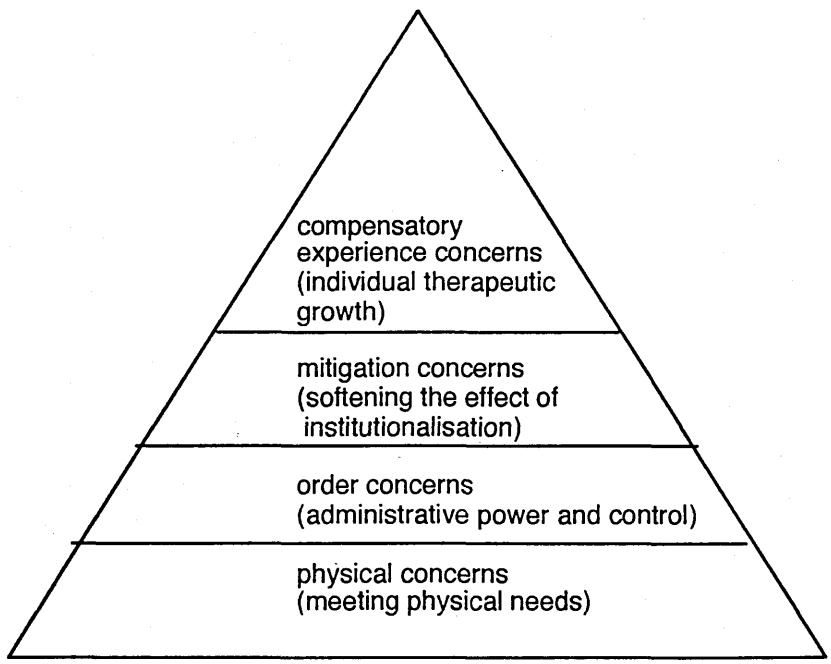
The danger with this complex framework is that the focus on the individual can become lost within the emphasis on processual relationships. The model over-emphasises organisational aspects to the detriment of personal and social relationships.

Brown and Clough (1989) identify a range of key group variables characteristic of groups and groupings within residential and day care. These include

purpose; membership and entry criteria; membership-group composition; membership-size of group and the large group; membership - open/closed format; time; role of the worker; inter-group relations; tasks and maintenance; functions and interplay; stages of group development; the individual and the group; the group as a system; allocation of roles; and physical space.

Their identified variables support the importance of context and complexity. Both frameworks illustrate the influence of the ecological perspective (Whittaker, 1979; Whittaker and Tracy, 1989; Bronfenbrenner, 1979, discussed above). Organisational relationships are implicit. With their recognition of the place of the individual in a group setting, their frameworks do not lose sight of the value of personal relationships, even when these occur in a group setting. Mitigating the effect of institutionalisation or diminishing its negative features (discussed above) is identified by Atherton (1989, adapted from Maslow, 1987 edition, discussed above) as part of the hierarchy of concerns of a residential establishment. Atherton suggests that the care practices of residential life can be understood within the hierarchy.

FIG 14 Atherton's Hierarchy of Concerns (1989; adapted from Maslow, 1987)



Atherton suggests that it is possible and desirable to ascend the hierarchy in order that good practice may be achieved. The last two steps of the hierarchy imply concern for individual relationships. Atherton's adaptation (1989) of Maslow (1987) successfully portrays the complex processes which characterise organisational relationships (discussed in Chapters One and Three), and in turn influence the nature of social and personal relationships. Again, the ecological paradigm (Bronfenbrenner, 1979, discussed above) is reflected in the importance given to contextual factors. Atherton includes the themes of care and control, good care practices and institutionalisation, but his model does not provide specific practice advice to practitioners who may wish to develop the desired outcomes at each level of the hierarchy.

4.17 Group Care Practice

The model of group care practice provides a template for developing good practice in the field of residential care. It addresses the lack of specificity of practice competences noted above. From 1981, the term 'group care' (Ainsworth and Fulcher, 1981) understood as indicating both residential and day care work in a variety of settings and with a range of client groups, was used increasingly to establish a 'domain of practice' (Ainsworth and Fulcher, 1981; 1985) within professional social work. Eight areas of knowledge and skills were identified as a framework for group care practice (CCETSW, 1983). These are:

organisation of the group care environment;
team functioning;
activity programming;
working with groups;
on-the-spot counselling;
nurturing care;
developmental scheduling; and
formulation of individual care and treatment plans.

The eight areas identified include opportunities for the enhancement of personal, social, and organisational relationships. The frameworks were developed for application largely within the area of residential child care (Ainsworth and Fulcher, 1981; 1985), despite the generic nature of the skills that are identified. This indicates the greater attention given to the needs of children compared to the needs of elderly people (Seebohm, 1968; Black et al, 1983; Barclay, 1982, discussed above).

In support of the development of group care practice as a professional intervention, the Central Council for Education and Training in Social Work commissioned and published guidelines for group care practice with elderly people (Biggs, 1989; Kerr, 1985). These exhortatory guidelines challenge the former lack of professional interest in residential care. The guidelines are intended to stimulate good practice and good standards of care, but they also expose the discrepancy between theory and practice. The reality of life within many residential homes falls far short of the standards demanded by the criteria (Stevenson, 1989). Despite these developments, group care practice remains a low priority within the caring professions.

In the 1990s, two major scandals in the field of residential child care drew attention to the need to develop good care practice in residential care for all client groups. The Utting review of residential child care in England (Utting, 1991) resulted from public concern about residential child care after the 'pindown' experience in Staffordshire in which children in care were subjected to extreme and demeaning methods of punishment. An 'expert group' established by the Department of Health, CCETSW, and the Local Authority Associations made recommendations for residential child care training and practice (CCETSW Expert Group, 1992). The 'expert group' re-affirmed

the concept of group care practice as a domain for professional social work (Ainsworth and Fulcher, 1981; CCETSW, 1983). It provided guidelines for group care practice which were deemed applicable to the entire range of group care, not just to residential child care. The Report and recommendations of the expert group (CCETSW Expert Group, 1992) are relevant to the context of residential care of elderly people. Within the Report, group care practice guidelines are based on the rules and requirements for the training and education of all professional social workers (CCETSW, 1989, 1995). The Report emphasises the importance of recognising the complex network of relationships between staff and clients and between individuals and groups which is characteristic of the context of group care (CCETSW Expert Group, 1992). In support of this conclusion, the Report of the Expert Group (1992) recognises its debt to the ecological perspective (Whittaker, 1979; Whittaker and Tracy, 1989; Bronfenbrenner, 1979; discussed above and in previous Chapters) for understanding the variety of environments within group care. The distinctive feature of group care within professional practice is identified as its diversity of relationships. Relationships, including personal, social, and organisational relationships, are recognised as important.

Shortly after the publication of the CCETSW Expert Group Report (1992) prompted by the Staffordshire 'pindown' controversy, the Warner Report (1992) was published, addressing the staffing of children's homes. The Warner Report was triggered by a different scandal in residential child care, in which Frank Beck, the head of a children's home in Leicestershire, was convicted of sexual abuse. The Warner Report called for better screening of applicants for posts in residential child care, but was more modest in its recommendations for training. Economic considerations about the cost of professional training rather than theoretical considerations about good practice may have prompted the Warner Report's recommendations against professionalising residential work with children (Guardian, 8 December, 1992).

The Wagner Report on Residential Care (1988) succeeded in reasserting the importance of the individual within the group setting, and especially the individual's right to enjoy fulfilling personal and social relationships. It recommended practice standards for all client groups, including extension of registration and inspection to local authority-run homes. The Report recommended that the decision to enter residential care must be a positive choice. Residents should have the right to invite and receive relatives and friends as they choose, and to exercise their rights as individuals. The Wagner Report is an important document which stimulated projects to develop and promote the recommendations. The Wagner Development Group was established in 1988. Subsequently, the DOH developed five demonstration projects as part of the Caring in Homes Initiative (Brunel University, 1992), to result in models of good practice. Three of the five projects are particularly relevant to the argument for the importance of relationships in residential care. One project is concerned with the relationships between care homes and the community. Another is concerned to develop quality assurance mechanisms, involving gathering information about quality from residents (Kellaher and Peace, 1993). A third is concerned to develop a complaints procedure for residents.

4.18 Summary of the Discussion on Models and Frameworks of Care

A number of models of good care practice have been developed which draw attention, *inter alia*, to the importance of residents' personal and social relationships. These include the warehouse/horticultural model (Miller and Gwynne, 1972); activity theory (Havighurst, 1948, 1960, 1972, discussed in Chapter Two); and disengagement theory (Cumming and Henry, 1961, discussed in Chapter Two). Normalisation or social role valorisation (Wolfensberger, 1972, 1982); Maslow's hierarchy of needs (1987 edition, discussed in Chapter Three); family substitute/complement/alternative analogies (Davis, 1981); space and design strategies (Harris, Lipman and Slater, 1977; Willcocks et al, 1987, discussed in Chapter Three) provide other models. More complex frameworks

of good care practice include processual relationships between inputs/outputs of resources and variables (Davies and Knapp, 1981); key group variables (Brown and Clough, 1989); and Atherton's adaptation (1989) of Maslow's hierarchy of needs (1987). Group care practice (CCETSW, 1983) identifies eight areas of knowledge and skills for residential work.

Two residential child care reports (Utting,1992; and Warner, 1992), CCETSW Expert Group guidelines (1992), and the Wagner Report (1988) are applicable to the residential care of elderly people. They suggest that improved staff practices within homes, improved assessment and admission procedures before entering the home, the leadership of the Officer-in-Charge, and better staffing ratios would make a positive difference in standards (Sinclair and Payne, 1990). Only one of these recommendations concerns itself with the 'hard' resources of investing more money in increasing staffing levels. The other recommendations, if implemented, would lead to indirect investment in staff development and the professionalisation of practice. Could it be that the outcome envisaged is really the creation of a different 'enterprise' (Estes, 1979) consisting of a network of residential homes firmly embedded within professional practice? These recommendations do not reject the notion of residential care itself as Townsend (1962, discussed above) proposed. The recent outpouring of guidance on standards fits the paradigm identified by Booth (1985, discussed above) in which the detrimental effects of institutionalisation are attributable to the shortcomings of practice. Bad practice is capable of improvement, rather than regarded as a necessary aspect of the experience of institutionalisation.

Two opposite trends are at work. On the one hand, Care in the Community policies are intended to reduce the need for residential care. On the other hand, good care practices are promoted for use in residential care. As discussed above, it is unlikely that residential care can be replaced entirely by domiciliary care (Henwood, 1992; Sinclair, 1990), so that the 'good care practice' movement will need to provide effective strategies for the realities of the future. The 'good care practice' movement emphasises the importance for residents of personal and social relationships. It may ignore the ongoing existence of detrimental organisational relationships within residential regimes which thwart the desired personal and social relationships.

The next section discusses frameworks for evaluating residential homes, and explores how they value relationships.

4.19 Frameworks for Evaluating Residential Homes and the Importance of Relationships

The development of frameworks for evaluating residential care was accompanied by the development of guidelines for implementing good care practices within homes. The two developments complement each other's concerns and are related to the identification of specific aims of residential homes (discussed above). Aims and practice guidelines provide criteria for evaluating residential homes. Following the Wagner Report (1988), Social Services Departments expanded their roles in the inspection and registration of residential establishments in both the private and public sectors. An increase in the number of frameworks and criteria for evaluating residential care followed. With the requirement for inspection, greater attention has been paid to the nature of organisational relationships within residential care.

Booth's thoughtful study (1985, discussed above) of dependency in residential environments for elderly persons considered the complexity of trying to measure institutional environments. He points to potential sources of bias in the responses of staff who may confuse what they would like to do with what they actually do in practice, and the responses of residents who may not feel able, because of the power imbalance between them and their staff, to state their true feelings and opinions. Measurement of one particular factor, such as management practices, must take account

of other environmental factors, such as physical, social and interpersonal features. Attitudes must be contrasted with actual behaviour. Staff perspectives must be balanced with the perspectives of residents and observers. Booth's study (1985) does not shirk the difficulties of evaluating care practices. It takes account of organisational relationships and the importance of environmental contexts. His findings reveal the power of staff, and the social control function (Townsend, 1986) of residential homes. Booth (1985) argues that evaluating standards is a complex undertaking and one for which there is no commonly agreed framework. He also points to the difficulties of using American models for measuring subjective well-being in Britain, as they may not be free of cultural bias.

Willcocks, Peace and Kellaher (1987, discussed above), Goldberg and Connolly (1982), and Bond and Bond (1987) present useful overviews of definitions and measurement instruments. These areas of research are concerned with different aspects of the individual's relationship to the organisational structure. A detailed survey of these instruments lies outside the scope of the present research, but a summary of their features is helpful for development of the research. Willcocks, Peace and Kellaher (1987) identify three specific areas of research on care provision for elderly people:

ones that build on Goffman's concept (1961) of the 'total institution' - (King, Raynes, and Tizard, 1971; Apte, 1968; Townsend and Kimball, 1975);

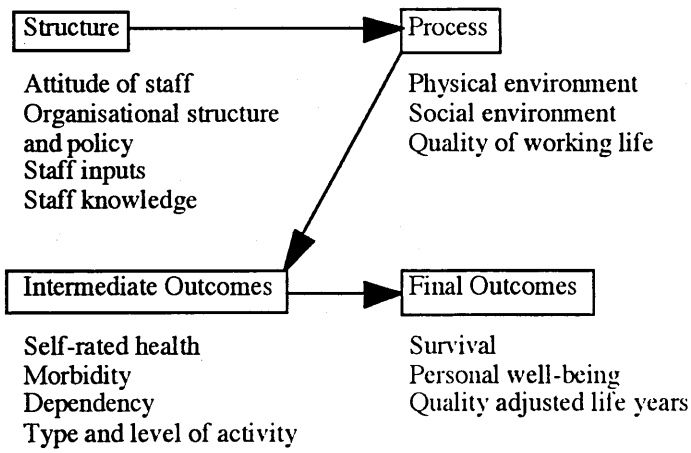
ones which study transactions or psychological constructs between people and their environment (Kleemeier, 1961; Pincus, 1968; Kahana, 1974); and

ones which are based on an ecological perspective (Bronfenbrenner, 1979, discussed above and in previous Chapters) and develop a model of an 'environmental press' on the individual (Lawton and Nahemow, 1973; Moos et al, 1979).

Tizard et al (1975), although developing Goffmann's ideas, criticise the 'steam press model' which over-simplifies residential care by emphasising the common features of institutions, as Goffman (1961) did. Goffman ignored individual differences, which include variables of admission, interaction, and social climate. With this criticism, they recognise the complexity of context noted by Atherton (1989). King et al (1971) present a useful framework (also developed from Goffman's 1961 analysis) which suggests that the 'total institution' is at one end of a sliding scale denoting institutionally oriented regimes. At the other end lie 'inmate- or resident-oriented regimes' which re-inforce the importance of personal, social and organisational relationships.

Bond and Bond (1987) develop the concept of the relationships between inputs and outputs (Davies and Knapp, 1981, discussed above) into an evaluative model which measures structure, process, intermediate outcomes, and final outcomes.

FIG 15 An Evaluative Model for Long-Term Care (Bond and Bond, 1987)



Davies and Knapp (1981) implicitly consider individuals' relationships with each other and with staff. Context (CCETSW Expert Group, 1992, discussed above) is important in this framework, as well as the complexity of processes and the range of variables to be taken into account. The ecological paradigm (Bronfenbrenner, 1979, discussed above) is useful for appreciating the different layers and strands in Davies and Knapp's analysis.

Goldberg and Connolly (1982) identify nine features of a residential environment which have the potential to influence life in a home in a positive manner:

(i) flexibility of management practices;
(ii) individualisation and autonomy for residents;
(iii) opportunities for privacy;
(iv) opportunities for social stimulation;
(v) communication and interaction with the outside world;
(vi) social interaction between staff and residents (in addition to instrumental communication);
(vii) maximum delegation of decision-making to care staff and to residents;
(viii) good communication channels between staff;
(ix) a minimum degree of specialisation of roles and tasks among staff.

Three of these nine features are specific to staff practices (i, viii, and ix); two are relevant for both staff and residents (vi, vii); and four are specific to the interactions of residents (ii, iii, iv, and v). The features emphasise the importance of relationships. They foreshadow the recommendations of the later research of Willcocks, Peace, and Kellaher (1987, discussed above and below) in their identification of the need for both privacy and social stimulation.

These prescriptions for good practice which pre-date inspection were followed by Home Life (CPA, 1984) intended by the Avebury Working Party as a guide for inspection practice. Home Life recommends standards for principles of care, including

specific guidelines for individual client groups, including elderly people.

the rights of residents;
terms and conditions of residence;
residents' security of tenure;
financial affairs;
physical features;
social care admission procedures;
general administration;
privacy and personal autonomy;
health care;
staff.

These standards acknowledge emotional needs for intimate and personal relationships as part of the rights, privacy, and personal autonomy of residents.

The Department of Health Social Services Inspectorate issued a series of publications (DOH, SSI, 1990 a, b, c, d) which provide models for evaluating care and the quality of life within homes. Homes are for Living In (DOH, SSI, 1990c) was produced by a project team based in the Northwest which involved six Social Services Departments. Its model of evaluation was tested in seventeen homes, reporting favourably on its effectiveness, although the model apparently was not subjected to any in-depth critical analysis. The model promotes six values and rights (after the Wagner Report, 1988) which are considered essential for residents:

privacy;
dignity;
independence;
choice;
rights;
and fulfilment.

It contains a pro-forma which incorporates these criteria within checklists and procedures. Implicit in these values and rights is the enjoyment of personal and social relationships supported by appropriate organisational relationships.

Guidance on Standards for Residential Homes for Elderly People (DOH, SSI, 1990b) includes a summary of the recommendations of Homes are for Living In and a number of other criteria denoting not only values, but also a definition of standards, quality of life, quality of care, and quality of management. A focus on the resident as an individual with certain human rights is implicit in these guidelines for the evaluation of residential care. The opportunity to develop and sustain human relationships is important as a means of developing individual self-fulfilment (Perlman, 1979; Sinclair and Williams, 1990), thus establishing a connection between individuality, relationships, and quality of care (Booth, 1985; Hughes, 1990).

4.20 Summary of the Discussion of Evaluative Frameworks and Their Views of Relationships

Frameworks for evaluating residential care encounter the difficulty noted by Booth (1985) and others that residents are reluctant to reveal their true opinions. Research has centred on the concept of the total institution (Goffman, 1961); studies of transactions (Kleemeier, 1961); and those based on the ecological perspective (Bronfenbrenner, 1979). Bond and Bond (1987) take up the input/output theme developed by Davies and Knapp (1981) for their evaluative model. Department of Health documents set criteria for evaluation intended for use by inspection and registration officers. All of the frameworks acknowledge the diversity of organisational relationships and regimes. They promote implicitly, and in some cases explicitly, personal and social relationships. They recognise the interconnection of personal, social, and organisational relationships in the context of residential care. Organisational relationships promote and/or deter personal and social relationships, and personal and social relationships are influenced by organisational relationships and structures.

4.21 Resource Centres: Development for the Future?

Despite lobbying for improved care practices, it is doubtful whether existing residential care structures can stimulate the development of personal and social relationships. Institutional regimes continue to dominate residential care and stigmatise the residents (Booth, 1985; Willcocks et al, 1987, discussed above). Locating community based services within homes is regarded by some as a means of softening the stigma (Goffman, 1963) of residential homes and defeating institutionalisation (Wagner, 1988, discussed above). Homes which become resource centres provide sheltered housing services, day care, health services, domiciliary services, counselling services, and leisure activities within one large complex residential centre. Few examples of this model exist, partly because of the cost of capital investment and partly because of the need for Housing Departments, Social Services Departments and Health Authorities to work together in planning and managing the centres (Wilkin et al, 1982; Macdonald, Qureshi and Walker, 1986; Wright, 1991). The organisational relationships needed for operating resource centres must be collaborative, complex, and multi-professional. The lack of sophisticated organisational relationships inhibits their development. Shardlow (1989) notes the potential for conflict between different groups of users, which may be more difficult to resolve in resource centres than in traditional forms of residential care. He argues that the ultimate decision for reconciling the conflicting demands of users must be values-based.

Creating a complex of services under one roof is viewed by others as institutionalisation running counter to the aims of normalisation (Wolfensberger, 1982, discussed above). Stevenson (1989) is positive in her advocacy for resource centres, seeing them as having the potential to provide needed support to family carers. However, she warns of the danger of neglecting permanent residents and taking away

their sense of belonging by introducing too many projects and transient people into the home's environment. Shardlow (1989) discusses resource centres as part of innovatory practice. Their essence is hard to describe because of the uniqueness of each centre and the small body of literature which exists. Their characteristics may include an involvement with the surrounding community (Bonnington, 1984), more permeable role boundaries between workers and clients with the concept of reciprocity (Homans, 1958, 1974; Dowd, 1975; discussed in Chapters Two and Three) included in these relationships. Anecdotal evidence suggests that some social workers view resource centres as the key to developing good practice. Willcocks (1983) supports the concept of resource centres, provided the initiatives are sensitively planned and implemented. Townsend (1981) is scathing about the ghettoisation of old people who are socially abandoned in residential homes. A trainer of residential staff, met while the research was in progress, agreed with the latter view, commenting that introducing day care groups into residential homes was fine in theory, "but would you like to have to sit in a lounge which is like a railway station all day?"

A further, even more cynical comment about the enthusiasm for resource centres for elderly people was expressed by a senior social worker who saw their development as a defensive move by Social Services Departments to ward off the threat of privatisation. By locating and operating a range of services for elderly people from within a residential home, it becomes more difficult to sell and privatise the local authority-owned home. The resource system is preserved and the enterprise (Estes, 1979, discussed above) continues to grow. In such a strategy, the aim of enhancing personal and social relationships may take second place to organisational needs and requirements.

4.22 The Views of Residents: Forgotten voices?

Part of the philosophy of good care practice is to enable users or consumers of services to become more powerful in expressing their wishes and preferences (CCETSW Expert Group, 1992). Consumer views are important for discovering the nature of relationships, but direct approaches to residents may not succeed. The voices of the consumers are often neglected or remain unheard by professional practitioners (Tinker, 1992; Power, 1981; Booth, 1985), while the authoritative voices of professional practitioners dispense expertise. In these relationships, power is firmly weighted on the side of the professionals concerned with maintaining social control (Audit Commission, 1992; Estes, 1979; Wilding, 1982, discussed in Chapter Three). The power imbalance is particularly acute when physically and mentally frail consumers are dependent on the provision of physical care. Physical and mental frailty, including confusion and sensory deprivation, can create communication difficulties (Nussbaum et al, 1989). Living in an institution increases the power imbalance (Goffman, 1961; Willcocks et al, 1987, discussed above). Booth (1985, discussed above) points out the difficulty for the researcher of gathering the views of elderly residents in residential care. Sinclair and Payne (1990) attribute the well documented problems of eliciting the opinions of residents to the reluctance of some residents whose care was subsidised by the state to complain about services they had not paid for. Some elderly people are reluctant to complain because their thresholds of satisfaction are lower than the rest of the population. They fear retribution by staff if they complain. The implications of Sinclair and Payne's argument are, first that it is part of good practice to seek residents' views; and second, that the emerging views will consist of complaints rather than satisfactions.

Willcocks, Peace and Kellaher (1987, discussed above) sought the views of residents of a hundred old age homes on what might make an ideal home. Despite a noted tendency of residents to endorse the status quo, 80% of those interviewed expressed a preference for a single room and for small tables in the dining room. Living in groups and sharing a bedroom ranked in the last three preferred categories, but receiving friends in the bedroom ranked eighth out of twenty-eight items. Much of this research

was concerned with the physical environment of the home so that relatively few items were about relationships. Perhaps the emphasis on visual rather than verbal communication (these researchers used a ranked visual card game to determine preferences), and avoidance of the sensitive topic of relationships aided the respondents' expressiveness.

Sinclair (1988) and Willcocks, Peace and Kelleher (1987) note too that residents are inhibited from expressing views because they cannot envisage any alternative to their existing situation. Not all residents want the same things, but most research indicates that they value comfort, physical security, freedom from worry, and security of tenure. Although many are lonely in residential care, they have few suggestions for overcoming this (Sinclair, 1988).

4.23 Summary of the Chapter: Residential Care and Its Influence on Relationships

The picture painted of residential care thus far is of a growing enterprise and industry (Estes, 1979; Tinker, 1992; Audit Commission, 1986) which may be in the process of colonialisation by professional social work (CCETSW Expert Group, 1992), aided by the requirement for inspection of standards within the Registered Homes Act 1984. The impact of demographic change (Audit Commission, 1992) and government financial support for private care (Peaker, 1988; Tinker, 1992) created a demand for places which have been funded without any real financial incentive to encourage community-based services as alternatives (Audit Commission, 1992; Parker, 1990; Challis, 1990). Care in the Community legislation is intended to reduce the numbers of elderly people entering residential care. It introduced compulsory assessment and screening of the individual's needs and wishes before government funds are released to pay for a place in a home. It promotes more flexible use of resources in community-based services. Residential care will continue, but with changed practices. The climate of change will affect the organisational relationships, and ultimately the personal and social relationships of residents.

The continued existence of the enterprise (Estes, 1979) of residential care for elderly people is bolstered by professional social workers and academics who reject Goffman's (1961) and Townsend's (1962) views of the inherent harm in institutional life. Instead they promote the development of good practice in order to create a high quality of care for residents, implicitly including the enhancement of residents' relationships (Tinker, 1983; Kellaher, 1986; Wagner, 1988). Determining which aspects of residential care represent good care practice, and how good care practice can be achieved is now the focus of much professional interest. Questions to be asked include: to what extent are residents able to contribute to that definition? What, if anything, can prevent or negate the stigmatising effects of institutionalisation? Although the concept of the ecological paradigm (Bronfenbrenner, 1979) provides a useful framework for appreciating the complexity of personal, social, and especially organisational relationships within residential care, the various experiments in physical design (Barrett, 1976; Lipman and Slater, 1977) have not been completely successful in mitigating the effects of institutionalisation and promoting relationships.

Despite some cynical views, the changes in style and design and the move towards professionalisation of care practices reflect a genuine concern about standards and improving the quality of the residential experience. In the midst of professional debates about bringing about change, recognition of residents' individuality and their personal and social relationships can be overlooked. This study of relationships will seek to discover individual identities of individual residents and how these residents experience and value their relationships in the home.

In the next Chapter, the three components of the research topic (relationships, elderly people, and residential care) will contribute to the shape of the research design. The

issues raised within this and the preceding Chapters will influence the methodology of the research.

Relationships of Elderly People in Residential Care

Chapter Five

Research Methodology

5.1 Over-view of the Chapter

This Chapter focuses on issues of methodology, including the choice of methods and design and their development. Harvey (1990) defines methodology as an interface between epistemological underpinnings, substantive theory, and methodic practice. The epistemological underpinnings refer to theories of knowledge which constitute views of the social world. Substantive theory refers to organised sets of propositions which attempt to provide coherent explanations derived from these world views. Methodic practice refers to the way data are collected: research methods, designs, and the technical issues of implementation. These interfacing components of methodology need to be related to the particular demands of the research topic of relationships of elderly people in residential care. Five aspects of methodology will be considered:

1. the nature of the research topic;

2. how it relates to the epistemological underpinnings and substantive theories implicit in the topic;

3. the research strategies which may be suitable for a particular topic (Layder, 1993);

4. the intended use of the research findings for the benefit of practice;

5. technical issues of operationalising the topic in relation to the resources available.

The choice of design and methods will be influenced by growing understanding of the nature of the topic and the questions it asks. This understanding was developed in preceding Chapters which discussed the reasons for and purposes of the research, together with perspectives and concepts of ageing, relationships, and residential care. Arising from this understanding, the relevance to the topic of particular substantive theories and their undergirding philosophies becomes clearer.

Different philosophies of the social sciences argue alternative explanations of the social world. They have different epistemological underpinnings. They generate different substantive theories. As a starting point, there needs to be a reasonable fit between the questions the topic raises and the philosophies which articulate the perspectives of the social world implied in the questions. Particular philosophies tend to be associated with particular approaches to research, which generate particular substantive theories. Taking the concept of the reasonable fit a step further, one might expect the choice of design and methods to be congruent with the particular philosophies which influence the development of the topic. Philosophies are associated also with particular methods of intervention at practitioner level. The research topic has emerged from practice-based concerns. The findings are intended for use within the context of professional practice. The notion of a reasonable fit suggests that the research design and methods should be related appropriately to practice values and skills. Alternatively, the need for a reasonable fit can mean a technical consideration of practical issues of implementation arising from the nature of the topic. For example, the extent of the resources available for the research will influence choices of design and methods.

To what extent is the concept of a reasonable fit itself realistic and viable? Different views need to be considered. Each discussion, whether about values concepts, underlying social philosophies, substantive theories, or research methods, presents arguments for adopting different methodic practices. Different categories, styled

variously as 'approaches', 'paradigms', or 'frames of reference' seem to promise logical means of achieving clarity, but it is not as simple as that. No single framework or approach can explore the issues definitively. As long as their flaws are recognised, various categories are helpful for understanding the implications of, and choices imposed by, the nature of the research topic. Once a beginning understanding has been achieved, one can consider how different approaches might contribute to the research design. The first step towards achieving this is to review different approaches and their strengths and weaknesses in relation to the research topic.

This Chapter begins with a summary of the understanding gained in Chapters One to Four. The understanding is based on perceptions of the social world implied by the topic. Values issues, perhaps the most important and difficult area of discussion, will be identified. Early in the Chapter, it will become apparent that values are key determinants of the research questions. Values influence the research design, methods, and processes. They play a major part in identifying the reasonable fit of philosophies and theories to the research design and methods.

A number of philosophies will be discussed critically. The relevance of different research traditions will be considered in relation to the philosophies, and to the Values Concepts. Then, approaches arising from the different research traditions will be considered for their suitability to the research topic.

5.2 The Nature of the Research Topic: Summarising the Understanding Gained in Chapter One

Chapter One presented the purposes of the research. It established the importance of discovering the experience of living in residential care from the consumers' point of view, by exploring their emotions and feelings and seeking their opinions. This approach is consonant with the values of good practice (Ainsworth and Fulcher, 1981; Atherton, 1987; also discussed in Chapter Four). Good professional practice seeks to value the individual (Biestek, 1958, 1973). It avoids perpetuating stereotypically negative views (Perlman, 1979; Johnson, 1976) of old age in residential care, in which the power imbalance between residents and staff can diminish elderly residents' identities (Goffman, 1961). There may be inherent conflict between the values of professional practice and those of residential models of care. The influence of institutional traditions (Longmate, 1974) inhibits disclosure of individuals' feelings and opinions, because of fear of negative consequences. The methods must take this into account by selecting comprehensible, non-threatening approaches. The research requires sensitive strategies for the design which enable individuals to tell their stories, while at the same time avoiding emotional pain as much as possible.

The values of professional practice also lead to consideration of potential areas of bias in the researcher, who may approach the topic with the *a priori* view of residential care as emotionally depriving, relationships as intrinsically good, and old age as devoid of relationships. Recognising that relationships form and change over time leads to a choice of methods which seeks to understand the present situation from the perspective of the past. The research will explore possibilities of new relationships forming in old age. The research will take a multi-faceted approach to relationships, considering them from personal, social, and organisational perspectives. It will consider the interplay between the individual and the various levels of the environment (Bronfenbrenner, 1979), recognising that the individual shapes, and is shaped by, the environment.

The implication for the research design arising out of Chapter One is that an approach which explores the nature of individual experience is appropriate. The use of an historical approach using biographical material is indicated. Individual interviews and participants reports provide means of valuing individual respondents. The active involvement of respondents is sought. They are seen as capable of development and

change. Relationships are recognised, however, to be rooted within social and organisational contexts.

5.3 The Nature of the Research Topic: Summarising the Understanding of Ageing and Elderly People in Chapter Two

In Chapter Two, the overview of various studies of ageing suggests that studies which accept ongoing development and change (Jung, 1969, 1982, 1989 edition; Gutmann, 1987; Erikson, 1950, 1986) in old people are consonant with the values of professional practice. In studies of ageing, we learn again that individuals are shaped by, as well as shape, their own environments (Bronfenbrenner, 1979), in consonance with discussion in Chapter One. From these studies we see the influence of the environment as an interactive reciprocal process (Piaget, 1932). The importance of a perspective over time as a means of understanding the individual is affirmed (Freud, 1953, 1976, 1986 editions; Jung, 1969, 1982, 1989 edition; Erikson, 1950, 1986). We observe the importance of time: life time, social time, and historical time as key components of development (Kohli, 1986; Blaikie, 1992). We learn that ageing consists of the processes of development, socialisation, and adaptation (Clausen, 1986). We see that there are many separate strands of experience and many different perspectives incorporating different academic disciplines which are brought together in the life course perspective.

The implications for the research design arising out of Chapter Two are that a triangulation (Denzin, 1970) of methods is essential to explore the multi-stranded nature of the ageing experience. The importance of a historical perspective over time implies that life histories of individuals will comprise one method. Because the inter-relationship between the environment and the individual is important, methods which acknowledge the relationship between the researcher and the respondent will be used.

5.4 The Nature of the Research Topic: Summarising the Understanding of Relationships in Chapter Three

Chapter Three acknowledged the difficulty of agreeing operational and conceptual definitions of relationship. Relationships assume a personal fulfilment orientation or a utility value orientation. The study of relationships, like the study of ageing, is shown to be multi-disciplinary and multi-layered (Hendrick, 1989). Relationships are considered within an environmental context (Bronfenbrenner, 1979). Diversity, interaction, and social change also influence the nature of relationships. We study the layers of personal, social, and organisational relationships. We observe that some research methods claim a scientific approach which attempts to be value-free. We are warned about the tendency to generalise relationships into needs and to explore the salience of relationships (Lawton and Moss, 1987), rather than the nature of relationships. Relationships are acknowledged to denote a search for meaning which differs from individual to individual, from group to group, and from organisation to organisation. Within much of the research we note a neglect of the views of the consumer and of historical process. We note also the difficulty of researching intimate relationships due to the reticence of many elderly individuals (Booth, 1985).

The implications for the research design arising out of Chapter Three are that relationships are difficult to operationalise. The many layers and aspects of relationships create problems for conceptualising the research topic. Too many variables may make it difficult to select appropriate methods. As in Chapters One and Two, concerns about values are evident. A multi-stranded, triangulated methodology is needed to take account of the complex layers of relationships and the meanings given to relationships by the elderly residents.

5.5 The Nature of the Research Topic: Summarising the Understanding of Residential Care in Chapter Four

Chapter Four explores the context of residential care. We trace the historical development of residential care for elderly people and the current climate of change. It becomes evident that organisational relationships (Katz, 1984; White, 1984; Bond and Bond, 1987) are key influences on the personal and social relationships of residents. Practice values permeate the discussion of residential care, ranging from Goffman's revelations of the total institution (1961) to the more recent Warner Report (1992). We note the ambivalence of professional attitudes towards residential care, and the ill-defined aims of residential care which derive from workhouse-derived traditions (Townsend, 1962; Longmate, 1974) as well as from a more humanitarian ethos. As yet there is no agreed definition of the role of residential care in professional practice. Bias on the part of the researcher, either to over-condemn or over-champion residential care, is a possible pitfall. The current concern to develop and evaluate standards in residential care has implications for practice. Within the present climate, individual residents' relationships may be overlooked in favour of an emphasis on managing organisational relationships in residential care as a key to good practice.

The implication of Chapter Four for the research design is that an historical perspective is important for understanding the nature of organisational relationships which characterise residential care. The need to appreciate changes and developments affecting residential care influences the choice of research methods. Rather than seeing situations as static, the underpinning view of the social world is one of change and development. Ambiguity and bias have been identified as possible pitfalls, so that the design and methods need to be well thought through, with safeguards against over-hasty conclusions about the nature of residential care. The impact of values on practice is evident in this discussion of residential care, so that the selection of research methods and design should reflect the importance of values.

5.6 The Underlying Concepts in Chapters One to Four: the Influence of Values

Chapter by Chapter, likely difficulties in operationalising the topic are acknowledged. Recurring concepts push the research towards choices of methods and design. The concepts depict ways of perceiving the social world and social interactions which may be characterised as Values Concepts.

These are:

Values Concept One: a belief in the worth of the individual, which leads to the desire to discover the experience of individuals' relationships in residential care from the residents' point of view;

Values Concept Two: a belief in change and development in adult life, which leads to adoption of an historical perspective so that the present is understood within the context of the past;

Values Concept Three: a belief in the reciprocal influence of the environment on the individual, and the individual on the environment, which triggers a need to take account of the complex, multi-layered nature of the topic.

Professional practice values (Biestek, 1958, 1973; CCETSW, 1989, 1995) and the researcher's own values influence the research process. As we have seen, values are a central component of professional social work practice. Because of professional practice's attempt to colonialise residential care practice (Ainsworth and Fulcher, 1981; Atherton, 1989; Brearley, 1990, discussed in Chapter Four), the same professional values influence residential care. It is appropriate that values feature prominently in the

shaping of the research design of this practice-oriented research project. But what is the nature of these professional values? How are these professional values related to the Values Concepts arising from the nature of the research topic? In reviewing the development of understanding about professional values since the 1960s to the present day, two approaches to professional values, an individualistic approach and a structural approach, can be identified. These correspond to the self-fulfilment and utilitarian values orientation of relationships (discussed above and in Chapter Three).

Professional values consistently championed the individual's need for basic human rights. For example, a seminal text on social work values, The Casework Relationship (Biestek, 1958, 1973) addresses the importance of building a relationship between the helper (professional worker) and the person being helped (client or resident) which respects the individual by observing confidentiality, a non-judgmental attitude, encouraging the client in self-determining decisions, etc. Biestek's individualistic interpretation of professional values corresponds with the research topic's Value Concept One, the belief in the worth of the individual, and also with Values Concept Two, the belief in change and development. It is consonant with the self-fulfilment orientation of relationships.

In the 1960s, social action, increased awareness of inequalities of race and gender which needed to be addressed by practice (Hamner and Statham, 1988; Dominelli, 1988), and the growth of radical social work ideas based on sociological theory rather than psycho dynamic theory (Thompson, 1993), caused a move away from the individualistic value base. Individual insight and individual relationships as key factors in the helping process (Rojeck et al, 1989) lost support to a structural approach. Biestek (1958, 1973) and other advocates of individualistic values in professional practice (Hollis, 1972; Perlman, 1957) were criticised for assuming that individuals are helped only through one-to-one therapeutic relationships, and for neglecting the structural inequalities which cause people to seek help in the first place. This development corresponds with the utility value orientation of relationships and Values Concept Three, the influence of the environment on the individual.

More recent interpretations of professional values in social work are expressed in two documents: Paper 30 Rules and Requirements for the Diploma in Social Work (CCETSW, 1989, 1995) and Paper 31 The Requirements for Post Qualifying Education and Training in the Personal Social Services (CCETSW, 1992). These Papers present the values, skills, and knowledge required for professional social workers at qualifying and post-qualifying levels in a codified, competence-based form. Following a DOH review of qualifying social work, Paper 30 was published in a revised version in 1995, strengthening the competence format, and including new practice competences for Care in the Community. The values statements in both Paper 30 and Paper 31 reveal that expectations have moved beyond the individualised statements which defined professional values in the 1950s and 1960s. A structural approach which identifies inequalities in social structures as appropriate for social work intervention has been promoted. The value base of social work practice, as well as requiring social workers to be "respectful, trustworthy and reliable" also commits social workers to :

"identify, challenge and deal with discrimination, racism, disadvantage, inequality and injustice, using strategies appropriate to role and context; and practice in a manner that does not stigmatise or disadvantage either individuals or groups". (CCETSW, Paper 30, 1995).

Paper 30 asserts that although the individual is important, the professional social worker must recognise social structures which oppress individuals (CCETSW Paper 30, 1989, 2.2.3, 1995). Similarly, in Paper 31 (CCETSW, 1992), at post-qualifying level, professional workers are expected to:

"demonstrate actively an ability to promote anti-racist and anti-discriminatory practice and to alleviate, through their practice, the impact of poverty, discrimination and institutionalisation; understand the need to, and be able to, empower others" (CCETSW, Paper 31, 1992, 3.5).

The purpose of intervening in individuals' lives moves beyond achieving insight and understanding to the need for empowerment, facilitating others to take control of their lives (Solomon, 1976, discussed above). Paper 31 also defines the expectations of professionally qualified workers at advanced level (e.g. at a further stage in professional development beyond the post-qualifying level). At advanced post-qualifying level, professional workers are expected to:

"review and critically evaluate the value base of their work in the light of continuing social and political change and demonstrate the ways in which these values are integrated and have been sustained in their work; demonstrate over a significant period a high standard of anti-racist and anti-discriminatory practice, and be able to define and develop policies and practices which reflect these values" (CCETSW, Paper 31, 1992, 4.4.3).

These statements support the research topic's Values Concept Three, (the importance of environmental context) but the individualistic approach characterised by Biestek (1958. 1973) tends to ignore this concept. Values Concept Two (the belief in change and development) is a shared concept of both the structural and individual approach to professional values, and it bridges the two approaches. Both Paper 30 and Paper 31 recognise that it is not easy for an individual worker to achieve the requirements of both approaches to professional values. Attention is drawn to the need to recognise probable values conflicts. Paper 30 (CCETSW, 1995) calls for knowledge and understanding of:

"ethical issues and dilemmas in practice, and the potential for conflict between organisational, professional and individual values" (CCETSW Paper 30, 1995).

Paper 31 (CCETSW, 1992) makes explicit the need to:

"recognise and work with value conflicts in practice" (CCETSW Paper 31, 3.5).

The individualistic and structural values of professional practice are mirrored in the Values Concepts identified in the research topic. The research topic seeks to study relationships of elderly people in residential care from the individual point of view of individual residents (Values Concept One and the individualistic practice values). Yet the topic recognises the historical impact of structural inequality (CCETSW, 1995) on each individual through his or her experience of the social structures of society and the present experience of institutionalisation (Goffman, 1961; Townsend, 1964) in residential care (Values Concept Three and the structural professional values). The research also explores the changes in each individual over the life course (Values Concept Two and the individualistic professional value).

5.7 The Relevance of Social Philosophies to the Research Topic and its Underpinning Values

Individualistic and structural practice values are based on certain underlying beliefs about the nature of the social world and the place of human beings within it. These beliefs or epistemological underpinnings shape the growing body of social philosophies and their related substantive theories which provide tools of analysis for our understanding. Philosophies are diverse. Each presents a different perspective. It is helpful to consider some of the ways in which they have been characterised, and how they relate to the Values Concepts.

In their discussion of organisational structures, Burrell and Morgan (1979) suggest that there are three general broad categories of philosophical debate. The first debate is of

an ontological nature: the realism/nominalism argument, about whether reality is external to individuals and therefore 'real', or whether it is the product of individuals' own consciousness and therefore 'nominal'.

The second debate is epistemological, about which forms of knowledge can be verified as true and real: the 'hard' Positivist knowledge (Comte, 1970 edition, discussed below) of observed phenomena perceived as social laws, or the 'soft' anti-Positivist knowledge of subjective understanding and individual experience. The third debate is one of determinism/voluntarism, which argues two opposing views of the relationship of the individual with the environment, one in which the individual is shaped and determined by the environment, the other in which the individual acts voluntarily using free will and influencing the environment.

Within the preceding debates, Burrell and Morgan (1979) discuss two contrasting world views, that people are either subjects or objects. Order is either imposed on people from an external societal level (objects), or people make their own social order (subjects). The nature of society may be seen as a contrast between order (stability) and conflict (change). Since Burrell and Morgan devised their categories in 1979, organisational structures are facing new issues. An updated version of this contrasting nature of society might consider on the one hand, collectivity, and on the other, fragmentation, to denote the changing nature of organisations in the 1990s, and at a deeper level, the fragmentation of approaches to social research (discussed below).

Beliefs about the social world are implicit within the knowledge and theory base of professional practice in social work and in social care, although they are rarely made explicit. Howe (1987) analyses social work theories for practice, drawing on Burrell and Morgan's debates (1979) to suggest a taxonomy of social work theories. He calls practitioners who use radical humanist theories (feminist social work and radical social work) the raisers of consciousness; practitioners who use radical structuralist theories (Marxist social work) the revolutionaries; practitioners using Interpretivist theories, discussed below, (client-centred social work) the seekers after meaning; and those using functionalist theories (psychoanalytic and behavioural social work) the fixers. In debates about the effectiveness and validity of different practice theories, links with individualistic and structural Values Concepts are apparent. All accept the belief in change, but the raisers of consciousness and revolutionaries place more importance on structural values than the seekers after meaning, who are concerned with individual change.

Philosophies of the social sciences influence the knowledge and theory base of professional practice. Certain academic disciplines are often associated with particular frames of reference which provide means of differentiating between the different underlying views of the social world. Within the discipline of psychology, both individualistic and structural values exert influence. Frames of reference from within the discipline of psychology include:

the mechanistic frame of reference, the belief that humans are reactive to their environment, reacting like machines to external stimuli;

the organismic frame of reference, which views humans as active beings, selectively synthesising and integrating experiences, changing themselves with time and experience; and

the interactional frame of reference, which assumes a half-way position, that there is a two-way interaction of influences between the individual and the environment (Adams and Schvaneveldt, 1985).

These frames of reference correlate with the Values Concepts underlying the research. The organismic frame of reference supports Values Concepts One and Two, the belief

in the individual, and in change and development over time. The interactional frame of reference supports Values Concept Three, the reciprocal relationship between the individual and the environment. The mechanistic frame of reference appears to be in opposition to the values of the research, but this framework might be evidenced as an underlying value (although a negative one in my view) influencing the rigidity of care practices within institutional environments (Townsend, 1962) and testifying to the reality of structural influences. Its outcome is the de-humanising of the residents.

Sociology also contributes frames of reference as exemplars for particular perspectives. Ritzer (1975) identified three frames of reference established in sociology and social work:

the social fact frame of reference,

the social definition frame of reference, and

the social behaviour frame of reference.

The social fact frame of reference (Durkheim, 1897, 1951) argues that social facts are external to individuals and exert power over individuals. This view of the social world corresponds in part to the structural approach within professional values (discussed above). For example, group life exists as an entity apart from the individuals within it, and influences individuals within the group. The social world is depicted as a separate entity over and above the lives of individuals who make up the social world. The nature of the social world is external to, and exerts a powerful influence on the lives of individuals. Social institutions are perceived as coercive to the individual. Social structure (Merton, 1957, 1968) is an important concept within this frame of reference.

An approach arising from the social fact frame of reference is structural functionalism (Parsons, 1951; Merton, 1957, 1968; discussed in Chapters Two and Three). Structural functionalism argues that societies consist of networks of relationships between parts of the social structure, whose task is to ensure continuity. It views the social world as external to the individual. The ongoing life of a society can be analysed according to the functioning of its structure. Functionalist approaches differ according to the level of analysis. Some focus on the individual institution, others on the social system (Malinowski, 1922). Radcliffe-Brown (1945) claimed that social institutions contribute to the integration, stability, and maintenance of the social system as a whole. The structural professional values approach (discussed above) is consonant with functionalism's epistemological underpinnings .

The social definition frame of reference focuses on social action. This view corresponds to the individualistic professional values approach (discussed above) and is consonant with Values Concept Two, the belief in change and growth. Human behaviour is studied with regard to its subjective meaning for the individual actor. Behaviour has meaning and gives direction to social life. The focus is on mental process, social relations, and interactions. The social world is viewed as possessing the potential for development, creativity, and change. Social development is caused by, and causes, acts of individual creativity (Craib, 1984).

An approach associated with this frame of reference is symbolic interactionism (Mead, 1934; Blumer, 1969; discussed in Chapter Two). Developed by W. I. Thomas (1928) and Robert Park (1950) at the University of Chicago, symbolic interactionism views social life as a process in which the individual interprets his or her environment and acts on the basis of that interpretation. The social world is comprised of individuals who influence the social world through their interactions with each other, much like actors on a stage. The social world is not perceived as an entity separate from the individuals who comprise it. It is individuals who form and shape the social world. Individuals' actions are based on the meanings that things have for them. Language is important

within symbolic interactionism because it provides symbols which reflect meanings. Meanings result from social interactions modified by interpretative processes developed by individuals to deal with the features of the social world that each person encounters (Blumer, 1969). Values Concepts One and Two are consonant with the epistemological underpinning of symbolic interactionism.

The social behaviour frame of reference suggests a focus on the functional relationships between behaviour and behavioural reinforcements in environmental settings. It is consonant with Values Concept Three, the reciprocal influence of the individual and the environment on each other. This frame of reference draws on an ecological interpretation of the relationship between an organism and its environment, which featured in previous Chapters in the discussion of ageing and relationships (Bronfenbrenner, 1979).

The contrasting and sometimes complementary frames of reference, practice values, and Values Concepts discussed above are set out in the chart below (Fig 16). Falling partly outside the correspondence of the different analytic structures are the social fact (Ritzer, 1975) and mechanistic (Adams and Schwaneveldt, 1985) frames of reference which take a pessimistic and limited view of the power of individuals in the social world. The psychoanalytic and behavioural perspectives do not fit the Values Concepts One and Two entirely, because they are based on an acceptance of structural influences on behaviour (psychoanalysis recognising the unconscious as a structure, and behaviourism recognising the influence of the environment). They are included in the discussion because they have been used effectively to bring about change.

Fig 16 **The Consonance between Values Concepts, Orientations, and other Frames of Reference and Analytic Structures**

Values Concepts arising from the Topic	**Professional Practice Values**	**Organisational Structures (Burrell and Morgan, 1979) super-ordinate world views**	**Taxonomy of Social Work Theories (Howe, 1987)**	**Frames of Reference (psychology) Adams and Schvaneveldt 1985; (sociology) Ritzer, 1975**	**Relationship Orientation**
Values Concept One: the worth of the individual	individualistic values (Biestek, 1958, 1973; Hollis, 1972; Perlman, 1957)	conflict (change) *fragmentation*	seekers after meaning (client-centred work)	organismic (1985): individuals are active beings; social definition (1975): behaviour has meaning for the individual actor	self-fulfilment
Values Concept Two: change and development in adult life	individualistic values	conflict (change) *fragmentation*	raisers of consciousness (feminist social work, radical social work); fixers (psychoanalytic and behavioural social work)	organismic (1985): individuals change themselves; social definition (1975): the social world has the potential for change	self-fulfilment

Values Concepts arising from the Topic	**Professional Practice Values**	**Organisational Structures (Burrell and Morgan, 1979) super-ordinate world views**	**Taxonomy of Social Work Theories (Howe, 1987)**	**Frames of Reference (psychology) Adams and Schvaneveldt 1985; (sociology) Ritzer, 1975**	**Relationship Orientation**
Values Concept Three: reciprocal influence of the environment and individual on each other	structural values (CCETSW Paper 30, 1995; Paper 31, 1992)	conflict (change) and order (stability) *collectivity/ fragmentation*	revolutionaries (Marxist social work)	interactional frame of reference (1985): a two-way interaction between the individual and environment; social behaviour (1975): functional relationships between individual behaviour and environmental reinforcements	utility value
The Frame of Reference on the right falls outside the scope of the Values Concepts	The Frame of Reference on the right falls outside the scope of the Professional Practice Values	order (stability)	The Frame of Reference on the right falls outside the Taxonomy of Social Work Theories	mechanistic frame of reference (1985): humans are reactive to their environment; social fact (1975): the social world exerts external power over individuals. The Marxist view that social structures are paramount and need to be changed by revolution.	utility values

5.8 The Relevance of Social Theories, Research Methods and Strategies to the Research Topic

Epistemological underpinnings and substantive theories or philosophies must be recognised as influences on research methodologies, but there is no single approach which can provide a complete explanation. The different categories and concepts provide a means of organising our understanding so that further problems can emerge. They are not fixed and unchanging. Rather than succumbing to the crossword puzzle trap of debating methods without considering the links between methods and these different perceptions of the social world, Craib (1984) suggests that a research design should emerge after due consideration of these resulting complexities. For example, the Values Concepts and frames of reference (discussed above) are built around belief systems, which make assumptions about the nature of humanity and social behaviours.

Once understood and popularised, the beliefs/frames attract followers to schools of social theories, comprising different epistemological underpinnings. Craib (1984) argues that all social theories eventually undergo a necessary fragmentation in order to explain the wide range of different social phenomena. Variations and developments are generated, so that no theory remains classically pure and sufficient in itself as an explanation of social behaviours. This supports the exploration of different theoretical approaches as a part of the process of selecting research methods.

With the growing interest in exploring the links between philosophical issues, substantive theories, and research methods, technical arguments about the relative inferiority and superiority of quantitative and qualitative methods have been subsumed by more sophisticated arguments about different epistemologies and beliefs about the nature and purposes of social research. In the next part of this Chapter, characteristics of different underpinning approaches to social research will be considered, before moving to a discussion of the relevant technical issues. Blaikie's overview (1993) of the different approaches to social enquiry has been drawn upon particularly in the discussion which follows.

5.9 The Positivist Approach: Philosophical Underpinnings

Positivism is founded on the position and beliefs of Naturalism, which argues for a natural scientific study of society - the unity of scientific method, in which the same kind of method and logical explanation used for the natural sciences is considered appropriate for the social sciences (Mill, 1879; Popper, 1961, Blaikie, 1993). Positivism has constituted the dominant philosophy of the natural sciences, and has influenced the emergent social sciences.

The term Positivism was popularised by Comte (1830, 1970 edition), who argued that knowledge is based on causal laws founded on empirical observation of phenomena, and that all sciences, including sociology, are unified in a hierarchy. He believed that social reality which is independent from the reality of the sciences does exist in the hierarchy, and its laws cannot be reduced to the laws of other sciences. Logical Positivism emerged in the 1920s and argued, unlike Comte, that the laws of the natural sciences (the higher level sciences) could be reduced to the level of the social sciences (the lower level sciences) within the hierarchy. The third view of Positivism, developed in the last fifty years, argues that all sciences develop explanations as universal laws or generalisations. Phenomena are explained as specific instances of general laws.

To summarise, Positivism (Comte, 1970 edition) argues that the natural sciences provide an empirical standard for evaluating knowledge. Only those phenomena which are observable can constitute knowledge. The Positivist stance on values is to try to rid the researcher of bias and personal values. Value judgements and normative statements are not viewed by Positivism as valid expressions of observable experience, and so need to be separated from facts and knowledge. The influence of Positivism (Comte, 1970 edition; Parsons, 1942, 1951; discussed above) is evident in structural functionalism (discussed above).

5.10 Reactions to Positivism

Positivists argue that the methods of natural science are transferable to the study of society. But not all philosophers and researchers agree. Historicism, Critical Rationalism (Popper, 1959, 1961, 1976) and Classical Hermeneutics (Schleiermacher, Dilthey, Heidegger, as discussed by Blaikie, 1993) reacted to Positivism in different ways. Criticisms of Positivism drew attention to the issues raised by the complexities of different cultures existing within the social world. Social laws change across time and space, and are historically and culturally specific rather than universal. Using experimental procedures within social situations brings about new learning based on

experience, rather than discovering universal laws. Objectivity in social enquiry is affected by the values of the social scientist whose influence cannot be discounted. With regard to the topic of relationships of elderly people in residential care, Positivism's rejection of the importance of values in the research process means that it is unlikely to be compatible with the aims of the proposed research.

5.11 Interpretivism and Critical Theory, Structuration, Feminist Theory, and Realism

Interpretivism provides the major reaction to Positivism. The Interpretive approach, with its emphasis on individual meanings and actions, is more compatible with the research topic and its intentions. Interpretivism draws on the traditions of Hermeneutics and Phenomenology. It differs from Positivism because it argues that the subject matters of natural and social sciences are different. Unlike the natural world, which requires interpretation by the scientist, the social world is already subject to interpretation by its social actors and participants in everyday life (Giddens, 1974). The philosophies influencing Interpretive research include those of Weber (1930, 1964); and Schutz, (1962, 1972, 1983 a and b). These philosophies are consonant with the individualistic Values Concept One and the professional values approach. Their boundaries overlap, but they share a common understanding that individuals attribute meaning to the social world, and that individuals' actions determine the nature of the social order.

Interpretivist views have been developed and modified by Structuration, Feminism, Realism, and Critical Theory. Structuration is argued by Giddens (1984) not so much as a theory but as an understanding of social reality to fill the gap caused by the lack of consensus about the relationship of the natural and social sciences. Giddens (1976) viewed society as being produced and reproduced by social actors, but they are historically located and not always able to act with free will. Giddens argued the duality of structure: social structures are formed by human action and also form the medium of human action. Social structures are both the conditions and consequences of social interaction. They are the rules and resources social actors use. Applied to the research topic, the concept of the duality of structures supports the notion of the individuality of residents within the wider social structure of the institution, each influencing the other.

Feminism is critical of the methods and approaches in both the natural and social sciences, arguing that all science views the world in an androcentric masculine manner (Oakley, 1974; Smart, 1976). Feminism requires research to be based on women's experiences; to deal with what women regard as problematic; and to relate to the people and issues being researched (Harding, 1987). Feminism argues against rigid boundaries between the subjects and objects of research and advocates bridging the distances between knowledge and its uses, and between thoughts and feelings (Fee, 1986). Feminism finds it difficult to know how to incorporate class, race and culture, which result in similar experiences of oppression as those experienced by women (Harding, 1987). The proposed research takes into account Feminist suggestions about the importance of the researcher relating to those being researched, but considers age as a central source of oppression, an aspect which Feminism neglects. In other aspects, the research topic is consonant with the Feminist approach, because of the dominance of elderly women in residential care, and the intention to explore residents' points of view.

Realism (Harré and Secord, 1972; Bhaskar, 1979, Layder, 1990) is a bridge-building approach between Positivism and Interpretivism. Realism tries to preserve the Positivist scientific approach towards social analysis, recognising at the same time the importance of individual meanings. It argues that social science subject matters cannot be reduced to the subject matters of natural sciences. They need to be studied scientifically but with different, appropriate methods. Realism accepts that social reality

is produced and reproduced by its members, and is a condition and outcome of human activity. The concept of underlying social structures is characteristic. Realism is relevant for the research topic because of its balance of individuality and social structure.

Critical Theory, associated with the Frankfurt School, whose members included Adorno (1973), Horkheimer (1974), and Marcuse (1964), is interested in achieving autonomy and emancipation from the power structure which underpins human existence. Its process for understanding reality is dialogic, individuals communicating their experience within a shared framework of meanings. Habermas (1976, 1979) emphasises the reciprocal nature of relationships, perceiving society as simultaneously a system and a life-world. The life-world is comprised of culture, personality, meaning, and symbols which constitute the basis of communication. In the modern world, the society of the life-world has become separated from the society of the social system. Although it is possible to integrate the two aspects of society through the potential for communication contained within the life-world, there is a tension between the two aspects. Crises occur at the point of engagement and interconnection of the social system and the social actor's life-world.

Critical Theory argues that one must understand the world from the point of view of the group or individuals being studied. It recognises that people's actions are often dictated by conditions which are beyond the control of individuals. Theory is related to practice, so that its truth depends on its ability to be translated into action - the "pragmatic view of truth" (Fay, 1975). Critical Theory deconstructs abstractions in order to analyse hidden relationships, then reconstructs the concepts in terms of the social relationships which govern the abstractions. For example, Critical Theory explores how values, history, and social systems relate to the oppression of the individual. It argues that the social patterns and structures which shape subjective understanding must be taken into account. Subjective understanding is mediated by oppressive social structures such as class, race, and gender (Everitt et al, 1992). Critical Theory's approaches support the research topic's intentions and its links to professional practice. Professional practice works with the principles of deconstruction and reconstruction of oppressive social systems to bring about change in people's lives. The situation of elderly people resonates with this argument. Elderly people in residential care live in institutions which are potentially oppressive social systems.

5.12 Summary of the Discussion and Relevance for the Research Topic

Previous sections of the Chapter argued that methodology should be related to the characteristics of the research topic of relationships of elderly people in residential care. There should be a reasonable fit between the questions the topic raises, the philosophies and related substantive theories which articulate its underlying perspectives of the social world, the practice-based concerns which prompted the topic choice and its uses, and technical issues of resources available. The discussion established that no philosophical framework or epistemological approach provides an absolute fit, but from the understanding gained in Chapters One to Four, three Values Concepts were seen to underpin the topic. These assert beliefs in the worth of the individual, in change and development in adult life, and in the reciprocal influence of the environment on the individual and the individual on the environment. The Values Concepts are consonant with the professional value base for practice, incorporating both an individualistic approach as in Values Concepts One and Two, and a structural approach, as in Values Concept Three.

The discussion then continued with a focus on issues of methodology, which was defined by Harvey (1990) as an interface between epistemological underpinnings, substantive theory, and methodic practice. The philosophies of the social sciences and related substantive theories are important influences on the research methodologies and the knowledge and theories which inform professional practice. A review established

links, although with the same caveat about flaws existing in every framework. The connection between the philosophies, substantive theories, the Values Concepts implicit in the topic, and the professional practice's knowledge and theory base resonates throughout the review. For example, the life course perspective (Hareven, 1982; Pearlin, 1982), with its emphasis on context, as discussed in Chapter Two, supports Values Concepts Two and Three, as does the ecological approach (Bronfenbrenner, 1979, discussed above and in previous Chapters).

The discussion about methodology explored the various approaches, such as Positivist approaches (which are likely to adopt a structural view) and Interpretivist approaches (which are likely to take a more individualistic view). It recognises that conforming to rigid boundaries between different approaches to doing research is not appropriate for operationalising the topic. The life course perspective (Kohli, 1986; Blaikie, 1992) and the ecological approach (Bronfenbrenner, 1979) emphasise both individuality and social structure. The knowledge and value base of professional practice, and the three Values Concepts are both individualistic and structural. Perspectives which overcome the artificial barriers between individualistic and structural approaches are needed.

The characteristics of Interpretivist philosophies most readily fit the topic of relationships of elderly people in residential care. Starting with this epistemology, we have seen that our unterstanding of the topic is grounded in the values of professional practice. It emphasises the insider view, seeks to explore subjective meanings from the individual resident's point of view, and maintains an optimistic view of the possibility of change and development in relationships in old age. The topic's recognition that the institutional settings of residential homes result in routines and rituals which affect the lives of residents is consonant with the approaches of Critical Theory (Habermas, 1976, 1979, discussed above) and Structuration (Giddens, 1984, discussed above) to the Interpretivist methodological template. Taking into account social structure (Merton, 1968) and environmental contexts (Bronfenbrenner, 1979), organisational relationships (discussed in Chapter Three) are important considerations for the methodological choices. One of the identified Value Concepts argues the reciprocal influence of the individual on the environment, and the environment on the individual. Previous Chapters emphasise the importance of the ecological perspective (Bronfenbrenner, 1979, discussed above) as a key to understanding the implications of the topic. The interactionist frame of reference (Adams and Schvaneveldt, 1985; discussed above) and the social behaviour frame of reference (Ritzer, 1975; discussed above) suggest that the topic must take a broad approach. The importance of organisational context, social structure, and reciprocal influences on behaviour, fall outside an orthodox Interpretivist methodology. They suggest that some of the epistemological underpinnings of the topic could lead to an approach which emphasises structure and order.

Critical Theory (Habermas, 1976, 1979; Harvey, 1990) provides a suitable approach because it places the individual within social contexts. Critical Theory offers the possibility of a view which bridges different methodologies. Its substantive theories and epistemological underpinnings provide a theoretical argument for a broad approach to the research topic. Habermas' ideas are relevant to the research topic, particularly for its intended use within practice. The implications of Critical Theory for the research topic of the relationships of elderly people in residential care are apparent. The elderly resident's life-world becomes alienated within the context of the regime of the residential home. The residential home represents society and the social system. Within professional practice, interaction between individuals, whether resident to resident, or resident to worker, needs to be understood as an expression of meaning and personality which influences and is influenced by the wider setting of the residential home. Relationships of elderly people in residential care are mediated by the social stratification (Riley et al, 1972; Neugarten and Neugarten, 1986; discussed in Chapter Two) of age and by institutionalisation (Goffman, 1961; Townsend, 1962). The topic is consonant with the structural aspect of professional values, as discussed

earlier in this Chapter, and the ecological approach (Bronfenbrenner, 1979; discussed above and in previous Chapters).

For example, concepts of ageing, relationships, and residential care (as discussed in preceding Chapters) need to be deconstructed from stereotypical assumptions and reconstructed according to the underlying values prompting the thesis. Critical Theory does not deny the importance of subjective meaning and values as means of transforming aspects of society, so it achieves consonance with the Values Concept of change and belief in the individual which is characteristic of professional practice. Critical Theory confronts reality at two different levels, that of the life-world and the social structure, just as the elderly person in residential care is forced to do.

5.13 Research Strategies: Inductive, Deductive, Retroductive, and Abductive Strategies

The different approaches to social enquiry, discussed above, are associated with different research strategies. The next part of the Chapter evaluates the appropriateness of the different research strategies for the topic. Blaikie (1993) identifies four broad strategies, each of which uses a different kind of logic to explore the social world: the inductive, deductive, retroductive and abductive approaches. They assume different starting points for research and make use of different processes and methods.

Inductive research strategies typify the Positivist scientific approach, sometimes called empiricism, which emphasises careful observations to establish facts. Inductive strategy adopts logical procedures. It uses inductive reasoning, which starts with a particular single statement and ends with a universal or general statement. In contrast, deductive research strategies move from universal or general statements to particular or single statements. Sometimes known as the hypothetico-deductive or falsificationist approach, it is linked with Popper's Critical Rationalism. It begins with a question or a problem which needs explanation or understanding. First, a possible answer or hypothesis is formed. This is subjected to attempts to refute or falsify it. The theories emerging from this process move towards truth by continuous criticism and testing.

Kuhn (1970) stimulated criticism of the views of both inductivists and deductivists. He argued that the source of hypotheses lies within scientific communities which pursue dominant paradigms (clusters of beliefs which influence what is studied, how research is conducted, and how results are interpreted). Kuhn argued that social theorists work within contexts of assumptions (ontological and epistemological) about society and how it functions, about what methods should be used, about where explanations should be sought, and about what constitutes acceptable explanations. Creativity takes place within a particular paradigmatic framework. Kuhn portrays the social sciences as 'pre-paradigmatic', with no single paradigm identified for each, but with several pre-paradigms competing for status.

The inductive and deductive strategies, deriving from paradigms which emphasise an outsider view of reality, are not compatible with the aims and values of the proposed research which seeks to understand and explore the relationships of elderly people in residential care from an insider perspective. The recognition of flaws in the inductive and deductive strategies led to more eclectic views about which strategy is suitable and allowable within social enquiry. This parallels the trend toward fragmentation of social theory.

Retroductive and abductive strategies provide more suitable research strategies for the topic. They share characteristics with each other, but Retroductive strategy, as discussed by Blaikie (1993) is concerned with constructing hypothetical models according to the Realist approach, while Abduction is preferred by many Interpretivists as the appropriate means of constructing theories. Abduction is concerned with the process of moving from everyday descriptions to technical descriptions of the social

world and social interactions. The abductive approach is a layered one, consisting of actors' accounts of everyday events, their reflective construction of meanings, and the piecing together of fragments of meanings from the research process. The layers are comprised of everyday meanings which provide foundations for action and interaction. This emphasis on layers echoes the multi-layered nature of relationships (personal, social, and organisational), discussed above and in Chapter Three. Actors give accounts of actions and interactions, social scientific descriptions are formed from these, and theories and perspectives are generated from the descriptions. Aspects of abduction are found within many contemporary approaches, for instance, Critical Theory, Realism, and Structuration. It is dominant within Feminism. These approaches agree on the importance of describing the social world on its own terms. This is important for the proposed research topic. The retroductive and abductive strategies' emphasis on every day language, the relationship between the researcher and the researched, and the importance of action and structure are consonant with the characteristics of the proposed research topic.

5.14 Summarising Characteristics of Different Approaches and Strategies

Reviewing different approaches contributes to an informed choice of research strategy. Blaikie (1993) provides a useful overview of the different approaches. All approaches and strategies involve judgements and compromises. Four considerations are important, as we have seen: the researcher's world view, different ontological and epistemological views, and different ways of constructing theory. These considerations need to be evaluated in relation to their suitability for the topic and its research strategy.

The world view (especially the values and beliefs) of the researcher and how various approaches relate to this world view influences the choices to be made. The researcher's professional culture and personality will shape choices. Past and present experiences influence decisions. Relationships between the researcher and the researched, and the relevance of concepts of objectivity and truth, need to be considered. Relationships between the researcher and the researched vary according to the concept of objectivity adopted. Positivism and Critical Rationalism (Popper, 1976) argue that the relationships should be detached, but this has been shown to be impossible. Hermeneutics (Gadamer, 1989; Ricoeur, 1981), reacting against Positivism, has moved toward the other extreme, in which language is used to develop understanding, and immersing the self in the actors' world is valued. Critical Theory views researchers and those who are being researched as engaged in a dialogue, with the researcher as a reflective partner who facilitates emancipation. Feminism is most involved with those who are researched, and argues for active participation with the researchers' and respondents' experiences.

Selecting an appropriate strategy involves adopting certain ontological and epistemological views which correspond most nearly to the particular strategy chosen. The main choice is between different ontological (realist or constructivist) and epistemological (outsider or insider) points of view. The realist view of ontology, held by Positivism, Critical Rationalism, and Realism, argues that reality exists independently of the observer, and that social science can observe and explain this ordered reality. Positivism and Critical Rationalism see action as the product of the influence exerted by external forces. Realism accepts this external view, but, influenced by social psychology, places the external forces in different arenas, for example, within internal cognitive resources. Interpretivism, Critical Theory, Structuration, and Feminism are constructivist in ontology, assuming that social reality is constructed by social actors. (Realism also contains some elements of constructivism). The world is interpreted and contains many meanings and social institutions, and because of this, there are multiple realities. Social conditions influence social actors, who may be unaware of these influences. Structuration Theory argues

the duality of structure, in which the influence of social structures is limited because structures are also products of these interactive processes.

With regard to epistemology, approaches differ in how and to what extent they assume social reality can be observed. Positivism accepts only directly observable phenomena. Critical Rationalism accepts that knowledge of reality can be achieved by using theoretical concepts to determine what should be observed. Interpretivism, Structuration Theory, social psychological Realism and Feminism argue for the insider view of immersion in the social world. As we have seen, the choice between approaches and strategies depends on the nature of the research questions and their purposes. The purposes of social research range from exploration, description, understanding, explanation, change, and evaluation. Positivism is interested in description of observed regularities which lead to generalisations, and Critical Rationalism tries to arrive at universal propositions which can explain and predict. In contrast, some types of Interpretivism simply report social actors' accounts and meanings, describing situations which will produce understanding. Other types of Interpretivism seek to generalise and explain. Structuration Theory rejects the distinction between understanding and explanation, but accepts that explanations are limited by time and space. Realism rejects prediction because of the impossibility of social experimentation in the manner of the natural sciences.

Induction (used within Positivism) builds generalisations out of specific observations. Deduction (used within Critical Rationalism) begins with generalisation and uses observation to test the hypotheses. Realism rejects both these approaches. Realism starts with observed regularities and proposes models of social structures and mechanisms to explain them. Reason and imagination are required to form the model, and research is used to establish the model's existence. Approaches differ on whether they aim for explanation. Interpretivists who are concerned with explanation use abduction for constructing theories. They need to penetrate frames of meaning and generate ideal types. For example, Weber (1930, 1964), Schutz (1963a), and Rex (1971, 1974) advocated ideal types as a foundation for propositions which could subsequently be tested. Ethnomethodology does not develop general propositions, but requires that all accounts are considered within the contexts in which they are used. Some approaches generalise from everyday language and decontextualise accounts. Interpretivists such as Weber and Schutz accept some decontextualisation. Another issue is the relationship between everyday language and social science discourse. Positivism and Critical Rationalism reject everyday language, relying on scientific knowledge to demystify common sense beliefs. Interpretivism and Realism, supported by abductive strategy, suggest that social scientists should build knowledge through use of everyday language.

5.15 Choice of Methods Arising from the Approaches

Positivism has already been discounted as an approach for the research. The methods which are usually linked with the Positivist approach, such as social surveys and experimental designs, operationalise concepts in order to measure them, and seek to establish causal relationships between concepts. They are concerned with issues of validity, reliability, generalisation, and replicability. They place an emphasis on the role of theory. These kinds of research are organised typically in orderly sequences, starting with theory and moving from hypothesis, observation, data collection, data analysis, to findings which prove or disprove the hypotheses. They use inductive and deductive strategies. Because of their link with Positivism, and the ease with which they explore reality as existing outside the consciousness of the individual, social surveys and experimental designs do not suggest themselves as appropriate methods for the research topic. The research topic takes the opposite view of seeking to explore the feelings and subjective realities of individuals. More appropriate research strategies exist to facilitate this purpose.

In one aspect, research based on a Positivist approach may claim to be individualistic. Its individualism is located in its techniques of data collection, not its world view. The individual is the focus for the collection of data. Social surveys seek the views of individuals rather than collective groups of individuals. The approach known as aggregate psychology (Coleman, 1958) views society as an aggregate of disparate individuals (Blumer, 1948). This approach is inappropriate for the study of relationships which involve interaction between individuals.

With this in mind, the next consideration is of methods linked to the Interpretive approach which, as we have seen, is consonant with the purpose of the research topic. Research (Bryman, 1988) which draws on an Interpretive approach seeks to describe and analyse the culture and behaviour of humans and their groups from the point of view of those being studied. This approach makes use of retroductive and abductive strategies. Frequently used methods are participant observation (Mead, 1935; Becker, 1963; Goffman, 1961) and unstructured interviewing (Becker et al, 1961). Participant observation examines social processes over time in natural settings, requiring the researcher to spend a prolonged period of time developing a relationship with those whom he or she seeks to study with a view to generating a rounded in-depth account. Gans (1967) portrayed the various levels of participant observation as a contrast between the role of the total researcher, the researcher-participant, and the total participant. Some writers use 'ethnography', a term used to describe the approach of participant researchers and researchers influenced by the traditions of anthropology (Hammersley and Atkinson, 1983), or 'field research' (Burgess, 1984) to denote this approach. Symbolic interactionism (Thomas, 1928; Park, 1950, discussed above) is a well known Interpretivist approach which, although not inevitably linked with participant observation (Mead, 1935; Goffman, 1961), is often associated with this kind of research.

Because Interpretive researchers may not be able to observe everything, they need to back up observation with other techniques. They may examine documents (Thomas and Znaniecki, 1919), carry out structured and unstructured interviews on an individual and group basis, and take life histories (Plummer, 1983). The group discussion (Pahl and Pahl, 1971; Cohen and Taylor, 1972), structured around key topics, enables differences and contradictions within and between replies to emerge. Life history research involves the reconstruction of the lives of one or more individuals, using diaries, autobiographies, and extended unstructured interviews. It reveals the development of perspectives over time through the historical and contextual data which has been gathered.

Critical Theory influences the choice of research methods. Critical Theory has shown that the dichotomy between approaches which have been characterised traditionally as 'quantitative' and 'qualitative' is inappropriate. Because Critical Theory does not promote exclusivity of methods, a more flexible approach is possible which brings different views together. The way in which the central concepts are argued becomes more important than the choice of methods. Critical research may use different methods such as observation, formal interviews with random samples, semi-structured and unstructured interviewing, analysis of documents, examination of official statistics, techniques of ethnographic research (Malinowski, 1922), action research (Winter, 1987, 1989), and multi-variate analysis (Harvey, 1990). In using these methods, it is the approach to evidence that is essential for Critical social research.

Realism provides another bridging perspective for the choice of research methods. Layder (1993) argues its strengths as a multi-strategy approach which views Positivist and Interpretivist approaches as complementary to each other. Research strategies must be concerned with the layered nature of social reality, the unfolding nature of social activity over time and space, and the integrated nature of macro and micro elements of social life. The three essential elements of the textured multi-strategy approach are identified as power, history, and general social theory. Power is embedded in settings

and activity contexts, (such as work), influencing behaviour in subtle ways. Structural power is based in different settings and contexts, some in formal organisations, some in informal types of social organisations, and in the researcher's own strategies used for the research. Historical data provide an understanding of how power and domination have been built into institutional structures and social behaviour. The social theories which help to develop the research strategies must have a dual frame of reference, both to subjective interactions and to more objective social structures. Layder (1993) embodied the textured or inter-woven nature of different levels and dimensions of social reality in a research map. The research map includes the following elements and foci :

Fig 17. The Research Map (Layder, 1993, P. 8)

Research element		Research focus
context	<---------->	Macro social forms (class, race, gender)
setting	<---------->	Immediate environment of social activity (school, family, work)
situated activity	<---------->	Dynamics of face-to-face interaction
self	<---------->	Biographical experience and social involvements

Layder argues that the advantages of the multi-strategy approach include its generation of a greater density of empirical coverage, with more likelihood that data will be valid. The possibility of developing theory is increased because more complex data is available for interpretation. The multi-strategy approach also encourages a range of analytic views. This could mean using as many different methods and techniques as possible, or borrowing perspectives and concepts (Bryman, 1988; Layder, 1993) to help form new theory from the research.

To summarise, an Interpretivist methodology, drawing on the contributions of Critical Theory and Realism, appears most appropriate for the topic. The research's intended outcome of discovering useful knowledge for professional practice supports this preference. Social work practice is compatible with epistemologies that take account of processes and structures through which subjective understanding is gained and with methodologies which create and validate data through participatory processes (Everitt et al, 1992). The topic of relationships of elderly people in residential care has been conceptualised in a way which is consonant with the tradition of symbolic interactionism (Thomas, 1928; Park, 1950). It seeks to discover and describe in detail the nature of social encounters in particular settings.

Layder's multi-strategy adaptation of Realism is relevant to the topic. His research map resembles the ecological layers (Bronfenbrenner, 1979, discussed above and in previous Chapters) which argue for the micro, meso, exo, and macro systems of the environment. The use of power, a concern of both Critical Theory and Realism, is central to the research topic. For example, elderly people in residential care (discussed in Chapter Two) are relatively powerless in relation to the control exerted by the staff on their range of choices and daily routines, and in relation to the approach of the researcher. The perspectives of Critical Theory (Habermas, 1976, 1979, discussed above) reinforce the relevance of the historical approach to the research topic. The life course perspective (Kohli, 1986; Blaikie, 1992; discussed in Chapter Two) values the influence of personal and social events over time in shaping people's lives, personalities, and as a means of gaining individual understanding. The life course perspective (Kohli, 1986; Blaikie, 1992), the ecological layers (Bronfenbrenner, 1979)

and the differentiation between personal, social, and organisational relationships, (discussed in previous Chapters) and the Values Concepts, are the kinds of typologies used for conceptualising this research topic. From the view of methodic practice, the topic lends itself to methods such as participant observation and unstructured interviews (discussed above) which are used to gather 'soft', rich data which describe situations and processes within particular contexts.

5.16 Technical and Pragmatic Issues for Selecting Methods

In contrast to the discussion which explores the link between social philosophies and research methodology, Bryman (1988) urges a pragmatic approach to research methodology. The crucial question, for him, is the appropriateness of particular methods, and combinations of methods, for particular issues. Layder (1993) also concurs, but concedes that because of practical considerations, it is not always possible to select from every possible method. There may be a limited type or amount of data available because of restricted access or lack of budget, or both. The source and availability of funding will shape choices. The costs involved in combining different approaches in a research project are likely to be high, and may be beyond the scope of a project's available funding.

Arguments for adopting particular approaches to research, taking into account their different epistemological positions, have been discussed. Bryman (1988) states that the argument for a watertight link between epistemology and methods is not credible, based on the use of a mix of methods in a number of research studies. If the link between epistemology and methods does exist, Ritzer's paradigms (1975, discussed above) of social fact, social definition, and social behaviour should correspond both to an epistemology and accompanying methods of research. Bryman (1988) calls attention to Snizek's study (1976), which analysed over a thousand research articles in sociological journals to discover whether there was a link between Ritzer's paradigms, epistemology, and methods, but could not find a conclusive link with regard to methods used.

Bryman (1988), as well as Layder (1993), argues that it is possible and desirable to combine different approaches. He mentions the need for triangulation, using different methods, data, or theories as a means of establishing validity of findings (Denzin, 1970). Bryman claims that research known as qualitative (usually associated with an Interpretivist approach) which is based on interviews or observation helps to form hypotheses which may facilitate subsequent quantitative Positivist-associated approaches to research. Conversely, survey data may be used as a basis for subsequent ethnographic exploration. Interpretivist approaches may help to interpret the relationships between variables, by helping to explore the connection between clusters of data. Layder (1993) argues that survey data undertaken by others can be used in Interpretivist research as a resource. Different approaches to research may be combined to obtain a broader picture of the social phenomena under investigation. Some research methods provide a view of social life as process, while other research methods provide a more static structural account, and therefore they can be used as complementary strategies. The combination of different approaches enables both researchers' and subjects' perspectives to be obtained. Qualitative research's generality is overcome when measures of counting associated with quantitative approaches are used (Silverman, 1972, 1985).

5.17 Summary of the Chapter and the Next Steps

This Chapter has discussed issues of methodology. It considered the nature of the research topic and its implicit ontological and epistemological underpinnings, philosophies, and substantive theories, the implications of its intended use for the benefit of professional practice, the research strategies which may be suitable, and the pragmatic issues of selecting methodology. The likelihood of achieving a reasonable fit

between philosophies, the concerns of the research, the methods, and the links to professional practice was explored. The discussion established the importance of Values Concepts, of taking an insider view for exploring the relationships of elderly people in residential care, of using a historical approach, of valuing the individual, of being open to the possibility of change, and of considering both individual and structural factors through a layered approach. Rather than seeking to arrive at the 'truth' through Positivist approaches, the research will use an Interpretivist approach to explore the reality of the residents' lives through their individual experiences. The research is constructivist in its ontology. It draws on the bridging perspectives of Critical Theory and Realism, and accepts the duality of structure of Structuration. It could be said to adopt an eclectic, pragmatic view within an Interpretivist tradition.

The next Chapter carries the discussion forward, drawing on the issues discussed in this Chapter, and moving towards operationalising the three foci of the research (elderly people, relationships, and residential care) through an appropriate multi-strategy approach. Specific methods, the research design, and technical issues will be discussed in some detail.

Relationships of Elderly People in Residential Care

Chapter Six

Addressing the Topic

6.1 Developing a Multi-Strategy Approach

This Chapter relates the development of a multi-strategy approach to the issues which the research topic seeks to explore, and its related resource-based concerns (discussed in Chapter Five). The topic's underlying philosophies, practice values, and implied practice skills will be taken into account. No framework or approach can provide definitive solutions. The approach adopted, influenced by Interpretivist philosophy, will be eclectic and pragmatic. The research design will be worked out according to the three foci of the research (elderly people, relationships, and residential care), the Values Concepts, and other issues identified in the previous Chapter. The research process will be discussed, from the beginning steps of gaining access, designing and piloting the instruments, to an analysis of the significant planned and unplanned events of the research process. Problems occurring during the process will be evaluated.

6.2 Preliminary Decisions for a Multi-Strategy Approach

As established in previous Chapters, relationships of elderly people in residential care are insufficiently understood. The research needs to discover what happens in residential settings, to be open to the happenings and interactions which contribute to the relationships being explored (Kelley et al, 1983). Methods which complement each other help to improve the findings of the research. The process of triangulation (looking at things from more than one direction, Denzin, 1970, discussed in Chapter Five and below) is essential for developing the multi-stranded potential of the research topic into a multi-strategy approach. In choosing an appropriate combination of methods for a multi-strategy approach, the characteristics of ageing, the nature of relationships, and the special settings of residential care need to be taken into account. Pragmatic considerations are important. The methods must be implemented within the available time scale and resource limitations. They also must achieve consonance with the Values Concepts, philosophies, and theories underpinning the topic.

Conceptual frameworks, although flawed, are needed to provide focus, clarity, and understanding. The frameworks need to take account of areas of bias which influence perceptions. Because personal and professional values have influenced the choice of research topic, objectivity is an ideal (rather than a realisable) goal. The need to avoid bias is important. These frameworks were identified in previous Chapters as:

the life course perspective (Kohli, 1986; Blaikie, 1992),

the ecological approach (Bronfenbrenner, 1979),

consideration of personal, social, and organisational relationships, and

the three Values Concepts.

As Chapter Five established, there is no single approach or method for doing research. The approach for this research falls within Yin's definition (1984) of a case study with its proposed in-depth exploration of particular residential settings using different techniques and methods to study more than one example. I wanted to explore the effects of size, design, and regime on the relationships of the residents. These might be discovered more effectively through a comparison case study rather than through a study (Yin, 1984) which explored a single case in depth. The single case study

approach would not have revealed the variety of residential settings and regimes, and differences in size and design.

It has already been established in Chapter Five that a Positivist approach is not compatible with the aims and purpose of the research. Methods such as surveys or experimental designs are usually linked to the Positivist approach. If a survey approach (Hoinville, Jowell, et al, 1978) had been chosen, I could have designed a questionnaire for use in many residential homes, but I would have had to rely on the staff to complete it. This would have failed to capture the residents' point of view. A field experiment on relationships would have been ethically dubious because it would involve the exercise of power over relatively powerless residents. It would have been difficult to implement as it would have required more resources and time than were available. The flaws of Stanger's experiment (1988) on emotional care within residential homes (discussed in Chapter Two) were evident in the rigid way it communicated with the residents, the presence of too many variables, the pre-determined classification factors, and the possibility of the Hawthorne effect (the attention paid to the residents influencing the outcome rather than, or as well as, the actual experiment activities; Roethlisberger and Dickson, 1939) affecting the findings.

This research design will be based on an Interpretivist approach because of its suitability for interpreting meanings and describing processes which underpin relationships. In considering a range of methods commonly associated with an Interpretivist approach, a group interview (Hammersley and Atkinson, 1983; Burgess, 1982) method was rejected because elderly residents do not necessarily form viable sub-groups within a home. Group interviews would not be effective in revealing personal relationships. They would simply replicate on a smaller scale the group milieu of residential life in which individuals rarely have any privacy. The lack of privacy within the group interview might inhibit confidences about personal relationships. A critical incident format (Bell, 1987) could provide a trigger to discover significant relationships, but this might result in the respondents becoming blocked with the most recent critical incident in their lives - their admission to residential care. This is the one incident of their lives which they hold in common, but the purpose of the research was to explore residents' individual differences over and above exploring their shared experience. The principle of empowerment (enabling the voice of the consumer to be heard and so begin to share in decision-making, Solomon, 1976) needed to be incorporated into the research process.

After considering a number of methods, I chose participant observation, life histories, and participant reports in the form of semi-structured interviews for the research design. These provide the most reasonable fit between the nature of the topic and its associated concerns. They provide ways of empowering elderly residents by taking an insider view, using a historical approach, valuing the individual, being open to change, and taking account of individual and structural factors through an abductive strategy. The next sections explain the reasons for these choices in greater detail.

6.3 Addressing the Topic: Participant Observation

Decisions about how to address the topic of relationships of elderly people in residential care derive from the underlying values base of the research. Values Concept One (the belief in the worth of the individual, leading to the desire to discover the experience of individuals' relationships in residential care from the residents' point of view) suggests an approach which is Interpretive - a method such as participant observation (Mead, 1935; Becker, 1963; Goffman, 1961). The priorities are to discover and understand relationships of the participants by exploring their attitudes and values, and the meanings they attached to them. Because definitions of relationships are elusive, I needed the participants to help me explore the meanings they intended.

Participant observation is an approach associated with ethnography (Park, 1950; Goffman, 1961; discussed in Chapter Five), whose essence is the study of participants in their natural settings through the systematic use of the senses (Fennell, Phillipson, and Evers, 1987). Lofland (1971, p. 93) describes participant observation as "being in or around an ongoing social setting for the purpose of making a qualitative analysis of the setting". Lofland notes the choices and pitfalls of using this method: whether to be an unknown observer (which may be morally questionable), or a known observer (which may inhibit or influence the social events under observation); and the impossibility of maintaining impartiality. He portrays participant observation (p. 93) as an "interweaving of looking, listening, and asking". This method is appropriate for studying relationships within residential care, because it takes account of the probable institutional values which inhibit individuals from disclosing their feelings and opinions for fear of reprisal. Individuals can be observed in their natural settings and routines rather than asked to comment directly on the care provided. It allows the researcher to appreciate social life and its interconnections in the round, rather then keeping them artificially separate (Fennell et al, 1987). Participant observation as a method provides the rewards of rich and detailed information and sequences of action in a natural setting (Altergott, 1988).

There are problems with this method. Altergott (1988) cites the costs and effort of data collection, the likelihood that samples will be small and non-representative, data reduction and analysis tasks which are time consuming, and observer error and bias. Observation of people is difficult o manage, and the observation may change the behaviour under investigation. The private nature of society, in which so many aspects of social life take place in private rather than in public settings, limits the use of observation to public settings, such as residential care (Fennell et al, 1987). It is suitable for group situations rather than for individual situations. For example, in a home where the residents use their own single bedrooms (as available) as private bed-sitting rooms, participant observation would not be possible.

Another problem is that because of the age difference between myself and the residents, I could not disguise myself as a resident or a day care user. The age difference also carries the consequence of not being able to blend into the social setting unobtrusively (Fennell et al). This, as Lofland (1971) suggests, might inhibit interaction, but inhibition can be overcome by a careful introduction to residents, allowing enough time to become accepted. A middle-aged researcher can enter the world of residential care as an unknown observer by taking a job as a Care Assistant for a period of time (Fontana, 1977, discussed in Chapter Three). That was not a realistic possibility for me. Since I was already known as a lecturer to many of the staff working within residential care, the risk of discovery would be too great. Further, the professional reactions which might ensue from the revelation of hidden identity would damage the working relationships the University had established with Social Services employers. Because the research was conducted on a part-time basis, taking additional employment would not fit into my full time work schedule. I also doubted the effectiveness of assuming a Care Assistant identity as a means of getting close to the residents. My knowledge of residential regimes led me to suspect that staff do not find many opportunities to relate to residents other than through giving physical care. Going into residential homes as a known observer seemed the only approach. This allowed me to become acquainted with the residents and learn about their relationships without having to divert my attention to other tasks as part of a cover. I assumed as neutral an outsider role as possible in order to gain an insider view of residents.

I predicted (from previous knowledge of residential settings) that some residents would be disabled and/or confused, making interviewing difficult to carry out. Participant observation facilitates learning about those residents who cannot be approached easily in other ways. It would enable me to observe social relationships instead of relying solely on the personal self-disclosure of residents for sources of information. The process of observation could explore the extent to which organisational relationships,

predominant cultures within homes, and institutional practices and regimes influence personal and social relationships. Participant observation as a known observer whose purpose is understood by the residents, and who gains acceptance over a period of time, is a method consistent with Values Concept One and the other values underpinning the research topic.

6.4 Addressing the Topic: Life Histories

Values Concept Two, the belief in change and development in adult life, leading to the adoption of an historical approach so that the present is understood within the context of the past, suggests that the use of life histories may be an appropriate method. A life history is an autobiographical account of an individual's life (Plummer, 1983). It is obtained usually through the technique of interviewing, but includes the analysis of written documents (Thomas and Znaniecki, 1919), such as school reports, letters, photographs, diaries, and newspaper accounts. The life history, or biographical interview, combines aspects of a research interview (because certain topics have to be covered); a clinical interview (which follows threads of meaning); and a conversation between friends (in which they are on an equal footing) (Levinson, 1978). Erikson et al (1986) and Butler (1974) promote the life history or life review as a means of enabling psycho-social development in old age. Erikson et al (1986, discussed in Chapter Two) suggest that the task of the eighth and last stage of psycho-social development is to overcome despair by achieving integrity. In old age, the individual needs to make sense of the experiences and relationships of the life course in order to achieve integrity. Integrity consists of competence, love, care, wisdom, and understanding. Integrity gives a sense of completion to the life course. Reminiscence activity as a life review has been used increasingly but selectively as a therapeutic technique with elderly people (Coleman, 1986, 1994). Used as a research method, life histories enable the researcher to discover the meaning of the individual's life within its social setting, encouraging the individual in the construction of meaning. This attention to context and setting, advocated by Layder (1993, discussed in Chapter Five), embodied in the life course perspective (Kohli, 1986; Blaikie, 1992; discussed in Chapter Two) and in the ecological approach (Bronfenbrenner, 1979, discussed throughout) is also characteristic of Erikson et al (1986, discussed in Chapter Two). It relates also to Values Concept Three (discussed above and below).

The voice of the consumer is heard and empowered (Solomon, 1976, discussed above) through the use of life histories. The life history enables relationships experienced in the present to be set within the perspective of relationships which were experienced in the past. Life histories can provide a counterbalance to possible researcher bias, in which residential care may be perceived as deprivation, relationships as 'good', and old age as barren of relationships. A method like this which takes into account the ways in which situations and people change over time helps the researcher reach a more open conclusion. The life history enables each respondent to construct his or her own reality (Berger and Luckmann, 1966). Participant observation reveals aspects of current relationships but a more complete picture of an individual's changing relationships across the life course will be gained through the life history.

In addition to interviews, written records in each resident's file provide alternative sources of biographical material for discovering the relationships of elderly people. Residents enter residential care with a case file which contains their application for admission and the Social Work Interview which assesses need. The case files represent the views of professionals and not those of the consumer, so at best they supply a secondary source of data and at worst, biased accounts. As they are not kept up-to-date, their usefulness rapidly diminishes. I decided not to draw on them extensively for the life histories, but to use them for demographic information by stratifying the information in the files and drawing from this a sample to be interviewed. In this way, some quantitative measures of counting were introduced to a modest degree into the largely 'qualitative' design (Silverman, 1972, 1985, discussed

in Chapter Five). Interviews were to comprise the main source of information for the life histories. A careful introduction to the residents and staff, and a life history interview guide needed to be designed, as well as deciding how to sequence the life-history interviews with episodes of participant observation.

6.5 Addressing the Topic: Semi-Structured Interviews

Values Concept Three (the belief in the reciprocal influence of the environment on the individual and the individual on the environment) makes it necessary to take account of the complex, multi-layered nature of the topic. One approach is to compare the regimes, structures, and organisational relationships (Katz, 1984; White, 1984; Raynes et al, 1979, discussed in Chapter Three) within residential homes. Relationships are rooted in social and organisational contexts, with an interplay between the individual and various levels of the environment. Although relevant data can be gathered from participant observation and life histories, the contextual aspects of relationships within residential care are important. These relationships were characterised in Chapter Three as personal, social, and organisational. Organisational relationships are elusive, needing a multi-strategy methodology to grasp them. Semi-structured interviews contribute to the contextual depth by providing an additional strategy to gather unstructured data. These interviews, structured through an interview schedule, supplement life histories with more detailed information on relationships which locates individual respondents' accounts within the social settings of the residential homes.

Because of the nature of the topic and pragmatic considerations, the relationship between the researcher and the respondents is important. This, together with the lack of resources for paying others to assist in conducting the research, meant that I would be conducting the interviews, life histories, and participant observations myself rather than employing interviewers. Burgess (1984) affirms the desirability of establishing a relationship between the interviewer and the respondents so that they understand the purpose of the research. Burgess conducted his research with school age children, an age group which is relatively powerless in society. Elderly people also comprise an age group which lacks power (Townsend, 1986, discussed in Chapter Two). By establishing a relationship with the elderly people who were to be my respondents, I hoped to ensure that they understood the purpose of the research so that they could exercise some choice over the extent of their involvement. This strategy sought to empower (Solomon, 1976) the respondents by providing information and choice.

6.6 Addressing the Three Foci of the Research: Elderly People, Residential Care, and Relationships

The concepts are the basis for identifying the observable and identifiable components of abstract variables (Stang and Wrightsman, 1981). This process took place over an extended period, as I read and reflected on the implications of the topic. The process was like a circle at first forming a loosely drawn perimeter around the core concepts of the research. Then in time, through the sifting and weighing of ideas, the circle became more tightly drawn until the perimeter formed a bulwark for the concepts. The process was influenced by practice theory (Whittaker and Tracy, 1989), drawn from social work literature. Practice theory's most important contributions are its concern with relationships (Perlman, 1979, discussed in Chapter Three) as an expression of values, and the principle of empowerment (Solomon, 1976; discussed above) which led to the decision to listen to the voice of the consumer. Research findings contributed to the expanding knowledge of the topic and helped identify issues, including the recognition of residential homes as part of an industry of care (Estes, 1979), influenced by social policy decisions (Henwood, 1992). Practice wisdom (Whittaker and Tracy, 1989), gained from years of doing social work and teaching during which I visited many residential homes, helped to form a picture of the possible life styles of elderly people in residential care, to prepare for the practicalities of data gathering, and to anticipate some of the technical and communication problems likely to be encountered.

Pragmatic considerations, viz. the limited available time and resources for the research project and the need to find a geographically convenient field of research, shaped the research design. Ageist opinions (Townsend, 1986, discussed above) were a negative influence. I expected to find depression and isolation within the homes, few viable relationships, and rigid institutionalised regimes (discussed in Chapter Four). Counterbalancing this pessimistic view was my optimism, fuelled by professional values, which led me to hope for the discovery of a rich array of relationships, enlightened regimes, and a sense of community within the homes. Addressing the topic needed clear thinking to form as balanced a design as possible, without succumbing to excessive pessimism or optimism.

The process of addressing the topic was assisted by regular contact with my tutor and other students in the early stages, in which I explained, described, and defended my thinking on the topic; by initial brainstorming on the major foci, and by the hypothetical construction of an 'ideal' residential home (drawing on the concept of the ideal type, Weber, 1930, 1964; Schutz, 1963a, as discussed in Chapter Five). Collating the increasing amount of preliminary information and insights into an orderly format was helpful. The effectiveness of the research outcome depended to a large extent on how the three foci (relationships, elderly people, residential care) were defined and developed into concepts to be explored. The questions asked of the elderly respondents needed to illuminate the central issues and concepts of the topic rather than explore different issues entirely. The respondents needed to understand the research questions and be able to respond to them. Ambiguities had to be clarified, choices made, and priorities asserted. For example, not every resident could be interviewed or observed in each home. Time was not available to do this. A basis for selecting some residents rather than others had to be established, so that the integrity of the concepts was preserved. In addition to the task of selecting the actual questions to be asked, each concept needed a definition with identifiable characteristics or indicators to help shape the selection of a sample population to be studied. Study of the literature, together with previous practitioner experience and consideration of the underpinning social philosophies, helped decide what to ask and observe.

6.7 Addressing the Concept of Residential Care

Residential care (Fennell et al, 1988, discussed in Chapter Four) is diverse, with many providers of care and different regimes, sizes, and designs of homes. It was not possible to study every type and example of residential care. The first important decision was to limit the frame of reference to residential homes provided under Part III of the 1948 National Assistance Act by local authorities, eliminating nursing homes, geriatric wards in hospitals, sheltered housing, and private homes from the research design. The choice of local authority homes guaranteed a large range of size and design. Local authorities, despite the growth in numbers of private homes (Audit Commission, 1986; Tinker, 1992, discussed in Chapter Four), remain major providers of residential care.

The diversity of size and design of residential homes was identified as a possible factor influencing the relationships of residents (Willcocks et al, 1987, discussed in Chapter Four). As discussed in Chapter Four, Willcocks et al advocate the development of 'residential flatlets' (self-contained bedsitting rooms) within residential homes. As a former social work practitioner, I had seen examples of the communal design with large central dining rooms and large lounges, and the contrasting Unit design homes with bedrooms grouped around smaller lounges and kitchenettes (Lipman and Slater, 1977, discussed in Chapter Four). Because of my interest in exploring the significance of the design factor on relationships, I proposed conducting the research in three different homes, each chosen on the basis of a different design. One would be a communal design; one a Unit design; and one with self-contained residential flatlets. Size as a

factor influencing relationships could be addressed in the research design, by selecting homes of different sizes.

The impact on relationships of different care regimes within different homes and within the same home (Booth, 1985) also seemed significant. The role of the Officer-in-Charge has been noted by Willcocks, Peace and Kellaher (1987), Sinclair (1988), and Booth (1985) as crucial in determining the regime of the home. I wanted to examine the role of the Officer-in-Charge in relation to the amount and type of training she or he had received, to link evidence of good practice with professional qualifications. This proved an unrealistic idea. Few Officers-in-Charge, and even fewer assistant Officers, have professional qualifications (Willcocks et al, 1987), and those who are qualified tend to move out of residential work into field work.

6.8 Addressing the Concept of Elderly People

My assumptions about elderly people in residential care were based on the review of the literature (discussed in Chapter Two) and previous professional contacts. My literature review counterbalanced the ageist bias (Townsend, 1986) which professional and personal experience had fostered. The challenge, as discussed above, was to establish a framework for the design which recognised the influence of both negative and positive perceptions, and could balance different views. A significant event (discussed above) for all of the residents, perhaps the only common factor uniting them, might be their admission to care. The length of time each elderly person had been resident in the home might be influential in determining the nature and extent of the relationships experienced. These and other reflections led to the conclusion that skill and tact would be required to gain the active involvement of residents, because of their physical and mental conditions, and their present circumstances.

The issue of sampling was important. When ready to begin the life histories and structured interviews, how could a representative sample be selected? Pragmatic considerations shaped the choices. Eliminated from consideration were the severely disabled residents, including those who were highly confused, because they probably would be unable to respond without experiencing personal distress. Creating distress was incompatible with professional practice values and research ethics. Residents who were eager to participate would not be rejected. If the process of interviewing proved too stressful because of confusion or other factors, the interview would be terminated. Observation would facilitate knowledge of the relationships of the very confused residents whom it would not be possible to interview. Some researchers conclude that it is possible to get reliable information from very old people (Bucke and Insley, 1976; Ridley et al., 1979). Bury and Holmes (1991, discussed in Chapter Seven) conducted self-interviews with respondents over ninety years of age, 47% of whom lived in residential homes. They designed questions to allow for difficulties in sustaining long interviews and for rephrasing in cases of deafness. Some respondents needed prompting. Of those living in residential homes, 25% were unable or unwilling to participate because of confusion or dementia,

6.9 Addressing the Concept of Relationships

Addressing the concept of 'relationship' (discussed in Chapter Three) is a more complex task than working with the concepts of 'elderly people' and 'residential care'. In Chapter Three, related concepts were identified, including attachment (Bowlby, 1951, 1986), friendship (Matthews, 1983 b; Allan, 1989; Jerrome, 1989), and the importance of theories of human growth and development in defining relationships. Three categories of relationships were identified as significant: personal relationships and social relationships; and organisational relationships which influence the first two categories within the residential setting. In Chapter Three the interconnection of the different interpretations of relationships was shown. In seeking to learn about relationships within the residential setting, I could ask about the residents' opportunities

for establishing relationships within the home. These might include relationships with other residents, including roommates, residents in the same unit, those sitting at the same table in the dining room, and in neighbouring chairs in the residents' lounge. Same-gender relationships and different-gender relationships need to be considered. The possibilities of relationships with staff include relationships with Care Assistants, Officers, domestic staff, cooks, and volunteers. There may be possibilities of relationships with visiting professionals, including doctors, community nurses, chiropodists, clergy, social workers, and hairdressers. Relationships with relatives are likely to include children, grandchildren, great-grandchildren, nieces, nephews, cousins and siblings, (assuming that residents' spouses have previously died before admission). Relationships based within the community include friends, former business associates, neighbours, and members of churches and community groups.

Another issue needing resolution was how to note the existence and nature of a range of relationships. Relationships should not be equated solely with friendship. Some relationships may be negative and hostile rather than positive. Since conflict is part of human interaction, this needed to be taken into account. Although some researchers, including Retsinas and Garrity (1985, discussed in Chapter Three) have used frequency of social interaction (who talks, sits with, and notices each other) as an indicator of well-being, sociability, and friendship, this seemed inappropriate for research which attempts to gauge the feelings and perceptions of the individuals. Observed interactions may reveal aspects of social and organisational relationships, but deep personal relationships probably will remain hidden from view. The relationships which matter most, and which are felt most intensely, may be with people who live outside the home, and with whom there is only infrequent current contact. By using a combination of methods (Denzin, 1970, discussed in Chapter Five), observations could be balanced with the respondents' own statements. The greater emphasis was to be on residents' self-disclosure.

The priorities in designing the instruments, so that the elusive concept of relationship might be grasped from different aspects, are these:

(a) Social relationships are to be noted as well as personal relationships.

(b) The impact of organisational relationships on personal and social relationships will be considered.

(c) The residents' own accounts of their relationships will provide data which are equally, as if not more important than, data from observed social interactions.

(d) The possibility of residents' relationships with other residents, with the staff, with visiting professional staff, and with the community and relatives will be considered.

(e) Negative as well as positive relationships will be considered.

All the above priorities arise from the Values Concepts discussed earlier, and are influenced by the discussion in Chapters One to Four.

The aspect of reciprocity in relationships (Gouldner, 1960; Cairns, 1979; Kelley et al, 1983; Dowd, 1975; Parker, 1990) is central to the working definition of relationships which was devised in Chapter Three. Reciprocity supports the value of empowerment (Solomon, 1976) and a balanced power relationship between an elderly person and others. This explains why, in addition to priorities (a) to (e) above, a further priority must be identified:

(f) Reciprocity within relationships will be considered.

In addition, the investigation of relationships will take account of Erikson et al's (1986) view of the potential for growth and development in old age (discussed in Chapter Three), which was incorporated in Values Concept Two. Central to the belief that individuals change and grow at each stage in the life course is the need to take a dynamic look at how relationships change as circumstances change, without attributing the negative expectations of ageism (Townsend, 1986) to the changes taking place. This leads to the next priority:

(g) The change in relationships over time, and in particular, in response to the event of entering residential care will be considered.

Arising from this interest in the life course, and incorporated in Values Concept One and Three, is another aspect of relationships: the individual's perception of his or her own identity and role within the group. The resident is part of a social group, but will retain a sense of individuality and separation from the group even as the necessity of interacting with the group becomes apparent. The next priority emerges as:

(h) The residents' are perceptions of their individuality and their roles within the groups within the home will be considered.

Expression of feelings is a personal act which defines individuality, reveals personal values, and establishes a basis for relationships (Perlman, 1979, discussed in Chapter One). Within residential care, some feelings may be heightened and others diminished. The discovery of feelings (to the extent that residents will be willing to confide them) will provide clues about relationships. Hence, another priority is:

(i) The residents' expressions of their feelings and the ease with which they can express their feelings within residential care will be considered.

A concept so elusive as relationships may not be defined precisely before undertaking the research. The priorities which have been identified, all of which are consonant with the Values Concepts identified in Chapter Five, will shape the instruments for the research. A more extensive understanding of relationships will await the outcome of the research.

6.10 The Location of the Research: Gaining Access

As the research had to be fitted around a full time work schedule, the residential homes to be investigated needed to be geographically close so that travel time was not excessive. The data collection was planned to take place beginning in April 1989 and continuing into 1990 on a one-day a week basis. The homes selected were part of an East Anglian Social Services Department network of 63 elderly persons' homes. The University where I was employed was located in the same county. To avoid travelling excessive distances, I chose to base the research in the local area. The staff of the homes included potential and past students. This was an advantage because contacts had already been formed. It was also a disadvantage (as discussed above) because of the possibility of an overlap in roles as a lecturer, course leader, and researcher, with the potential for loss of impartiality as a researcher. A further disadvantage was that by basing the research in East Anglia, the effect of ethnic and racial diversity on relationships was less likely to be investigated. East Anglia, although close to London, has a primarily white, British-born population with relatively little cultural diversity, especially in the older population.

In October 1988, before the data collection was due to start, two tasks were undertaken: to learn about the characteristics of the 63 homes so that an informed choice of homes could be made, and to gain access to the homes. Both of these tasks proved lengthy and frustrating experiences because of the size and nature of the local Social Services Department. It was a large organisation with a central directorate and fourteen

decentralised area organisers, each of whom carried responsibility for social work teams and residential homes in their area. Rather than write to the Director of Social Services, initiating a formal contact which could be rejected, I used informal contacts to penetrate the organisation and (hopefully) to reduce the bureaucratic procedures. I first spoke to my Head of Department at the University about possible contacts within the Research Section of Social Services. He suggested approaching the senior researcher within the Social Services Department. A phone call to the researcher and a subsequent letter directed me to a research assistant employed by the Social Services Department. She was undertaking research on elderly persons homes. There were reservations about giving permission for my proposed topic because of fears that it might conflict with her research. I met with her and learned about her current research on emotional care in residential homes (Stanger, 1988, discussed in Chapter Three). We established that my proposed topic would not conflict with her research. She then suggested that I write to the Assistant Director of Research and Planning for formal permission. After a long delay during which there was no response to my letter, I finally managed to contact him by phone and he agreed in principle to my request for access.

The next step was to meet with the Training Officer with responsibility for training staff working with elderly people. She was reputed to have the best overview of all 63 elderly persons' homes in the county. She shared her perceptions of the homes, and I discussed with her the examples of homes I hoped to investigate - e.g. differences in size and design. From our discussion emerged the choice of three homes which met my criteria of size and design. (Their names, below, are pseudonyms. Also, the names of residents mentioned in the account are pseudonyms). The homes are:

(1) Southam, a 25-bed home;

(2) Eastview, a 63-bed home;

(3) Northfield House, a 58-bed home.

The fourth home suggested was Bay Tree Close, the only Social Services Department home modelled on a flatlet design. This home was one used for Stanger's research (1988), and she preferred that this home should not be used for my research. It was also being researched by another University. Instead I decided to consider a new home in the process of development, called Kings Court, which was due to open in July 1989. This home would provide the basis for a case study which would not only offer an example of residential flatlet design, but also the concept of a resource centre. Initially I decided to include this home in my research despite the pressure of time. There was a risk that it would not open in time for my data collection, but I felt the risk was worth taking. The method used for studying this home was to be a single case study, as it would not be possible to do a comparison with the other homes for technical reasons (discussed above) relating to the timing of its opening. Although interesting data were collected, I decided finally not to include them because of the lack of comparability with the other homes. Kings Court was mainly a resource centre and secondarily a residential home. I also felt that sufficient material emerged from the study of the three homes originally designated.

Having decided on the particular homes in which to base the research, I wrote to the Area Social Services Organisers within whose areas the homes were located. I received written permission from two of the Organisers. The third Organiser personally took me to two of the homes, Southam and Eastview, to introduce me to the Officers-in-Charge. He also suggested I meet with the Principal Officer who was the line manager of the Officers-in-Charge. By the time I received complete permission to undertake the research, almost six months had gone by. A circuitous route to gain access had been completed, from the Research Section to Central Headquarters, to the Area Offices, and then finally to the individual establishments. The machinery of bureaucracy moved slowly. Persistence in following up long delays in which there was no response to my

letters was needed. I was fortunate to have received permission when I did. Only a few months later, during the summer of 1989, the management structure of this Social Services Department was changed, doing away with Area Offices and creating regional Groups instead, with changes in the staffing of key posts. Fortunately, none of the Officers-in-Charge of the homes I studied left their jobs during the research. Had I been seeking access six months later, it would have been less clear whom to approach, as responsibilities were in the process of being re-aligned. My request might have been turned down. However, once I had gained access to the homes, the research continued with no question of permission being rescinded.

6.11 Designing and Using the Instruments

It was now time for specific 'nuts and bolts' considerations in order to set up the research design. The process of gaining access had shown that the Social Services Department operated in hierarchical layers. As an outsider, I had to gain acceptance for the legitimacy of my role as researcher at different levels of the hierarchy. Within the homes, the same hierarchical levels operated in miniature. The same careful approach in gaining acceptance was necessary before the data collection could begin. This was not only a pragmatic consideration, it also related to the value of empowerment (Solomon, 1976) which underpinned the research. It required staff and residents to be thoroughly informed of the purposes and extent of the research so that they could decide whether or not to participate, rather than have this decision thrust on them. An initial meeting with the Officer-in-Charge of each home to discuss the research topic followed the formal introductions and letters. During these visits information about the philosophy and characteristics of each home was gathered. To prepare for these meetings I wrote an introductory letter (Appendix One) in non-technical language which I gave to the Officer-in-Charge to circulate in each home, so that staff and residents were aware of my forthcoming visits.

Although I had not anticipated using written records as a major source of data, it was helpful to review the brief written records for each resident, noting the name, date of birth, place of birth, address at time of admission, and date and reason for admission. This review could be construed as contrary to the value of empowerment (Solomon, 1976), because it gave me access to private information. Although I had explained my purpose, I had not specified that I wanted to see the case files. Only the Officer-in-Charge at Northfield House denied permission to examine the case files because she felt they contained private information. In fact, very little additional information was noted in the case file. The most useful current information was the contact name and address of next of kin. It was not the custom within the homes to keep an up-to-date case file for each resident (discussed in Chapter Seven and above).

The information from the case files at Southam and Eastview (and at Northfield House, from the day book which I was given permission to see) was used to identify the names of the residents to be observed within informal groups, and most importantly as a means of choosing a sample for life histories. This was an example of using a more Positivist approach within a primarily Interpretivist design (Bryman, 1988, discussed in Chapter Five). The selection followed the principles of non-probability sampling (Hoinville, Jowell, et al, 1978), using judgement and the opportunities available. I was interested in exploring whether differences in space and time, key concepts of the life course perspective (Kohli, 1986; Blaikie, 1992) and of Realism's contextual approach (Layder, 1993, discussed in Chapter Five), would make a difference to the relationships. Accordingly, I grouped the residents according to how long ago and how recently they entered the home. From this list, the residents whom the Officers advised me were very ill or very confused were excluded. Then I was left with three broad bands of residents:

(1) those who entered the home in the preceding three months;

(2) those who had entered the home three months to two years previously; and

(3) those who had been resident longer than two years.

Although each home contained residents who had entered care ten years or more ago, these were in the minority. The average length of stay of residents before death was eighteen months to two years, thus echoing Booth's findings (1985) of the rapid turnover of residents. Selection of residents for life history taking and interviewing would be drawn from each of the three bands, with a representative gender balance. Two of the homes contained a few day care users and short stay residents, who were integrated in the dining room and lounges with the permanent residents. I decided to interview one or two of these elderly people, in order to explore whether their perceptions and experiences of relationships were different from the permanent residents.

During the period when participant observation began, I oriented myself to the homes and to the residents. The Officers, in response to my questions, showed me the room allocations so that I could see which residents had single rooms, which had double, triple or quadruple rooms, and who was sharing with whom. I studied the allocation of seats in the dining room and the lounges to gain an overview of the group formations. I began to build a file on each home. The use of a tape recorder in the group settings where much of the research was conducted proved problematic, due to movements and noises from many sources. I took notes, openly in the Officers' presence in the Office of each home, and more surreptitiously when in the lounges, dining rooms, and bedrooms. I carried a small note pad in a pocket and jotted notes when I went to the staff room or WC. It was impossible to do this while observing, as much of the time was spent in activity. As soon as I left the home I wrote down my observations in expanded notes which I dated and turned into narratives later. Whilst engaged in this activity, it was difficult to know which events were significant and which were not. Once the routine or regime of each home had been noted, the temptation was to ignore or overlook individual vignettes, stray comments, or particular happenings. I determined to note down as much as possible rather than make decisions at this stage of data collection about what was or was not important.

Designing an interview guide for the life histories required shape, structure, and forethought in the preparation, more so than for participant observation. In order to gain a picture of the whole person, including how each individual lived his or her life before becoming a resident, it was important not to over-structure the information-gathering process. The life history format is intended as a guide, a series of triggers or prompts to enable the person to tell his or her story, and should not be conducted on a question and answer basis. Learning about the chronology of individual lives, with significant turning points noted as the story is told, is important for gaining an understanding of how relationships are threaded through the passage of time, and how they change and develop at times of transition (Mandelbaum, 1973, 1982). The emphasis given to particular episodes, and the omission of certain stages (Erikson et al, 1986, discussed in Chapter Two), may reveal personal values and identity as the teller progresses through the story. The guide needed to be a series of prompts, preceded by a careful introduction of myself designed to set the respondent at ease. The setting of the scene for confidences to be exchanged could not be rushed. Again, the purpose of the life history, the uses to which it would be put, and the preservation of confidentiality, needed to be clear to respondents. To encourage trust, I disassociated myself from any perceived identity as a Social Services employee and emphasised my role as a teacher (although it could be argued that the teacher role is perceived as an authoritative, judgmental one, which inhibits trust to the same extent as identification as a social worker). I gave respondents the opportunity to refuse to take part and was concerned to convey to them that there were no 'correct' answers required. The Life History Guide/Interview Schedule (Appendix Two) used the technique of the funnel (discussed in Chapter Three) in the ordering of topics. Beginning with telling the story

of childhood, it led respondents to the here-and-now, and then ended with specific questions, moving from the general to the specific.

The Questionnaire Interview Guide (Appendices Three and Four), used for the semi-structured interviews, formed the interview schedule. It was the most specific, focused approach to the topic of relationships, and was intended to follow last in the sequence which began with participant observation, and then moved to life histories of a selected sample. The same respondents who had shared their life histories would be approached for the questionnaire. By then, I reasoned, their commitment would have been secured. The data gathering would proceed smoothly once the barriers of unfamiliarity had been overcome. In most instances it would be preferable to leave a gap of time between the life history and the questionnaire in order to allow a period of reflection. The draft Questionnaire Interview Guide (Appendix Three) was designed in several sections, each organised around a particular theme. The themes were devised to express the operational concepts defined earlier in the Chapter. In order, these themes were:

Theme	**Operational Concept**
(a) Expectations of new relationships	change in relationships; range and scope
(b) Keeping old relationships	change, range of relationships
(c) Establishing identity	individuality
(d) Group life	social and organisational relationships
(e) Expressing feelings	individuality, personal relationships
(f) Effects of the home on relationships	organisational relationships
(g) Attachments	personal relationships
(h) Giving and getting relationships	reciprocity

The themes were developed from the designation of personal, social, and organisational relationships (discussed above and in Chapters One, Two, and Three), and from the Values Concepts identified in Chapter Five. The organising principle of the Questionnaire Interview Guide was to move from the less personal and less potentially threatening questions to the more personally directed queries (Lofland and Lofland, 1984). For example, Theme (e), 'expressing feelings', and Theme (g) 'attachments' are placed lower in the sequence than Themes (a) and (b) about old and new relationships. Within each section, a non-threatening approach was sought, by moving from the positive aspects of relationships to the less positive. The questions tried to avoid leading with negative stereotypes. For example: Q. 32 (final version; Appendix Four), "Do you think you have changed towards people since being here?" is a more open question, but "do you think you have become less sociable since moving here?" is an example of a closed style rejected as inappropriate. Finally, the Questionnaire Interview Guide concludes with an open question to encourage further reflections triggered by, but not mentioned specifically in the Questionnaire Interview Guide. In designing this Questionnaire Interview Guide, I noted the difficulties expressed by Booth (1985) and Sinclair (1988), both discussed above, of eliciting the true opinions and feelings of elderly people in residential care. The design was planned to incorporate a gradual approach in which the relationship between the researcher and respondents would have an opportunity to develop and thus assist in the research process.

I decided to interview certain staff in each home in order to balance the data gained from clients, and to triangulate the data (Denzin, 1970, discussed in Chapter Five). I adapted

the same Questionnaire Interview Guide (Appendix Four) but added a section (Appendix Five) to gain staff perceptions of the role of the home in meeting the needs of residents. I chose to interview the Officer-in-Charge of each home and three other staff within each home, selected on the basis of varying lengths of service in a range of roles - another means of triangulation (Denzin, 1970) which preserved a symmetry with the principles used for selecting the elderly people for the sample.

6.12 Piloting the Instruments

At this point, I needed to pilot the instruments and my own skill in data collection in another residential setting in order to see whether any amendments or changes were needed. A private elderly persons' home with only five residents, which had opened recently in a nearby town, was chosen. One of the reasons for its choice was the ease of access compared with Social Services homes. Observation took place mainly in the kitchen/dining area, observing interactions between staff and residents. Later, the Life History Guide and Questionnaire Interview Guide were used with four residents, and the staff interview schedule with two staff. No major difficulties in gaining the information occurred. I was reasonably satisfied that the instruments and my skills in using them would suit the intended purpose, though one important change resulted from the pilot experience. This was the modification of the Questionnaire Interview Guide to enable better communication with and from the respondents. The pilot revealed that some of the wording was ambiguous, the order of questions less suitable than they might have been, the questions too jumbled together, and the transitions between sections insufficiently clear. (Contrast Appendix Three with Appendix Four). These changes were made before the data collection in the selected homes began.

6.13 Successes and Problems of the Research Process

On the whole, the methods of participant observation, life histories, and interviews worked well, complementing each other and permitting me to gain a broad perspective of individual residents' relationships in the homes. I found that residents in all three homes adopted the same sorts of roles, and used similar strategies to form relationships. Looking back at the research process after completion of fieldwork and data analysis prompts a desire to replicate the research in order to profit from the experience I gained in the process. One issue which had troubled me before starting was my bias towards old age and residential care (discussed above). As I reflected on the research, I developed a more balanced view which modified the process, but objectivity remains a goal which can never be attained completely.

The significant issues influencing and emerging from the process can be grouped into three broad categories. The first category includes issues arising from the social system - the external world; specifically, these are the delay in gaining access, illness of residents disrupting the research process, organisational routines, uncompleted interviews and refusals, the lack of privacy and space, the residents' cultural inhibitions, and the control of the Officers-in-Charge over selection of residents and opportunities for observation and interviewing. The second category relates to my own life world (Habermas, 1976, 1979, discussed in Chapter Five) - my assumptions, values, and meanings which came under scrutiny and were challenged during the research process. The issues arising from this challenge include my need for expertise, identity as a social worker and a teacher, my outsider status, feelings, and ethical considerations. The third category of issues arise from technical considerations, including the instruments, techniques, and their reliability and validity.

6.14 Issues Arising from the Social System

Discussing the success or failure of the methods leads me to admit the inadequacies of the methods when faced with some unavoidable features of the environment in which the research took place. The long bureaucratic delay in gaining access to the homes

might have resulted in abandonment of the topic if I had not initiated the request for access six months before the research was due to begin and had continued to be very persistent. From this, I learned the importance of preparing a careful strategy for access. If the research were to be replicated, I would spend more time preparing for the research with the Officers-in-Charge, so that some of the issues about space could have been handled better. The delay caused me to become more biased against local authority residential care because of the closed nature of the bureaucracy, and its rigidity. The advantages of the delay were an insight into Social Services' organisational relationships as they actually operated.

On several occasions illness disrupted the research process. In Northfield House, fieldwork started late because of the prolonged illness of the Officer-in-Charge. Later she became ill again and was away from work for several weeks, and during her absence none of the other staff at that home felt able to accept my visits, which gave me insight into the power she wielded. At Eastview, during the winter of 1989-90, many residents and staff were ill with influenza to the extent that I was advised not to visit for a period of time. (In one week, five residents died and fourteen staff were ill and unable to work). Nothing could be done to shorten the delay caused by illness. I had to wait until the situation improved before resuming the fieldwork. At Southam, the Officer-in-Charge was troubled by her husband's illness and unemployment. Besides slowing down the research process, these were instances when my growing sense of affection for these women might have diverted me from my primary purpose and led me to concentrate on their needs. By realising the importance of keeping to focus, I continued with my research strategies.

Altogether I gathered 33 life histories, and interviewed 32 residents and 15 staff in the different homes, so that the rate of refusal was not significant. Residents were given the opportunity to refuse to participate in an interview or to withdraw if they wished. There were only two residents who refused to talk to me. One, Mrs. Clarinda Instrall, at Eastview, refused, I think, because she would have had to get up from her chair in the lounge where she was settled and move to a more private area - not easy to do when walking is painful, slow, and possible only with the assistance of a walking frame. The second refusal was partial. Mrs. Sally Cooper, an Eastview resident, refused to share any details of her marriage with me. I accepted this refusal and went on to the next section of the Interview Guide. The next week I learned that she had complained to the Officer-in-Charge. I subsequently visited Mrs. Cooper in her room to clarify my acceptance of her right to refuse. She seemed satisfied with my assurances.

On three occasions I had to break off a life history or an interview because of the distress of the respondent. Mrs. Ruth Beckett, a 103 year old resident of Northfield House (discussed also in Chapter Eight), shared her life history, but became increasingly distressed and confused as I attempted to use the interview schedule. Mrs. Maisie Freane, a 74 year old Southam resident, projected an intelligent, plausible manner, but her memory was impaired. When asked about her childhood she could not distinguish between father, brother, or husband, and became very upset. A third respondent, Mrs. Ivy Verity at Northfield House, had experienced three strokes, was emotionally fragile, and burst into tears very readily. The interview had to be cut short because of her emotional distress.

The Officers-in-Charge to a great extent controlled the choice of residents for interviews and my availability to the residents. Of the three Officers, Mrs. Black at Northfield House, was most controlling, discounting my requests to interview certain residents, and limiting information. She refused to let me examine the residents' files on the grounds that they were private (discussed above). She did let me see her day book in which the entry of residents was recorded, so that I could find the name, date of birth, and date of admission, but not the reason for admission or any other information. She also eavesdropped on some interviews. She provided me with a quiet corner of the Day Room for my interview with a resident, Mrs. Fannie Goodchild, but afterwards

revealed that she had overheard my conversation. She said she just 'happened' to be in the dining area behind the screen, and she was interested in my interviewing technique. This was her characteristic behaviour which helped me to understand the nature of organisational relationships within Northfield House. By the end of my fieldwork I began to feel rather paranoid and devalued. Perhaps this was a useful insight into how the experience of being in care affects residents.

Many practical issues arose from conducting interviews in establishments where there was little private space and potential interruption at any time. The lack of privacy and space meant that interviews usually took place in a corner of a communal area. At Southam, there were no spare chairs in the lounge and no stools or benches for me to sit on. Holding a conversation with a resident meant crouching down to their level, borrowing a seat from a resident who had left the room but who might come back at any time, balancing precariously on the edge of a coffee table, being overheard by other residents, and blocking their view of the television. Since there were few single rooms at Southam, going to a bedroom did not ensure privacy, nor were there necessarily space or chairs to sit on in the bedrooms. The dining room was used as a staff room when the residents were not at meals so it was not a possible venue for interviews. Consequently, interviewing had to be conducted in as quiet a corner as could be found, but rarely was full privacy able to be guaranteed. This raised problems with tape-recording interviews. The tape-recorder picked up too much extraneous background noise and was also a symbol of broadcasting to most residents, thus ensuring a great deal of attention from other corners of a communal area, rather than the privacy hoped for. I had begun by taking notes and using a tape recorder at the same time, but eventually found that note taking as I went along was less obtrusive and as effective in gathering information.

When I was able to interview a resident in the privacy of a single bedroom, I felt more comfortable. I cannot claim that more significant data were gathered in these instances. Residents were used to living their lives in public spaces. A quiet corner of a public space enabled confidences to be shared if the resident had strong motivations to do so. The frailty and disability of many residents meant that they preferred to stay put in the communal lounge rather than make a painful journey to a distant bedroom. The strong personalities of individuals took precedence over the inhibitions of the setting. In some instances, seeking out privacy was seen as going against the home's culture and therefore grounds for suspicion. I had to blend into the routine and yet gain individual time and space with residents. This was not easy.

The same issues were evident when I wanted to observe the residents. In some small lounges at Northfield House and at Southam there were no spare chairs. I found myself standing at the edge of the room, waiting until a glance came my way. Eye contact helped break the ice, a tentative expression, and then an innocuous comment started an interaction, sometimes involving me, sometimes not. It was hard to know where to place myself and to know, when observing, who was inside the circle and participating and who was not. Many elderly residents sat quietly but listened carefully; others seemed lost in a world of their own. The public area was inhibiting to my efforts at first as I did not know where to direct my attention.

Residents were inhibited not just by the organisational relationships but also (as discussed above) by their own cultural reticence about revealing feelings and preferences. It was part of their cultural tradition to deny the existence and expression of distressing feelings. They were perhaps not always accurate about their preferred style of revealing themselves. Stoic silence and putting up without complaint with life's injustices was the way they portrayed themselves. This did not match the staff's perceptions of residents as demanding, selfish, complaining children. Residents saw other residents as complaining and selfish, but presented themselves as noble and long suffering. Triangulation of methods gave a rounded picture of relationships and perceptions. Both perceptions were true, because residents varied in their individual

reactions to changing circumstances in care. Their outward selves were often demanding and selfish but their inner anxieties about growing frailty and losses drove residents to demand attention in the only way possible within institutions which did not individualise care.

Equally frustrating was the clockwork routine which divided up the days and which often cut short an interview. Morning coffee at 10.30 am, lunch at 12.30 p. m., cup of tea at 3 p. m., tea at 4.30 p. m.; these were fixed events and residents hastened away at the designated hour. Often I had to return and try to pick up the threads of an interrupted interview. At Eastview, when a Care Assistant decided to give a bath to a resident, Mrs. Amanda Rogers, she interrupted my conversation with Mrs. Rogers, and took her away without any apology. When it was time for toiletting (a common practice in residential care, involving taking residents to the toilet one after the other at the same time, usually before a meal), the residents at each home were taken to the lavatories no matter what activities they were involved in, and regardless of whether I and the resident were speaking together. When 'pocket money' (the weekly personal allowance) was paid, the trolley with cash contained in envelopes was wheeled round regardless of any interviews or other activities being conducted. Morning coffee at Eastview made its rounds interrupting the interviews, but I was never offered a cup. After a while I began to feel marginalised by the relentless routine which herded people together according to a rigid time pattern. Patience and persistence were called for in order to gather the data in the face of these frustrations.

Although I had carefully communicated my role to staff and residents beforehand, acknowledgement of my purpose got lost in the unrelenting reality of the routine. Because I was not working side by side with staff as a co-worker, my interactions with residents were thwarted by the staff's lack of recognition of the legitimacy of a role which involved developing relationships with residents. My relationships with residents were not viewed as important enough to prevent constant interruption. I felt that staff would have liked to talk to me more about themselves and did not fully understand my focus on the residents themselves. Through these frustrations I learned how organisational relationships dominate other kinds of relationships.

6.15 Issues Arising From My Life World

The need to be an expert almost caused me to lose my focus on the residents. I had set aside my usual work role for the unfamiliar role of researcher in unknown territory. It was all too easy to be drawn into the alternative role of a member of the care staff, to try to prove myself to be as good as the staff and so forget that listening to the residents, not undertaking physical caring and domestic tasks, was my priority. When the Care Assistants complained of stress due to the amount of their work load, it was difficult not to offer to help them. I felt incompetent and rather useless when I sat listening to the residents rather than bustling around as the staff did. Lofland (1971) argues that the researcher should not be concerned about being seen as a bumbling amateur and an outsider when doing field research. I learned to keep to my focus and accept the 'outsider' status in relation to the staff (discussed below), but I also recognised the strong influence of the dominant staff culture which equates the work role with performing physical tasks - not surprising, since the staff were employed as manual workers.

Although an experienced interviewer, I feared that my previous interviewing role as a social worker, in which I identified and dealt with problems, might cause me to lose focus and be drawn into resolving the day-to-day problems of my respondents. I did acquire an identity as an Advocate-Expert with some residents, who sought my advice on money matters or how to make contact with a social worker. They did not perceive the Care Assistants or Officers as suitable to answer queries which ranged beyond the concerns of the daily routine. These unsought-for roles might have disrupted the research process had I let myself get distracted from my research focus on the

residents' relationships. For example, Mrs. Olive Jenkins, a resident of Southam, mistaking me for a social worker, drew me aside to ask how she could get her pension money transferred. Mrs. Violet Batty, a resident of Northfield House, burst into tears in the middle of life history taking and told me how much she hated the residential home and wanted to leave.

The dilemma was how to respond. If I ignored individual need by responding disinterestedly, I would lose credibility and betray my professional values. If I began problem-solving, my focus as researcher would be lost. My response was a compromise. Reasoning that elderly people are not passive objects to be acted upon, but are social actors capable of determining their own life course (Mead, 1934; Blumer, 1969; discussed in Chapter Two; Matthews, 1979, discussed in Chapter Three), I quieted my protective anxiety which welled up inside at these incidents. I listened, acknowledged the importance and validity of their needs, and advised each individual on a further step, to seek advice from a more appropriate person. From these incidents I learned that there are many ways in which objectivity may be threatened. One of my weaknesses was my desire to give good value by being helpful and effective, whether as an expert, a social worker, or in whatever other role.

Another example of the possible threat to a balanced view was the contrast between the assumed role of researcher and my current work role in education. My full time job was in an academic post at a nearby University. This was known to staff in the residential homes. The academic identity served to legitimise the reasons for undertaking research. It helped me to appear, I hoped, objective in attitude, because staff knew that I was not part of the line management hierarchy of Social Services and would not report what I was observing to their administrative system. The residents also knew of my academic identity, and I viewed this as a helpful factor. Inwardly, I had difficulty in observing events with an open mind because my role as a teacher had immersed me in the literature of dysfunction.

During the research I began to be aware that I had unwittingly assumed the role of the Researcher as Catalyst of Change. By entering the homes and discussing my purpose with the Officers-in-Charge and other staff, I upset the status-quo. Although I avoided any sense of criticism or outward discussion about care practices, all three Officers-in-Charge instituted organisational change while I was conducting the research in their homes. For example, Mrs. White at Southam created more private space for residents in a previously unused kitchenette on the first floor of the home by placing chairs in it for residents. She made contact with the son of one of the residents, Mrs. Olive Jenkins, to encourage him to renew his severed relationship with his mother, which he did consequently. Mrs. Olds at Eastview created a small dining area for the more disabled residents from a little used lounge area which adjoined the large dining room, thus providing more space in the large dining room and making it easier for frailer residents to walk to and from their meals. Mrs. Black at Northfield House decided to move the more disabled residents downstairs so that they could be nearer the Activities Room. Most of these changes involved use of space. All were intended to improve the quality of residents' care. The changes acknowledged implicitly the need to individualise care for residents through introduction of multiple regimes.

The Care staff turned to me for advice and 'wisdom' in acknowledgement of my other role. For example, a Senior Care Assistant at Eastview, Mrs. Lane, asked me whether it was right to tell a confused resident, Mrs. Laura Lowther, who mistakenly thought her husband and daughter were coming to visit her, that they both were dead. There was no easy solution for this and other situations. I tried to listen to the concerns expressed by Mrs Lane, but not fall into the trap of solving the problem for her by 'teaching' her.

My concern that my objectivity might be compromised by my need to be an expert, and by my roles as a social worker and as a teacher has been discussed. Another concern

was related to my 'outsider' status (Lofland, 1971). I could have been perceived as a cultural outsider, so that the exchange of information might be inhibited. I was younger than the residents by far (but not younger than most of the staff); better educated than all; and American by birth, with an identifiable North American accent. The last factor was the most worrying. Would my accent, but also choice of words and phrases be understood? The pilot was an important tool for testing this concern. Afterwards, I felt reasonably assured that I had designed the instruments in easily understood language. My twenty years spent in Britain had resulted in a degree of cultural acclimatisation. Many of the staff and residents at these homes in East Anglia had migrated to south-east England from all over Britain and they themselves spoke in different accents. When observing, my role as researcher was that of an observer-as-participant, present at the events which I observed but not really participating (Gans, 1968) so the outsider status was actually part of my strategy. My over all aim was to gain an 'insider' view of residents' relationships through the choice of methodology, but I found that I had to accept a partial role as an outsider. This did not deter me from pursuing the aim of gaining the residents' own views, but I began to see it as a complex undertaking involving unavoidable compromises.

The feelings evoked by the time spent in the homes were depression and anxiety. I experienced a violent dislike of residential care in the first weeks of the fieldwork. Townsend (1957) and Fennell et al (1988) note that the professional discomforts of research lead to fieldwork avoidance, due to the need for sensitivity combined with sufficient toughness to manage the intrusiveness into people's lives. They argue that this may explain the small number of personal involvement studies of elderly people, relative to survey studies. I struggled with these feelings throughout the period of the research. Two incidents occurred which shocked me and almost ruined my ability to continue.

The first incident occurred on one of my initial fieldwork sessions at Southam. I was sitting in the lounge with ten residents when one resident had a violent heart attack and died, writhing in spasms while her face turned purple. I felt helpless, and useless. I noted how communal life carried on in the home. Only an hour later at tea time, residents filed into the dining room, leaving an empty chair at her place, and no-one mentioned her absence. It took a great deal of courage for me to return and carry on with the fieldwork, but I recognised that the residents had to learn to cope with this and other deaths, since they cannot move from the home.

The second incident occurred one evening as I was about to leave Eastview. An 85 year old confused resident, Mrs. Harriet Gascoyne, walked out of the front door unnoticed, and fell on the pavement behind my parked car just as I switched on the engine. She had been crouching behind the car and I had not noticed her. I felt distraught, despite the observation of staff and other residents that the resident was to blame and my car had not moved before she fell. I volunteered to take her to the hospital to be checked. She needed two stitches but recovered. It was very difficult for me to continue to visit that home afterwards. My outward manner at the time of the accident was calm, but inwardly I felt upset and destructive in my actions. By continuing to visit the home I eventually overcame my negative reactions. However, in every home there were painful moments at times. Death was always present and I wondered whether I, or any of the staff or residents, could truly be said to have come to terms with it. This helped me to understand why staff at times appeared distant and detached from opportunities for relationships with the elderly residents.

Ethical considerations did not trouble me initially. I felt protected by my professional values. I would respect the respondents and ensure confidentiality. No resident or staff member would be forced to respond. Later, I began to ponder my choice of residential care as a topic for research. Fennell et al (1988) argue that residential care has been a more frequent topic of research than other aspects of old age. In other areas of sociological research, people who may be described as deviants have been studied

more than the rich and powerful. My choice of elderly people in residential care guaranteed me a research facility which would be available 24 hours a day, seven days a week, with respondents who lacked power. If they did not want to speak to me, they could not easily walk away. Perhaps I had deceived myself about the reasons for my research. Expediency may have mattered more than values of empowerment in guiding my choice. The topic itself may have proved upsetting to some of the elderly people interviewed as it aroused memories of bereavement and loss. Many respondents choked back tears as they spoke to me. I could not have hoped to have succeeded in doing 'insider' research, meeting the residents as one of them. I was always the outsider, and probably always perceived as an authority figure despite my attempts to establish my separate identity. My initial assumption that I had thought through the ethical dilemmas, in retrospect, seemed superficial and complacent. On the other hand, it could be argued that my role achieved a neutrality (Trice, 1970) which allowed residents to share their views more openly than if I had been a complete 'insider'. The stranger role has the advantage of being able to break down taboos of silence by asking seemingly naive questions (Vidich and Shapiro, 1955). This power of the stranger role needs to be contained within ethical considerations.

6.16 Technical Issues

It was not possible to draw conclusions about the influence of different space and design on relationships, because of the many counterbalancing factors. I was able only to observe relationships conducted within public spaces and did not see the more private relationships between two room mates or between residents able to find some private space together. This limited the scope of the research. The many residents who were confused and who could not be interviewed prompted me to question what kinds of relationships might be viable within residential care if the incidence of confusion rises beyond its present levels.

'Relationship' is a conceptual notion with many possible connotations and interpretations which my methods tried to grasp in a more subtle way than using direct questions. It is possible that the subtlety may have missed some points which direct questions might have revealed. I might have benefited from an earlier shift from the general observation of the residents as a group, to the more specific observation of selected residents from whom I was going to take a life history and an interview. The selection of respondents occurred just as I was about to begin the life histories. The selection needed to be guided and informed by the general observation, and so it was; but there was not enough time to spend subsequently in particular observation. More available time would have given me the opportunity to probe more deeply into the life histories by going back several times. In that case I might have had to reduce the numbers of respondents and homes.

Although I prided myself on my technical skill as an interviewer, when I looked back on the experience it seemed that I had not probed sufficiently to draw out the respondents. I gave them leeway, did not pursue a point - or so it seems. This is a matter on which I cannot be sure. Some respondents revealed deep feelings without any prompting. Others were reserved. I felt that in some cases I was too protective of what I felt to be the vulnerability of my aged respondents. I was afraid of upsetting them, confusing them, or causing too much stress. Perhaps I then handled the schedule in too routine a way. Yet I succeeded in taking the life history of Mrs. Hazel Hill, a resident of Southam who had attempted suicide, and of Mrs. Ruth Beckett, the 103 year old resident of Northfield House. My success was sufficiently good to offset situations which I might have explored in more depth. There was the risk always that if I probed too much, I would lose the participation of the respondent.

The pilot interviews worked well and I gained a lively response from the pilot respondents. Although the pilot interviews provided a useful means of testing my skill as an interviewer and improving the reliability of the life history guide and interview

schedule, in retrospect I thought that the liveliness of the pilot respondents could be explained by their recent admission to the private home and its small size. None had been subjected as yet to a rigid routine or to large numbers of residents. When I began interviewing in the local authority homes, I noted passive acceptance of every aspect of the regime by the residents. Interviewing became more difficult, even allowing for the frustrations of lack of space and time. Residents were more inhibited in their emotional response, and had less to say.

In re-examining my Questionnaire Interview Guide (Appendix Four), I was dissatisfied with two sections: the questions on identity, which needed expansion in order to draw out the respondents; and the section on reciprocity, which I felt did not work well. In the pilot, however, this section seemed to elicit appropriate responses. Despite careful explanations, nearly all respondents in the local authority homes could not respond to it except in a concrete, literal manner.

The term 'multiple strategies' has been used by Burgess (1984) and overlaps with terms such as 'triangulation' (Denzin, 1970), 'combined operations' (Stacey, 1969), and 'mixed strategies' (Douglas, 1976). These terms refer to the different types of triangulation: data, investigation, theory, and method. They have the same purpose of testing reliability, validity and generality of findings. Findings from different methods may not always be congruent, and may need further investigation to explore the reasons for incongruity. The research design used a multiple strategy in its use of methods, but I was the sole investigator for technical reasons. I selected three main instruments, observation, life histories, and interviews, which served as cross-checks on each other. The reliability of the design measures is less able to be vouched for in this kind of research. I spent a great deal of preparation time working out how to address the concepts, but 'relationship' (as discussed in Chapter Three) remains an elusive concept. I was the only researcher in the field investigating a subjective concept which is highly personal to each individual respondent. Given the same instruments, a different researcher might have emerged with somewhat different data, because of a different interpersonal communication style and a different value system. But because of the nature of the methods, I could not be too concerned about typicality or randomness. By comparing the different accounts, I tried to resolve the issue of observer reliability, and the way in which my values and bias influenced perceptions (Fennell et al, 1987).

Because of the Interpretive nature of the research, validity was more likely to have been achieved than reliability. Bury and Holmes (1991, discussed above) made validity checks by comparing informal replies and the comments of carers. The aim of my research was to discover the relationships as seen, felt, and understood by the respondents in their own world. I entered into their world, although not as a true insider, in order to gain a picture of this. What ensued, and was recorded, was an attempt to portray a valid picture of the relationships of elderly people in residential care. At the same time I was aware of the pressures against validity which I noted previously: my bias, the insider/outsider strains on my role, the respondents' reluctance to share fully, and the possible intrusion of environmental influences on my role as a researcher.

6.17 Summary of the Chapter

This Chapter discussed the issues and experiences of developing and working out a multi-strategy approach to the topic. My previous certainty about values as the driving force of the research became less assured in the face of the powerlessness of the residents, not only in relation to the regimes of the homes, but also to my own requests for their participation in the research. I made much of the fact that I had carefully prepared for my presence and purpose in the homes. Although the effort was made, I could not be certain that the letters I wrote were actually circulated to the staff and residents, or whether the Officers of the homes did explain my purpose to the residents, or even when they did, whether these were understood or accepted. My identification

as a teacher still placed me in a powerful, authoritative role in relation to the residents. Was I really empowering the residents with my research process? The intent was there, but the practice did not achieve all that was hoped. My role was that of an outsider with privileged insider access - an outsider on the inside. Was I really able to gain an insider view? I had to settle instead for an outsider role from the inside.

The process did affirm the importance of context and environmental influences on the lives of residents, thus supporting the ecological approach (Bronfenbrenner, 1979, discussed in previous Chapters), Realism's layered approach (Layder, 1993, discussed in Chapter Five) and the life course perspective (Kohli, 1986; Blaikie, 1992; discussed in Chapter Two). I perceived the effect of the daily regimes that I encountered as negative and devaluing the individual (Goffman, 1961; Townsend, 1962; discussed in Chapter Four), including myself as the outsider seeking to gain an insider view within the homes. My greatest struggle was with my inner self - the feelings, values, past identities and roles - which shaped my assumptions and expectations of the research process. Here was an example of the collision between the life-world (Habermas, 1976, 1979, discussed in Chapter Five) of the researcher and the social systems of the residential homes. For example, my life-world led to bias against the residential routines I encountered, but to sympathy and identification with the hard-working, dedicated staff. My values were more ambivalent and compromised than I first assumed. I worried about whether my negative bias towards residential homes and my uncertainties as a researcher might preclude achieving a balanced view within the research.

This remains a question. I dealt with the worry by reviewing the data systematically and doing a self-checking process for bias, as well as adopting the multi-strategy methods. Awareness and preventive action helped to minimise the potential of an excessively narrow view affecting the conclusions. Another way of looking at this issue is to accept the inevitability of bias, and value it positively. According to Becker (1971), bias is not an issue which can be resolved by better technique. Accusations of bias arise when challenges to accepted power structures are made, as (for example) by Feminist arguments (Roberts, 1990). An appropriate response might be to adopt a reflexive process in which the researcher's own concerns and values are incorporated into the research process. Feminism's response is to argue a Feminist perspective at an ideological level; my response might be to argue for an anti-ageist perspective.

Although the approach to the research is Interpretive in spirit and intent, and uses methods commonly associated with this approach, the analysis of the data will attempt to go beyond description and discovery of relationships. It will discuss the assumption, based on the life course perspective (Kohli, 1986; Blaikie, 1992; discussed in Chapter Two) and the ecological approach (Bronfenbrenner, 1979, discussed in previous Chapters), that relationships are affected by contextual differences of space, size, and time. Hence my wish to choose homes of different size and design, and to interview residents and staff with different lengths of residence/employment in the homes. The research process made use of Critical Theory's process of the deconstruction (Habermas, in Harvey, 1990, discussed in Chapter Five) of old assumptions and reconstruction of new, rather precarious *a priori* assumptions about relationships of elderly people in residential care.

The next Chapters present the findings, drawing on the relevant data and the issues identified in this and previous Chapters.

Relationships of Elderly People in Residential Care

Chapter Seven

Overview of the Three Homes, the Staff and Their Residents from the Perspective of Organisational Relationships

7.1 Introduction: The Inter-Relationships of the Homes, the Staff, and the Residents

The data from the research are presented in this and the next two Chapters. Chapter Eight will explore the residents' identities revealed through their life histories. Chapter Nine will focus on the nature of residents' relationships. This Chapter contains an overview of the inter-relationships of the three residential homes, the staff, and the residents. It explores personal and social relationships within residential care from the perspective of the organisational relationships which influence the delivery of care. The organisational relationships of residential homes are influenced by the size and design of each home (Harris, Lipman, and Slater, 1977; Willcocks et al, 1987), by the historical context of each home's development, and by each home's location in a particular environment (Townsend, 1986; Means, 1986; Tinker, 1992). The administrative requirements of the Social Services Departments which own and operate the homes (Estes, 1979; Wagner, 1988) affect the relationships of the home and the residents. The personality and management style of the Officer-in-Charge (Booth, 1985); and the caring practices (Wagner, 1988; Atherton, 1989; Ainsworth and Fulcher, 1981; Townsend, 1962; Goffman, 1961) are influential. Each home has a distinctive culture (Znaniecki, 1952; Parsons, 1951), comprised of the elements cited above. Each home has its own life course (Kohli, 1986; Blaikie, 1992, discussed in Chapter Two) based on its history, organisational relationships, and culture. The life courses of the homes influence the relationships of staff with residents.

One of the first areas for exploration was the influence of space and design on relationships (Harris, Lipman, and Slater, 1977; Willcocks et al, 1987; discussed in Chapter Four). The three selected local authority-run residential homes provided contrasts of size:

Eastview, a large communal home;

Northfield House, a large unit living home; and

Southam, a small communal home;

and design:

two communal homes, Southam and Eastview; and

one Unit living home, Northfield House,

but, as discussed in Chapter Six, the study of the residential flatlet design was not possible.

7.2 The Contrasting Size and Design of the Homes

The three chosen homes, Southam, Eastview, and Northfield House, were different in character.

Southam, a small communal design home with 25 beds, is sited in an attractive village in rolling countryside, on the edge of a new development area about ten miles south of the county town. Resembling a small country house, its Edwardian red-brick building

(formerly the vicarage) stands next to the village parish church and is set in acres of gardens. Southam has

two lounges,

one dining room,

two four-bedded bedrooms,

seven double bedrooms, and

three single bedrooms.

Eastview, in contrast, with 63 beds, is a much larger, modern brick building purpose-built in the 1960s in the centre of a commuter, semi-industrial small town. It lies about ten miles north of the county town. Eastview's design is also communal, with

four lounges,

one large dining room,

two four-bedded rooms,

fifteen double rooms, and

twenty-five single rooms.

A totally different design is represented by Northfield House, located on a council estate in a small coastal market town in a rural area, about ten miles east of the county town. Built in the 1960s to the identical communal design as Eastview, Northfield House was reconstructed and refurbished in 1987 into group living Units at a cost of £225,000. It has

seven Units, each one self-contained;

four with seven beds and

three with eight beds.

In each Unit, single and double bedrooms cluster around a Unit sitting room, dining area, and kitchenette. The large communal dining room on the ground floor is used by about sixteen of the more mobile residents, and it doubles as an Activities Room. Unlike the other homes, Northfield House has a separate Day Care Room.

7.3 Placement Policies and Their Effect on Relationships

Admission begins the process of institutionalisation of the applicants. The Admissions Panel comprised of social workers, Officers-in-Charge, and the Principal Officer (line manager of the Officers-in-Charge) decides which residents should be admitted. The decision to offer a bed in a particular home is not based entirely on the home's proximity to the applicants' own communities. Applicants can express a preference for a particular residential home, but are not guaranteed placement in the home of their choice. Nor are they offered a choice of bedroom. They are entitled only to a bed which is designated by the Officer-in-Charge.

Admission Panels consider a written application and Social Work Report for each applicant. Although the Officer-in-Charge attends the Admissions Panel and can voice an opinion, the evidence supporting the application in the Social Work Report is

compiled by social workers who have undertaken a home visit to the applicant. Social workers compete for the few available beds for their clients, each presenting a case of need for residential care. The power of the Officers to determine admission is exercised negatively, as a right to veto an application which may be considered unsuitable. The elderly resident's initial entry is classified as short-stay. The short-stay becomes permanent after about six weeks when a Review Meeting determines how well the resident has settled and whether he or she agrees to becoming a permanent resident. Comments from the Review Meeting are written and noted by the Officer-in Charge. These are largely concerned with organisational relationships of adjustment to the routine, fitting in with the group, and acceptable behaviour, rather than personal and social relationships.

When residence becomes permanent, contact with the social worker ceases, leaving ongoing care to the Officer-in-Charge and her staff. Social workers do not maintain sustained relationships with the residents. Since the social workers' offices are not in or near the residential homes, it would be difficult for them to maintain contact with residents following admission, even if this were seen as part of their role. Social workers do not carry any organisational responsibility for ensuring that good care practice is followed. There seems to be no strategy for developing accountable individual practice on an ongoing basis other than provision of practical care. Like the Care Assistants, the social workers complete short-term tasks in their relationships with residents. They are not responsible for care management within the homes. The Officers, who have responsibility for ongoing care, do not gain an over-view of the residents' personal and social history prior to admission. Their insight into residents' life course perspectives (Pearlin, 1982; Hareven, 1982; Blaikie, 1992) is limited. Relationships suffer as a consequence. Insufficient links are made between the past, the present, and the future relationships of the individual residents when they enter care. Placement decisions are made often on a functional basis rather than by taking note of individual preferences for a particular location near relatives or familiar neighbourhoods.

For example, the admissions policy for Eastview isolated the home from the community in which it was located because local people living in the same village were not permitted to become resident there. The Area Social Services Office had designated Eastview as an overflow facility for the elderly people from the county town, about ten miles away to the south. Local applicants for residential care who lived within walking distance of Eastview were placed in a home which was about ten miles away in the opposite direction from the county town. Eastview was accessible by train (but the station was almost a mile away) and by bus. Existing relationships were affected adversely by the isolation of the residents from the local community and from their own former neighbours and family. Relationships with people who lived outside the home were difficult to sustain. Southam drew most of its residents from a nearby community which had developed in the 1980s as a privately built new town. Southam's accessibility by public transport was poor, but the distances were not as far as those for Eastview, so that sustaining relationships was somewhat easier. Existing relationships were impeded because residents and relatives could visit only if the relative owned a car and could drive. Most of Northfield House's intake of elderly residents came from the villages surrounding the market town where it was located. With its location on a bus route, Northfield House was easily accessible by public transport. Existing relationships were more likely to be sustained because relatives could visit easily. The Day Care Room activities, also open to permanent residents, kept them in touch with local people who attended for day care, many of whom they had known from childhood.

7.4 Short Stay and Day Care Services and Their Impact on Relationships

Broadening the provision of services within the residential care setting can provide a means of softening the stigma of residential care (Wagner, 1988), as well as providing needed support to family carers (Stevenson, 1989). By establishing organisational relationships with individual carers through the provision of short stay/respite residential care, permanent entry to residential care can be postponed or prevented (Sinclair and Williams, 1990). Relationships between elderly people living in the community and the permanent residents can be facilitated by the use of short stay care. On the other hand, mixing short stay and permanent residents can be disruptive, because it upsets the permanent residents' established relationships. The potential for using short-stay residential care more fully was not realised in the three homes. There were no separate Units designated specifically for short-term residential care, although Northfield House's Unit design would have permitted this without disruption to the long-stay residents. The three homes offered respite or intermittent short stay care to only one or two elderly people each week. Short stay beds were allocated on a fortnightly basis to elderly people who had been judged to have high priority needs for temporary care or whose carers needed relief. Short stay residents were given a single bedroom but in other respects they had to fit into the general provision of care for permanent residents. Some short stay residents eventually applied for permanent residency in the same home, with no guarantee that they would be offered a bed there rather than in another unfamiliar home.

For the same reasons, locating Day Care Units in residential homes is controversial. Day care can disrupt permanent residents. It creates an even larger institution (Wolfensberger, 1982) unless the Unit is truly separate in design. Only Northfield House had a separate Day Care Unit for ten clients, planned as part of the refit of the home in 1987 (although as noted above, it had not designated one of its group living Units for short-term residential care). Because the Day Care Unit at Northfield House had its own entrance and exit, the arrival and departure of day care clients did not disrupt the permanent residents. It provided programmes of planned activities in which permanent residents as well as Day Care clients were able to participate by choice.

Eastview did not offer day care, although it could have done so. One of its lounges could have been designated as a Day Care Room. Eastview's large number of single bedrooms (25) meant that not all residents sat in the lounges, because they preferred to use their bedrooms as sitting rooms. The loss of one lounge would not have been detrimental to the space available to permanent residents. The Officer-in-Charge, Mrs. Olds, was not in favour of day care. Although policy decisions are usually made at Principal Officer or Senior Management level, Mrs. Olds used her influence to veto plans, claiming that she was short of staff.

Southam, the smallest home, provided one day care place to a different elderly person each day. Southam's implementation of day care illustrates some of the dangers articulated by Stevenson (1989) of introducing transient people into the home's environment. At Southam, there was no apparent possibility of separate day care facilities. The day care client entered the ground floor lounge, sat in a designated chair alongside the permanent residents, and ate with them in the dining room. The day care client was able to take part in whatever activities might occur, but no special day care programme was designed. The burden of adjustment fell on the day care client, a lone individual in a crowd of unfamiliar faces. Equally, permanent residents encountered a different face in the same chair each day, and this could be disruptive. The heavy smoking of one of the regular day care clients at Southam disturbed the permanent residents. Relationships between permanent residents and day care clients were marked by mutual tolerance rather than by more positive relationships.

7.5 The Loss of Residents' Past Relationships and Identities on Admission

Residents enter homes with personal, social, and organisational relationships formed throughout their life courses (Hareven, 1982; Riley and Riley, 1986; Blaikie, 1992). I was interested to discover how these relationships were acknowledged on admission and afterwards. In two of the three homes, Southam and Eastview, I studied the residents' individual files and gathered information about previous circumstances and reasons for admission. (At Northfield House, as noted in Chapter Six, the Officer-in-Charge refused to let me see the files because she felt that the contents were private. Instead I was able to look at the Day Book and note the residents' date of birth, date of admission, age on admission, and place from which admitted.) Residents' files at Southam and Eastview consisted of the Social Work Report completed at the time of admission, and the brief follow-up Report six weeks later, together with records of financial transactions. I found that residents' files were not updated during the months and years of residence, except to include recent details of next of kin. Day-to-day occurrences affecting individual residents were noted in a daily log book and read by staff as they changed shift. There was no requirement to transfer this information to a resident's individual file. An individual's relationships, activities, general well-being, and crises over months and years were not recorded systematically. They were carried in the collective memory of the staff, if at all.

The Officer-in-Charge was most likely to assume responsibility for knowing the residents as individuals with individual needs, although she did not offer direct care to residents except in an emergency. I was assured on more than one occasion at Southam by Mrs. White, the Officer-in-Charge, that "We know our residents very well". This may have been possible at Southam, a 25-bed home, but I doubted whether in larger homes like Northfield House or Eastview any resident could be "well known", given the lack of individual case file recording of residents' ongoing life events in care.

The accuracy of the information in residents' files was dependent on the interviewing skills of the social workers who conducted the pre-admission interviews. The pro-forma Report used for admission purposes did not require a complete social history. The Social Work Report rarely achieved a portrait of an individual. After looking through the files, I experienced a curious sense that life for these individuals had ceased following admission, because of the absence of any records about their previous life courses before admission and their life courses after they entered care.

Information about the residents who became known through observation and interviewing is presented in charts as a guide for the discussion to follow in this and in successive Chapters. This style of presentation draws on the suggestions of Miles and Huberman (1983) for the display of qualitative data. Fictitious names are used throughout.

FIG 18 SOUTHAM RESIDENTS: An Overview

Name	Age, status, as of 1989/1990	Year of admission to Southam	Observation	Life history	Interview
Mr. Leslie Atkins	81, never married	1977	yes	yes	yes
Mrs. Annie Baker	85, widow, two daughters	1983	yes	yes	yes
Mr. David Brooks	81, widower, no children	1986	yes	no; too confused	no
Mrs. Bessie Carr	83, widow, one daughter	1977	yes	no	no

Name	Age, status, as of 1989/1990	Year of admission to Southam	Observation	Life history	Interview
Mrs. Florrie Dakins	87, twice widowed, two sons, both deceased	1987	yes	yes	yes
Mrs. Alice Edwards	88, husband in geriatric ward, one daughter	1979	yes	no	no
Mrs. Irene Ellis	85, widow, one daughter	1978	yes	yes	yes
Mrs. Maisie Freane	74, widow, no children	1988	yes	abandoned because of distress, confusion	no
Miss Joan French	89, never married	1970	yes	no; too confused	no
Mrs. Gladys Garrett	78, widow, one son	1984	yes	no	no
Mrs. Hazel Hill	83, widow, two sons	new resident, transferred from Eastview	yes	yes, but refused permission to use specific data	no
Mr. Patrick Hillier	84, widower, no children	1988	yes	yes	yes
Mrs. Lily Irving	94, widow, one daughter	day care and short stay care	yes	yes	yes
Mrs. Olive Jenkins	79, widow, one son, one daughter	1987	yes	no	no
Mrs. Katie Kirk	80, widow, one son, two daughters	1987	yes	no; too confused	no
Miss Cissie Lawrence	87, never married	new resident	yes	yes	yes
Mrs. Eliza Montgomery	93, widow, one son	1979	yes	no; too confused	no
Mr. Michael Morris	79, widower, one daughter	1982	yes	no	no
Miss Jane Norris	76, never married	1988	yes	no; too confused	no
Mrs. Cora Oliver	82, divorced, one son, one daughter	new resident	yes	yes (died during period of research)	yes
Mrs. Kathleen Perkins	83, widow, no children	1988	yes	yes	yes
Miss Minnie Russell	98, never married	1981	yes	no; too ill (died during period of research)	no
Mrs. Teresa Sanders	94, widow, one son	1982	yes	no; mentally ill	no
Mrs. Dora Turner	80, widow, one son, one daughter	1988	yes	no; too ill (died during period of research)	no
Mrs. Winifred Walters	85, widow, one son, one daughter	1982	yes	no; too ill	no

Name	Age, status, as of 1989/1990	Year of admission to Southam	Observation	Life history	Interview
Mrs. Queenie Xavier	86, widow, two sons	1986	yes	no; too confused	no
Mr. Vincent Young	80, widower, one son, one daughter	1989	yes	no	no

FIG 19 EASTVIEW RESIDENTS: An Overview

Name	Age; status as of 1989/1990	Year of admission to Eastview	Observation	Life history	Interview
Mr. Bert Arthur	81, separated from wife, one son, one daughter	1985	yes	no	no
Mrs. Maggie Askew	85, widow, one daughter	1989	yes	no; very confused	no
Mrs. Maude Baker	92, widow, two sons (one deceased)	1987	yes	no; very frail	no
Mr. Edward Booker	80, widower, one son	1986	yes	no	no
Mrs. Gertrude Caulkins	95, widow, one son	1988	yes	no	no
Mr. Henry Clifford	87, never married	1988	yes	yes	yes
Mrs. Sally Cooper	96, widow, no children	1979	yes	yes	yes
Mr. John Davis	87, widower, two daughters	1988	yes	yes	yes
Miss Evelyn Eastwood	71, never married	1986	yes	no	no
Mrs. Olga Frederick	84, widow, no children	new resident	yes	yes	yes
Mrs. Harriet Gascoyne	90, widow, two sons	1988	yes	no; very confused	no
Mr. Wilfred Graves	85, divorced, then widowed, one daughter	1987	yes	no; very frail	no
Mrs. Mary Hooper	79, widow, one daughter	1981	yes	no; mentally ill	no
Mrs. Clarinda Instrall	91, widow, one daughter	1985	yes	no	no
Mrs. Kitty Jones	87, widow, no children	1982	yes	no; mentally ill	no
Mrs. Xavia Kelly	75, widow, seven children	1988	yes	no; limited knowledge of English language	no
Mr. Richard Llewellyn	92, widower, two daughters	1989	yes	yes	yes
Mrs. Laura Lowther	90, widow, two children (both deceased)	1982	yes	no; too confused	no
Mr. Robert Martin	55, never married	1981	yes	no	no

Name	Age, status, as of 1989/1990	Year of admission to Southam	Observation	Life history	Interview
Mrs. Molly Nabbut	83, widow, no children	1987	yes	yes	yes
Mrs. May Orville	88, widow, one son, one daughter	1987	yes	no	no
Mrs. Ida Plumpton	94, widow, one daughter	1985	yes	no	no
Mrs. Abigail Quinn	96, widow, one daughter	1983	yes	no; too confused	no
Mrs. Amanda Rogers	87, widow, no children	1988	yes	no	no
Mrs. Iris Rowlands	92, widow, one daughter, one son (son deceased)	1987	yes	yes	yes
Mrs. Avril Shearing	94, widow, one daughter	1984	yes	no; mentally ill	no
Mrs. Bertha Tarrant	79, twice widowed, one daughter	new resident	yes	yes	yes
Mrs. Polly Towell	83, widow, one son	1982	yes	yes	yes
Mr. George Urquhart	79, never married	1975	yes	yes	yes
Mrs. Barbara Veal	93. widow, one son, one daughter	1980	yes	no	no
Mrs. Emily Warne	84, widow, one son	1984	yes	no	no
Mrs. Miriam Youens	83, widow, one daughter	new resident	yes	yes	yes
Mr. Frank Young	76, never married	1975	yes	no	no
Mrs. Betty Zander	90, twice widowed, one son	1987	yes	yes	yes

Note: Twenty-three additional residents were not observed; of these, fourteen were confused, and nine very frail.

FIG 20 NORTHFIELD HOUSE RESIDENTS: An Overview

Name	Age; status as of 1989/1990	Year of admission to Northfield House	Observation	Life history	Interview
Mr. Joseph Archer	85, never married	1964	yes	no; (died during period of research)	no
Mrs. Ruth Beckett	103, widow, no children	1978	yes	yes	had to be abandoned because of distress and confusion
Mrs. Violet Batty	80, widow, no children	1989	yes	yes	yes

Name	Age; status as of 1989/1990	Year of admission to Northfield House	Observation	Life history	Interview
Mrs. Doris Clarke	92, married, husband also resident	1988	yes	no	no
Mr. Ernest Clarke	95, married, wife resident	1988	yes	no; (died during period of research)	no
Mrs. Frieda Grantham	78, married, husband also resident, one son, one daughter	1986	yes	yes	yes
Mr. Kenneth Grantham	79, married, wife resident, one son, one daughter	1986	yes	yes	yes
Mrs. Fannie Hewitt	80, widow, one daughter	day care, short stay	yes	yes	yes
Mrs. Enid James	82, widow, one daughter	new resident	yes	yes	yes
Miss Julia Jessop	84, never married	1979	yes	yes	yes
Mrs. Clara Marshall	87, widow, one son	1983	yes	no	no
Mrs. Flora Needham	85, widow, two sons, two daughters	1989	yes	yes	yes
Mr. Albert Quinton	82, widower, three daughters	1986	yes	yes	yes
Mrs. Ursula Quayle	83, widow, one daughter	1985	yes	no	no
Mrs. Connie Redmond	89, widow, two sons, three daughters	1986	yes	yes	yes
Miss Edith Reed	63, never married	1989	yes	no	no
Mrs. Thelma Simpkins	90, widow, one son	1983	yes	no	no
Mrs. Ivy Verity	76, married, husband also resident, one daughter,	day care and short term care	yes	yes	yes
Mr. Walter Verity	84, married, wife also resident, one daughter	day care and short term care	yes	yes	yes
Mr. Hugh Wylie	77, never married	1981	yes	no	no

Note: contact with other residents at Northfield House was limited, due to the restrictions of the Officer-in-Charge, and the boundaries imposed by the Unit design. The home's records about the observed residents were not made available by the Officer-in-Charge.

7.6 The Residents' Past: Reasons for Admission

The files of Eastview and Southam's residents, corroborated by snippets of information about Northfield residents, revealed that admission was based on multiple reasons. Often, a chain of events resulted in admission to care. The reasons for admission grouped together in four constellations:

1. bereavement and lack of relationships;

2. poverty, homelessness and self-neglect;

3. factors relating to family and carers; and

4. physical and mental health. (see Appendix Six).

At Southam, even allowing for its smaller size, proportionately more residents were admitted because of their reactions to bereavement and isolation, memory loss, estranged relationships with carers, and self-neglect. At Eastview, homelessness, the inability of relatives to care, and physical dependency and illness were the most cited reasons. The differences could be attributed to the different styles of the social workers completing the Social Work Admission Reports, or to the Admissions Panel's decision to admit a certain applicant to a particular type of home. Southam's philosophy of "make them happy" (discussed below) seemed suited for a depressed, isolated applicant. Another reason accounts for Southam's particular kind of resident. It was only recently that a lift was installed. Until then, new residents had to be able to walk upstairs. They were physically stronger but mentally and emotionally more frail than residents placed in other homes.

A typical constellation of reasons for admission is illustrated by the circumstances of Mrs. Kathleen Perkins (discussed in Chapter Eight). Aged 83, she was a childless widow who had lived all her life in Scotland. Because of the death of her husband, her bereavement reactions, and her increasing frailty caused by arthritis, she was persuaded to move to East Anglia to live with her married nephew and his family. She became even more unsettled and depressed, strains developed between her and the carers, and she experienced memory loss. Once the relationship with her nephew had broken down and it became clear that she could not continue to live with him, she became homeless far away from her familiar Scottish community . Her nephew applied for admission to care, she agreed reluctantly, and was given a bed at Southam.

Eastview, with its large size and brisk style of caring (discussed below), was better suited for physically dependent applicants who were not so depressed. At Eastview, another typical constellation of reasons is illustrated by the admission of Mrs. Iris Rowlands (also discussed in Chapter Eight). Aged 92, she had lived the earlier part of her life in London, but moved to East Anglia after World War Two. Following the death of her husband, she worked as a seamstress until she was 72. She then experienced failing eyesight and arthritis which limited her mobility. She sold the family home and moved to a sheltered housing flat where she made new friends. Her continued physical deterioration and loss of sight prompted her admission to care at Eastview at the age of 89. She felt she could not move to her daughter's household as she did not wish to be a burden. Her daughter's flat was on the first floor up a flight of stairs which would have been difficult for Mrs. Rowlands to manage. Her entry to care was less traumatic than Mrs. Perkins, because she exercised some choice and took control of the decision. Mrs. Rowlands' relationship to the home was relatively positive, while Mrs. Perkins, who had not chosen to enter care, had a more negative yet grudgingly accepting relationship to care.

Women residents, particularly at Southam, expressed the repeated feeling that they felt "safe" in care, and would not want to be "out there" any more. At Southam, Mrs. Irene

Ellis, an 85 year old physically active woman who had experienced depression resulting in brief hospitalisation prior to admission, said this over and over. Mrs. Gladys Garrett, a physically active 78 year old woman at Southam, expressed the same sentiment. She had attempted suicide following the death of her husband. Both women had survived as residents in the home for almost ten years. Care offered a refuge from a world which they found troubling. They expressed contentment with their dependency in care. Their relationships in the home were positive. In contrast, Mrs. Violet Batty (discussed in Chapter Eight), aged 80, had entered Northfield House after a fall in which she broke her shoulder. She expressed violent dislike of the home. She had been persuaded to seek admission by her brother and the hospital social worker, but she did not like the rules and lack of freedom. She hated the ritual surrounding the payment of the residents' weekly allowance by the staff, feeling it was demeaning. The reluctant entrants to residential care, like Mrs. Batty, were less likely to form positive relationships to the home and with other residents, unless two like-minded residents formed a relationship based on mutual dissatisfaction.

At all three homes, certain residents had been admitted for different constellations of reasons. They did not fit the usual criteria for admission. They had learning difficulties, long-term mental illnesses, or physical conditions which had led to previous institutionalisation in a long stay hospital. Their placement in an elderly persons' home showed the lack of specialist community-based facilities for people who formerly had lived in long term hospital care. For example, at Northfield House I witnessed the death of Mr. Joseph Archer, a man of 85 with a learning disability who had been resident in the home since it opened in 1964. He had spent most of his life in an institution, having entered the Workhouse in childhood. Miss Evelyn Eastwood, an Eastview resident with epilepsy and physical disability, had lived in and out of institutions all her life. At Southam, Mrs. Katie Kirk sat muttering incoherently in a corner day after day. She had been placed in a mental hospital at the age of 26. She left hospital only when she entered the elderly persons' residential home at the age of 72. Her adult children lived in New Zealand.

In addition to those who became resident because of earlier placements in long-term institutional care, one or two residents with learning disabilities were admitted when their parents died. These residents were younger than other residents. Mr. Robert Martin at Eastview was only 46 when he entered care after his father died. He was 55 at the time of the research. In my view he was wrongly placed in a home where many residents were old enough to be his parents or grandparents. Miss Edith Reed was 62 when she became resident at Northfield House after her mother's death. She also was much younger than everyone else. Their relationships with other residents were disadvantaged by their different life courses. They had never worked, married, had children, or maintained their own homes. They were a generation younger. The other residents (for the most part) did not understand the nature of learning disability or mental health problems. Relationships tended to be distant and reserved because of ignorance and fear.

7.7 Gender, Length of Residence, and Age of Residents: Their Influence on Relationships

The residents of each home were predominantly women, who comprised approximately three-quarters of the population of each home (Appendix Eight). Although there are examples of residents surviving in the homes for more than ten years, the usual length of residence before death was eighteen months. For example, at Southam,

six residents entered the home between 1970 - 1979;

five residents entered between 1980 - 85; and

twelve residents between 1986 - 1989, with most of these more recent residents having arrived in the previous twelve months.

At Eastview,

four residents had entered between 1970 - 79;

sixteen residents between 1980 - 85, and

thirty-six between 1986 - 89.

At Northfield house, it was much the same story:

two residents had entered between 1970 - 1979;

twelve between 1980 - 85; and

twenty-eight between 1986 - 1989. (see Appendix Seven).

Some new residents had experienced short-stay respite care in private homes before taking up permanent residence at Northfield House. These residents felt forced into the local authority home because of they lacked the funds to pay the rising fees charged in the private homes. Consequently, their relationships to the residential homes were ambivalent because their admissions were second best choices.

Two residents had transferred from a different local authority-run home to their current home, at their own request. One was Mrs. Polly Towell, aged 83, who had been unhappy in her previous home some miles away. She quickly lost her depression by assuming a position of leadership amongst her new companions once she moved to Eastview. (Eastview was also nearer her brother's home and on a bus route, so that he could visit her regularly which he could not do when she was in the more distant home.) The other transfer resident was Mrs. Hazel Hill, aged 83. She transferred from Eastview to Southam, which she knew well from previous short-stay respite care there. Mrs. Hill was the widow of a well-to-do farmer. She attempted suicide following her husband's death. This failed attempt resulted in permanent disability. She preferred the smaller size of Southam, and declared herself to be satisfied and happy once she made the move. Mrs. Towell's and Mrs. Hill's relatively happy relationship with the home of their choice suggests again that the ability to choose, as in the case of Mrs. Ellis, Mrs. Garrett, and Mrs. Rowlands (Wagner, 1988, discussed in Chapter Four), is an important factor for individual well-being in residential care, including relationships.

Residents live in residential care until their deaths. Even if they wanted to leave care, they did not, usually because they had nowhere else to go. Residents were not discharged automatically into hospital care if their health worsened. Some spent periods of time in hospital for acute care, but returned to residential care if they survived. In consonance with current demographic data, women exceeded the number of men in each home, although there were relatively more men at Eastview (see Appendix Eight). The usual age of residents was in the upper 80s. As already discussed, there were exceptions. In each home, a few individuals had been resident for ten years or more. For example, Mrs. Ruth Beckett, a childless widow, had entered Northfield House in 1978 at the age of 91 when her niece (with whom she lived) died of a stroke. She was ambulatory and alert at the age of 103. Every day she fed bread crumbs to the sparrows outside the window. She probably could have managed to live in the community rather than having had to enter care had there been a network of home-based services in 1978. No-one expected her to survive for twelve years in residential care. On the other extreme of the survival rate in residential care is Mrs. Cora Oliver. She became a resident of Southam in February 1989 at the age of

82, and died suddenly after two months, with no particular indication that her death might be imminent.

The frequency of deaths within the home undoubtedly played a part in the stress felt by staff and explained their emotional distance in their relationships with the residents (Willcocks et al, 1987, discussed in Chapter Four). Some of the residents, too, appeared disengaged and emotionally flat towards other residents. The constant turnover of the population because of deaths of residents inhibited the development of relationships. Surviving residents observed with a detached air the changed faces in the lounges, the bedrooms, and the dining room. In my view this detachment was due to the frequency of deaths, the lack of privacy (Willcocks et al, 1987) and enforced group living in the homes, rather than the process of disengagement in old age (Cumming and Henry, 1961).

7.8 Occupational, Social, and Cultural Backgrounds: Their Influence on Relationships

At Southam and Eastview, but not at Northfield House, (except for those I was able to interview), I learned about the occupational range of residents' work history, or in the case of widows, their husband's work history. This gave some indication of the social background as well. The three homes tended to admit working class people. At Eastview, the occupation range for the women was in domestic work, farm work, factory work, or shop work. Relatively few continued to work after marriage, except during World War Two when many married women returned to work. The male residents' work histories were similar to those of the deceased husbands of the women residents. They had been farm workers, labourers, factory workers, drivers, and fitters. A minority of residents had enjoyed a more prosperous life-style linked to a somewhat better education and a different range of occupation. These included school teaching (particularly at Southam); ownership of a small business, shop or farm; and secretarial and clerical work. They comprised no more than 20% of the residents in each home.

In each residential home, some residents had moved into East Anglia from East London after World War Two, or had come from other parts of Britain (such as Tyneside) to the Southeast in the 1920s and 1930s in search of work. These people had settled in the area relatively happily. Mr. Richard Llewellyn, an Eastview resident (discussed in Chapter 8), had been a miner in Wales before moving to East London to work as a labourer on the construction of the Chingford reservoir in the 1930s. Another male resident at Eastview, Mr. John Davis, had many stories to tell about his experiences as a fireman in London throughout World War Two. As well as those migrants who had made the move in their youth or middle age, there were those who had moved in old age from a considerable distance to be near relatives. At Eastview, there was Mrs. Perkins (discussed above and in Chapter 8) from Scotland; at Southam, Mrs. Dora Turner from Oxfordshire, and Mrs. Florrie Dakins from rural Yorkshire. These residents were less settled. They tended to pine for their former locality. Again, residents who felt that they had exercised some choice about their moves were more positive in their relationships with relatives, with other residents, and with the home itself than those residents who felt forced into a move to the local area and then into the home.

Only one resident's cultural and racial origins differed from the white, native-born British majority. Mrs. Xavia Kelly, aged 75, was a Tamil from Sri Lanka. Her son had settled in the nearby county town. She had spent her widowhood visiting her seven children, most of whom lived in Singapore and the Far East, and the son in Britain. When the son's marriage broke up and Mrs. Kelly developed Parkinson's disease, she was admitted to Eastview. Her son rejected a proposed placement for her in a London borough home where she would have lived with other residents from ethnic minorities, because he would have had an increased distance to travel to visit her.

She had difficulty communicating with other residents and staff because of her lack of English, and their inability to speak her language. An interpreter, and culturally relevant care practices, such as choice of diet, skin and hair care, might have helped her form relationships in the home. Her pastoral relationship with the local Roman Catholic priest, who visited her regularly, sustained her morale. Relationships with other residents were hindered by the language problem and perhaps by their fear and dislike of her racial identity. One resident, Mrs. Gertrude Caulkins, however, was observed saying in a loud voice in the dining room "I like that coloured lady", perhaps in response to some negative views, and expressing positive support for her dining table companion.

7.9 Levels of Dependency and the Effect of Relationships

The purpose of my research was to explore relationships rather than survey residents' mental and physical health, but their health influenced their relationships. Health was part of their over-all identity. It could not be ignored. The residents' present social interactions were related to their individual health needs (Phillipson, 1982; Townsend, 1986). Health needs affected residents' communication with each other and their potential for personal and social relationships.

Nearly all residents experienced varying degrees of physical frailty. Sometimes frailty discouraged new relationships. Sometimes it stimulated a carer/cared for relationship with an unequal power balance. Arthritis and circulation problems caused lack of mobility. Some residents were diabetic and some were blind. Parkinson's disease affected a number of residents. Residents experienced hearing loss, which limited communication, and many of these did not use hearing aids. Incontinence affected many residents. Depression was present, to a level beyond that which might have been expected as part of residents' experiences of bereavement and loss, but which might be expected as a result of being in a home with nothing to look forward to except death. As already mentioned, a small but significant minority in each home had led a restricted life style within institutions or in their parents' care for much of their lives because of learning difficulties, mental illness, or physical disability.

The organisational relationships of each home were influenced to a great extent by the availability of resources to support specific staffing levels. Individual health needs determined whether the ratio of staff to residents was higher or lower. The actual amount of individual care provided by the homes was determined by the officially designated dependency level of each resident. The higher dependency level, designated when a resident was judged to be more physically and mentally frail, earned more Care Assistant hours, so that the staffing level could be improved slightly. Categorising some residents as highly dependent and others as less dependent perpetuated multiple regimes (Booth, 1985) within a home. The 'usual' staffing levels were considered insufficient for offering personalised care and developing relationships. This perceived lack of staff justified the continuation of institutional practices as part of the home's organisational relationships.

None of the three homes was jointly registered as a nursing home and a social care home. If specific nursing care for a health problem was needed, a referral was made to a community nurse. If medical treatment was required, a GP attended the home or arranged for hospital admission. Employing qualified nurses (or qualified social workers) in the home was considered too expensive. As the frailty and dependency of the residents increased, the unqualified care staff undertook tasks which overlapped with nursing care. The argument for social care homes rather than nursing homes involves pragmatic issues of cost and ideological issues of models of care. The medical model of care (Katz, 1983; Weick, 1983; Payne, 1991) is portrayed as authoritarian, rigid, health-centred, and based in institutions. The social model of care is portrayed as more individualistic, person-centred, holistic, and based in the community. By implication, the organisational relationships of social care homes would seem more likely to facilitate personal and social relationships. In reality, social care homes turn

out to be as rigid as any medical model home but they lack the professional expertise of health professionals. A key-worker and care planning system could have monitored the health needs of particular residents, including screening for communication needs, but key worker and care planning systems were not used in any meaningful way.

7.10 The Effect of Residents' Health on Relationships: Confusion

The level of confusion experienced by residents was the condition which most limited the potential for relationships. It was not possible to attach a medical diagnosis to the different types of confusion shown by residents. Case files indicated confusion or loss of memory. Confusion could be caused by acute illness, Alzheimer's Disease, dementia, depression, or crisis. Residents (and staff) in all three homes reported curtailment of day-to-day communication and relationships because of confusion. The Officers followed Social Services Departmental policy of integrating confused residents with mentally alert residents. They tried to treat each resident in the same way because they did not want to value mentally alert residents more than confused residents. Northfield House tried to place the more confused residents in a separate Unit but it was not possible to keep to this principle because there was too high an incidence of confusion amongst the residents. The other homes, Eastview and Southam, could not separate the confused residents from the mentally alert ones because of their communal design. They did not match potential room-mates or dinner table companions according to levels of confusion. The basis for making decisions about placing residents together or apart within the homes needed greater consideration . An internal placement policy could have created more opportunities for forming relationships.

Miss Cissie Lawrence, a resident of Southam, expressed agreement with the Officers' practice of mixing confused and alert residents at the dining room tables. (Significantly, she had worked for many years in an institutional setting, first as a teacher, then as a matron at a boarding school, so she was able to understand the issues of managing group living). She said: "If we could choose who we wanted to sit next to, some people would be left out completely. Nobody would want to sit next to them. It's best if Officers tell us where to sit."

The potential number of residents available for interviewing was sharply reduced by the incidence of confusion. For example, Mrs. Olds, the Officer-in-Charge at Eastview, considered twenty residents "too confused" to be able to participate in an interview. (These residents became known subsequently through observation, which corroborated Mrs. Olds' opinion.)

At Eastview,

six residents were considered mildly confused (and I interviewed three of them);

twenty residents were considered severely confused;

ten residents were judged to be too ill, both physically and mentally to be interviewed; leaving

twenty-one residents who were mentally alert, although physically frail.

At Southam,

three residents were considered mildly confused (and I interviewed all three);

eleven residents were considered too confused to be inteviewed, and

ten were mentally alert.

At Northfield House, as discussed above, I was unable to gain an over-view. Mrs. Black, the Officer-in-Charge, informed me that there were hardly any other residents (apart from those I interviewed) who were capable of participating because of the high incidence of confusion.

Few of the mentally alert residents in all three homes were aware of the many different causes of confusion. One of the mentally alert residents at Eastview, Mrs. Polly Towell, confided "My greatest fear is that I'll get to be like them and not know who I am or where I am". A typical reaction to the confused residents was expressed by Mrs. Betty Zander, who had lived at Eastview for five years. She complained to Mrs. Olds, the Officer-in-Charge, about the new residents coming in: "They're incapable of holding a conversation, poor dears. I can't talk to them at all. They shouldn't be allowed to come here. They're ruining the atmosphere of the home." Her complaints were typical of the reactions of the mentally alert residents - a mixture of fear, pity, intolerance, and above all, recognition of a barrier to forming relationships.

The mentally alert residents who had to share their bedrooms with a confused resident were the most intolerant. For example, Mrs. Winifred Walters, a resident of Southam, said angrily, "She keeps me awake all night with her jabbering." An extreme instance of confusion was displayed by Mrs. Maisie Freane, a 74 year old widow living at Southam, who had been admitted to care at a relatively young age in her late sixties because of her memory loss. Physically fit, pleasantly spoken, and well-groomed, she could not remember whether she had eaten a meal only five minutes after leaving the dinner table. She forgot the location of her bedroom and chair in the lounge. She wandered around the home because she was lost, intruding on, interrupting, and irritating the residents. The mentally alert residents pitied her, gave her help, but found her behaviour difficult to tolerate.

Another example at Eastview was Mrs. Abigail Quinn, a 96 year old widow, who wandered through the lounges and corridors in an incessantly hyperactive manner, shouting for attention in a foghorn voice, "Lady - lady". She was unable to say anything else. She interrupted a bingo session with her repeated outcry to the annoyance of the participants.

The blend of confusion, physical disability and social factors affecting relationships is illustrated by the circumstances of Mr. Bert Arthur, an 81 year old resident of Eastview. He entered the home at the age of 76 in a crisis, when his wife and family rejected him after many years of marital problems. He had Parkinson's Disease, experienced a series of strokes, and was deaf, confused, and often aggressive. While I was visiting the home, he became physically violent. He threw a chair at another resident, and threatened staff. After he was sedated by the GP, the staff phoned Mr. Arthur's son, requesting that he visit to help calm his father. The staff said that the other residents were terrified of him. The Officers also looked frightened and apprehensive. They regretted that Mr. Arthur could not be admitted compulsorily to mental hospital under the Mental Health Act 1983. They said that with their poor level of staffing, they could not watch him or care for him adequately in the home. Mr. Arthur's relationships with the staff, and theirs with him, were marked by fear and wariness.

7.11 Summary of the First Part of the Chapter

The first part of this Chapter has established that institutionalisation begins with the process of admission. Admission does not always provide residents with placement in a home near their local neighbourhood which is accessible by public transport for relatives' visits. Admission is based on a constellation of reasons ranging from bereavement and lack of relationships, to increasing frailty. It is usually provoked by a crisis. Residents who perceive their admission to care as their own choice develop more positive attitudes and relationships. The potential for using short stay respite care

and day care to overcome applicants' lack of familiarity and fears of residential care is not fully realised, but Northfield House, which was located on a bus route, drew its residents from the local community, and had a Day Care Unit, made the most of these opportunities to develop outreach relationships with prospective residents and their relatives.

Once admitted to care, the residents tended to lose their previous identities. The social workers who visited the individual applicant before admission no longer took any responsibility for residents' ongoing care. Individual case records were not kept. The past, present, and future relationships of residents' life courses were not noted. Residents lived on average for eighteen months in care before dying. The frequency of death within the homes inhibited the development of relationships. The confusion of some residents could exert a negative influence on relationships.

The next part of the Chapter discusses how the roles, motivations, and training of the Officers and staff, and the philosophy and goals of each home, influence relationships.

7.12 The Role of Officers-in-Charge as Influences on Relationships

The role of the Officer-in-Charge in a local authority residential home is powerful within the home's hierarchy, and affects the relationships of residents. The Officer's role developed from the historical traditions of the Master of the Workhouse and the Matron of a nursing home. It is a managerial role within a bureaucracy. Outside the residential home's immediate environment, the Officer has less power. Major decisions and policies affecting the day-to-day running of the homes, including admission (discussed above), are made at higher levels. The contributions of Officers-in-Charge to these processes are not defined. They exert influence according to their own perceived priorities.

The Officers-in-Charge of the homes studied each had typical patterns of career progression within residential care. The Officers-in-Charge at Northfield House and Eastview, Mrs. Black and Mrs. Olds, had begun nurse training but dropped out for personal reasons. Southam's Officer-in-Charge, Mrs. White, had joined the armed forces and had travelled and lived abroad before her marriage. Each Officer-in-Charge entered residential care work after a number of years caring for their own children at home. Mrs. Black worked as a manager for a busy GP practice before deciding to enter residential care work after her husband died. Mrs. Olds began residential care work because of its convenience and part-time availability when her children were young. Each woman gained experience in Social Services' elderly persons homes, first as Care Assistants, then moving to similar and more senior jobs in different homes, with eventual promotion to Assistant Officer status. They were appointed to their first post as Officer-in-Charge in the homes where they were currently working, and had acquired several years' experience in their posts. Because each had risen through the ranks of care staff, they expressed loyalty and support to their employing Department. They accepted the practices established by the hierarchy rather than challenging institutional procedures. Lacking professional qualifications for the most part, they drew on their personal experiences of caring for their own families as the basis of their motivation and competence. They were vocationally and administratively focused, rather than professionally oriented. The relationships they fostered reflected these aspects of their life course. They were good employees who valued organisational relationships above the personal and social relationships of residents.

7.13 Staff Motivations and Training, and Their Influence on Relationships

In all the three homes I observed that staff motivation was influenced by the Officers-in-Charge, but is also determined by the social and personal characteristics of the staff themselves. The residential care work force was motivated initially by instrumental,

pragmatic reasons rather than any particular wish to work with elderly people. Most of the staff applied for their jobs in the residential homes because of the convenience of their locations and the ease with which the job fitted in with their family duties. The staff members lived (for the most part) near the home and walked, bicycled or used public transport to get to work. For example at Eastview, my car was often the only one in the car park at six o'clock in the evening, which was always a very active time when many staff were on duty for meals, evening activities, and bedtime.

Care Assistants and domestic staff were employed part-time as manual workers. Only the Senior Care Assistants and Officers were full-time employees. Staff in the three homes were all women, with a single exception at each home, the gardener/handyman. (Northfield House had employed one man as a full-time Care Assistant, having inherited him along with other staff and the patients from the geriatric hospital which closed when Northfield House opened in 1964. During the period of the research he retired and was replaced by a part-time woman Care Assistant).

Like the residents, the Care Assistants' choices were limited. Few of the staff had any qualifications or training. Some of the care staff had completed a non-assessed in-service social care course. At the time of the research, national vocational qualifications in social care (NVQs), which enable staff to gain vocational qualifications for competences acquired on the job, had not yet begun to have any impact. Achieving a professional qualification in social work was not regarded as essential. Social work practice at professional level was seen as the responsibility of better paid field social workers who did not undertake shift work. This explains the ambivalence in encouraging residential staff to become qualified in social work. Once qualified, social workers leave residential work for the more favourable conditions of field work. The majority of residential care staff would not be offered the opportunity to gain a professional qualification. They would not be able to choose any other career pathway within Social Services, except for the one or two who rose through the ranks to become Officers. Most of them were institutionalised in their roles and had no training.

Neither Mrs. Olds at Eastview nor Mrs. Black at Northfield House had undertaken any formally assessed training for residential care management. Mrs. Black had attended a short, non-assessed course in care management fairly recently. Neither was professionally qualified in social work. Unlike the other two Officers-in-Charge, Mrs. White had completed a part-time social services qualification ten years before becoming Officer-in-Charge at Southam. At Northfield House, the Deputy Officer, Mrs. London, recently had completed her part-time social services qualification. At Eastview, the Deputy Officer, Mrs. Timson, had completed her part time social services qualification some years before. These Deputy Officers who were professionally qualified were meant to provide a professional contribution to balance the Officer-in-Charge's lack of professional qualification, but I could find no evidence that a distinctive professional role had been identified. This is not surprising, because it would have been very difficult for them to introduce any significant changes without the support of the Officer-in-Charge, and professionally-based changes might have threatened the Officer-in-Charge's own role.

Because of the staff's lack of professional qualifications (or, indeed, any qualification), and the failure of the system to recognise the need for an identifiable role for professional practice in residential care, organisational relationships within the homes are shaped by the life courses of staff and their personal identities rather than by any attempt to work out concepts of organisational relationships as part of good practice. For example, Mrs. White did not perceive her qualification as enabling her to practice professional social work. She defined professional social work as taking place in the field rather than in residential care. Of the three Officers, Mrs. White was the least professional in her style, drawing heavily on her mothering ability for fulfilling her role and defining 'mothering' as the most essential attribute of staff.

The following charts present the staff's characteristics.

FIG 21 Over-view of Southam Staff Characteristics

Number of Staff: 23

Designated Roles: Officer-in-Charge, Deputy Officer, two Assistant Officers, one Senior Care Assistant, eleven Care Assistants, one Gardener/Handyman, two Cooks, four Domestic Workers.

Full time/part time: all part time except for the four Officers, Senior Care Assistant, and the Gardener/Handyman.

Male/female: all female, except for Gardener/Handyman.

Staff who were interviewed: 4, as below.

Name	Work Role	Length of Service	Motivation for Work	Previous Experience	Training
Mrs. White	Officer-in-Charge	Five years (seventeen years experience with elderly people in previous residential posts).	Convenience; fitted in with family.	Served in Air Force in Wireless Radar Unit, worked abroad in bank in Cyprus. Office worker; Care Assistant, Senior Care Assistant, Deputy Officer (in different homes).	Completed part-time professional social work/social services training while she worked for Social Services.
Mrs. Allen	Senior Care Assistant	Twelve years	Convenience; wanted a local job which would fit in with caring for own children. Enjoyment; nice to work with people rather than in an office.	Had worked in solicitor's office, and in school kitchens. Had looked after her mother when mother had a stroke; left work at 18 to care for mother.	None, as far as known.
Mrs. Downs	Care Assistant	Six months	Convenience; suits family although she does not like shift work. More money than previous part time job as a school meals assistant.	Ten years as a nursing auxiliary in a geriatric hospital; then worked as a school meals assistant.	None in present job; previous training as a nurse auxiliary.
Mrs. Green	Domestic worker	Twenty-four years	Convenience; it fits in with us (husband and self). "I like the old people, they're easy to get on with."	Always in domestic work; went into service at the local hall, then in a farmhouse, then at Southam.	None, as far as known.

FIG 22 Over-view of Eastview Staff Characteristics

Number of Staff: 42

Designated Roles: Officer-in-Charge, Deputy Officer, two Assistant Officers, two Senior Care Assistants, twenty-four Care Assistants, nine Domestic Workers, two Cooks, one Gardener/Handyman.

Full Time/Part Time: Officers, Cooks, Senior Care Assistants, and Gardener/Handyman are full-time; the rest part-time.

Male/Female: one male (Gardener/Handyman)

Staff who were interviewed: 4, as below

Name	Work Role	Length of Service	Motivation for Work	Previous Experience	Training
Mrs. Olds	Officer-in-Charge	Five years	Likes continuity of care, not change; being of service to others; likes hospital life.	Receptionist in hospital, day nursery assistant, student nurse for eighteen months, Care Assistant, hospital auxiliary, Senior Care Assistant, Third Officer, Deputy Officer (in different homes)	Nurse training (incomplete); no subsequent training.
Mrs. Lane	Senior Care Assistant	Ten years	Convenience of local job; thought it would be a challenge.	Factory work, Care Assistant.	None, as far as known.
Mrs. Ellicott	Care Assistant	Sixteen years	Likes caring for people, "I couldn't work in a shop or office."	Auxiliary nurse in a mental handicap hospital; helped mother care for bedfast father.	Previous training as an auxiliary nurse.
Mrs. Jackson	Care Assistant	Eighteen months	Convenience; lived locally, was unemployed; did not want to travel to work; no qualifications for anything else.	Worked in a factory which closed down.	None, but expects to have some soon.

FIG 23 Over-view of Northfield House Staff Characteristics

Number of Staff: 42

Designated Roles: Officer-in-Charge, Deputy Officer, two Assistant Officers, two Senior Care Assistants, seventeen Care Assistants, one Day Centre Assistant, fourteen Domestic Workers, two Cooks, one Clerk, one Gardener/Handyman.

Full Time/Part Time: all part-time, except for Officers, Senior Care Assistants, and Gardener/Handyman.

Male/Female: all female, except for the Gardener/Handyman. A full-time male Care Assistant, who had transferred to the home from the Geriatric Hospital when the home opened as a replacement for the Hospital, retired during the research period.

Staff who were interviewed: 4, as below.

Name	Work Role	Length of Service	Motivation for Work	Previous Experience	Training
Mrs. Black	Officer-in-Charge	Eight years	Tired of travelling as a sales rep; wanted "to put something back" after death of husband, first applied to become field social worker; she is a workaholic, and says she even dreams about the home.	Care assistant, doctor's receptionist, GP practice manager, medical sales representative, Assistant Officer, Deputy Officer (at different homes)	Two years nurse training, not completed. Recently attended a short course on residential care management
Mrs. Carter	Care Assistant	Twenty-one years	Convenience of local job, fitted well with family responsibil-ities. "I like old people; you areneeded".	Domestic Assistant in kitchen of Northfield House	None, as far as known. "The thought of old peoplemade me cringe, I wasfrightened of them before I came to work here."
Mrs. Lowther	Care Assistant	Three years	Convenience; location of home five minutes from own home, much more rewarding than domestic work, likes to work with elderly people. Previously caredfor an elderly great aunt.	Factory work, domestic work at Northfield House	None, as far as known. Thought she wasn't capable of care work, feared "the mucky side", had a delicate stomach.

Name	Work Role	Length of Service	Motivation for Work	Previous Experience	Training
Mrs. Elder	Care Assistant	Nine months	Convenience; part-time hours and location suited her. Did not know whether she was capable of doing it.	Telephonist	None, as far as known; "it was shocking at first - bodily functions embarrassing."

Southam, the smallest home, had very little staff turnover and much stability in the staff team, which (I was told) was unusual, compared to other Social Services residential homes. Relationships were marked by continuity and stability which resulted in a positive commitment to the home. The Officer-in-Charge at Southam, Mrs. White, claimed to have no difficulty getting or retaining staff. She cited a low incidence of staff illness and absenteeism. The average length of employment was eight to ten years. Mrs. White preferred to employ mature women, feeling that "being a mother" was an important qualification for the job. She attributed the stability of the staff group to the friendliness of the home and to the lack of alternative employment in the surrounding villages. The environmental context, a small rural village, strengthened the staff's loyalty to the home. The Southam staff took an interest in the home. Their husbands helped with fund-raising events. The longest serving staff member, Mrs. Green, a domestic worker, had worked at Southam for twenty-four years. The shortest serving staff member, Mrs. Downs, a Care Assistant, had worked there for six months.

In contrast, Mrs. Olds, the Officer-in-Charge at Eastview, reported that she found it difficult to recruit and retain staff. She blamed this problem on external forces such as Social Services employment procedures, the inferior calibre of the staff, and the competition from local industry for workers, rather than to factors over which she might have some control. She complained about the slow bureaucracy of the Personnel Section of Social Services, blaming the long gap between the closing dates for employment applications and the subsequent interview dates for the loss of many potential staff members. She attributed her shortage of staff to the competition from local factories where the rate of pay was better. She was concerned about decreasing levels of motivation and commitment of some of her staff. She felt that few job applicants had any notion of what shift work and personal care entailed, and when they found out, many left. The longest period of service at Eastview was fifteen years, but the average period of service was about five years, lower than that of Southam. The greatest turnover of staff occurred in 1989 when three staff retired and several moved away.

Many of the new Eastview staff were younger women. One of these, Mrs. Jackson, a Care Assistant, had worked at Eastview for eighteen months, after having been employed previously in a local factory. Mrs. Jackson said "the staff were the problem". When she first started her job, none of them felt it was their responsibility to tell her what to do. They delighted in playing practical jokes on her. She was still uncertain of her ability to do the job and wary of her relationships with the staff. An Induction Programme would have helped her to become part of the staff team and built her motivation. Like many of the staff, she was uncertain of her role. Lack of role clarity for staff also created uncertainty about how they should relate to residents. Eastview's Officer also reported a high incidence of illness amongst staff. During the winter of 1989 (noted in the previous Chapter), fourteen care staff were absent with influenza. Six residents died of influenza during this period. An interview with Mrs. Ellicott, a Care Assistant at Eastview, had to be postponed twice because of Mrs. Ellicott's extended sick leave.

At Northfield House, the Officer-in Charge, Mrs. Black, complained about her difficulty in recruiting suitable staff. In the small town where Northfield House was located there were other opportunities for employment including shops, factories, and private elderly persons' homes. I noted that at the private home (located in the same community as Northfield House) where I completed the pilot interviews, the owner reported no difficulty in recruiting excellent staff. The average length of service at Northfield House was 5-6 years for care staff. Here the issue was one of suitability rather than availability. Northfield House had a stable core of long-serving local staff but Mrs. Black was not satisfied with the motivation and commitment of her newest staff member who began work only a few weeks previously. Her attitude illustrated her style of management and the relationships she developed with staff. She demanded much of herself and others. She was always disappointed in staff. Her demands flowed from her personal interpretation of good practice rather than from professionally based concepts.

7.14 Philosophies and Goals of the Residential Homes, and Their Influence on the Study of Relationships

Good care practice and good management procedures (discussed in Chapter Four) emphasise the importance of establishing clear aims and objectives (Willcocks, 1986) as part of a philosophy of the residential home. When these are articulated explicitly, staff can be held accountable for their activities and practices. I was interested to discover how the philosophy and goals of the three homes differed and to what extent relationships figured in the stated goals. A Good Care Practice Guide for Elderly Persons Homes in the Social Services Department (Operational manual, vol. No. II, pamphlet K - Elderly Persons' Homes, 1984) had been written by a team of social workers, trainers, and managers as part of a review of the homes in 1984. It was intended to improve the quality of care by enabling 'an audit of good care practice' and the training of staff.. Although the guide stated that each home needed to define its own specific objectives, none of the homes had an individually articulated philosophy or written aims and objectives. There was no systematic quality control or quality assurance. At the time of the research, annual inspection requirements for the local authority homes had not been established. Officers had no incentive to define and attain objectives. No penalty was attached to their failure to achieve objectives. The Good Care Guide was not an operational manual, despite its title, but rather a training guide which was used only on an optional advisory basis.

The guide was comprehensive in scope with sections on residents' rights, living and working in a home, and staff roles and job descriptions. Its threefold philosophy emphasised helping people to help themselves, rehabilitation or maintenance, and provision of direct care only when safety needs cannot be met by other means. Relationships were not mentioned directly, only implicitly within the rituals of daily living. The section on social and emotional care referred most directly to relationships, stating that "residents should be actively encouraged to maintain relationships with family and friends. At the same time carers should help the resident promote new relationships in the home." (Pamphlet, p. 57). The guide proposed social and emotional care as a response to the problems and needs of residents. The problems and needs were defined as admission to care, family rejection, death of spouse, bereavement, and loss of faculties. Confusion, incontinence, loss, disability, and integration of confused and mentally alert residents also were identified as particular conditions needing emotional care. Emotional care, according to the guide, is to be used as a solution to problems and crisis situations rather than as part of the fabric of day-to-day life. A utility value orientation to relationships (discussed in Chapter Three) was assumed. One of the problems which residents (not staff) were judged likely to develop was "over-reacting, getting emotionally involved in the home" (p.48). Detached relationships with other residents rather than close personal relationships were promoted as ideal.

Despite the lack of individually designed philosophies and goals, each of the three homes presented a somewhat different interpretation of what 'good care' was meant to be. Their definition of 'good care' emerged as part of the personal stamp placed on the home by the Officer-in-Charge. Each had their own personal management style. The findings of Sinclair (1988), Booth (1985) and Willcocks, Peace and Kellaher (1987) that the personality and characteristics of the Officer-in-Charge were the most important elements in determining the nature of the care regime were re-echoed. The dominance of the Officer-in-Charge was evident.

For example, Mrs. Black, Northfield House's Officer, was a strong leader who had firm views on how all aspects of the home should be run. She projected so powerful a presence that some of the residents were afraid of her. One resident, Mrs. Ruth Beckett, told me, "I made sure I asked her if I could tie my room curtains back because she would notice if mine were different from the others. She'd be sure to say something. I don't want to get into trouble." Northfield House had the most clearly articulated philosophy, mainly about admissions to care, and a placement policy. Mrs. Black, wanted all admissions to be phased, with prospective residents having a chance to try day care and short-term care first before entering permanent care. She distrusted social workers, feeling that they tried to push old people "into a bed - any bed". I noted that on several occasions she was highly critical of attempts to push widows experiencing bereavement into residential care. She was aware of the need to grieve. During the research I discovered that she had chosen to work in the field of residential care after her husband's death from lung cancer ten years ago. She entered residential work with a mission to help elderly people, particularly those who had been bereaved. She made it her new career following her own bereavement. She had developed a philosophy of care which concentrated on transitions into care following bereavement (drawing on her own personal experiences) but which said little about care practices once people had become resident. The philosophy she articulated was one of aspiration towards quality and good practice, but she perceived this aspiration as being threatened by possible privatisation, by social workers demanding beds, by lack of support from the Area Office and line management, by changes in Social Services structure, and by staff shortages. Her philosophy could be summed up as, "If I don't fight for (the old people), who will?"

Mrs. White, Southam's Officer, whose approach was one of maternal concern (discussed above), described herself as a kind of "overseer" of the staff and residents. The staff and residents called her "Matron". Mrs. White articulated no philosophy of care other than "make them happy", which she said resulted from the friendliness of staff who "really get to know the residents". The 'happiness' philosophy was demonstrated on occasions when residents joined together in musical movement sessions in the lounge, and by parties at Christmas, displayed in photographs. Mrs. White's philosophy was implicitly supportive of activity theory (Havighurst, 1963, discussed in Chapter Three). She had no views about selective admission. She felt the pressure for beds in her area was so great that "we should be told whom to take, and shouldn't be allowed to pick and chose whom we get." Southam was the only home where a truly positive image of residential care was promoted. For example, I was given a Christmas card with a colour photograph of the Home looking like an embodiment of an Edwardian country house. This, I was told, was a "special" card given only to "special" people.

Mrs. Olds, Eastview's Officer-in-Charge, beset by illnesses and staff shortages, seemed to lurch from one emergency to the next with crisis management as the norm. At Eastview there appeared to be no philosophy articulated or even inferred by the opinions and views of Mrs. Olds. The home had a local but erroneous reputation as a nursing home. Staff felt that residents were ready to "give up" when they came to live there. The home's philosophy as expressed by staff was the creation of a "warm, friendly atmosphere but no airs and graces; we keep them clean and tidy". The philosophy expressed by the staff's behaviour was that of piecework in a factory. The staff worked with total interchangeability. Most of them had worked in factories before they were employed in

the home and, I felt, tackled their current jobs in the same way. The staff demonstrated camaraderie as they bustled around in pairs through the daily routine getting residents up, dressed, washed and fed. They joked and chatted to each other in loud cheerful tones over the heads of frail and confused residents. They were task-oriented, completing routines with great speed. For example, staff serving the afternoon cup of tea from a tea trolley in the lounge divided the task sequence into precise actions (like a conveyor belt) in order to get it over as quickly as possible. Despite their jolly exteriors, I received the impression that Eastview staff were harassed and distressed underneath their bluff joking manner.

7.15 Summary of the Second Part of the Chapter

The second part of this Chapter established that the Officers-in-Charge are powerful within the homes, but have little power within Social Services' wider organisational relationships. Officers-in-Charge have risen through the ranks. They express loyalty to the bureaucratic structures of organisational relationships rather than challenging the care practices which inhibit the development of personal and social relationships. They are vocationally and administratively driven rather than professionally motivated. Both Officers and staff draw on their own life course experiences of mothering for establishing their relationships with residents, viewing residents as elderly children or conversely, like their own parents. Staff have little training and are motivated initially by the convenience of the job. Like the residents, staff are institutionalised by the homes' routines. Staff turnover varies from home to home. At the time of the research, practice guides were advisory rather than mandatory. The local Good Care Practice guide portrayed relationships as 'emotional care', used for the purpose of resolving problems. Otherwise, it was suggested that relationships needed be detached and distant. None of the homes had developed explicitly stated aims of care and a philosophy.

The final part of the Chapter discusses the cultures and life courses of the homes, the effects of institutional practices, including the failure of to develop the key worker system, and takes note of positive caring practices as influences on relationships. The Officers' perceptions of issues affecting relationships and the staff's perceptions of residents' relationships are discussed. The Chapter concludes with an overview of residents' perceptions of their relationships with the staff.

7.16 The Culture and Life Course of the Homes as an Influence on Relationships

Participant observation over a period of time began to disclose aspects of interaction, vignettes of activity, statements, and events which, upon reflection, defined the culture of the home. Culture is comprised of shared language, customs, *mores*, social organisation, rules, production, and exchange (Znaniecki, 1952; Parsons, 1951). Each residential home, although sharing certain characteristics with the others, had its own distinctive culture. New residents contributed to and influenced the culture, but also were influenced by it. Each home was distinctive. Space and design, the context of the wider community in which the homes were located, the history of the home and its relationship to the particular local community, the imprint on the regime by the Officer-in-Charge, and the residents' life courses contributed to the culture of the home. These cultural characteristics make up each home's distinctive life course. The life course of each home evolved further during the research, influenced not only by the residents and staff but by changing social policy requirements for community care, and by the presence of an observer.

For example, Southam's culture and life course emerged from its history and position as part of the village establishment. Its positive image resonated with its former role as a vicarage and country house. It contributed to village tradition, with its annual Christmas Bazaar (for which the residents prepared for weeks), its Open House on

Christmas Day with punch and mince pies which the local Vicar, GP, and publican attended; and its elaborate fancy dress parties. The Vicar left the keys to the village church at Southam. The ambience of a genteel residential hotel permeated the daily routine of the residential home. Southam was furnished with carpets, brass ornaments, and traditional furniture. It had four acres of garden tended by its own gardener, which produced fresh vegetables as well as flowers. Southam had pets: a cat, a rabbit, a dog, and budgerigars. Some of the staff were local women who had worked in their youth as domestic servants at nearby big houses. At Southam visitors were served tea and biscuits in bone china cups and saucers. It was reported by Mrs. Gladys Garrett, a Southam resident, that her son commented, "It's better here than a two-star hotel". Mrs. White, the Officer-in-Charge, affirmed the home's sense of tradition when she said, pointing to the large automatic clothes drier in the laundry room, "We don't like to use that. We hang our clothes out on the line. We're old fashioned". Arising from her insistence that the staff should be mothers, staff-resident relationships at Southam were warmly authoritarian and predictably reliable.

Eastview's culture and life course were very different. Eastview adopted the culture of the factory, with staff taking pride in maintaining cleanliness, speedily completed tasks, and denial of death. As discussed above, the staff were encouraged to keep busy and work at speed as if doing piece-work at a factory. Keeping despair at bay by joking, laughing, and singing songs as they went about their tasks was a behaviour I observed often. The staff denied death. When Mrs. Laura Lowther, a 90 year old resident, said, "It won't be long before I reach the end of my days", the Care Assistants responded, "Oh, no, you're not going to go for a long while yet". Their response might have been appropriate to avert an occasional negative thought, but Mrs. Lowther's repeated comments about herself were linked to her continual questions about when her husband and sons were arriving to visit her. The staff were reluctant to tell her that her husband and children had died some years ago. There was a feeling of unease behind their determined cheerfulness, because they were bewildered by the reality of death (Tinker, 1992; Willcocks et al, 1987). This was demonstrated in the way the topic was avoided, even when referring to the death of a pet. For example, Mrs. Lane, the Senior Care Assistant, explained to Mrs. Maude Baker, one of the residents, that the home's parakeet had "fallen down in the cage". She avoided saying that the bird had died. The pride of the staff in their work at Eastview was reflected most fully in the cleanliness of the home and of the residents. Doubly incontinent residents, and those who spilled cups of teas over their clothes two or three times a day were changed quickly into their own clean, attractively matching clothes. The washing machine and drier were constantly in use. Care was taken to ensure that residents' personal clothing was not lost in a communal pile but was returned to their own drawers in their bedrooms.

In contrast, Northfield House's culture and life course were those of a local establishment run by local people for local people. Its history as a purpose-built replacement for the former Workhouse / Geriatric Hospital, and its naming for Mrs. Northfield, the local councillor who campaigned for the home to be built in the 1960s, gave it a place in civic pride. Its catchment area was local, and the staff were local. Admissions were phased over a period of time beginning with short-term intermittent respite care and day care rather than an abrupt transition to permanent care. Its ability to offer these resources (which the other two residential homes could not) affirmed its position as a local centre. Its expensive refit into Units re-established its image as a valuable resource. Transforming the home from a communal design to Units had so improved its appearance and facilities that residents and staff expressed little regret for the former communal design. The over-all culture of Northfield House had been broken down by this structural change into six or seven mini-cultures. The Units functioned as self-contained establishments. The residents rarely gathered together as a total group. It was only in the Day Room and Dining Room where activities took place that the separation of residents into Units was overcome to some extent. These activities became the unifying cultural feature of the home, but as attendance was voluntary, not all residents chose to take part in activities.

Northfield House's culture and life course were influenced by the benevolent despotism which was the management style of Mrs. Black, the Officer-in-Charge. She changed those aspects of the regime which she perceived as the rigid and institutional culture of her predecessors, to aspects which reflected her own style of good practice, but these were equally rigid. She made the rules and ran the home, investing much of her own energy into its functioning. As she herself said, "It's my life; I'm a workaholic". The central control she exerted and the acquiescence of her Assistant Officers meant that external influences on the home's culture were diluted by her own definition of good practice. She did not recognise that her own regime was as powerful and controlling as the regime she had changed.

7.17 Institutional Practices and Their Influences on Relationships

In each home I observed routines and incidents which demonstrate the continuing influence of the Workhouse and the 'total institution' (Goffman, 1961, discussed in Chapter Four). Organisational relationships were based on institutional practices which, for the most part, supported the implicit aim of residential care as social control (Townsend, 1986, discussed in Chapter Four). Characteristics of space and design (including the lack of adequate space) imposed institutional practices on the residents. Mrs. Olds, Eastview's Officer, unlike the other Officers, identified the lack of space as a problem. She pointed out the lack of choice in bedroom allocations and dining room seating. At Eastview, which had only one dining room for 62 residents, institutional ambience was achieved by the slow procession of elderly people with Zimmer frames and wheelchairs making their way to the dining room. The staff removed these essential aids to mobility once the residents were seated. The food was served and removed rapidly. The dining room was very crowded with each resident assigned to a place. There was no free choice of seating and no spare chairs to provide a choice. Each resident was forced into a fixed relationship with the other three occupants of their table. If residents were dependent on walking aids, they could not move out of the dining room until the staff were ready to bring back the frames and walkers. This was an example of structured dependency (Townsend, 1986).

The routine for meal times and other routines was similar at Southam. For example, at Southam (and at the other two homes) meals at midday and in the late afternoon took place at fixed times. I observed a newly admitted Southam resident, Miss Cissie Lawrence, break off her conversation with me several times to look at her watch, anxious that she might be late for her meal, (although if she had missed it, I was told, the staff would have prepared food for her). She was unaware of this.

Southam's genteel and attractive public aura hid an apparent acute lack of space. Most bedrooms had only a small upright chair on which to sit, making it impossible for most residents to use their rooms during the day. In the lounges each resident was assigned a chair. Spare chairs for visitors were not provided. Southam had no Visitors Room in which residents could receive guests. I noticed that during the hot days of summer, some residents sat outside in the garden. The new resident, Miss Cissie Lawrence, was the only one to use the small glass conservatory at the back of Southam . While the research was taking place, Mrs. White, the Officer-in-Charge, put a few chairs in the upstairs kitchenette for residents' use, which improved the availability of space. I wondered at the time if my research topic influenced her thinking, but she denied any connection. I accepted the lack of space at Southam, and the limitations it imposed. To my surprise, when I told Mrs. White I was ready to interview the staff I was shown a spacious suite of rooms on the ground floor which was completely unused. This was the flat of the previous matron. It now stood empty, fully furnished. I was able to use it for the staff interviews, but not for interviews with residents. The space in the flat could have been used for Day Care activities, to give more privacy for residents, or as a Unit for the more dependent residents. The reason for not using the empty flat was said to be the forthcoming plans for expanding the home. Those plans were not

imminent, and meanwhile the flat stood empty rather than being used for the residents. Southam's Officer-in-Charge, Mrs. White, did not perceive or exercise her power to designate the temporary use of the flat for the residents' benefit, in keeping with her refusal to influence the selection process (discussed above). In contrast, Mrs. Black, Northfield House's Officer, would have used her power to influence decisions about the use of space within her home.

At Eastview, in the double rooms and four-bedded rooms, residents were dressed and undressed, washed, and placed on the commode in view of each other with no screen or curtains to provide privacy. There was only one battered chest of drawers for residents in shared bedrooms. Each resident had only one drawer, labelled with their name. A resident of Eastview, Mrs. Maggie Askew, who went to bed early was disrupted from her sleep when the light was switched on two hours later as her room-mate came to bed. Because of the lack of single rooms, residents who became ill at Southam and Eastview were moved into a 'sick bay' bedroom in which there was a hospital style bed. The WCs at Eastview and Southam consisted of two cubicles inside a larger room, like a public convenience. There was no distinction between women and men's toilets in practice. Doors to W. C. cubicles were left open.

The lack of choice and control over public and private space was criticised by Willcocks, Peace, and Kellaher (1987). At Eastview and Southam I discovered that opportunities for developing relationships were dependent on the functional allocation of space to meet institutional needs. Lack of space is an issue which is not easily resolved because of the extra money needed to expand or alter living arrangements. Most of the comments about institutional practices arising from lack of space were based on my observations at Southam and Eastview.

Other institutional practices at all three homes, including Northfield House, could not be excused because of lack of space. More disturbing was the evidence that staff practices were institutional. For example, in each of the homes, the care staff (except for the Officers) wore uniforms. Uniforms of different colours indicated whether a staff member was a 'Domestic', undertaking cleaning and laundry tasks, or a Care Assistant providing physical care to residents. At Northfield House, I observed the habit of nicknaming residents in a jocular yet inaccurate way. For example, Mrs. Ruth Beckett aged 103, a resident of Northfield House, was called "Granny Beckett" by the staff, although she was a childless widow. At Northfield House, I noted the staff gathering for their morning cup of coffee in the dining area of one of the Units. Despite having their own staff room, they intruded into the privacy of residents who were watching television in the open plan lounge and dining area. At Eastview, as the early morning shift began at 7. 30 a.m., I observed the staff stacking chamber pots in the corridors. One resident was being shaved by staff in the public corridor. At Eastview, staff did not knock on residents' doors in the morning as residents got up. Care Assistants bustled in and out, talking to each other over the heads of the residents. This kind of practice was especially noticeable with the more disabled residents who lived in double or four-bedded rooms. Bath times for individual residents were timetabled to suit the staff. At Eastview my interview with a resident, Mrs. Sally Cooper, was interrupted by a Care Assistant who approached abruptly with towels over her arm and announced to Mrs. Cooper, "It's time for your bath." No apology was given to either Mrs. Cooper or myself for the interruption. The residents' social interactions and relationships were not important enough to take precedence over the institutional routine.

Batch toiletting (taking residents to the toilet in a group) was practised in both Eastview and Southam. In both Northfield House and Eastview, I noticed Care Assistants lift the skirts of women residents to check that the women wore clean unsoiled underwear or pantyhose. They did this as the residents walked past in the corridor without ensuring any privacy for them. At Southam, Mrs. Higgins, a Care Assistant who had worked in the home for many years, revealed how little she knew about one of the

residents, Mrs. Annie Baker. I observed her standing in the doorway of the residents' lounge, asking Mrs. Baker, "How do you like John Wayne?" She was referring to the film with John Wayne on TV. Mrs. Baker made a non-committal reply and there followed desultory conversation about John Wayne westerns on TV and favourite TV programmes. After the Care Assistant left the room, Mrs. Baker said to me, "I never watch TV, so I don't know what's on because my eyesight is too poor." She had not dared to correct or inform Mrs. Higgins of this. Mrs. Higgins had no real knowledge of Mrs. Baker's limited eyesight or her true opinions. She had not been encouraged to develop any kind of significant relationship with any of the residents. She probably only struck up the conversation because she was aware of being observed.

Another institutional practice was witnessed in Southam: the paying out of the weekly allowance. Each resident is entitled to a small weekly allowance of 'spending money' after the cost of their residence is paid. At Southam, brown envelopes with cash sums inside were wheeled around on a trolley. The Officer, Mrs. White, presented the envelopes to the residents, who each signed a receipt and said, "Thank you very much, Matron", one after the other. This was done publicly in the communal lounge, an example of the remnant of an old Workhouse custom in which power, charity, and humble gratitude from the recipients were intertwined in a socially enacted drama.

The internal placement policy was the most telling example of institutionalised practice within the homes. There were no checks and balances to curb the power of the Officers to place residents in certain chairs in the lounge, at certain tables in the dining room, and in certain beds in bedrooms; and then, without notice or right of appeal, move the residents around from one chair to another, from one table to another, and from one bedroom to another. Although I have called this the internal placement policy, the policy was not based on openly stated principles. It was an ad-hoc use of power, justified on health grounds (if at all), to transfer residents from one living space to another. Residents' relatives and people outside the network of residential care were surprised to learn that residents had no tenure, no tenancy agreement within the home, and no rights to their own room. As residents, they were entitled to a bed, meals, and personal care, but no particular space was safeguarded as their own. They had no rights and no means to appeal against any decision to move them about internally within the home. There were a number of examples of this in each home.

At Southam, two devoted room-mates, Mrs. Kathleen Perkins and Miss Jean Mills, were separated when Mrs. White, the Officer-in-Charge decided to move Miss Mills, who was becoming more confused, to a downstairs four-bedded room. A new resident, Miss Cissie Lawrence, was placed in the bedroom to share with Mrs. Perkins. Mrs. Perkins was distraught at losing her closest friend. Staff expressed no concern about the emotional disruption to residents or the possible break-up of established relationships. Separating Miss Mills and Mrs. Perkins at Southam was considered desirable. Since Mrs. Perkins was so attached to Miss Mills, the staff wanted to protect her from feelings of loss when Miss Mills died. As it was felt that Miss Mill's health was deteriorating, the pair were separated in advance of her anticipated death. (The logistics of having to integrate new residents within the home also led to the imposition of 'musical chairs' for re-allocating beds and other space.) At Eastview, Mr. Robert Martin, following a stroke, was moved from his usual table in the dining room to a new location at the rear of the dining room where he had less distance to walk, (although he could walk with a Zimmer frame). At Northfield House, Mrs. Black, the Officer-in-Charge, decided to move residents of two upstairs Units downstairs, and the downstairs Units upstairs. She justified this step as enabling the less active residents (who were to move downstairs) to take part more easily in activities and to go out shopping. There was some cogency to this decision, because sometimes it is a question of deciding between two good outcomes, but I did not learn of any process of prior consultation with the residents or staff over the move.

At Northfield House, Mrs. Black had developed some principles for an internal placement policy. She placed residents in Units according to the degree of infirmity, confusion, or the cohesiveness of personalities, but these seemed to be loose concepts rather than well-structured policy. She opposed pairing ill-matched individuals in double rooms. For example, she refused to accept a new resident with confused and wandering behaviour and place her in the same room with a grieving widow whose husband had died only the week before. She argued that the widow needed either privacy or a stimulating companion and would not be helped by a disturbed and confused room-mate. (She was able to refuse the new admission because other vacant beds were available in the area). Her insistence on certain practices demonstrated the potential power and influence of the Officer-in-Charge on the organisational relationships of the home.

7.18 The Failure to Develop a Key Worker System in the Homes

The key worker system (Mallinson, 1987) is an accepted procedure associated with good practice in residential care. Key working is a widely used management practice intended to promote closer and more satisfying staff/resident relationships by assigning a designated worker to a small group of residents. In the three homes, instead of a key worker system, the policy was to maintain a distance between staff and residents. The staff were protected by the regime from becoming too close to the residents. Close relationships with residents were felt to be detrimental to staff motivation. When residents died, staff would be left with bereavement and grief feelings. There was no organised system of staff support to help resolve these feelings. Relationships with residents were not encouraged in order to avoid evoking feelings of grief. For example, at Southam, the key worker system was not thought necessary because Southam was a small home with only 25 residents. Workers were assigned to particular residents only for giving baths, and the rota was changed regularly. In justification for the lack of a key worker system, I was told by the Officer-in-Charge, Mrs. White, on more than one occasion "We know all the residents very well."

At Eastview, the key worker system was used only for the bath rota. This was changed every three months to prevent residents and staff getting too attached to one another. Attachments between workers and residents did develop, even in that short time, so that a change of worker could cause a resident to become upset. For example, at Eastview I observed a resident, Mrs. Xavia Kelly, crying in the entrance hall. One of the Care Assistants told me, "Xavia is crying because I'm no longer her key worker. We used to talk while I bathed her and I gave her time to talk. Now her current key worker gets the bath over as soon as possible and Xavia is upset."

At Northfield House, the existing staff/resident ratio made it impossible to assign an individual worker to each Unit. Units were staffed by floating workers, rather than by a constant worker in each Unit. The key worker system could not be implemented because of insufficient staff.

The key worker system did not succeed in these environments because it was not used to plan outcomes for the individual resident. If it had been linked to care planning (Brandon, 1993), another tool for individualising practice within social care, the key worker's role would be to carry out the agreed care plan for the resident. Since residents had no care plans, Care Assistants had no identified roles other than to complete tasks on a routine 'batch living' (Goffman, 1961) basis. The combination of staff shortages, the lack of sufficient staffing hours for a favourable staff/resident ratio, and the desire to protect staff from emotional involvement with the residents led to a task-centred rather than a client-centred management style in all three homes. Its effect on the residents' potential for forming and sustaining relationships was negative.

7.19 Positive Caring Practices and Their Influence on Relationships

It is easy to be critical and to focus attention on the deficiencies of care practices. Sometimes it is more difficult to notice and commend procedures which support good practice and enhance rather than deter relationships. These positive practices provide sources of stimulation. Sources of stimulation involve residents in relationships with the outside world and with each other. The practices I observed fulfilled four of the nine features of a residential environment which have the potential to influence home life positively (Goldberg and Connolly, 1982, discussed in Chapter Four). These features were:

individualisation and autonomy for residents;

opportunities for social stimulation;

communication and interaction with the outside world; and

social interaction between staff and residents (in addition to instrumental communication).

For example, local scout groups and religious groups visited each home. From time to time bingo afternoons took place. In Southam and Eastview, the television was not switched on in the morning, giving residents the opportunity to chat and to read their daily newspapers which were individually ordered and delivered. In each home, certain women residents had adopted a helping role in the kitchen, assisting the staff in laying the tables and washing up. At Southam, a male resident, Mr. Vincent Young, helped to clear away the morning coffee cups from the lounge. The availability of pets - the dog, fish, budgerigars, rabbit, and cats - was a positive practice at Southam;, as were the large print books available for residents' use. The garden and views of rolling countryside from each Southam bedroom window provided beauty and peacefulness. At Southam, the upstairs lounge was small enough (ten chairs) to enable all those seated to hold a conversation with each other. I also observed the Officer-in-Charge, Mrs. White, try to introduce a resident gradually to a changed seating position in the lounge. Mrs. Eliza Montgomery was almost blind and experiencing memory loss. Instead of moving her from her own chair, the chair was moved two inches to the right every day, so that space was created to insert another chair at her side in order to provide seating for the day care user. Although it could be argued that it would have been better consult Mrs. Montgomery openly about moving her chair, in order to accommodate the day care user, Mrs. White would have had to impose the change if Mrs. Montgomery had refused. Mrs. White felt the likely result would have been an emotional upset for Mrs. Montgomery.

Eastview's Residents Committee met regularly to discuss issues of concern. Eastview's Social Club was run by the staff in the evenings in the dining room. Residents could buy alcoholic drinks and attend regular activity programmes, including trips to the pantomimes, parties, and musical movement. These activities were linked to the culture of the home which was based on a factory ethos. The Social Club was like a version of a Working Men's Club. At Eastview, due to the large lounges, it was not possible for all the residents in a lounge to participate in a conversation together, but the home had a Visitors' Room, and a separate smoking area. Because it had a relatively large number of single rooms there was more freedom to sit in any chair in the lounges (although most residents stayed put in a particular place), and more opportunity to find a private corner. At Eastview I noticed other attempts to individualise. Names of residents were signposted on bedroom doors, and menus for the day were posted (although in scrawled handwriting that was very difficult to read).

Northfield House, which recently had been transformed into Units, appeared less institutional. My failure to observe as many institutional practices there may have been

attributable to the greater privacy of the Units. I was not able to observe as much interaction at Northfield House as in the communal homes. At Northfield House residents were permitted to keep their walkers and frames next to them at their tables. (At the other two homes, as discussed above, the removal of frames was carried out as a matter of routine, justified because of the lack of space, but a routine which the care staff accepted as normal procedure.) Mrs. Black, Northfield House's Officer, told me she felt it was wrong to take away an aid to mobility. It was like stripping a person of their identity and freedom. Northfield House's Units enabled meals to be served from a trolley brought to the Unit with the result that helpings were personalised: "Do you want dumplings?" "Gravy or no gravy?" "Pineapple and a fritter or just the pineapple?" Residents here had more choice of food, with more leisurely duration of meals. Residents were encouraged to wash up their dishes in their own kitchenette when they were finished.

It was possible in the Unit-designed home, Northfield House, to cluster residents in small sitting rooms where conversation could take place (but also where, arguably, there was less opportunity for private conversations). Northfield House had a purpose-built Day Care Room with the space and staff to provide activities for the permanent residents as well. A highlight of the year at Northfield House was the residents' annual holiday to the seaside, planned by staff.

7.20 Officers' Perceptions of Issues Affecting Good Practice

Issues affecting good care practice which the Officers-in-Charge raised fell into three general categories:

1. external threats to the homes' continuing existence caused by changing social policy;

2. the lack of sufficient staff;

3. characteristics of the residents themselves.

The issues identified were primarily organisational. Uncertain purposes and policies in senior management affected the Officers' ability to sustain morale. At the time of the research, implementation of Care in the Community policies (Griffiths, 1988; Sinclair and Williams, 1990; Henwood, 1992) was awaited with fear. The Principal Officer for Elderly Persons' Services had written to all the Officers-in-Charge to ask them to think about the possibility of handing over local authority elderly persons' homes to private ownership, although there were no concrete plans for such a transfer of ownership. Other local authorities had sold their elderly persons' homes to avoid the capital costs of bringing antiquated buildings up to a more rigorous physical standard. For example, a neighbouring local authority Social Services Department had embarked on a policy of selling most of its elderly persons homes' to housing associations, only retaining those homes which were of a higher physical standard. It was recognised by the Officers that both Eastview and Southam had four-bedded rooms which would need to be converted into two-bedded rooms if they remained within local authority ownership.

All three Officers-in-Charge were concerned about the threat of privatisation (Phillips and McCoy, 1990, discussed in Chapter Four). They demonstrated their self-interest in preserving the enterprise of care (Estes, 1979; Townsend, 1981). They were also concerned about standards of care. Their anxiety about privatisation was based on the following assumptions: first, that employment conditions would worsen and many staff would lose their jobs (Peterborough Citizen, 3-12-92, discussed in Chapter Four); secondly, that private care homes would only take the "good" (e.g. less dependent) elderly residents, leaving a more disabled group for the residue of local authority-run homes (Willcocks, 1986; Townsend, 1986; Wade et al, 1983); and thirdly, that the profits derived from private care homes precluded the possibility of developing good care practice. The first assumption that pay levels and working conditions would deteriorate was well founded, based on actual events. The second and third

assumptions could not be corroborated. The staff had little knowledge of actual conditions in private care. (The three Officers-in-Charge, upon learning that I had completed my pilot interviews in a private home, were curious and asked me for information.) Linked to the issue of privatisation was concern and worry about the recent re-organisation of the Social Services Department's senior management structure. This had removed their familiar supportive line manager, the Principal Officer, and placed new staff in new line management roles. Their identities and policies were not known at the time of the research.

A second issue (already discussed) was the difficulty of finding and retaining sufficient staff. Two Officers, Mrs. Olds at Eastview, and Mrs. Black at Northfield House, found this an issue. Mrs. White at Southam did not.

The third issue identified by all three Officers as relevant to the residents' relationships was their perception that residents were older, more disabled, and more confused than ten or fifteen years ago (Willcocks et al, 1987; Stevenson, 1989; Sinclair, 1990; Booth, 1985; Townsend, 1986, discussed above and in Chapter Four), resulting in an increased burden of caring for the staff. Mrs. White, the Officer-in-Charge of Southam summed up their views when she said "One of my domestics who has worked here for over twenty years told us about a resident who got the bus to town every Wednesday morning. He walked back from County Hall starting on the stroke of two in the afternoon and arrived back at 5 p.m. in time for tea, having walked ten miles. No-one thought that was unusual. The residents used to belong to social clubs in the village. Now they don't participate; they don't venture very far - they can't walk and their eyesight is poor. All the relaxation of rules doesn't matter when they are so frail. They can't take advantage of the opportunities. Now they have to be 'bad enough' for Part III accommodation rather than 'good enough'."

Mrs. Olds, Officer-in-Charge of Eastview, said "I had three admissions last week, aged 91, 93, and 95. They all use Zimmer frames and one is doubly incontinent. Some of them don't know who they are or where they are. The level of confusion ruins the opportunities for relationships. The 'with-it' residents don't like the confused ones. How can we cope with these pressures on the staff?"

Multiple regimes (Booth, 1985) within the homes were not recognised explicitly. Mrs. Black, Northfield House's Officer, tried to place new residents in the Units according to dependency levels but could not sustain this policy because she claimed, probably with good reason, that there were so many confused residents. Threats to establishing good practice were expressed as external threats to the homes' continuing existence and the changed characteristics of the residents. The Officers did not articulate areas of concern which they could remedy. They did not evaluate care practices for which they themselves were responsible. Relationships remained little recognised and were not seen as important aspects of good practice. Good practice itself was not conceptualised to any degree. The Officers did not recognise the extent of their own power to influence events in their homes because they felt powerless within the wider organisation.

7.21 Staff Perceptions of the Residents' Relationships

In each home, the Officer-in-Charge, not surprisingly, was the one least appreciative of the consideration of individual relationships because of her preoccupation with the need to manage the home as an institution. I interviewed, in addition to the Officers-in-Charge, three other staff in each home (chosen to ensure a range of experience, responsibility, and length of service). My questions about relationships appeared to be the first time the topic was discussed by any of the staff. They were not used to thinking through, reflecting, or sharing their perceptions of relationships. The staff lacked knowledge of group dynamics, organisational structures, and how staff roles affect the relationships of residents. Common-sense knowledge abounded, but there was little sharing and exploration of individual residents' life courses. Four themes

emerged from staff's perceptions. The first two themes were expressed predominantly by Officers-in-Charge, and corroborated by the staff:

1. the effect of organisational relationships (staff ratios, size, design); and

2. the effects of frailty and confusion.

The third and fourth themes were expressed predominantly by the staff, and were corroborated by the Officers-in-Charge. These were:

3. the effects of individual personalities and power of certain residents; and

4. the analogy that caring for residents is like caring for children, or in some cases, for one's own aged parent.

The four themes tended to be perceived separately, without much recognition of the interconnection between the themes. For example, staff viewed residents' attention-seeking behaviour (whining, crying, temper tantrums, and complaining) as socially disruptive. This behaviour was described as childlike and selfish. Apart from being critical of certain elderly residents, the staff did not consider the implications of this behaviour for the organisational relationships of the homes and the impact on other residents both individually and in groups. The following charts present the staff's perceptions of residents' and their own relationships within the home.

FIG 24 Southam Staff's Perceptions of Residents

Name, work role,	Relation-ships of, and with residents	Residents' qualities	Issues and views of relation-ships	Defining good care	Additional comments
Mrs. White, Officer-in-Charge.	Overseer of the regime; old style leadership; residents see me as someone they can talk to.	They're over-protected; they ask certain staff to do things for them. Residents' true feelings are muffled. Residents are selfish and manipulative	I discourage special relationships between residents. I avoid placing the same residents together in bedroom, lounge, and dining room table. They envy other residents' visitors. Residents stand back from a resident who bucks the system; their friendships have a power imbalance.	Being a mother to the residents; making them happy and safe. Small size of home is important; need more space for privacy. Staff need to fit in; should be mothers, should be white, shouldn't patronise the residents. Staff attitudes are important.	Staff know the residents.

Name, work role,	Relation-ships of, and with residents	Residents' qualities	Issues and views of relation-ships	Defining good care	Additional comments
Mrs. Allen, Senior Care Assistant	Residents are like children. Residents are interested in service, not in the staff as individuals.	Residents have power; they resist doing what the staff want. Residents are very selfish, show no reaction to death of others. Residents are forceful; they never apologise; they can't express feelings. Residents become institutional-ised; can't or won't do anything for themselves.	Residents close ranks on a newcomer. Some are determined not to fit in. Residents get attention by doing something anti-social; friendships mean domination. The confused residents won't be pushed about.	Staff have to stick up for a new resident. A dominant resident can make the lounge miserable. Residents want to forget about the upsetting things in the world outside. The residents feel safe here. Staff should talk to residents as a group. Staff know them individually.	Most of the work is geared to physical needs, I can't say what residents think; do I take them for granted? I tend not to delve too deep. There are certain ones you're fond of, but you see them go downhill. I act protective.
Mrs. Downs, Care Assistant	The residents are like children. They're like an extension of my own parents.	They're here because they can't cope; they're withdrawn from society.	The residents can express their feelings; they feel secure here. I don't know how they get acquainted. They help each other out.	Matron is like a mother figure. I kiss the residents good night like my own child. It makes me feel good. It's very important for them to keep in touch with family. The small size of the home is important.	I don't know the residents' backgrounds.
Mrs. Green, Domestic Worker	Most residents don't pick out one staff member for a special relationship. They help each other; their talk of the 'old days' establishes a bond.	Residents are fearful and shy of expressing themselves. They are afraid of being laughed at by other residents. They envy each other. Friendships of residents are only based on circumstances of being in the home together. There are leaders in each lounge.	Lack of space and not enough single bedrooms causes aggression and nastiness. There are two camps - those who are confused and those who are not.	Residents should have their own single bedroom. The home provides security, most fear the outside world. Doing things together (activities) creates a good atmosphere.	Residents resent being put here. They change, some don't settle. Most residents rely on Matron as a mother figure.

Staff at Southam presented themselves as benevolent. They perceived the residents as children needing care, who used their relationships to fight powerful rear-guard actions against the pressure of group living and lack of space. Their regime was intended to protect staff from too close an involvement with residents. Although Southam's Officer-in-Charge, Mrs. White, said she liked residents who "bucked the system", she discouraged special relationships amongst the residents and felt that "residents who accept what is happening to them are easier to work with." She felt that residents tended to stand back from someone who "bucked the system" and that residents were "overprotected".

The most recently appointed staff member, Mrs. Downs, who had worked at Southam as a Care Assistant for only six months, took the most positive view of the home, down-playing the organisational relationships and emphasising her own mothering. She saw the residents as children: "matron is a mother figure"; "I kiss the residents goodnight like my own child and it makes me feel good." She accepted without question that residents were in the home because they could not cope in society, and that they were withdrawn from the world.

In contrast, Mrs. Allen, the Senior Care Assistant at Southam, with twelve years experience, saw the residents as powerful actors, with a keen appreciation of the dynamics of group living, pairing, and unofficial leadership roles. She said "old residents 'take over' a new resident"; "residents cause upheaval if you change places around"; "friendship between residents means domination."

The long-serving staff member, Mrs. Green, a domestic worker who had worked at Southam for 24 years, was critical of the close proximity of group living. "Aggression and nastiness" of the residents were attributable to the enforced proximity and lack of space. "The lack of single bedrooms is wrong". Her work did not involve physical tending of residents, but she disliked the institutional, organisational relationships which prevailed. She portrayed residents as fearful and shy of expressing themselves in a group. Mrs. Green noted the leaders in each lounge, and the "two camps - those who are 'confused' and those who are not." She acknowledged the power and individuality of the residents.

FIG 25 Eastview Staff's Perceptions of Residents

Name, work role	Relationships of, and with residents	Residents' qualities	Issues and views of relationships	Defining good care	Additional comments
Mrs. Olds, Officer-in-Charge	Residents are like the elderly parents of the staff; I'm one of their carers.	Residents are self-centred and critical; some help each other. A dominant resident leads each group. Only one group relates well.	The home is too large; we're not part of the community. Confusion, territorial claims over space, and dominant personalities of certain residents cause problems for staff. Relatives are too far away.	Staff should treat residents like their own parents. It's important not to have favourites. Staff inflict a routine. I challenge this.	Staff who are professionally qualified find they can't change things. We've not got it right. Units are the answer. The staff ratio is too low. Can I face it till I'm sixty? I wouldn't go into residential care myself.

Name, work role	Relation-ships of, and with residents	Residents' qualities	Issues and views of relation-ships	Defining good care	Additional comments
Mrs. Lane, Senior Care Assistant	Residents don't recognise us without our "pinnie" (uniform). I put on a front, make a fool of myself to motivate the residents, trying to jolly them along. It's devastating when they die.	Many are confused. Some think they need more help than they do. They help each other. Some assert territorial rights. Residents don't express feelings. I wish they'd get along with each other better.	The home's location and size overwhelms the residents. Some don't make friendships.	Is it right to force them into activities when so many are not interested and are confused? Teamwork amongst staff is important. A happy group of girls motivates residents. The design of the home is not suitable.	The home is not designed for this type of resident. I don't want to go into a residential home myself.
Mrs. Ellicott, Care Assistant	I coax the residents, treat them like children or like my own mother. I'm soft with them.	There are leaders and pairs amongst residents. The active one of the pair looks after the "little dear" who is frail. The leader in each lounge tells staff what to do. Personality is important. Territorial claims are important. A lot help each other.	Residents withdraw after admission. Confusion causes problems. Residents don't talk to each other much. The home has an excellent relationship with the community.	Staff make residents happy, joke with them. My guide is: how should it be if this were my own mother?	Personality of the residents is important. The home has good staff and good relationships with residents.
Mrs. Jackson, Care Assistant	I mother them - one reminds me of my own mother.	Some residents can be hurtful and some give orders. Only the extroverts keep their own personalities. They don't say please or thank you to staff.	The staff are the problem. They had a go at me when I started here. They didn't feel it was their role to tell me what to do. The enforced rules rob residents of their individuality. Relatives live too far away.	I'm used to the routine now. More understanding of residents and more time to talk to residents would be good. The toilets are too far from bedrooms and the lounge. The dining room is too far away for them to walk to.	I've become more understanding. I've learned to stand up for myself. I'm an observer of the groups.

Eastview's staff expressed stress and dissatisfaction with the residential home, their roles, and the residents' relationships (with the exception of Mrs. Ellicott, one of the Care Assistants). However, as noted above, Mrs. Ellicott had taken extended sick

leave and her interview had to be postponed twice - perhaps an indication that she was not entirely immune to the stressful conditions related by the others. Eastview's Officer-in-Charge, Mrs. Olds, was critical of the design and location of the home: "We've not got it right, the home is too large and not part of the community" but she did not make a connection between size and design and a possible effect on the relationships and roles of residents and staff. Like Southam's Officer, she felt that the parent/child analogy was important. Instead of seeing the residents as children, she portrayed them as elderly parents needing care from adult children: "staff should treat residents like their own mothers and fathers." She saw herself as "one of the carers of the residents." She felt it was "important not to have favourites." The residents were "very self-centred and critical"; "confusion, territorial claims, and dominant personalities caused problems for staff."

Mrs. Jackson, a Care Assistant employed at Eastview for eighteen months revealed perceptions of the residents which were similar to her perceptions of the staff: "some can be hurtful and some give orders. Only the more extrovert keep their individuality." She remarked that she mothered the residents. One resident, she said, "reminds me of my own mother." Mrs. Ellicott, a Care Assistant at Eastview for sixteen years, had no criticisms of the home, portraying the personalities of the residents as the most important factor in determining relationships. She acknowledged the existence of pairs and leaders, and the detrimental effect of 'confusion' on relationships.

In contrast, Mrs. Lane, the Senior Care Assistant at Eastview, employed for ten years, expressed criticisms of the home's location and size, which were similar to the comments of the Officer-in-Charge. She did link these to the relationships of residents: "they're overwhelmed by the size"; "some don't make friendships". Mrs. Lane was the only staff member in the three homes who discussed openly the central dilemma for staff: how to care for very old, frail people in a manner which values them, but which does not devastate the carer, when, inevitably, the elderly residents die. If the staff member develops close relationships with the elderly residents, the residents' inevitable death and the subsequent feelings of loss could be devastating. She saw herself "putting on a front, making a fool of myself to motivate residents, trying to jolly them along", but inwardly she was depressed: "It's devastating when they die"; "is it right to force them into activities when so many are not interested and are so confused?"

FIG 26 Northfield House Staff's Perceptions of Residents

Name, work role	Relation-ships of, and with residents	Residents' qualities.	Issues and views of relation-ships	Defining good care	Additional comments
Mrs. Black, Officer-in-Charge	I try not to make relationships in work environ-ments. The residents expect attention and affection. Affection is important to provide for all.	Common interests or shared complaints lead to friendships. Some residents "throw wobblies". Residents have been taught by their upbringing to suppress feelings.	Low staffing levels, pressure put on by social workers for inappropriate admissions, and peculiar habits like coughing and spitting cause problems. There is a strong resident in every group. Staff get offended when residents turn on them and find fault.	Residents should not whinge or whine. Phased admissions, appropriate placement of residents, and key workers are important. Need to encourage residents to do things for themselves. Relatives could visit more.	The staff and the residents don't really know each other. Staff are the peacemakers because they have to be.

Name, work role	Relationships of, and with residents	Residents' qualities.	Issues and views of relationships	Defining good care	Additional comments
Mrs. Carter, Care Assistant	Residents are like children. You get attached to the job.	Residents' character is important. They put on a false front and make bids for attention. They are changed by confusion.	Residents are more isolated now. They stay in their Units and don't go down to activities. Personalities cause problems.	They're like a little family in their group living Units, but are Units good for old people? Staff try to help. More staff are needed.	Your kids don't need you as they grow up. I feel needed here. I like the Units.
Mrs. Lowther, Care Assistant	Staff are like friends to the residents. Relationships are good.	Personality is important; some are withdrawn, some are naturally friendly. Some don't want to be here. Residents do make friends.	There are bossy leaders in each Unit.	Staff organise activities - these are important. Chats with residents are important - I have the knack. Units, respite and day care are important.	We include residents in activities from start to finish.
Mrs. Elder, Care Assistant	It's like having old children.	The residents are all individuals, with bossy leaders. They're all resigned to being in care.	Residents get along with difficulty. Relationships are based on a bossy resident dominating. Lack of sight and hearing make relationships difficult. Not enough privacy for residents.	A good Care Assistant can create a good atmosphere and discourage dominance by a few residents.	Local catchment for admissions is important.

At Northfield House, similar comments were gathered, although they were nothing like Mrs. Lane's outburst at Eastview. The Officer-in-Charge , Mrs. Black, criticised the residents, saying: "they should not whinge or whine"; "they should do things for themselves."

Mrs. Carter, a Care Assistant at Northfield House for twenty-one years, described the Unit as "like a little family" but on the other hand, "residents are more isolated now; they stay in their Units and don't go down to the Activities Room." She saw the residents acting "like children", and changed by "confusion", but their "character was important".

Mrs. Lowther, a Care Assistant for three years, recognised the importance of "personality", the existence of friendships, and "a bossy leader" in every Unit. She felt that activities programming was important, that relationships between residents and between staff and residents were "good"; "the staff are like friends to the residents".

Mrs. Elder, a younger Care Assistant who had worked in Northfield House for less than a year, was critical of the lack of privacy and low staff ratios. She felt the residents "get acquainted with difficulty"; "relationships are often based on a dominant resident bossing another"; "the lack of sight and hearing makes relationships difficult".

7.22 Residents' Perception of Their Relationships with the Staff

The residents' own perceptions of their relationships with the staff were less sentimental, and reflected the pervasive influence of organisational relationships. Most praised the staff as hard working, but some tempered their praise with ambivalence about staff roles. Few residents were openly hostile to staff. In each home, nearly all the residents acknowledged their dependence on the care staff. The staff's roles were perceived as responding to residents' personal care needs, in the sense of being cared for or being looked after. Residents viewed the relationship as business-like and instrumental. None of the residents mentioned a parent/child analogy to describe the relationship. The residents denied themselves the roles of individual actors seeking individual inter-action with staff. There was no real recognition of the staff as individuals with names, except for the Officer-in-Charge.

The charts below illustrate the residents' perceptions of their relationships with the staff.

FIG 27 Southam Residents' Perceptions of Staff Roles and Relationships

Name	Perception of staff as helpful	Illustrative comment	Perception of staff as not helpful	Illustrative comment	Don't know, declined to answer, other comments
Mr. Leslie Atkins	√	Staff are important, play a big part.			
Mrs. Annie Baker	√	The staff are nice girls; they help. They play a big role.			
Mrs. Florrie Dakins	√	The staff are so helpful; you can ask them for help.			
Mrs. Irene Ellis	√	The staff encourage us to be friendly.			
Mr. Patrick Hillier	√	There are no arguments - the staff settle them.			
Mrs. Lily Irving	√	They introduce me to others.			
Miss Cissie Lawrence	√	The staff are wonderful, couldn't be better.			
Mrs. Cora Oliver	√	Staff are very good and kind.	√	If you don't worry them, they can make it nice (or nasty).	*Ambivalent about staff because she wanted to change her room and was not sure they would agree if she made a request.*

Name	Perception of staff as helpful	Illustrative comment	Perception of staff as not helpful	Illustrative comment	Don't know, declined to answer, other comments
Mrs. Kathleen Perkins			√	Staff don't play any part in helping group relationships. You're left to make your own friends. If you don't - too bad.	*She was upset because staff had separated her from her friend and room-mate Miss Jane Norris.*

At Southam, only one resident, Mrs. Kathleen Perkins, said "personality" was a factor in getting attention. Mrs. Perkins saw the importance of the staff as negative and interfering with relationships, saying that they played "no part" in helping the group relationships. She was angry because recently she been separated by staff from her long-standing room-mate, Miss Jane Norris, of whom she was very fond. Another resident of Southam, Mrs. Cora Oliver, said "the staff can make it nice or nasty."

FIG 28 Eastview Residents' Perceptions of Staff Roles and Relationships

Name	Perception of staff as helpful	Illustrative comment	Perception of staff as not helpful	Illustrative comment	Don't know, declined to answer, other comments
Mr. Henry Clifford	√	Staff are pretty good, nice women, no fault to find.			*Luke warm comments.*
Mrs. Sally Cooper	√	If you want help, they give it.			
Mr. John Davis	√	Staff talk to you, we all muck in, the mini-bus takes us out.			
Mrs. Olga Frederick			√	Don't want to tell. Staff are a great influence. I'm fighting it. They call me "Dear" and "Darling"; I'm not used to this kind of speaking.	*She had shared a room initially with her cousin, but the relationship deteriorated and they were separated.*
Mr. Richard Llewellyn	√	The staff help a lot, especially two Care Assistants.			

Name	Perception of staff as helpful	Illustrative comment	Perception of staff as not helpful	Illustrative comment	Don't know, declined to answer, other comments
Mrs. Molly Nabbut	√	Staff see who gets on together. They ask residents if they'd like to share a room together. Some feel lost if on their own.	√	Staff could put you with someone you don't get on with. I don't know if they'd move you if you asked.	
Mrs. Iris Rowlands			√	The biggest problem is being misunderstood by staff; I like strong tea, but staff say residents don't like it, so I don't get what I want. The Officer-in-Charge is friendly but aloof. Staff can slap you down if you speak out of turn. You can't be sure they're telling the truth. This happens whenever you have many people in your control. They have 60 residents to control.	*Reflective rather than emotional in her comments.*
Mrs. Polly Towell	√	I get on well with staff - they'd do anything for me.	√	I can't vouch for what happens between staff and residents in the downstairs lounges.	
Mrs. Bertha Tarrant			√	Staff are too busy. They just do their jobs. Nobody beats me down - I've never been frightened of any boss.	

Name	Perception of staff as helpful	Illustrative comment	Perception of staff as not helpful	Illustrative comment	Don't know, declined to answer, other comments
Mr. George Urquhart					√
Mrs. Miriam Youens	√	I appreciate what staff do.	√	They get paid for what they do.	*Rather angry in her comments.*
Mrs. Betty Zander	√	The staff work hard at it. They provide entertainment.	√	I'm not sure what staff do.	*Rather ambivalent.*

At Eastview, where staff adopted a bluff hearty manner and rushed through their routine, fewer of the residents linked their needs for attention to the role of staff. They didn't expect as much from staff. Several respondents said they did not get attention from the staff. Mrs. Bertha Tarrant said, "Staff are too busy"; Mrs. Olga Frederick commented "Attention depends on the length of stay", and "I'm trying to conform to the staff's demands." The part that staff played was viewed more critically at Eastview. Mrs. Molly Nabbut said, "The staff place residents in rooms, at the table and lounge, but I'm not sure whether they'd move you if you asked." Mrs. Olga Frederick said, "The staff play a big part and I'm fighting it." The most critical comments came from Mrs. Iris Rowlands at Eastview who said of staff, "They slap you down verbally and eavesdrop. You can't believe all they say". She tempered her remarks by saying, "This is a consequence of having to control sixty residents." A number of Eastview residents were critical of other residents' demands for attention by "whining, crying, demanding, carrying on."

FIG 29 Northfield House Residents' Perceptions of Staff Roles and Relationships

Name	Perception of staff as helpful	Illustrative comment	Perception of staff as not helpful	Illustrative comment	Don't know, declined to answer, other comment
Mrs. Ruth Beckett	√	I get on all right with the Officer-in-Charge; all of the others get put down except me. She has a difficult job to do. I'm careful to ask permission of the Officers if I want to do anything. It's all right if you do what they want.			*Ambivalent in her perceptions of staff.*

Name	Perception of staff as helpful	Illustrative comment	Perception of staff as not helpful	Illustrative comment	Don't know, declined to answer, other comment
Mrs. Violet Batty	√	The pink coats (domestics) are OK. They work hard. I help by laying tables, washing up but I don't get paid.	√	The blue coats (Care Assistants) aren't so good.	*Distinguishes between staff roles.*
Mrs. Frieda Grantham	√	The staff help with activities and provide leadership. The one who bathes us is good.			
Mr. Kenneth Grantham	√	Staff are ever so good, they talk to us, especially one of them.			
Mrs. Fannie Hewitt	√	They're very good.			
Mrs. Enid James	√	They talk to you nicely, will do anything for you.			
Miss Julia Jessop	√	Staff help when they have the time, they keep the atmosphere going, they work very hard.			*Somewhat ambivalent in her praise*
Mrs. Flora Needham					√
Mr. Albert Quinton			√	Staff don't help a lot.	
Mrs. Connie Redmond	√	We all mix together. We get on very well with them. No faults at all.			
Mrs. Ivy Verity					√
Mr. Walter Verity	√	Staff are very good.			

At Northfield House most residents warmly praised the staff's caring role, but not without some ambivalence. One Northfield resident, Mrs. Violet Batty, who had worked as a domestic assistant in a hospital, valued the Domestic Workers above the Care Assistants. She was able to distinguish them because of their different coloured uniforms.

7.23 Summary of the Third Part of the Chapter

The third part of the Chapter discussed how each home's life course and distinctive culture affected daily routines, caring practices, and relationships. Each home perpetuated institutional practices, often thoughtlessly rather than deliberately. Key working failed because it was used only to give baths and was not linked to care planning. Key working was limited because of a perceived need to protect staff from grief when residents died. Positive caring practices occurred mainly through activities, and residents' ability to make choices. Officers expressed anxieties about externally-based, organisational concerns: privatisation, shortage of staff, and residents' increased frailty and confusion. None of their expressed concerns were capable of resolution within their own span of control. Staff perceived size, design, staff ratios, and confusion as affecting relationships. Some staff recognised the power individual residents wielded over others. Residents attributed power to the staff whom they viewed impersonally and instrumentally. They acknowledged their dependence on staff but did not identify them by name except for the Officer-in-Charge.

7.24 Conclusion: What has been learned about Relationships

At the beginning of this Chapter, the statement was made that organisational relationships affect the personal and social relationships of the residents. Now, at the end of the Chapter, following the discussion of the data, what evidence is there to support such a view? The following reflections affirm the link between organisational relationships and personal and social relationships:

1. The **size, design and use of space** (Harris, Lipman, and Slater, 1977; Willcocks et al, 1987, discussed in Chapter Four) exert strong influences on the potential for developing relationships. The development of meaningful relationships is enhanced by opportunities for choice and privacy as well as personal contact. Conversely, limitations of space tend to inhibit the development of relationships.

The large number of shared bedrooms in the homes meant that dressing and undressing, getting up and going to bed, and using a commode could not occur as private activities. Personal contact was imposed when not desired, removing the element of choice from relationships. The shared bedrooms could not be used as private bed-sitting rooms. This lack of space resulted in crowded dining rooms at Eastview and Southam, with no choice of table partners. At Southam, the lounges were also crowded, with no space for visitors to sit with the residents. Communal toilets at Southam and Eastview were grouped in cubicles which did not give enough privacy, and offended the dignity of residents. Northfield House, with its expensive refit and Unit living, achieved a better use of space and design to promote relationships. It was able also to offer Day Care and respite short-term care with less disruption to long-term residents, because of its more generous space and well-planned design. (However, other factors, such as the culture of the home and the personality of the Officer-in-Charge, affected the development of relationships at Northfield).

2. Each home has its own distinctive **life course** (Blaikie, 1992; Kohli, 1986). The life course is influenced by the **history** of each home (and its design), together with its relationship to the community in which it is located and the characteristics of the locally recruited staff. These create a distinctive **culture** (Znaniecki, 1952; Parsons, 1951) which in turn affects the relationships within the home. For example, Southam, with its legacy as a former Edwardian vicarage in a traditional rural village, employed staff who had at one time been domestic servants in country houses. Southam successfully projected an ambience of gracious living. A programme of parties and entertainment helped to develop positive social relationships between residents and between residents, staff, and the community. Eastview, competing for staff with local factories, and with a 1960s utilitarian building with linoleum lined corridors, projected an air of brisk,

task-centred piecework, impersonal cheerfulness, and a general factory production style of regime. Northfield House, because of its history within a small market town as the replacement for the geriatric hospital, its location in the middle of a council estate, with shops and a bus stop across the street, and its Unit living and Day Care facilities, had developed an identity as a community resource for elderly people.

3. The life course of each home is influenced by the **personality and management style** of the Officer-in Charge (Booth, 1985). For example, Southam's Officer, Mrs. White, promoted maternal care and the provision of happiness as her management style, but did not concern herself with decisions about admission. Although Mrs. White chose not to influence the admissions process and had no strong views on placement policy, her maternal caring and the small size and positive culture of the home helped to promote relationships between residents at a later stage. Eastview's Officer, Mrs. Olds, recognised that the limitations of space and the organisational hierarchy of Social Services impeded the development of positive caring practices, including relationships. She projected an air of being so over-burdened by having to cope with day-to-day crises, that she was unable to deal with those institutional practices which were actually in her power to change. Mrs. Olds did not address the issue of relationships, but as her home had the largest amount of single rooms, a large minority of residents could exercise the choice of using their bedrooms as bed-sitting areas, thus gaining privacy and choice over relationships. Northfield House's Officer, Mrs. Black, functioned as an enlightened despot, concerning herself with every aspect of the home's organisation, and with clear views about the placement and admission of new residents. Mrs. Black took great care over admissions and established her own internal placement policy. Her enlightened despotism combined with her lack of care planning once residents took up permanent residency did not promote relationships beyond the beginning stage.

Positive and negative aspects tended to balance each other in each home. However powerful the Officer-in-Charge may appear, her power is limited and undefined in relation to the policy decisions made by the Social Services Department. The Officer-in-Charge can exert influence rather than exercise the right to decide on several key issues. A strong personality (like Mrs. Black at Northfield House) will exert influence, but other Officers may decline to do so. For example, the decision-making process concerned with admission illustrates the bureaucratic nature of the organisational relationships between the residential homes and the Social Services Department. As a result, accountability becomes diffuse rather than focused. Residents' personal and social relationships are not enhanced by diffuse accountability.

4. The organisational relationship between the Social Services Department and the residential staff encourages loyalty from the employees and a vested interest in **maintaining the enterprise** (Estes, 1979). Their loyalty and resistance to change are linked to the policy of employing manual workers who have no qualifications. The workers fear, realistically, that their lack of qualifications makes them particularly vulnerable to losing their jobs, rate of pay, or status if organisational change takes place, and then probably find themselves unable to find alternative employment. This makes them resistant to change and fearful of new developments. Since the regimes are task-oriented, and contain many institutional practices, development of personal and social relationships is inhibited.

5. The **lack of clearly articulated philosophies and goals** for each home prevents the development of positive caring practices. For example, individual care planning and key working for residents would help to individualise relationships between staff and residents. Relationships in the three homes continue to be conducted on a batch living basis (Goffman, 1961, discussed in Chapter Four). There are no incentives for care planning and recognising the individual's wishes and needs. Lack of recognition of the residents' life courses prevents the staff from facilitating the development of relationships between residents and between residents and staff. The

homes' staff adopt a task-centred approach to care, rather than one which is centred on the individual. The homes' institutional practices tend to be blamed on lack of space, understaffing, or on Social Services' bureaucracy rather than the homes' own management of their caring practices.

6. Many residents have chronic health needs, leading to more care demands on the unqualified staff. Residents' frailty creates uncertainty about whether social care homes are, *de facto*, providing nursing care, and whether there should be a sharp division between the two models of care. The homes' **organisational relationships to health care professionals are unclear**. Since the health and well-being of residents are important for enabling them to develop and enjoy relationships, promoting a positive relationship between health and social care is important.

7. The organisational policy of **not separating confused residents** from mentally alert residents **causes strain** on residents' relationships, and stress for the staff. Because of the communal design of most Social Services Homes, this is probably the only workable policy for the management of organisational relationships. A policy of segregation would be difficult to enforce, particularly if it meant moving a resident from a familiar environment to another. Rigid segregation also might be destructive to already established relationships.

8. Relationships between the residents and between the residents and the staff are inhibited by the **rapid turnover of residents due to death**. Little overt training or support is offered to enable people who live and work in the homes to cope effectively with loss and bereavement. Rather, there is a denial and avoidance of the deaths which are frequent occurrences in the homes.

In order to explore the nature of relationships of elderly people in residential care, it is necessary to move outside the framework of personal and social relationships and consider the importance of organisational relationships. The ecological paradigm (Bronfenbrenner, 1979, discussed in earlier Chapters) places personal and social relationships within a wider context of environmental influences, which include organisational structures of residential care. Organisational relationships cannot be expected to fulfil the same expectations as personal and social relationships. Katz' (1984) adaptation of Getzels' seven role dimensions (1974, discussed in Chapter Three) established the difference in expectations of organisational relationships and intimate, personal relationships. Personal relationships were portrayed as flexible, limitless in scope, and able to plead a special case for an individual; but organisational relationships were viewed as limited in scope, low in affect and attachment, and not able to plead a special case. The nature of relationships between residents, staff, and residents followed the role dimensions for organisational relationships, but more as a natural outcome of the need to protect the participants against stress and feelings of loss than as a self-conscious strategy. The role of the key worker is an organisational relationship which is flexible and individualised but also rational and planned. Unfortunately, as noted, key working was not implemented in any of the homes in a way which might have achieved its therapeutic potential.

Clearly, the data establish that the organisational relationships of each home influence the potential for social and personal relationships. Evaluation of residential life (Atherton, 1989, adapted from Maslow, 1954, 1970, 1987, discussed in Chapter Three) should take account of a four-fold hierarchy of concerns: physical concerns (meeting physical needs); order concerns (administrative power and control); mitigation concerns (softening the effect of institutionalisation); and compensatory experience concerns (individual therapeutic growth). The organisational relationships of the homes met physical needs (except for some uneasiness about meeting health care needs) and order concerns (except for the limited power of the Officers-in-Charge to influence policy and decisions taken outside the home). There was evidence of mitigation concerns in each home. Actions were designed to soften the effect of

institutionalisation, but there were few planned compensatory experience concerns for the self-fulfilment of residents, which is the most important area for the development of relationships. Some individual therapeutic growth through enhanced relationships did take place, but this came about by chance.

Ainsworth and Fulcher (1981; 1985, discussed in Chapter Four) recommend eight areas of knowledge and skills as a framework for developing group care practice: organisation of the group care environment, team functioning, activity programming; working with groups, on-the-spot counselling, nurturing care, developmental scheduling, and formulation of individual care and treatment plans. Of these, only nurturing care could be claimed confidently as part of the organisational relationships and priorities within each home. Northfield House, with its purpose-built Day Room centre and activities programme, offered the first four areas listed above as well. On-the-spot counselling, developmental scheduling, and formulation of individual care and treatment plans were not included within the organisational relationships of any of the three homes. Again, it is significant that the omissions are those practices which focus on the individual resident and which are relationship-oriented.

Douglas (1986) and Bond and Bond (1987) refer to the embedded nature of the social environment in institutions and how it is influenced by organisational relationships. The Wagner Report (1988) suggests that improved staff practices, improved assessment and admission procedures before entering the home, the leadership of the Officer-in-Charge, and better staffing ratios would make a positive difference in standards (Sinclair and Payne, 1990). These features within the three residential homes might improve opportunities for the development of relationships, although 'improved' is a vague term. The issue is how to achieve coherence and integration of many of these positive caring practices.

Throughout this summary, which illustrates how organisational relationships influence personal and social relationships, it has been demonstrated that many of the homes' procedures lacked coherence. When a positive caring practice occurred which enhanced relationships, it was unnoticed and unapplauded. It occurred by chance rather than through an agreed policy. Similarly, some of the institutional practices which impeded the development of relationships also occurred in a random manner and were not recognised as negative. Lack of practice coherence can be attributed in part to the absence of underpinning objectives and a philosophy of care. The starting point for promoting the personal and social relationships of residents is for each home to establish objectives and a philosophy which can determine its organisational relationships. In this way, a more coherent structure, in which organisational relationships enhance personal and social relationships, can be achieved.

Chapter Eight

Portraying Relationships Through the Life Course Perspective

8.1 Introduction: The Life Course as an Organising Principle

This Chapter presents portraits of individual residents' life course experiences, and how they established their relationships within the homes. Residents' personal and social relationships are influenced by multiple factors - by opportunities in the social setting, by inner motivations, by the respondents' levels of social skill in forming relationships, by cultural rules about the place of social and intimate relationships in the individual's life, and by respondents' past experiences of relationships (Argyle and Henderson, 1985). Residents' physical and mental frailties and the organisational relationships of the homes (as discussed in the previous Chapter) can influence residents' relationships negatively, because they overshadow the importance of the individual.

The life course perspective (Blaikie, 1992; Neugarten and Datan, 1973; Hareven, 1982; discussed in Chapter Two) provides a general principle for evaluating the data gathered from observations, interviews, and life histories. It directs attention back to the individual and his or her relationships and helps to link the past and present relationships of individuals. Thirty-three life histories were gathered through the use of an interview guide which set 'life event', 'chronological stage', 'transition' and 'turning point' perspectives for eliciting the data (Appendix Two). The guide progressed through the events of the life course, bringing out changes and continuities in relationships over time. Respondents were prompted to recall their life course, starting with their childhood, place of origin, then their parents, brothers and sisters, childhood experiences, school, work, marriage, interests, and family. The histories followed a chronological sequence to a discussion of residents' decisions to enter residential care, and culminating in a discussion of what life was like for them within the home.

Cognitive mapping, the expression of a person's beliefs and statements in diagrammatic form (Jones, 1985) provided an organising device for the data. The cognitive maps show the individual's progress through life course transitions (Parkes, 1971; Schlossberg, 1981; Hopson, 1981; discussed in Chapter Three) and the significance the individual attaches to each transition. The ecological paradigm, expressed as the eco-systems of the environment (Bronfenbrenner, 1979, discussed in Chapter Two), provided another device for organising life history data, particularly for recognising the environmental influences on relationships. For example, residents experienced their transitions within the context of a particular time and culture (the 1930s Depression, and World War Two), and these world events influenced the respondents' environments and their relationships.

The eco-systems of the environment were more useful than cognitive mapping for identifying the organisational relationships of an individual to the community and to the world of work (the exo-systems and meso-systems). Eco-systems analysis was an effective tool for capturing the life histories of chosen individuals who had had long working lives in external employment. It was not as effective for those whose working lives were brief (women respondents) unless the work histories of spouses and other close family members contributing financial support were used to supply contextual data. Cognitive mapping proved the better format for identifying personal and social relationships and the crisis situations (micro-systems) which elude eco-systems analysis. Cognitive mapping also provided a basis for analysis from the psycho-dynamic perspective of relationships, based on childhood attachments, deprivation, loss, and psychological drives (Freud, 1953, 1976, 1986 editions; Bowlby, 1951;

Erikson et al, 1986, discussed in Chapters Two and Three.) These aspects were less well served (as illustrated by Mrs. Grantham's life story, below) by eco-systems, which fail to provide a sense of contrast between past and present events, and cannot determine precisely which aspect of the life history should be attributed to which system.

This Chapter discusses methodological issues briefly, and then presents themes and patterns arising from the relationships which residents developed to establish their individual identities within the residential homes. Then the Chapter concludes with analyses of a number of individual life histories.

8.2 Methodological Issues: Stressful Remembering, Omissions, and Confidences

Problems arise in using life histories with very old people. Goldthorpe (1980) argues that older respondents often find it difficult to provide detailed retrospective information. Memories may fade over the years; very old people have more to remember than those who have not lived so long. The art of recall is a social construction (Berger and Luckmann, 1966) of things past. Retrospective bias occurs in remembering. Residents' present construct system may include inner acknowledgement of the loss of close relationships through death, and loss of familiar neighbourhoods and home surroundings through entering residential care. I discovered that some residents preferred not to remember painful events and simply glided over or omitted any mention of significant transitional events (Erikson et al, 1986, discussed in Chapter Three). Omissions of events provided clues to the residents' areas of emotional pain. The incidence of confusion in certain respondents increased when the interview touched on aspects of loss.

The increase in distress and confusion set off by particular memories calls into question the value of reminiscence for old people. Opinion is divided on this. Erikson et al (1986, discussed in Chapter Six) argues that reminiscence is a valuable tool for accepting one's individual life span and thus achieving integrity in old age, but that selective remembering and the omission of certain events are part of the task of integration. Butler (1963) advocates reminiscence within the life review in order to come to terms with what has gone before, and so prepare for the relinquishment of life itself. Coleman (1986) suggests that old people are best considered as individuals rather than as a group with no individual characteristics or differences, and while reminiscence can be helpful for some people, for others it may be of little interest or distressing. Coleman (1994) argues that for some, avoidance of reminiscence may be beneficial.

The need to avoid causing excessive pain and distress to individuals is an ethical issue to be kept firmly in view for both life history taking and reminiscence therapy. When a respondent's distress was evident, I had to make a choice: to probe (and if so, to what degree); or not to probe for more information. When the respondent omitted a major event or transition during the life history, a gentle probe to test the emotional climate explored the wisdom of going further. The desire to probe for more information was balanced by the resolve to avoid inflicting undue pain. On some occasions respondents' feelings may have been over-protected, because my judgement led me to draw back rather than probe further. At other times, for example when a resident burst into tears in response to questions, the research process felt destructive. My judgement was influenced by the eagerness of residents to tell their stories. The more eager they were, the more likely I was to probe in spite of distress.

Despite encouragement, positive reinforcement, and the use of minimal nods and verbal sounds to keep the story flowing, some residents closed their stories all too soon. The effect was one of telescoping ninety or more years of life into a few lines of spoken dialogue and then finishing with a flourish: "And that's what happened" or "Is that the kind of

thing you're interested in?" Steering a middle course through the emotional reactions of the respondents may be the reason why, to my initial surprise, the accounts of individuals' lives were, in some cases, so brief. (It also explains why on occasions probing was not taken further.) Several days of participant observation were spent in each residential home before approaching residents individually. They were given the opportunity to become acquainted with the researcher. In order to create confidence and trust, I emphasised my identity as a lecturer whose role was separate from the hierarchy of the homes' management structures (as discussed in Chapter Six). Many respondents were reluctant to share and expand into detail. Respondents were not accustomed, it seemed, to talking about themselves. A few words encapsulated the memories of their lives, because everything in their lives, at least on the surface, had been reduced to a minimal level. Possessions, home, work, privacy, and family life had been lost. Identity as an individual was difficult for the residents to establish within a group setting. One resident said typically, "Fancy being interested in my childhood," with wonder, as if acknowledging her individuality through her life history was not compatible with her present circumstances of group living in residential care.

This kind of reluctance was not due to emotional distress about revealing painful events, but rather because of the submersion of identities into an institutional regime (Goffman, 1961), and the apparent lack of need for reminiscence. Coleman (1986) noted that one major purpose of reminiscence activity was to maintain individual identity. The opposite also can be stated: when individual identity has been diminished through living in an institution, then the incentive for reminiscence also diminishes. Also, the reduction of individual identities may help the residents with the painful process of adapting to enforced group living. Some of the respondents had lost both the skill and the desire to recount their history because of lack of opportunity or the other reasons discussed. Their inner questioning of the appropriateness of sharing such intimate data with a relative stranger (probably a factor inhibiting confidences) was not allayed by careful explanations. Coleman (1994) draws attention to the obstacles in reminiscence work with elderly people: that some may have forgotten what they have done because they have not learned to value their achievements, while others do not see the connection between past and present, and some deliberately shut out events, or may recount only a persistent theme of failure. Once again, Booth's argument (1985) about the difficulty of eliciting the true opinions of elderly people in residential care, no matter how skilled the interviewer, or how well designed the interview schedule, is apt.

In most instances, life history material was gathered in one interview which lasted between around one and a half and two hours. The life history interviews were followed a few days later by another interview, specifically focused on relationships, with the same resident. When more than one life history interview occurred, it was usually because staff or the institutional routine interrupted the flow. Mr. Leslie Atkins, a Southam resident, provided a different diversion. He digressed from the interview guide in such an artless manner that it was necessary to go back to him several times. A single man of 78, Mr. Atkins had enjoyed a reputation as the 'life and soul of the party' in pubs and working men's clubs. He filled his life history account with jokes and stories so that the life story progressed very slowly. Because his accounts were part of his relationships and his identity, the pace and style he set were important for understanding his personality.

In contrast, some respondents were more than eager to share intimate details of their lives. The life history interviews of the residents who had experienced deprivation or abuse in their childhood were the most confident, open, and compelling (discussed below). Their need to form a relationship with the researcher as their confidante did not correlate with the length of their residence in the homes. It was related to the story they had to tell and to their own personality and individuality. Nor was their openness related to the type of regime or design of the home, because the incidence of these accounts of deprivation extended across all the homes.

8.3 Themes and Patterns revealed by the Analysis of Life Histories

Using primarily the cognitive mapping device (for reasons outlined above), the thirty-three life histories were analysed for significant themes and patterns. The findings of the life histories were supplemented by observations and subsequent semi-structured interviews to give a picture of the life course experiences of individual residents and how they formed relationships. The findings fell into recognisable groups of themes showing how the residents presented their identities as individuals. It was important for residents to assert their individual identity within residential care in order to build social relationships. Establishing identity and becoming known in a socially acceptable and/or distinctive manner ensured respect, attention, and acknowledgement from staff and other residents. This was the thrust behind the forming of relationships: not the search for deep personal attachments (with some exceptions, such as Mrs. Perkins and Miss Norris, discussed below), but gaining acceptance and recognition by the social group. Belonging, integration and identity (Thoits, 1982; Weiss, 1973, 1974) were identified in Chapter Three as motivating factors for social relationships. The analysis of life course experiences supported this interpretation.

The respondents expressed their individuality in complex patterns. Their identities could not be slotted into only one particular theme or pattern. Aspects of their life courses could be discussed under the headings of several contrasting themes. For example, a working mother could also be represented as a Londoner successfully transplanted and a deprived child - each theme representing an aspect of their past and present relationships. When residents attempted to establish new relationships in residential care, they drew on these themes which defined their individual identities. The most important themes were: locality, work role, spiritual belief, and deprivation.

The next sections discuss these themes in turn.

8.4 Defining Identity by Attachment to a Locality

The most popular theme was the individual's attachment to a locality. Many respondents created a source of identity through their attachment to familiar places where they lived in childhood and adulthood. They asserted this identity in old age when faced with the need to come to terms with the new surroundings of residential care. The life histories illustrated in microcosm the migratory trends of the past fifty years - the drift to the South-east in search of work, beginning in the 1920s and 1930s due to the Depression, and the subsequent flow of people out of London to new suburban development in the East Anglian county in the years following World War Two. Here, the life course perspective concept of context, and the eco-systems' emphasis on the exo-system of the environment were appropriate analytic tools. The mobility of residents' sons, daughters, nieces, nephews and siblings created an impetus towards further migration in later life, sometimes with unsatisfactory results. The sub-themes of émigré, Londoner successfully transplanted, still a Londoner at heart, rolling stones, and locals emerged from the theme of locality. The sub-themes of locality are illustrated below with a chart, indicating the residents who represented one or more sub-theme:

FIG 30 Asserting Identity and Forming Relationships by Attachment to a Locality

Name and Residential Home	Émigrés	Londoners Success-fully Transplanted	Still a Londoner at Heart	Locals	Rolling Stones
Mr. Leslie Atkins, Southam				lived in rural areas of the county.	lived in lodgings and caravans.

Name and Residential Home	Émigrés	Londoners Success-fully Transplanted	Still a Londoner at Heart	Locals	Rolling Stones
Mrs. Violet Batty, Northfield House				lived and worked in local village.	
Mrs. Sally Cooper, Eastview				born and lived in one town all her life.	
Mrs. Florrie Dakins, Southam	Yorkshire farmer's wife.				
Mrs. Irene Ellis, Southam		lived in Forest Gate, East London.			
Mrs. Maisie Freane, Southam	lived in Argentina.				
Mrs. Frieda Grantham, Northfield House				lived in Malham (where the home was located) all her life.	
Mrs. Lily Irving, Southam		52 years in Stoke Newington.			
Mrs. Enid James, Northfield House		grew up and lived in Kilburn.			
Mrs. Xavia Kelly, Eastview	from Sri Lanka.				
Mr. Richard Llewellyn, Eastview	former Welsh miner.				
Mrs. Flora Needham, Northfield House			lived and worked in Whitechapel.		
Mrs. Kathleen Perkins, Southam	from Glasgow.				
Mrs. Connie Redmond, Northfield House				married into local community.	transient life as a child.
Mrs. Iris Rowlands, Eastview		lived in Walthamstow and Chingford.			
Mr. George Urquhart, Eastview	lived 35 years in a mental handicap hospital.				

The émigrés were those who had come from far afield and who retained a strong identity with their place of origin. Mr. Richard Llewellyn, the former Welsh miner, was an example of an émigré who, fifty years ago, made a successful transition to life outside Wales. Nevertheless he was known throughout Eastview as 'Dickie Dai', a

nickname he did not like, but which defined his identity as Welsh. In his life history (discussed below), he told of the many birthday cards he received from Welsh relatives, and his regular visits back to the Welsh valleys. This Welsh identity sustained him in old age.

A less happy émigrée at Southam was Mrs. Kathleen Perkins (whose individual life history is discussed below) who had spent her life in Glasgow until she left in her 70s, a grieving widow, to live with her married nephew in East Anglia. Her move south resulted in family conflict and its outcome was her subsequent entry to care. Her unhappiness in the residential home was linked to her unresolved grief which now centred on the loss of her Glasgow life and identity. Glasgow - its shops and neighbourhoods and her association there - was a constant topic of her conversation. She kept a sprig of heather by her chair in the residents' lounge as a reminder of Glasgow and her beloved Scotland.

Mrs. Florrie Dakin's life as an émigrée at Southam mirrored the story of Mrs. Perkins. Mrs. Dakin's conversation flowed constantly on the topic of North Yorkshire, where she was born, grew to adulthood, and lived as a farmer's wife, until, like Mrs. Perkins, she was persuaded after she was widowed to join her grandson in East Anglia. Her move resulted in stress within the family and eventually, her admission to care. Now resident at Southam, Mrs. Dakins defined her identity as "a farmer's wife in Yorkshire".

Some émigrées, like Mrs. Dakins and Mrs. Perkins, were unhappy partly because the emigration away from their familiar territory took place in old age as a response to growing frailty and the invitations of faraway relatives. The reluctant move away from home ground resulted in disruption of family relationships and an even more reluctant move into care. Theirs was a double loss of home territory and a failure to make a fresh beginning with relatives in a strange area.

Mrs. Maisie Freane, at Southam, whose lack of memory and confusion were so marked that her life story could not be completed, is defined as an émigrée because of three inter-locking factors. She had lived for many years in South America as the wife of a wealthy Argentinean. She possessed a middle class manner of speech and demeanour in contrast to the predominantly working class origins of other residents. Her loss of memory and confusion prevented her from entering fully into social exchanges with other residents. Her identity as an émigrée was the most acceptable explanation for her sometimes bizarre behaviour. Her labelling by staff as "foreign" won more tolerance for her demanding habits arising from her confusion.

Mr. George Urquhart, at Eastview, was an émigré from a long stay mental handicap hospital where he had lived for thirty-five years. When he reached retirement age he was placed in the elderly persons' home. His experiences of institutionalisation defined his identity. The Sri-Lankan resident at Eastview, Mrs. Xavia Kelly, (discussed in Chapter Seven) was the most isolated émigrée because of her different race and language.

Many of the respondents had been brought up and lived in London, moving to East Anglia during or after World War Two. Most of these, who had made the transition in middle age as a desired move and for whom the move represented a greater level of prosperity, could be defined as Londoners successfully transplanted. They spoke vividly of their childhood in London, of the way of life they experienced, but without the longing for things and scenes past which the émigrés expressed. (It could be reasoned that as the Londoners were only thirty to forty miles away from their origins they could maintain contacts, but the émigrés came from much further away - Wales, Northumberland, Nottingham, Yorkshire and Scotland - and experienced a more complete break with their past.).

For example, at Southam Mrs. Lily Irving, a Londoner successfully transplanted, remembered Stoke Newington vividly. She said, "I lived in London all my life" but then added "I lived in Rington (in East Anglia) for the last twenty years." She recalled her fifty-three and a half years of married life spent in Stoke Newington, the house number and address where she lived, and her old school friend with whom she retained a friendship. She moved away from Stoke Newington to be near her grown up children who had migrated to East Anglia. Unlike Mrs. Perkins or Mrs Dakins, she moved initially to her own house and kept her independence. She made disparaging racist remarks about "the blacks in Hackney", giving this as a reason why she would not wish to return. Her life history is presented later in the Chapter.

Mrs. Iris Rowlands, another Londoner successfully transplanted, aged 93, and living at Eastview, looked back at a life lived first in Walthamstow in East London in childhood. She later lived in Chingford in the 1930s and 1940s during the first years of her marriage, ending with her move to the East Anglian county town after World War II. She recounted these moves in a dispassionate tone of voice, relating how she came to live in Suffolk with her paternal grandparents in 1899 and 1900 because of her father's illness with TB, before returning to London with her mother. Although her memories of scrubbing the floor of her mother's drapery shop in Walthamstow were vivid, emotionally she had moved away from the scenes of her youth. Her life history also is presented later in the Chapter.

A Londoner less successfully transplanted who remained still a Londoner at Heart was Mrs. Flora Needham, an 84 year old widow at Northfield House, who had lived and worked all her life in Whitechapel. She was widowed during World War Two and had brought up her children as a single parent. She worked full-time, sorting letters for the Post Office before retiring in 1965. She entered residential care in a private home in East Anglia, which subsequently became too expensive. Then she transferred to Northfield House because it was near her children. She complained "I don't know anyone here - I wouldn't know where I was going outside the front door - I've never lived round here." Unlike the successfully transplanted Londoners, she had experienced only institutional care in East Anglia, rather than an independent life in her own house. The move from London occurred too late in her life, and for negative rather than positive reasons.

In contrast, some respondents projected identities which had been shaped by their sense of having been part of a local community. These were the locals. Locals were noticeably more numerous at Northfield House, the home located in a small market town which had experienced less post-war development than the areas in which the other two homes were situated. Mrs. Frieda Grantham, (discussed below), is one example of a local. Another respondent, Mrs. Violet Batty (also discussed below), an 80 year old widow at Northfield House, had been born in a nearby village, the daughter of a publican. Despite having worked in Surrey "in service" from 1926, she returned home in 1934 to her parents with her strong local accent intact "which my employers commented on." Following her return, she worked as a barmaid in a nearby country pub until her retirement. She married late in life and remained in her cottage in widowhood. Then an accident resulting in hospital admission combined with subsequent pressure from her brother resulted in her admission to care. She also, like Mrs. Kathleen Perkins, disliked the residential home, because by entering it, she had lost links with her own local community. Although geographically near, she felt cut off. She had experienced, like the émigrés, a reluctant move away from home (into hospital) and then what she perceived as an enforced move into care.

The local person par excellence who defined herself as "local born and bred - and proud of it" was Mrs. Sally Cooper, a 94 year old widow at Eastview. Having grown up as the daughter of the local postman, she was familiar with every street and every house in the town. (Despite Eastview's policy of not accepting local residents due to its administrative function as an over-flow home for the county town ten miles distant, she was one of the few residents of this home who had been accepted from the surrounding

community and for whom the home preserved a continuity of surroundings.) She was satisfied with her residence in the home and "thankful to be in my own town". She related how the community had changed. She remained in touch with her church and her friends.

Some locals were rolling stones who had spent much of their lives working in transient, rural farm labouring jobs or in agricultural industries. They were local to the county as a whole, and to the rural way of life rather than to any community within it. One such respondent was Mr. Leslie Atkins, (discussed above) an 81 year old bachelor living at Southam, who had worked on farms and in sugar beet factories, cycling through the country lanes and frequenting the village pubs. Home, after the death of his parents, was a series of lodgings and caravans until he entered residential care in 1977. He was a raconteur whose stories about life in the field and in the pubs were calculated to ensure that he became "known". The rolling stones tended to be single men but there were some exceptions to this. One of the women residents at Northfield House, Mrs. Connie Redmond, an 89 year old widow, described her rolling stone childhood as the daughter of a "jack of all trades" who led a transient life with his wife and ten children as a farm worker and grass cutter - "but we weren't travellers". She recalled hop picking and potato picking with her mother and sisters: "It was hard work but we enjoyed it; I never went into service". She married a local man in 1919 and then settled in the local community. She recounted her early years with more clarity than the attachment she formed to the small town where she spent her married life.

The significance of defining identities in relation to locality was that it established both communality with, and differences from others. Residents' locality provided a conversation point, a source of reminiscence. It demanded a recognition from others that as an individual you had a history, a background, that you knew and understood in detail a place or way of life. This identity, as in the case of Mr. Richard Llewellyn, the ex-miner from Wales, might result in a little-liked nickname. On the other hand, it could provide a means of being known and remembered in the social setting of the home, where individuals might be lost in a crowd of others all seemingly alike. The identification with locality was not likely to trigger awkward social situations of avoidance, as might an over-emphasis on bereavement. Discussion of one's attachment to a particular locality provided opportunity for establishing social relationships. Noticeably, those residents whose grieving for their former communities had not been resolved satisfactorily were less able to use their past to build new relationships. Mrs. Kathleen Perkins from Glasgow (discussed above), and Mrs. Violet Batty from a nearby village (also discussed above) were apt to cry when speaking about their losses from the past. Staff reported that the exchange of conversation on certain topics became strained and awkward, and I also found this to be so. Confidences were avoided. These were residents whose admissions to the homes had not been voluntary but were expedient due to illness and dependence. Their social relationships were clouded by feelings of loss and ambivalence about being in care which the group environment could not easily resolve.

An example of how locality helped form a relationship between two residents of Southam was provided by Mr. Leslie Atkins, the raconteur, (discussed above) and Mrs. Irene Ellis, a rather quiet woman from Forest Gate in East London. They discovered a mutually recalled enjoyment of cycling, country lanes, and East Anglian villages. They also shared the experience of having lived in the same residential home for over ten years. They exchanged reminiscences about "the old matron who was very strict". Their shared life course experiences resulted in a friendship of opposites: the rough and ready farm labourer who liked to smoke and drink, and the rather prim, genteel, and reserved widow. Their relationship echoed Matthews' view (1983b, discussed in Chapter Three) of friends as individuals, who have known each other over a period of time and have shared experiences. They had constructed a shared life course experience within the home, and this created a bond.

8.5 Work Roles as Means of Identity

Some residents became known within the home by the particular work roles, both paid and unpaid, which they held in their working lives. These, too, served as socially acceptable means of becoming known and respected. Three categories of work roles emerged from the life histories: the vocationally committed worker, working mother, and carer. They are illustrated in the following chart.

FIG 31 Work Roles as Means of Asserting Identity and Forming Relationships

Name	Residential Home	Vocationally Committed Worker	Working Mother	Carer
Mrs. Ruth Beckett	Northfield House	machinist in clothing factory.		
Mrs. Bessie Carr	Southam	seamstress and dressmaker.		
Mr. Henry Clifford	Eastview			cared for parents.
Mr. John Davis	Eastview	fireman in London Blitz.		
Mrs. Olga Frederick	Eastview			cared for younger siblings.
Miss Joan French	Southam	wages clerk.		cared for father, invalid sister.
Mrs. Gladys Garrett	Southam	store detective in Woolworth's.		
Mrs. Fannie Hewitt	Northfield House		widowed young, worked in TV factory.	cared for blind father and semi-invalid mother.
Miss Julia Jessop	Northfield House			cared for younger siblings, and later, her aged parents.
Miss Cissie Lawrence	Southam	teacher, house-mistress.		cared for mother, niece.
Mrs. Molly Nabbut	Eastview			cared for husband with spondylitis.
Mrs. Flora Needham	Northfield House		widowed young, worked in Whitechapel Post Office.	single parent.
Mrs. Bessie Tarrant	Eastview		widowed young, worked in Mars factory.	single parent.

The vocationally committed workers projected this identity in their life histories by concentrating with the greatest detail and enthusiasm on accounts of their jobs rather than on family events. For example, Mr. John Davis, an 87 year old resident of Eastview, achieved acceptance and recognition within the residential home because of a local newspaper account about his experiences as a fireman in the London Blitz during World War Two. He said, "You had to be 100% fit. I wasn't scared. I never thought about the

bombs." These accounts, published in the local newspaper together with his photograph, helped him become acquainted and known: "In a few days (of entering the home) I knew everybody. That's the kind of fellow I am". He valued the social relationships which the home offered. Although he had been married and widowed, he did not speak a great deal about his previous personal relationships, instead focusing on his work history and his role in the home as a member of the Residents' Committee (another kind of work role).

Contrary to expectation, it was not always the men who portrayed themselves in this way. Several of the women had worked in paid employment for many years and took pride in their jobs. One vocationally committed worker was Mrs. Ruth Beckett, a childless widow of 103 at Northfield House. She had worked as a skilled machinist in a clothing factory. She enjoyed her work. Most of her life history centred on her working life. She began with an account of how good she was at needlework at school despite not having been "cut out for education"; how she worked in a confectioner's shop in 1900; then in a new "mica insulation factory" in 1902, which her father made her leave because of the dirty conditions; and then her favourite work as a machinist. She remembered making balaclavas and uniforms during World War One. She concluded her life history account by showing an apron and a cushion in her bedroom which she had stitched by hand. As well as details of her working life, she provided a careful account of the jobs and careers of all her extended family, including her two great-nieces.

A number of the women respondents had been widowed young (or had been separated or divorced), and continued working in order to bring up their children. Their role was that of working mother. They, too, discussed their working lives in detail. Mrs. Fannie Hewitt at Northfield House, an 80 year old widow, had been widowed at 37. Her husband was killed in a road accident when he was knocked off his motor bike whilst returning drunk from a pub. Following his death, she worked in a local factory making television sets. When she retired she was presented with a gold watch.

Mrs. Bertha Tarrant, aged 79, now at Eastview, after a period in her youth "in service" welcomed the opportunity to work in the Mars factory in Slough following the death of her first husband in 1947. She defined her expectation of relationships within the residential home as corresponding to the working relationships she had known at work: "I've never been frightened of any boss. I used to speak up for others at work. I won't let anyone here walk all over me."

Another important work role undertaken by many respondents was that of carer of their parents, spouses or other family members. These respondents developed close personal relationships within their families, but their relative detachment from networks of social relationships within the residential homes probably replicated earlier patterns of social detachment. Their most meaningful relationships were demonstrated in their memories of how their roles as carers for their families had made them feel needed.

Mrs. Fannie Hewitt, the working mother at Northfield (discussed above), was an only child who looked after her semi-invalid mother and her father after he was blinded in an accident in 1924, until her own marriage in 1932. Miss Julia Jessop, aged 84, also at Northfield House, was the eldest of seven children who helped her mother with the care of the younger children. Later she looked after both parents in their old age. She portrayed herself in her life history as "still the head of the family", in touch with her siblings, concerned and caring. At Eastview, Mrs. Olga Frederick, aged 84, presented a parallel story: the eldest of nine children, she helped her mother care for the younger siblings, a role which she continued throughout her married life, having had no children of her own.

Mrs. Molly Nabbut, aged 83, at Eastview, also was childless but had been a carer of her husband who had become progressively disabled with spondylitis. All of the

accounts of caring were from women except for the life history told by Mr. Henry Clifford, at Eastview. An 87 year old bachelor, he looked after his parents until they died, living in the parental home and working in the same factory as his father. His parents became disabled at an early age. Mr. Clifford never formed any other close relationships, saying "I keep myself to myself" to denote his detachment from others in the home. The women who never married were most likely to present a dual identity as a carer of their relatives, and as a vocationally committed worker. For example, Miss Joan French, at Southam, worked for many years as a wages clerk, at the same time caring for her widowed father and an invalid sister.

8.6 Spiritual Belief as a Means of Identity

Some respondents, often those who had experienced an unresolved bereavement together with deprivation, defined their identity through their spiritual belief. Participant observation had revealed the popularity of religious services in the homes. For example, the local vicar came regularly to Southam and to the other homes to celebrate Holy Communion. The Communion service, celebrated in the dining room, attracted about a third of the residents, but rarely was this or any other religious observance mentioned in the life histories. The exceptions were those whose religious allegiances were to a particularly distinctive denomination. This is illustrated in the chart below. The chart shows the incidence of deprivation, the loss of a parent in childhood or a being widowed twice, which may have been factors influencing the claim for identity through spiritual belief for these individuals. In contrast, other residents practised their religion but did not mention their beliefs in their life histories. The claim to identity through spiritual belief was known by others, but those who asserted it were not always close to other residents. Their religion sometimes made others uneasy. They themselves found consolation in religion rather than pursuing social relationships in the home.

FIG 32 Spiritual Belief as a Means of Asserting Identity and Forming Relationships

Name and Residential Home	Religion	Deprivation	Rolling Stone	Londoner Successfully Transplanted	Émigré /Local
Mr. Patrick Hillier, Southam	Spiritualist.	hints at cruel stepmother.	worked in local farms and factories.		local within rural county area.
Mrs. Lily Irving, Southam	Salvation Army.	father died when she was a child; poverty.		52 years in Stoke Newington.	
Mr. Richard Llewellyn, Eastview	Welsh Baptist.	mother died when he was a child.			émigré from Wales.
Mrs. Betty Zander, Eastview	Spiritualist.	lonely, isolated childhood; was widowed twice.			escaped to London, then returned.

Mrs. Lily Irving, aged 94, from Stoke Newington, now at Southam (discussed below), was an active Salvation Army member who said "I don't drink, smoke or swear and I try to be as good a person as I can." She said "prayer was important" to her well-being. She defined her relationships as "good, Christian". Her faith provided positive support for her determined optimism about her life course. She had not yet become a permanent resident. Her short stays in care enabled her to view the other residents with an air of critical detachment. Mr. Richard Llewellyn (discussed below), the ex-miner from Wales, also said that his religious beliefs, formed in the Baptist chapel, still shaped his relationships. Mr. Patrick Hillier, a widower at Southam, was a Spiritualist who used his religious belief as a means of searching for his own identity. He had been a rolling

stone, as well as a local, living in lodgings and working as a labourer. Late in life, he married his home help and sadly, was widowed soon after. He had no remaining relatives. He was very much the 'gentleman' with courtly speech and appearance which belied his former rolling stone existence. He had been brought up by a stepmother, and hinted at her cruelty to him in childhood. Like Mrs. Irene Ellis at Southam, and Mrs. Polly Towell at Eastview, he had been hospitalised with periods of depression. His claim of clairvoyance gave him an identity within the home and provided him with inner relationships which gave meaning to his life, in contrast to the deprivation of childhood, the rootlessness of adulthood, and his bereavement as a widower.

At Eastview, Mr. Betty Zander, a 90 year old widow, also found meaning within her Spiritualist religion. Growing up as the only child of a gamekeeper in a large country estate, she was discouraged from having friends because of the secrecy surrounding her father's work. She escaped to London at 16, working first in a shop, and marrying at 26. She was widowed twice, the second time when she was 53. Then she developed an interest in Spiritualism, finding it provided insights into life after death and the means to do "healing work." Estranged from her only son, she described herself as "always a loner". She felt that her Spiritualism prevented her from gaining acceptance within the home. Other residents were afraid of its potential powers.

8.7 Deprivation as a Means of Identity

The identities based on locality, and work enabled individuals to become known in a socially acceptable manner. These identities invited social conversation and established residents within the homes. They provided a means of forming social relationships. As well as the identities outlined above, confidences about and spiritual belief and deprivation within individual life courses were shared. Spiritual belief established identities which were regarded positively on the whole, although in some instances, the identities were viewed with uneasiness by others. The deprivation within the life histories was not used widely by the residents to establish identity, probably because deprivation is not a socially acceptable theme with which to build social relationships. These accounts were primarily about deprivation associated with poverty and abuse rather than maternal deprivation (Bowlby, 1951; Rutter, 1972; discussed in Chapter Two).

Accounts of material and personal deprivation in the lives of the respondents revealed the influence of economic and social history on their life courses. Deprivation because of poverty resulted in lack of education, restricted job choices, and in families moving from one locality to another in search of jobs and housing. The life histories, however, were told by individuals (Matthews, 1979, discussed in Chapter Three) who perceived themselves as having had choices and who, for the most part, claimed to have developed satisfactory social relationships. They recognised how their choices had been limited, but also how their prosperity had increased in comparison to their parents. Although one might speculate about the effect of childhood abuse on subsequent personal relationships, some respondents who had been abused in childhood successfully formed the social relationships needed for work, marriage, and parenthood, and for living in a residential home.

For example, Mrs. Polly Towell, an 83 year old widow at Eastview who assumed a position of dominant leadership in the residents' lounge, had, like Mrs. Irene Ellis at Southam, experienced periods of depression in her youth and again when she was widowed. She confided that her mother had been abused by her father and that venereal disease passed by her father had resulted in vision problems in her 20s. Both Mrs. Ellis and Mrs. Towell were now leaders in their social relationships within the residential home despite their hints and evidence of past deprivation. In all, evidence of deprivation was identified in twelve respondents through the life histories taken. This is illustrated in the chart below.

FIG 33 Examples Of Deprivation as Means of Asserting Identity and Forming Relationships

Name	Residential Home	Poverty	Abuse	Rejection	Family Disruption
Mrs. Annie Baker	Southam		sexual abuse by father.		
Mrs. Irene Ellis	Southam				hints that her mother was "saucy" and married three times.
Mrs. Frieda Grantham	Northfield House	poverty.	violence in home.		drunkenness of father, mother depressed.
Mr. Patrick Hillier	Southam		hints at cruel stepmother.		mother died when young.
Mrs. Lily Irving	Southam	poverty, mother a widow.			father died when young.
Mr. Richard Llewellyn	Eastview	poverty as Welsh miner's son.			mother died when he was very young.
Mrs. Cora Oliver	Southam	large, destitute family in Wales.			
Mrs. Iris Rowlands	Eastview				father died of TB when she was very young; she suffered from heart trouble as a girl.
Mrs. Bertha Tarrant	Eastview	poverty, Northumber-land miner's family.			
Mrs. Polly Towell	Eastview				serious visual problem due to father's syphilis transmitted to family.
Mr. George Urquhart	Eastview			institutional-ised at age 30 when parents died, due to his learning disability.	
Mr. Walter Verity	Northfield House			illegitimate child rejected by birth relatives, brought up by foster mother.	
Mrs. Muriel Young	Eastview	childhood poverty.		lifelong sense of inferiority due to poverty.	
Mrs. Betty Zander	Eastview				isolated, lonely childhood; was widowed twice.

Of these, Mrs. Cora Oliver, Mrs. Bertha Tarrant, and Mrs. Muriel Young were recent arrivals in care. The others had been resident from eighteen months to eleven years. Already noted was the prevalence of tuberculosis, resulting in the premature deaths of the parents of Mr. Richard Llewellyn and Mrs. Iris Rowlands (both discussed above). Poverty and abuse both featured in the life of Mrs. Frieda Grantham (discussed above). Mrs. Annie Baker, the 85 year old widow at Southam, is another example of both poverty and abuse. Resident at Southam for 18 months, she described herself as a "loner" unable to trust other people, despite her extended family of daughters and grandchildren who visited her regularly. She used the opportunity of the life history to confide what she had never told anyone before: her father had abused her as a child. She shared her feelings and the effects of her fear and loathing of her father, linking this to her present lack of trust. "I'd like to trust but I can't." She revealed her need to achieve completion and integrity (Erikson et al, 1986). The life history served as a vehicle for this. She said, "I've never told a living soul of this - not even my daughter."

Mr. Walter Verity, aged 84, at Northfield House, had been brought up in foster care in an East Anglian village, the illegitimate son of a married woman who had an affair while her husband was serving in India. He had no contact with his family of origin, and experienced a relatively harsh regime with his foster mother. Yet he grew up in a community where he put down roots through his marriage to a local girl whom he met at school. Unlike Mrs. Annie Baker at Southam, who longed to "trust" but could not, he had formed positive relationships with his foster siblings, school friends and work mates. Although he experienced poverty and the stigma of illegitimacy, he had escaped abuse and violence in childhood. He also experienced stability of care. Perhaps his attachment (Bowlby, 1951, discussed in Chapter Two) to his foster parent provided the foundation for his later successful relationships.

In contrast to Mr. Walter Verity, Mrs. Irene Ellis, the genteel widow at Southam (discussed above) gave a reserved, distant account of her relationships. She hinted at a past which might have contained abuse or deprivation, saying only, "My mother was a saucy sort who was married three times." She spoke more vividly about her home, dog, and garden than about her personal relationships with her husband, daughter, or sister. There was an air of detachment about her. She said, "I wouldn't want to live outside again - I feel safe here." Her relationships were social ones in which she watched the emotions of others benevolently, rather than trying to experience intense feelings herself. She did not reveal information about her previous breakdown in health. Staff volunteered information about her two periods of depression resulting in hospitalisation, one when she was in her early twenties and one when she was in her seventies, after her husband died. The last episode of hospitalisation resulted in her entry to the residential home.

The most telling effect of deprivation and poverty was exhibited by Mrs. Muriel Young, recently admitted to Eastview. Despite having worked, married, and moved away to a more prosperous area far from the poverty-stricken circumstances of her childhood in Nottingham, she had developed a life-long sense of inferiority and failure so that she was, in her own words "always miserable". Her conversation was a stream of complaints and self-pity reaching back to the years of wearing second-hand clothes as a child and now resulting in the feeling that her own daughter looked down on her for being "stupid". Materially, Mrs. Young had been successful in escaping her early deprivation, but her marriage had been unhappy. She did not appear to have sustained a satisfying relationship with her daughter. Within the home, her initial relationship was formed with another new resident, Mrs. Bertha Tarrant, who was also an émigrée (from Northumberland), a smoker, and who had experienced extreme poverty in her childhood. Both women felt rejected by their daughters and were resentful of being in the home. The basis of their relationship seemed to be the sharing of negative experiences, with a mutual love of smoking - the one enjoyable aspect of their time together. Again, there are echoes of Matthews' discussion (1983b, see above and

Chapter Three) of friendship as individuality, based on shared experience. In this instance the shared experience was recent, but the similar meanings they attached to their life course experiences created a bond.

8.8 Integrity: Achieving the 'Successful Career'

Certain respondents projected a sense of detached satisfaction with their lives, recounting successes and failures, gains and losses, with philosophical acceptance. Yet they were not resigned, stoic, or passive. These were individuals with a healthy level of self-esteem. They valued themselves and had not succumbed to despair at the final developmental stage of their life (Erikson et al, 1986, discussed in Chapter Two). Instead they had achieved a successful 'career', finding meaning not in a material sense but within the context of the life course. They were the self-actualising persons as portrayed by Maslow (1954, 1970, 1987), Jung (1969, 1982, 1989 edition), Rogers (1961), Kohlberg (1969), and Erikson et al (1986), and discussed in Chapter Two. Old age had brought wisdom of a sort. They perceived themselves and others around them clearly and without sentimentality. They had let go of the past and were as involved as they could be with the present. Each in their own way had assumed responsible roles within their personal, social, and organisational relationships. Yet each individual was very different in personality. Their integrity in Eriksonian style (Erikson at al, 1986, discussed above and in Chapters Two and Six) was conveyed by their rationality and continued involvement with others, both in the residential home and outside. Communicating this integrity through written accounts is difficult. Listening to their emotional tones and resonances revealed more than written words could achieve. Their relationships with their pasts were complete. They acknowledged losses but also the reality of their life histories in which the past intertwined with the present. These were the residents who were liked, appreciated, and mentioned over and over by staff and other residents as "nice, ...good sorts."

They accepted the good and the bad in their relationships and life courses. They had a rounded view of relationships and people, recognising faults in others and themselves with tolerance. For example, Miss Cissie Lawrence, an 87 year old resident of Southam, had spent her life as an unqualified school teacher, running her own small private school, and caring for her mother and niece. When her mother died, she closed her school and began a new role at 52 as a school matron in a Yorkshire boarding school, retiring at 70. She was philosophical about her reasons for entering the residential home. Although not wanting to be in care, she had chosen to become a resident in order to preserve the precarious health of her niece who had been her carer. She made an effort to be outgoing and develop social relationships with other residents and staff. She was determined to "stick it" at Southam.

Mrs. Iris Rowlands (discussed below), a 92 year old widow at Eastview, reviewed her life course as a sickly child with a heart murmur who survived into adulthood, trained as a shorthand typist, and married a man who was "nice but a plodder". She stated that in her old age she had learned to "come out of my shell and be more sociable" as a consequence of living in sheltered housing and in residential care despite the fact that "all my friends are dead."

Mrs. Cora Oliver at Southam, an 82 year old divorced woman, subsequently widowed, who experienced childhood poverty in Wales as one of thirteen children, and whose marriage had been unhappy, was able to analyse objectively her ambivalent relationships with her husband and daughter and her own progress since entering the home.

8.9 Individual Life Course Experiences

So far, individual life course experiences have been discussed only in categories of identities. The point was made at the beginning of this Chapter that the individual life

course is so complex that it cannot be contained in single or multiple categories. Throughout the life course, individuals assume more than one role or identity because they respond in different ways to different experiences at different times. Looking at individual life histories in greater detail by 'hearing the tale that is told' shows the blending of different roles and identities in one life course. A review of selected individual life histories also helps to illuminate two queries which arise from this study. First, to what extent are relationships in care influenced by previous life course experiences? Second, can the life courses of individual residents provide clues to the kinds of relationships which these residents might form in residential care? To explore these queries further, a more detailed review of selected individual life course experiences is presented in the next part of this Chapter. Cognitive maps and eco-analysis charts are used to assist with the review.

The life of Mrs. Kathleen Perkins, an Émigrée, is presented first.

Mrs. Kathleen Perkins, an 83 year old childless widow at Southam, told the story of her life lived in her beloved Glasgow, where she was born in 1910. Her father worked for the Co-op as a boot and shoe salesman. Her mother came from the Highlands and was the youngest of seven girls. Mrs. Perkins had one sister, seven years younger than herself. Mrs. Perkins felt she was "fortunate in my parents". She felt closest to her father. Her father ensured that she had a good education. She learned to love the poetry of "Rabby Burns, thanks to my father". She took a Higher Grade School Certificate, studying two or three languages, including Latin and German. She described herself as "a bit of a swot". She had a good memory. Her father took her out to plays and entertainments. She had many friends. When she left school at the age of 17, she went to Secretarial College, and took up office work. She became a secretary at a "high class department store" on Sauciehall Street. She felt very fortunate to have this job. She might have been a school teacher. (There was a hint of regret in her voice that she had not done this.)

She met her husband Thomas at a dance. Thomas worked for his father who had a butcher's business. They married when she was thirty and he was thirty-five. Thomas was like a son to her own parents, and they often told her, "Be good to that boy". They lived not very far from her parents at first, but then moved to a different district to be near the butcher's shop. Her younger sister meanwhile married and later died in childbirth. Mrs. Perkins and her husband subsequently reared her sister's child, a boy, from infancy until he was ten years old. Then the boy's father re-married and the boy (her nephew) went to live with his father and his new stepmother. She said, "It upset me dreadfully to lose the boy - my husband warned me that he might not be with us forever." One "heartbreak for me" was that she and her husband had no children of their own - but she quickly added, "I had a very, very, good husband". They enjoyed good holidays together to Majorca and other islands abroad. She never worked after her marriage. They both enjoyed bowling and belonged to a private club. Her husband golfed. They went out each Thursday and Saturday with friends. She taught in a Sunday School.

She remembered World War Two as a "dark, drab time", with planes, sirens, and bombing - "I was lucky to get through it." She was rather vague about the death of her husband, and spoke in more detail about her house and her old friends, whom she misses. Her nephew is now settled in a county town in Southern England, near the residential home. He is married, with a family, and works for a bank. Last year she sold the house in Glasgow. She came to live with her nephew for a while, and then entered the residential home. She finds it hard "to break in new friendships - there's no common ground here." She said, "I feel accepted now and settled, mixing with a general circle." She described herself as "choosy", and felt that being in the home meant that she "met people from different walks of life, having to live together here." She now knows "a broader spectrum of people, and I realise I can't change them."

Psycho-social developmental theory provides a useful analytic tool for understanding Mrs. Perkins' life history and her current relationships. Mrs. Perkins spoke lucidly about the loss of her beloved Glasgow when she moved to south-east England in her old age, but she cried and became muddled when asked about the death of her husband. She could not recollect when and how her husband had died. She began to ramble about the death of her parents. In her distress, she could no longer distinguish between the three events (deaths of mother, father, and husband). She sometimes denied that her husband was dead. Mrs. Perkins' selective confusion surfaced around situations which indicated unresolved bereavement reactions (Parkes, 1971). In Mrs. Perkins'

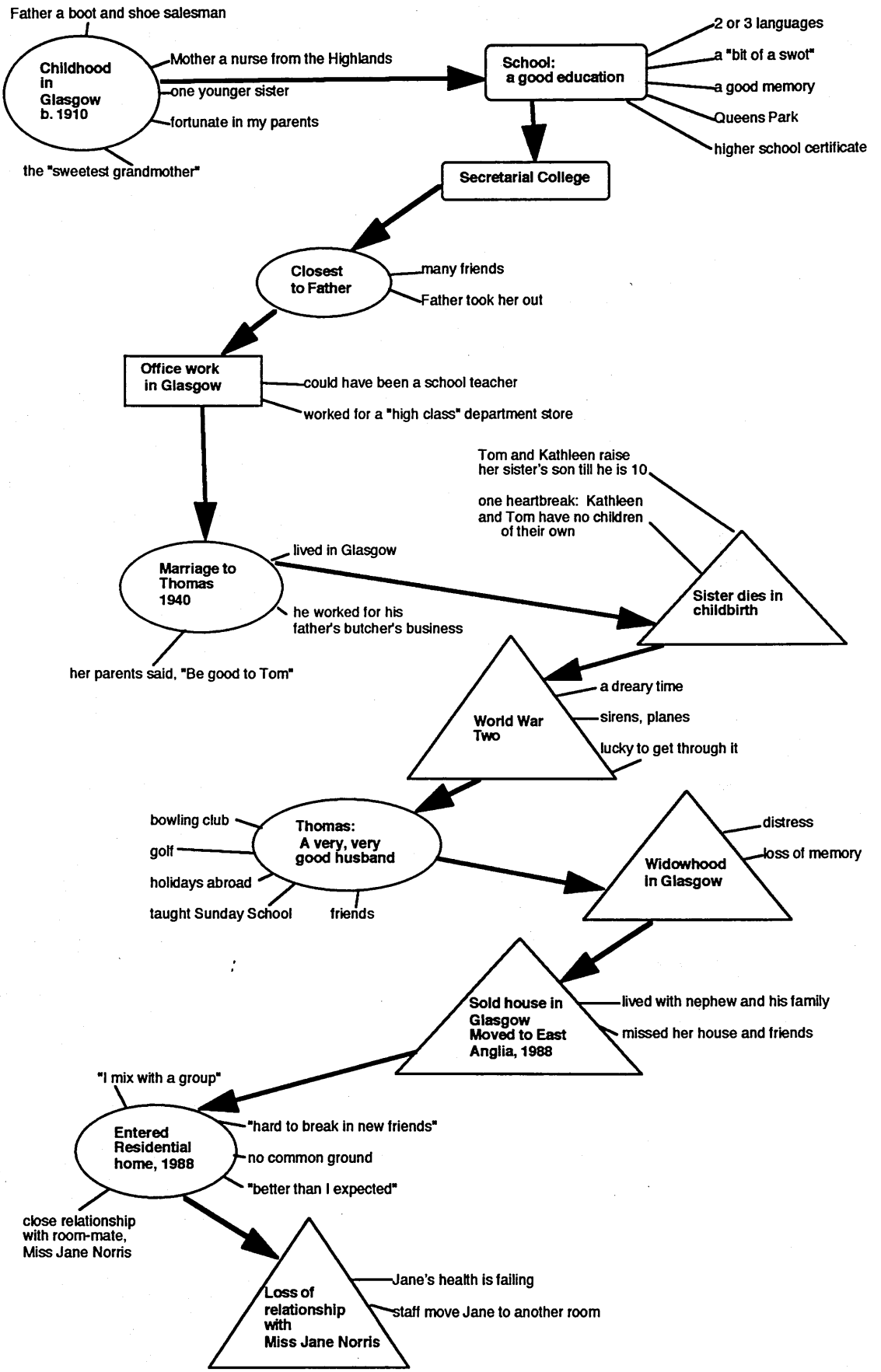
situation, certain reminiscences were too painful to be shared rationally and objectively. She showed examples of Erikson's selective remembering and pseudo-integration (1986).

Mrs. Perkins' bereavement reactions were exacerbated by the recent loss of her room-mate, Miss Jane Norris, who had been moved from their shared bedroom by the staff. Although the staff discussed the separation of the two residents openly, its significance to Mrs. Perkins was revealed only through her life history. As well as sharing her distress, her unresolved grief from earlier losses, and her selective confusion over dates and time, she also discussed her regret about her childlessness and her desire for attachment through a close relationship. Throughout her life she sought close relationships marked by emotional intensity which Bowlby characterised as attachment (1951). Her room mate, Miss Jane Norris, was a single woman who had no close relatives to rival Mrs. Perkins' bid for a close relationship. She provided an appropriate focus for Mrs. Perkins' need for intimacy. The significant relationships in Mrs. Perkins' life were her close, intimate relationships with male relatives - her father, husband, and nephew/foster-son. These relationships illustrate Freud's view (1953, 1976, 1986 editions) of relationships as a replay of previous relationships experienced in childhood. She was willing to become an émigrée for the sake of being close once again to her nephew - her only remaining relative. The failure of this relationship, resulting in her admission to care, was too painful to discuss. Within the residential home she repeated the pattern of her previous relationships by seeking out a close intimate relationship, this time with her room mate (not with a male figure). The disruption of the relationship with her room mate by the staff, when they moved Jane Norris to another room in the home, echoed the earlier loss of her nephew when he left her care to live with his new stepmother and his father. Mrs. Perkins showed confusion, despair, much emotion, but also a philosophical acceptance of some of the good aspects of being in care - "It's not what I expected, having read novels about life in a home - this is better than I thought it would be." I felt that she was attempting to reach the Eriksonian stage of reflective detachment (1986) and Gilligan's final relationship stage of integrity, balancing care for self and others (1982), rather than succumbing to depression at the loss of her attachments.

One could explain (and perhaps predict in part) Mrs. Perkins' current relationship-seeking behaviour from an analysis of her life through the psycho-social theoretical framework. Synchronic theories (such as age stratification, Riley et al, 1972, discussed in Chapter Two) draw attention to the wider processes and contexts of relationships, but do not enable such understanding of individual behaviour. They provide help in showing the modifying influences on relationships. Age stratification theory provides insight into the cohort effect on Mrs. Perkins' past relationships, illustrated by her own acknowledgement of the influences on her life experiences of increased educational and work opportunities for women, the assumption of a conventional role within marriage, the stresses on family life of World War Two, and the increasing prosperity of post-war years when holidays abroad became affordable. In residential care, the organisational relationships of the regime and the residents' frailties influenced her personal and social relationships. The cognitive map below captures the intimate relationships of Mrs. Perkins, who valued these above social relationships.

In this and the following cognitive maps, the progression of the life course is noted by the arrows. Significant life events perceived as personal relationships are noted by ovals. Rectangles enclose life events which denote organisational relationships, such as school and work. Events and transitions which were recounted as crises are enclosed by triangles.

FIG 34 Mrs. Kathleen Perkins' Cognitive Map



In contrast, an eco-systems analysis illustrates the relationships across the life course of Mrs. Lily Irving, a Londoner Successfully Transplanted, who had experienced Deprivation, and used Spiritual Belief as a means of asserting her identity. The eco-systems analysis is effective for Mrs. Irving's life course because of the way in which her relationships reflect the influence of social, cultural, economic, and historical trends.

Mrs. Lily Irving, a 94 year old widow, is a regular respite care/short stay resident and day care user at Southam, in order to relieve her widowed daughter Joan (herself over 70), with whom she lives. Mrs. Irving was born in Hackney. Her father was a foreman in a printing firm, but he died when Lily was four years old, leaving her mother a widow at 28 with three children to bring up - Lily, a six year old sister, and a two year old brother. They led "a poor life", and Lily's mother went out "scrubbing and cleaning" to keep the family together. As well as her mother's efforts "working herself to death", there were two major influences on Lily's early life which gave her much happiness: her Salvationist faith, and her role, promoted by the school she attended, as a champion swimmer.

Lily is still a Salvationist as in childhood, and she claims this belief as her guiding principle in life - "I don't drink, smoke, or swear, and I try to be as good a person as I can. Prayer is important, and I'm in the habit of praying". At school, she was "the champion swimmer of London" at the age of ten. The school "fed me well", with school dinners and Bovril ("the first time in my life I'd had it - to keep my strength up"). She won trophies for the school, and recalls that she was "very, very happy". She loved school, and "tried to behave myself". She was given a free ticket to the swimming baths, so she could swim there during the holidays. When she left school at 14, the school wanted her to train to become a swimming instructor, but her mother said no - "she couldn't afford it". Lily "had to do as I was told". She worked in a suspender factory, but did not like it, and wanted to swim instead. Eventually she found a job in another factory as a vegetable cook, remaining there until she married, by which time she was head cook.

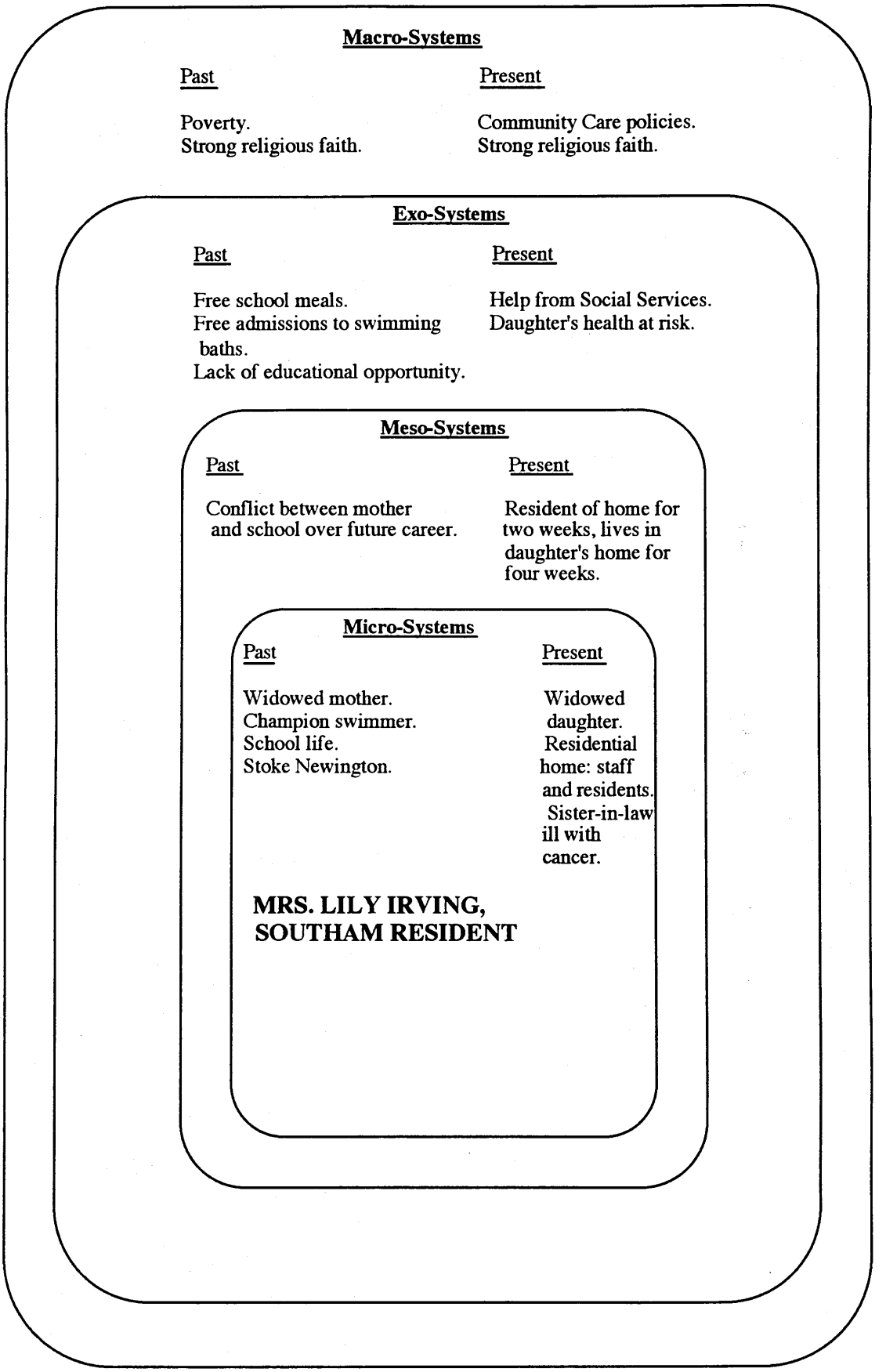
She met her husband Harry when she was on holiday with her friend Jenny at Great Yarmouth. He was an engineer, and then an inspector in the Post Office, retiring at 65 with "a good pension". Her life with Harry was "a placid, happy life", and they were married for 53 years. They "rarely quarrelled, and that's the Gospel Truth". They had two children, Joan and Tony. They lived in Stoke Newington until they were "bombed out" in World War Two, and came to live in a small town in East Anglia, "near the children", who were by then married with families of their own.

Mrs. Irving looked back at a life of enjoyment. She loved to cook, and continued to swim in her leisure time until she was 74. She and her husband had a car and caravan. Each of their children married and "turned out lovely - no one had to get married in those days". Her son Tony became a prison officer. Her daughter Joan married, had children, and is now widowed herself. Mrs. Irving spoke with particular pride about her grandson, who attends a private school and is interested in all sports, including swimming and gymnastics. Mrs. Irving tended to gloss over the difficulties of life and view relationships through the perspective of her optimistic faith: "I never hurt or upset anyone - life's too short. I'm pleased with my life - I have good relationships, and say good-night all, knowing that the sun won't set on a quarrel". She accepts that "life does change - when my husband died sixteen years ago, the world stopped turning. I don't want to live forever". Having admitted this, she hastily added, "I have the loveliest daughter - she looks after me so well - she even puts tooth paste on my brush".

It was for her daughter's sake that Mrs. Irving became a short stay resident and day care user. She said that the "food here is super and the staff are angels - I'd recommend it to anyone". Closer probing revealed that Mrs. Irving valued her own "marvellous sense of humour" and "character". Her faith provides her with a bulwark against the depressing consequences of old age: "I say, Dear Lord, look after me, don't get fed up with my nattering - life is sad, and I'd rather be dead than be like some of these poor souls". She characterised herself as "generally sociable, but never one for having neighbours in the house". Her Salvationist faith was "not everyone's cup of tea". In her long life, she named only three friends - her daughter-in-law, her sister-in-law, Elaine, currently ill with cancer, and her school friend, Jenny. Two of these have acquired kinship status.

The eco-chart below expresses Mrs. Irving's past and present relationships.

FIG 35 Eco-systems Analysis of the Past and Present Relationships of Mrs. Lily Irving



Throughout her life, health and social welfare policies (expressed through the meso and exo-systems) influenced her life opportunities. In her childhood, she was encouraged and sustained by free school meals and school sports (swimming), but prevented from attaining a career because of lack of educational opportunities. In her old age, she is sustained in the community through respite and day care provided as part of Care in the Community.

In Mrs. Irving's past, her micro-systems are identified as her relationships with her mother, her school, her activity as a champion swimmer as a child, and the neighbourhood of East London where she grew up. Her meso-systems of the past were characterised by a conflict between her mother and the school over Mrs. Irving's future career. Her exo-systems were affected positively by provision of school meals, and free admission to the swimming baths which stimulated her development and maintained her health. The macro-system of her past was marked by poverty and lack of educational opportunity due to her mother's early widowhood and working class identity, and also by her strong religious faith.

In reviewing the past, one learns that Mrs. Irving's strongest relationship was not with her husband or daughter but with her widowed mother, who struggled to make ends meet. Mrs. Irving's identity was shaped positively by her success in childhood as a champion swimmer, although her ambition of becoming a swimming teacher was not realised due to family poverty. The dynamic 'fight-to-win' qualities for which she won praise as a child were reflected in her present relationships in the home, where she was assertive, bold, and optimistic in contrast to other residents. Her religious faith provided an ongoing sustaining relationship in old age as in childhood.

The chart also identifies Mrs. Irving's current micro-systems: her relationships with her widowed daughter of 70; with her sister-in-law seriously ill with cancer; and with the residential home itself. Her current meso-systems are expressed by the balance maintained between her life as a resident of the home for two weeks during each six week period; and her life in her daughter's home, where she spends four out of six weeks. Her current exo-system is affected by her daughter's health. Any negative change in the daughter's well-being might result in Mrs. Irving's permanent admission to care. The exo-system is also influenced by the resources allocated to Southam by the Social Services Department, which enable the home to offer a short-stay and day care place to Mrs. Irving. The macro-system is represented by Mrs. Irving's belief system in salvation through her fundamentalist Christian faith (a constant throughout her life); and Care in the Community health and social welfare policies.

From this framework emerges a view of Mrs. Irving's present significant relationships: with her daughter; her sister-in-law; the residential home; and her religious faith. Instead of seeking a close personal relationship within the home, as Mrs. Perkins did, Mrs. Irving sought to become "known" through her Spiritual Belief, and her character as a "natterer with a good sense of humour". Her need for close relationships was satisfied through her carefully chosen relationships with her mother, husband, daughter, and two women friends/relatives. Within the home, she expressed the wish to have a single room rather than share, and she indicated that her Spiritual Belief would sustain her experience in care rather than any newly sought relationship. These actions were in keeping with her life course experiences and the meaning she gave to her life history. Although Mrs. Irving had experienced Deprivation in her childhood, the poverty was compensated by her Spiritual Belief, her mother's care, and her achievements as a swimmer, so that in old age she did not present her childhood Deprivation as a dominant influence.

Other residents, like Mrs. Irving, were able to escape early experiences of material Deprivation, but unlike her, their earlier psychological Deprivation continued to exert an influence. The life history of Mrs. Frieda Grantham, a resident of Northfield House,

who was a Local and had experienced Deprivation, illustrates the lingering effects of a more complex Deprivation.

Mrs. Frieda Grantham, a 77 year old married woman living at Northfield House with her husband, was born and had lived all her life in the small coastal town where the residential home is located. Her father was a fisherman who unloaded barges. He had been wounded in World War One, and was a "drunkard". He died at 56. Mrs. Grantham's mother was "hardworking, a good woman who got depressed". She worked in the fields. There were eight or nine children in the family, and Frieda was the fourth oldest. She remembers being "cold and hungry" and having to go "to the Parish Hall for soup". Family life was "hard times". Of home life, she said "it was rough". She remembers getting up at 4 a.m. to go pea picking. Her father did not give her mother enough money. "He knocked my mother about. Even though I was the favourite, he hit me". She said "I wouldn't want to see childhood days again."

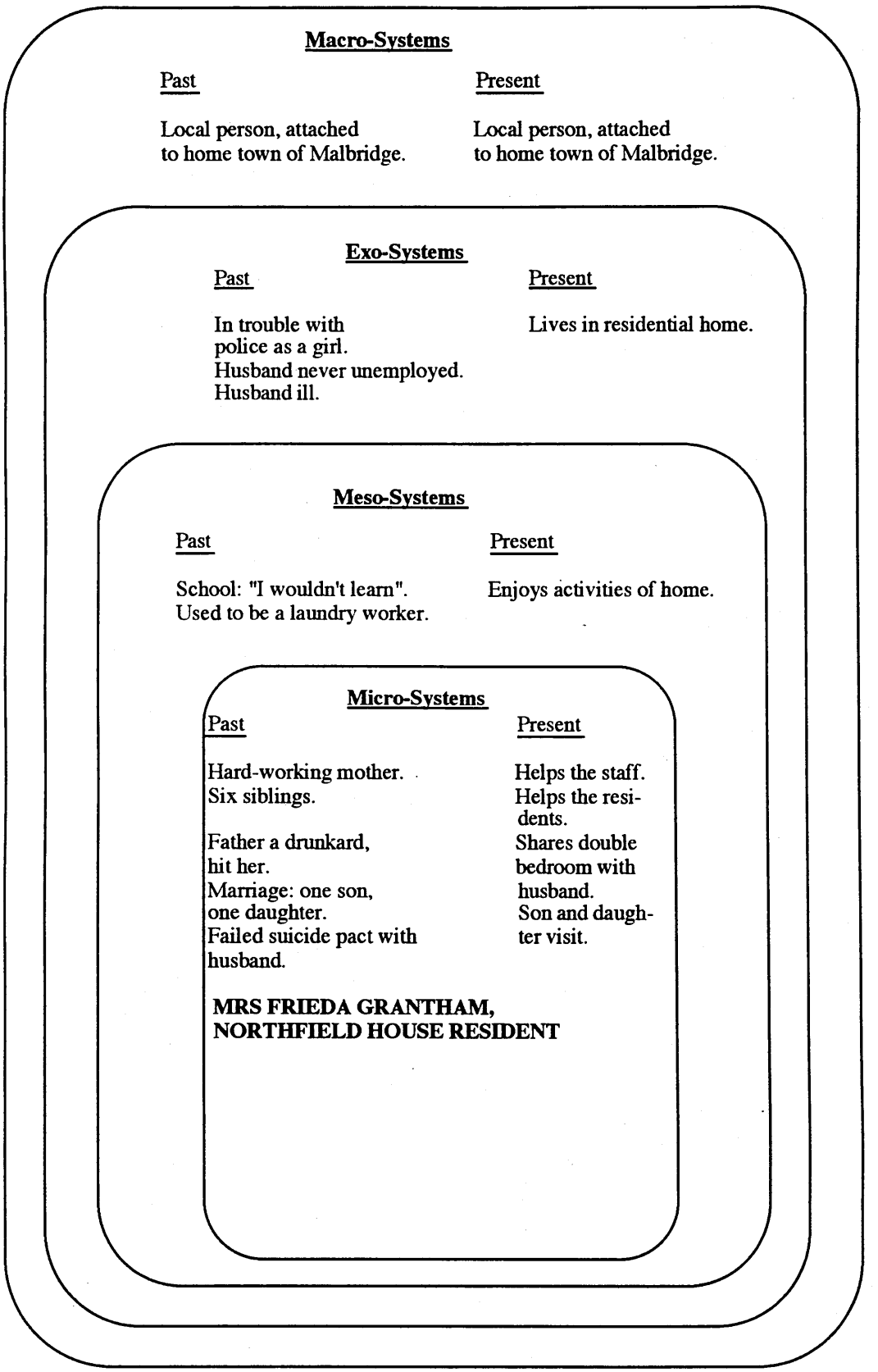
At school Frieda was, in her own words, "a devil". The teachers "couldn't do anything with me - I couldn't learn". The teachers gave her food because she was often hungry, and she recalls making tea for the teachers in exchange for something to eat. At the age of 14 she was in trouble with the police, breaking a curfew, and swearing at a policeman who challenged her. She said "he lied" about her actions. She appeared in court and was fined 10s. At 14, she left school and went to work ironing in the local laundry. She "enjoyed the work and got on all right with the foreman". She loved to swim in her youth. She met her husband Kenneth at school and they "courted from when I was 14, on and off". She recalls this time as "happy". They walked miles, and cycled through the countryside. They became engaged when she was 20 and married when she was 21. She gave up work when she got married. They had lived in just two houses in the same town since their marriage. She loves the local town, and has always tried to "help other people". She was "never a joiner". She does not drink or smoke. They had two children, a daughter and a son. The daughter had asthma from infancy, is now married with one son, and lives about ten miles away. Her son lives locally, is married to a Frenchwoman, has no children and works in a factory in London. She feels closest to her son, who "understands, but my daughter is sharp with me".

In 1937, her husband had a heart attack, followed by meningitis and pneumonia. Miraculously he survived. During World War Two he worked as a fitter, and was in the Home Guard. She remembers the "doodle bugs" during the war. Her husband worked nearly 20 years for one firm, and then 27 years with another firm. He was never out of work. After retirement, her husband developed arthritis. - "He couldn't do anything". She "had to do everything - I got so depressed, crying and full of worry." They made a double suicide pact, both taking overdoses of thirty sleeping pills each. Their son found them. Mrs. Grantham was still conscious - "my son was crying". They were taken to the hospital, then to the residential home for a short stay. Three years later, they are still living in the residential home.

Mrs. Grantham is very happy at Northfield House. She says "I'd be depressed if I was at home. The girls (staff) are good to us. I've got no worries." Her husband's health is poor. He had a slight heart attack two months ago and she had pleurisy. (This was said as a justification for their continuing stay in care). The home is "lovely - I dance and have fun. I'm the life and soul of the party - I've always been like that". She enjoys parties at Christmas time at the home. Taking her first aeroplane ride when on holiday with the home at the seaside was a valued experience which she prizes. She describes herself as "sociable and enjoying a laugh". She phones her daughter and son every week. She keeps in touch with her former neighbours, including her sister in law, who became depressed when she lost her husband. She helps another resident cut up her food, and she helps another male resident who has Parkinson's disease. She changes her bed and sheets, helps in the kitchen, sets the table for breakfast and tea, helps wash up, and gets the rabbit food for the home's pet. She says of herself nevertheless, "I won't be put upon." She feels that if she had a problem, she would not tell anyone. She has never confided. She said "it didn't help when people told me to pull myself together".

The significant past and present events in Mrs. Grantham's life course can be expressed through an eco-systems analysis chart, below.

FIG.36 Mrs. Frieda Grantham's Eco-Systems Life History



The eco-map shows the importance of life in the small town of Malbridge where she was born and lived all her life, and where she now lives in the elderly persons' home. Her close relationships as a child were affected by family poverty exacerbated by her father's alcoholism, and by his violence towards her. She developed anti-authoritarian relationships and behaviour towards school and towards the police, which she acknowledges with insight. She notes the kindness of teachers at school "who fed me" and shows growing social acceptance of benevolent authority in her social relationships as she matured. Marriage rescued her from her earlier Deprivation and gave her a satisfying close relationship, status, and security within her familiar small town surroundings. Unlike her own mother's experience, "my husband was never out of work and he wouldn't let me work." She had two children, unlike her mother who had nine.

A threat to her happiness occurred when her husband became ill, once in the 1930s and then again in the 1980s. The illness altered the nature of her dependent relationship on her husband. She needed her husband's support in order to avoid the pattern of her parents' lives, where her own mother was "depressed and hard working" and her father "drunk" leaving her "cold and unhappy".

World War Two, with its wider context of organisational relationships, seems not to have affected her life nor that of her husband to any great extent. Although she remembers the "doodlebugs", she lived in a rural area during the war, away from the bombing. The onset of old age and the frailty of her husband led to an altered relationship, eventual depression and attempted suicide. Admission to the elderly persons' home for her husband and herself following their failed mutual suicide attempt brought a release of her worries. She submitted to the benevolent authority contained within the organisational relationships of the home. Her life in the home enables her to compensate for her own missed adolescence. Now she is cared for and secure; able to join in the fun of activities which she never had as a child, and also able to help others in the role of 'mother's helper'. The location of the home in her familiar and loved community of Malbridge enables her to retain her sense of belonging.

Considered from the perspective of relationships throughout the life course, she experienced abuse and poverty in childhood and these deprivations overshadowed other environmental influences. Mrs. Grantham's deprived, abused childhood was mitigated through the support of her steady, hard-working husband, Mr. Kenneth Grantham. Equally important is the question: why did she choose to marry Kenneth Grantham, a man very different from her father? This question is illuminated through the psycho-dynamic insights (Freud, 1953, 1976, 1986 editions; Erikson, 1950, 1986; discussed in Chapter Two) about influences on early close relationships and subsequent relationships. It could be argued that her husband's secure employment was a factor which compensated for her father's inability to provide. When her husband became disabled, she could not move into the role of supporting him as it became too much like the pattern of her own parents' lives. She now accepts the benign authority of the home as an emotionally satisfying substitute for her husband's support and even more importantly for her own unsatisfactory childhood experiences. Her relationships with the staff and with the institutional regime itself are vitally important for her continued psychological well-being. As a consequence, she claims to be very happy in the residential home. She assumes a powerful role as helper and quasi-staff member (discussed in Chapter Nine) as well as, in her own words, "life and soul of the party".

These conclusions about her relationships were based primarily on the life history but also on observations and the subsequent interview which complemented the life history. She confided, "I left out some bad bits" of her life history, echoing Erikson et al's view (1986, discussed in Chapter Six) of selective remembering in the search for integration.

Using psycho-dynamic insights to analyse Mrs. Grantham's relationships helps the researcher to understand why admission to the residential home was welcomed by Mrs.

Grantham and why she formed particular social relationships in which she played the role of a Helper and an Entertainer. She replayed the role of her own hardworking mother, but the home protected her from falling into her mother's pattern of depression, and enabled her to enjoy her life as the carefree child she was never able to be. It supports the notion that the residential home in which she lives is appropriate because of its location in her own neighbourhood, enabling her to retain her social relationships established over a lifetime. The organisational relationships of the home with the local community facilitate Mrs. Grantham's social relationships which are so important to her. Mrs. Grantham's relationships can be expressed also through a cognitive map, below.

The cognitive map uses the same symbols as the previous cognitive maps. In the depiction of her childhood, supporting symbols of ovals are used to denote the positive influences of her mother and siblings on the one hand, and triangles for the negative influences of her father and the poverty resulting largely from his behaviour.

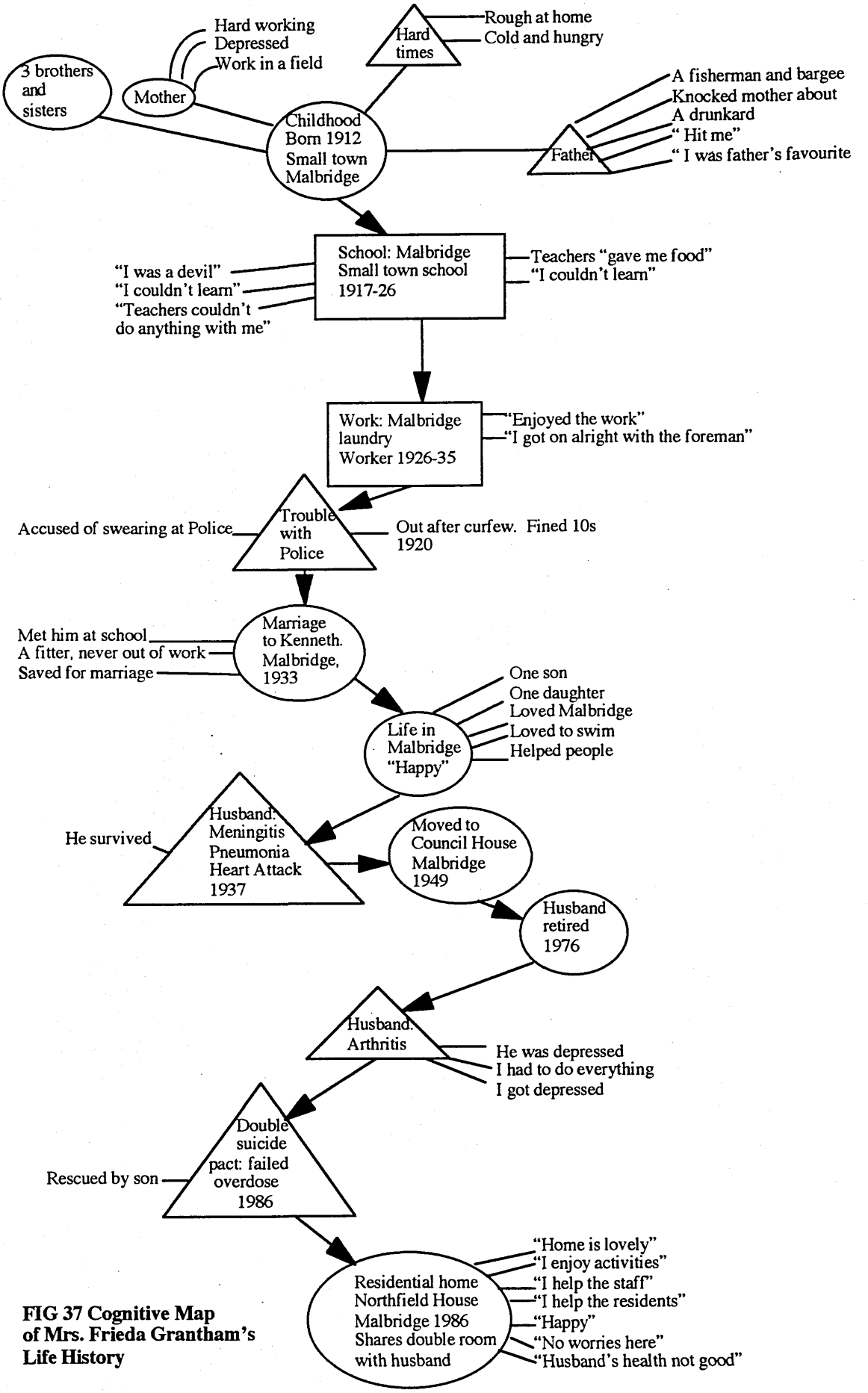


FIG 37 Cognitive Map of Mrs. Frieda Grantham's Life History

The life history of Mr. Richard Llewellyn, an Émigré living at Eastview, who had experienced Deprivation, and who used Spiritual Belief to sustain his relationships, echoes the importance of Spiritual Belief, as in the earlier life history of Mrs. Lily Irving.

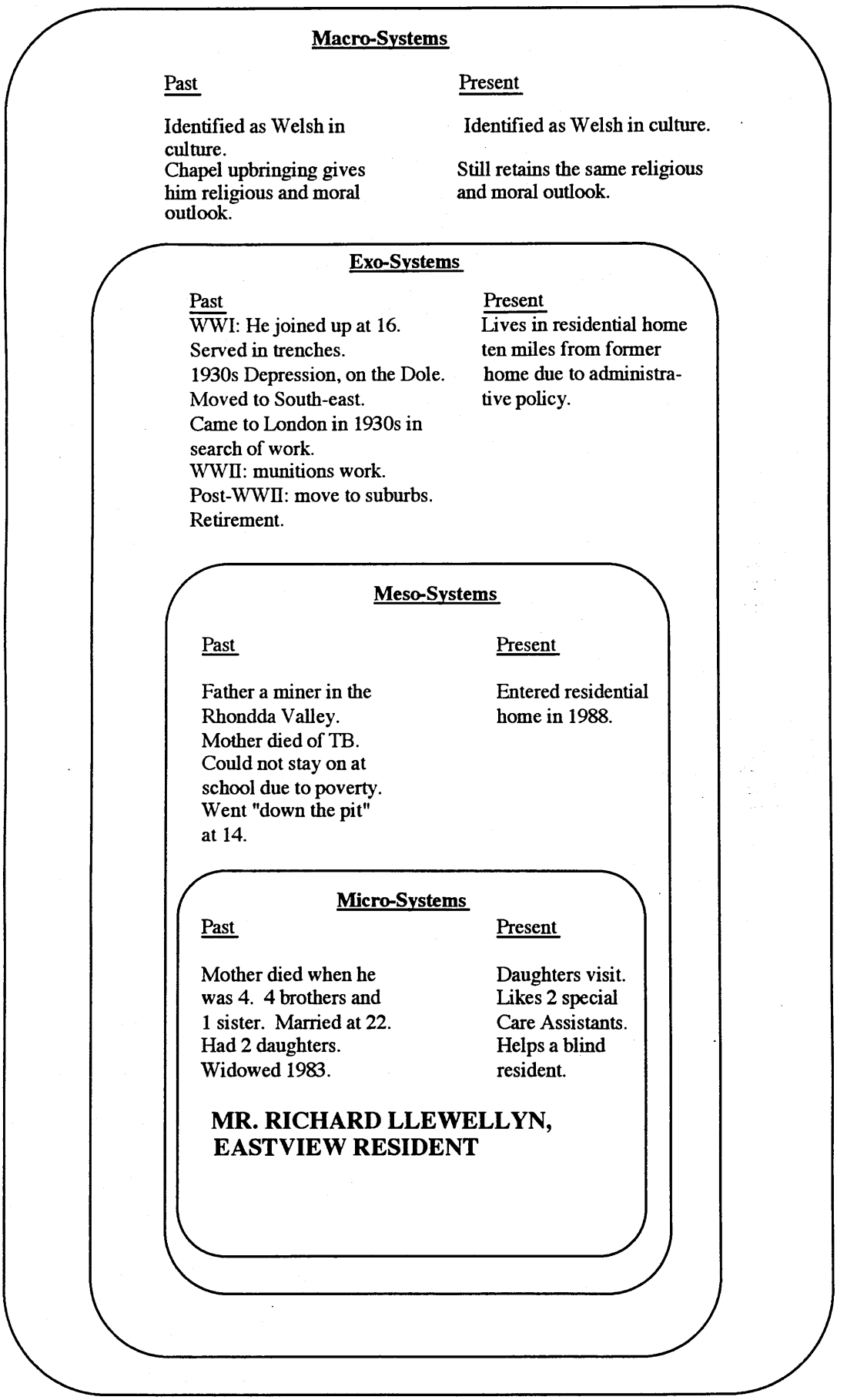
Mr. Richard Llewellyn, a widower of 92, was born in the Rhondda Valley in Wales. His father was a miner. Mr. Llewellyn had four brothers and one sister, and he was the second eldest. The sister died young. His mother had been very ill with consumption (tuberculosis) and died suddenly when Richard was 6 or 7. His father had been out of work for a year, and this and his wife's death affected him. Mr. Llewellyn recalls that "Father was very good, singing, and praying in Nazareth Chapel". Mr. Llewellyn liked school, and "I got as much schooling as I could". He "passed nearly first" for the grammar school, but because of poverty he had to "go down the pit" instead. He worked in the mines with an "old chap, who was always drinking". At the age of 16, he joined the army and went to France. He served in the trenches in World War One at Ypres, and was wounded once in the leg. He recognises how lucky he was to have survived when so many of his "buddies had their heads blown off".

While he was in France his father remarried. Mr. Llewellyn wrote to his girlfriend, who "helped me through the Great War". He married her in 1920, and their marriage lasted for 64 years. She died six years ago - "I miss her. She was always smiling. We got on all right". After the war, he went down the pit again, but in the 1930s he was "on the Dole". His brother and sister-in-law had moved to Chingford near London, so he came to London to join them and look for work. He found work digging trenches for the Chingford Reservoir. He and his family, which now included two daughters, settled in Chingford. He liked it there: "Anything my wife wanted, I wanted, and we got it together". He kept this job, which was "hard work with the clay soil", until the outbreak of World War Two. Then he went to work at a ball-bearing factory making munitions in the county town outside London. He remained with this firm (and became a supervisor) until retirement, moving to the county town after the Second War, again joining his brother there. After retirement, he "didn't do much", except for "some little jobs helping people". He recalled good holidays with his wife, in which they travelled to different parts of the country. His wife died suddenly of a blood clot six years ago. His daughters both married, and had children. One is now a widow.

He does not miss Wales, saying that of 63 collieries, now "none are left there at all". "Quite a lot of us got away from there". He first entered residential care almost a year ago at his doctor's urging, first "trying out another place for one month". Eastview is located ten miles from his former home, but he could not obtain a place in a nearer residential home due to Social Services admissions policy (discussed in Chapter Seven). His relationships in the home are balanced and sociable, but he calls himself "a loner". He describes everyone as "acquaintances" rather than "friends". He values his Christian faith, formed in the Welsh Chapels of his youth and uses this as a yardstick for evaluating others as individuals. He is faintly disapproving of other residents who smoke ("I gave up twenty years ago") and focuses his attention on his daughters and grandchildren who visit every week. He accepts with forbearance his labelling by staff as "Dickie Dai" and says he does not mind this. There is an air of self-containment and acceptance of his lot. Mr. Llewellyn is very popular with the staff, and notes that there are two "special Care Assistants who look after me".

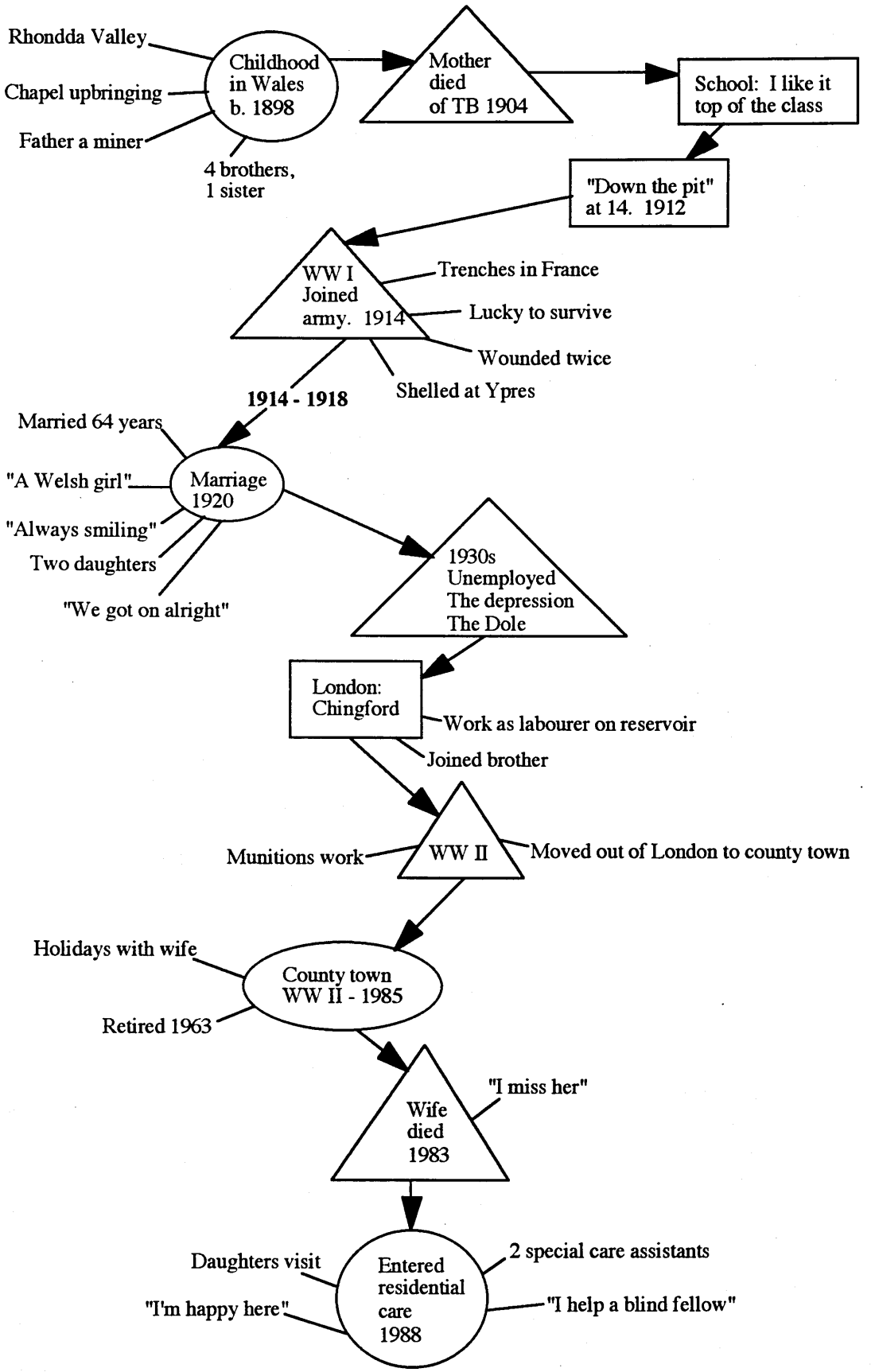
An eco-systems analysis shows the extent to which his life was affected by meso-systems and exo-systems. These systems show the influence of world economic and political events: mining in Wales during the period before World War One, the effects of two World Wars, the Depression of the 1930s, and migration to the South-East in search of work. Mr. Llewellyn's Welsh identity and Spiritual Belief emerge prominently in the eco-systems analysis.

FIG 38 Mr. Richard Llewellyn's Past and Present Eco-Systems



In contrast, a cognitive map reveals more about his personal relationships with his wife and daughters, his relationships in the home, and the changes which occur over time.

FIG 39 Cognitive Map of Mr. Richard Llewellyn



To what extent could Mr. Llewellyn's relationships in the residential home be predicted from the events of his life course? Clues are found as his story unfolds. Throughout his life course he developed good social relationships in his work and successfully moved away from his childhood culture with no outward regrets. This suggests an adaptability which helped him in the past. He weathered the bad times of his mother's death, the Great War, and unemployment by making changes to his lifestyle. His childhood deprivation was similar to that experienced by Mrs. Irving - the loss of a parent, and extreme poverty, but not lack of love or the experience of abuse. (Mrs. Grantham's deprivation was more profound because she experienced brutality as well as poverty).

Mr. Llewellyn was sustained throughout much of his life by his relationship with his wife, and by his family contacts with his own brother and extended family. Now his loyalty is transferred to his daughters and grandchildren. It is unlikely that he will seek a close personal relationship within the home, especially because his Spiritual Belief places moral barriers on talking to single women, and because his personal relationship needs are met by his family. Within the home, he presents a smiling face, is co-operative within its organisational restrictions, and does not complain. These were his coping strategies of the past. His Spiritual Belief sustains him through the difficult times and gives him the edge of a slight moral superiority over the others. He seeks respect and mutual recognition from others, and offers the same to them.

Mrs. Violet Batty, a 79 year old widow living at Northfield House, who was a 'Local', did not demonstrate Mr. Llewellyn's graceful strategies for coping with the change brought about by entry into residential care. She resented being in care.

Mrs. Violet Batty was born in a small village about ten miles away from the town where Northfield House is located. She was born in the Old Swan pub, the fourth youngest of seven children of the publican and his wife. She had three brothers and three sisters. Her "Mum was a good old soul, whose parents also kept a local pub". Her grandfather died of cancer and after that her father bought the Old Swan pub. She was closest to her father - "I was me old Dad's girl". She remembers soldiers coming to the village during World War One with a big gun - "I said, you'll never get that big gun in that field, but they did." She attended the local school and liked it sometimes, but "hated it sometimes, especially some of the lessons". She did not make friends - "I didn't try". She used to "tear home and do errands for Granny, my father's mother."

At 14, she left school and "did errands around the village." Then at 16, she went into service in Surrey. She served eight years, and had to do "all the work". Her employers used to talk about "sending me home to my local village, because of my broad local accent". Her father said to her "If they leave you in the house alone, pack your bags and come home". The house was burgled, and so she came home to stay. Next she got a job in the county town as a maid in a pub, but the publican's wife got drunk "so I came home". She found work as a housekeeper in a nearby village, and then began working for a local pub, the Green Man, remaining thirteen years, living in, and serving at various times as kitchen maid, under-cook, chambermaid and waitress. She loved the atmosphere of the pub, saying it was "lovely- a good old pub".

It was at the pub that she met her husband Jack, who worked at a local foundry. She has many happy memories of going out for the day with Jack, across the green fields to see her Dad. Jack would not get married till "he lost his Mum". His mother was a widow from the Boer War, and Jack never knew his father- "poor old Jack - he was good to his Mum". Violet and Jack married when she was 36 and he was 51. She kept on working at the pub. Six months later, she had "a big operation" which meant she could never have any children. At the age of 53 she had another operation for gall stones - "a beautiful shoelace in the tummy, I make jokes about it, but I'm here to tell the tale". They lived in a privately rented home. Those were happy years. She gave up work, because the business was sold at the pub and she disliked the new owners. When her husband retired he was "no trouble" and kept busy with the garden. He was well liked in the village. He died in 1978. He had an operation and was supposed to come home for Christmas, but he stayed in "and I had to cancel the meat". He had cancer of the lungs. When he did come home eventually, he never moaned about the cancer, "spared me the worry - never told me of his pain. I woke up one morning and couldn't hear him breathing. I went to the neighbour, and said, put on a strong cup of tea, he's gone".

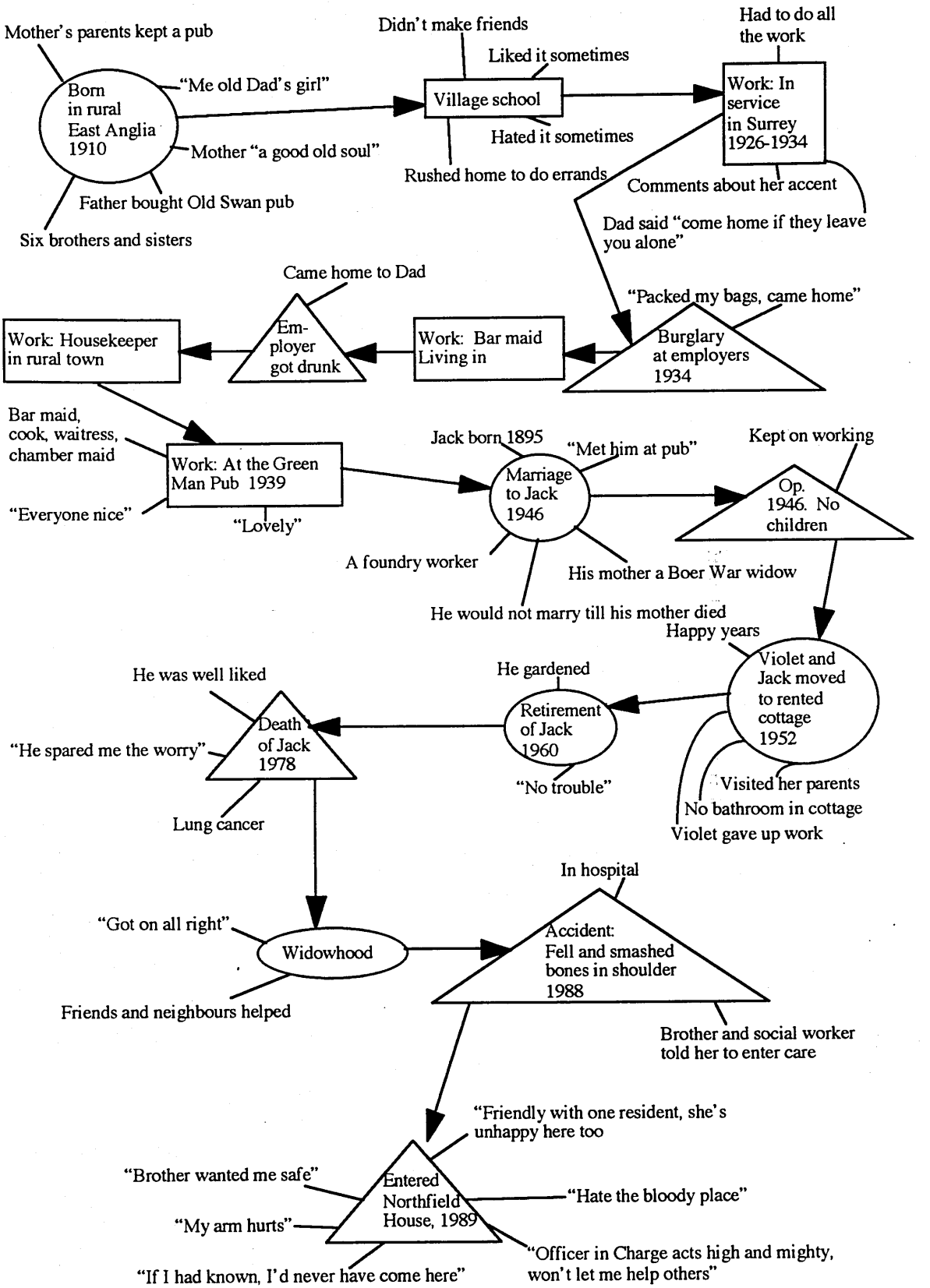
She showed me a picture of her husband and herself looking happy and hearty. She got on "all right" as a widow until she fell on the pavement and smashed the bones in her shoulder and hurt her leg. She had to go to hospital, and then entered residential care direct from hospital. "Coming here was my brother's idea. At home, the toilet was outside across a concrete yard. My brother wanted me to be safe, so I had to come here. If I'd known what sort of place this was, I'd have never come". She showed me the X-ray of her arm and her scars. Mrs Batty said with tears "I hate the bloody place. I'm a worker and like to get on with it, but the Officer-in-Charge told me not to help others". She accused the Officer-in-Charge of acting "high and mighty when she pays out the weekly allowances, as if she's giving us £1000 instead of £8". She made me promise not to tell the staff of her complaints.

She characterised herself as talkative and chatty, but inwardly shy - "I've always been bad at mixing". She is bitter about not hearing from old friends and neighbours, feeling that she has "always been generous and helped others, now these people don't visit. That hurts". She did not send any Christmas cards this year, and did not get many birthday cards. Her brother and sister-in law visit twice a week and one old neighbour visits when she can. She has formed a close relationship with another woman resident. Both are united by their dislike of the residential home, and their lack of relatives (e.g. children). They spend time together in each other's bedrooms, to the displeasure of the staff who would prefer that the pair sit in the Unit's communal sitting room. Her subversion has not gone unnoticed. She has made an enemy of Mrs. Enid James, whom she accuses of "having nasty ways, upsetting me and yapping, interfering with my visits from my brother".

Throughout her life course experiences, Mrs. Batty had developed two kinds of relationships: first, a close intimate relationship with a male figure, initially her father, then her husband (who was considerably older than she) and now her brother; and secondly, friendly, neighbourly social relationships similar to those she enjoyed in the village pubs where she had grown up and worked. Both of these kinds of relationships are difficult to find in the residential home. She lacks children who could sustain her need for a close intimate relationship, and her brother visits no more than twice a week. Her role as a worker in the pubs could not be continued in the residential home; she was prevented by the Officer-in-Charge from assuming her desired role of helping others as a Quasi-Staff member (discussed in Chapter Nine).

Mrs. Batty's relationship patterns in the residential home mirror her earlier ambivalent relationships at school, where she did not try to make friends. Unlike her earlier situations at work, she could not leave and "go home" when events do not go right for her. The circumstances of her entry to care were not well managed. She did not choose to enter care, but felt forced into it by her brother and the hospital social worker. Her vivid recollection of her husband's death suggested that she was revisiting her grief and sense of loss over his death because of her current unhappiness and the loss of her familiar home. Mrs. Batty could not accept the reality of residential care, perhaps because she was still relatively strong physically and mentally. Her level of frailty was not so marked as to remove all possibility of living in the community. It was not surprising that Mrs. Batty sought and found a close personal relationship with another resident, whom she perceived to be alone and friendless like herself. The cognitive map, below, illustrates her relationships.

FIG 40 Mrs. Violet Batty's Cognitive Map



Mrs. Iris Rowlands, an Eastview resident, provided the last of the six life histories to be reviewed. She was older and more disabled than Mrs. Batty, and nearly blind. Yet her attitude and her relationships were more positive than Mrs. Batty's. Mrs. Rowlands was a Londoner Successfully Transplanted, who had known Deprivation, but who had achieved a sense of Self-Actualisation and Integrity.

Mrs. Iris Rowlands, an 92 year old widow living at Eastview, was born in Battersea in London, the third youngest of four children. Her father was one of 13 children, and her mother, who was from Yorkshire, was one of 17 children. Mrs. Rowlands' older sister died young, and her brother, who was four years older, was killed in World War One. A brother two years younger lived to old age, but is now dead. Both of her parents were "in the drapery line" and lived over the shop. When Mrs. Rowlands was very young her father became ill with consumption (tuberculosis) and the family moved to Suffolk, to her father's village, where it was hoped he would recuperate. Her grandfather was a butcher and Iris' father helped to deliver the meat. Sadly, her father died when Mrs. Rowlands was 4. Around this time Mrs. Rowlands became very ill with rheumatic fever. She had "blisters round my heart" and she was not strong. She was "under the doctors all my young life". She started school in Suffolk, where she remembers the headmaster and headmistress and their three daughters. She always liked school. She was told that she could not dance at school because of her heart condition, so "I knitted instead because it's soothing."

When Iris was 11, her widowed mother had an operation for ulcers and moved back to London. Her mother opened a draper's shop in Walthamstow, and Iris helped her. The shop had an earth floor at first. "Later I would scrub the lino which we eventually put in". At Walthamstow, despite not being able to dance because of her illness, she "loved school". She started playing netball - "I was goalie because I was tall". She left school at 14 and started work as an apprentice to a dressmaker, but did not like this work. She attended shorthand and typing classes at Clarkson's Secretarial College for a few years, then went to work for the Prudential Insurance Company where her brother also worked. She was a secretary at the Prudential for 9 years until she married, and "was quite happy there".

Mrs. Rowlands' mother had to give up her shop eventually, and sold it. Mrs. Rowlands stayed with friends, then she and her fiancé Will decided to get married. Will was nine years older, "nice, but not a businessman". He had been in India, and worked as a "traveller in ropes and twines". He was a "nice man, but a plodder". They had two children, Anne and Bill. Despite her childhood illness, Mrs. Rowlands' pregnancies were normal. Her health had improved because "I was well looked after".

Before World War Two Mrs. Rowlands' husband had been unemployed. Iris and Walter took over an Off-Licence shop during World War Two, but a bomb smashed the window - "it was miserable". During these years, Iris belonged to the local Tennis Club, and Choral Groups. She loved these kinds of activities. After the war, her husband worked for wireless and TV shops for quite a time, selling TVs and doing evening work. He died at the age of 74. Mrs. Rowlands was then 65. She moved to the county town, and found a job at a local hospital (now closed) as a dressmaker and seamstress. She worked at the hospital until she was 73, when the hospital closed, and she retired.

Her son Bill went to live in Africa and worked as an air traffic manager. Mrs. Rowlands visited him there. Bill died ten years ago just after he retired. Mrs. Rowlands is still in touch with his widow and their son and daughter. Mrs. Rowlands' daughter Anne lives nearby and is married, with four daughters. After Mrs. Rowlands' retirement, she moved from her home into a council-run sheltered housing scheme, where "they got me home helps". Her daughter Anne "couldn't have me because she lives in an upstairs flat and I can't climb the stairs". Now Mrs. Rowlands' eyesight is very bad, and she cannot read or knit. She cannot write or phone, and all her friends are dead. Entering the residential home was an acknowledgement that "I can't do it (manage) on my own. I've given up my home - who would take care of me?" She feels that her experiences of going out to work at the age of 65, then living first in the sheltered housing scheme where she learned to take part in social activities in the communal lounge, and now living in the residential home, have helped her to develop. "I used not to be easy with others. I used to be afraid to speak, but now I can. I've lost my timidity". She feels that it is "nice to have a close friend, but all mine have died". She settles for "having company". Before coming to Eastview, she lived for a month in a private residential home, which she described as "deadly - we just sat and nothing was arranged. Here we have activities". She criticised some of the staff and some of the confused residents, but said objectively, "It's best if you don't chose your group at the dinner table. It wouldn't be so good for everybody. If you could choose your own group, some people wouldn't be wanted by anyone".

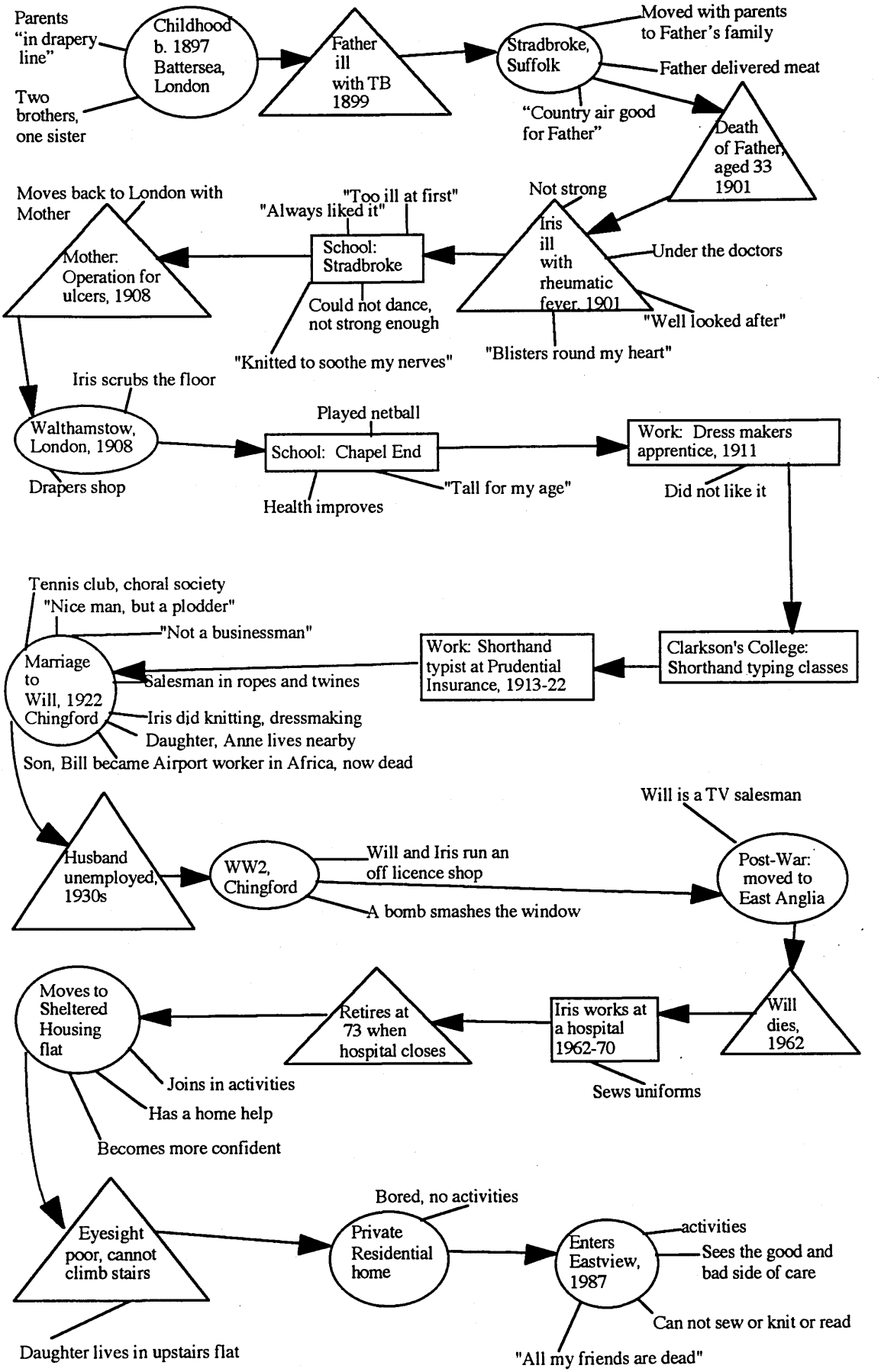
Mrs. Rowlands' life was marked by periods of misfortune and bad luck, but also by persistence and new beginnings which brought hope for the future. For example, her parents' move to Suffolk when her father was taken ill was an attempt to make a new beginning. Mrs. Rowlands' childhood illness, occurring after the premature death of her father, galvanised the love and attention of her family, and she acknowledged their love and concern for her. She accepted her physical limitations at school, but showed herself to be resourceful and capable in other activities. Her mother then made a fresh start in London, and Mrs. Rowlands describes her own training and work as a secretary in much the same way. She had been given the opportunity to train as a secretary rather than being forced to go into menial jobs like Mrs. Batty and Mrs. Irving. She experienced other new beginnings in her life, when she and her husband ran an off-licence shop, and after her husband's death when she began a new job at the age of 65. She cited a positive gain in her ability to make social relationships from this work experience and her subsequent life in sheltered housing and in residential care. She conquered her illness, but had ups and downs in her married life, and did not achieve as much material prosperity as some other residents.

Her memorable qualities were her ability to make fresh starts, and to take an objective view of events and of people, putting the good and bad along side each other. For example, she could describe her late husband as "nice, but a plodder". She discussed her son's career in the same breath as describing his death. She complained of certain aspects of life in residential care, but accepted the reasons for her entry into care and some of its institutional features. She had come to terms with the loss of her siblings, husband, son, and her friends without self pity. Mrs. Rowlands did not refer to any Spiritual Belief which sustained her, but there was a sense of balance in her perception of events and of people. She sustained good social relationships in the home, but was not looking for a close personal relationship. A number of residents mentioned her as a special friend, but she did not pick anyone out as a friend above the others. Yet she was content.

However, it was difficult to determine just why Mrs. Rowlands could maintain so objective a view when other residents did not. The clue might be contained in her life history. She had experienced a childhood in which her father died of TB when she was very young, and she herself had been the cause of concern because of a heart murmur diagnosed in her childhood. She had received much loving care from her family as a result, and attained good health in adulthood contrary to the predictions made in her childhood. Her survival, following the early death of her father, validated the efforts of her family and made her successful in their view. She had been given the opportunity to train as a secretary rather than being forced to go into menial jobs. Perhaps her knowledge of death and the need to confront the possibility of death in her childhood and youth, sustained by family support, enabled her to develop inner psychological resources. Her ability to think logically and systematically helped. Did her views indicate an intelligent mind or a self-actualising personality (Maslow, 1987; Erikson et al, 1986), or both? The question still remains, why was she not so defeated and depressed as some other residents by the bereavements and disabilities experienced in old age? This may be the elusive quality of individual personality.

The cognitive map below illustrates her life course relationships.

FIG 41 Mrs Iris Rowlands' Cognitive Map



8.10 Drawing Conclusions from the Life Course Experiences

At the beginning of the review of individual life histories, two queries were posed:

1. To what extent are relationships in residential care influenced by pervious life course experiences?

2. Can life course experiences provide clues to the kinds of relationships which residents might form in residential care?

In reviewing the individual life histories of these six residents and others not specifically discussed, it is possible to attribute links between the current relationships which residents form in the homes with the patterns of their relationships over their life courses. But it is easy to do this retrospectively. Retrospective analysis can become what one wants it to be. Further research would be required to establish whether different kinds of individual relationships in residential care can be indicated on the basis of individual life histories.

Some aspects of residents' relationships revealed in these life history accounts probably would be replicated in other accounts of life course experiences. I found that psycho-dynamic patterns of relationships tend to repeat themselves, particularly if earlier relationships involved some unresolved attachment need (Bowlby, 1951, discussed in Chapter Two). For example, Mrs. Kathleen Perkins and Mrs. Violet Batty, both attached to their fathers and their husbands, and with no children to meet their needs for intimacy, searched for a close intimate relationship within the home. Their motivation for seeking this kind of relationship was made more acute by their reluctant entry to care. Early Deprivation involving poverty and the death of a parent can be overcome (as in the histories of Mrs. Lily Irving, Mr. Richard Llewellyn, and Mrs. Iris Rowlands), provided there is sufficient love and self-esteem given to the child. Deprivation involving abuse and cruelty leaves a deeper scar, as in the history of Mrs. Frieda Grantham. She could not cope with the illness and resulting dependence of her husband because it brought back memories of how her father had failed to provide for her mother, with resulting depression for her mother. A successful transition to residential care (illustrated by Mr. Richard Llewellyn and Mrs. Iris Rowlands) is more likely to follow transitions and changes successfully encountered earlier in the life course. Social relationships within the home rather than close personal relationships are sought as a source of satisfaction when residents' needs for intimacy have been met through current or past intimate relationships outside the home. I suspect that these links between past and present would be found in further research.

8.11 Summary of the Chapter

This Chapter discussed residents' personal and social relationships throughout their life course experiences. Their life course experiences demonstrate the influence of multiple factors (opportunities in the social setting, inner motivations, levels of social skill, cultural rules, and past experiences) on relationships (Argyle and Henderson, 1985) as well as organisational relationships and physical and mental frailties. Analysis of the histories showed how residents used their life course experiences to establish themselves in their new relationships in the residential homes by presenting socially acceptable identities.

Identities were used to become known as an individual and to form social relationships. Establishing identities helped residents to avoid the experience of anonymity within the institutional settings of residential care. These were not mutually exclusive identities. Identities based on Locality, former Work Roles, and Spiritual Belief provided socially acceptable means of developing social relationships. Accounts of past Deprivation were less acceptable means of establishing identity, because they created feelings of unease in the listeners. Telescoping of stories and selective remembering (Erikson et

al, 1986), together with the difficulties caused by confusion and stressful remembering, contrasted with some residents' need to confide past experiences of Deprivation. Some residents established identities which achieved Integrity and Self-actualisation, expressed through their detached philosophical acceptance of their past and present lives.

The discussion of residents' individual life histories showed how patterns of residents' relationships in care might be influenced to some extent by their earlier experiences of relationships. A psycho-dynamic perspective, drawing on the contributions of Bowlby (1951), Freud (1953, 1976, 1986 editions), and Erikson (1950, 1986) provides insights into the kinds of relationships sought. Continuing research is required to establish a clearer link between past and present relationships. Residents' motivation for forming relationships is shaped by whether or not their admission to care is perceived as a positive choice (Wagner, 1988). Residents who enter care reluctantly are more apt to remain isolates or to seek a close intimate relationship in preference to friendship (interpreted in the social sense) with everyone. Those who made a conscious decision to enter care are likely to develop social relationships rather than intimate relationships. They are apt to expect a measure of contentment with life in care.

Once established as residents in the homes, the respondents move beyond their reliance on the past. They begin to engage in present relationships on a day - to - day basis. They develop strategies to achieve this aim. Their perceptions of their current relationships and their further strategies for forming relationships are discussed in the next Chapter.

Relationships of Elderly People in Residential Care

Chapter Nine

The Data: Developing and Sustaining Relationships in Residential Care

9.1 Introduction: the Nature of Relationships

Chapter Eight showed how residents asserted and used identities based on their life course experiences to form relationships. The present Chapter traces how residents' relationships in the homes developed beyond their initial assertion of their identities.

Three influences were important. First, as Chapter Eight established, the residents' life course experiences affected their motivations for present-day relationships. Secondly, the homes' organisational relationships influenced residents' relationships. Thirdly, the extent of residents' mental and physical frailty inhibited their opportunities for relationships. These three influences were acknowledged by the residents and became evident through observation.

9.2 Keeping Contact with the Community and with Relatives

Keeping contact with the outside world, with the community, and with friends and relatives known throughout the life course was important for most residents. These were, for the majority, the preferred relationships. The locations of the homes and residents' lack of income restricted their links with the outside world. Although all residents had the right to come and go as they pleased, in reality most residents could not walk unaided and were unable to leave the physical confines of the residential home. Because of their physical frailty, they could shop or attend external events only when the staff organised mini-bus transportation or when relatives took them out. For those who could walk, the expensive cost of public transport and taxis prevented them from going very far. Both Southam and Eastview were located in grounds with a long walk down the drive and through the gate before reaching the centres of their respective village and town. Northfield House was located more conveniently for access to the community. It was across the street from a row of shops and a bus stop. Northfield House's location, with its windows providing excellent views of local people coming and going to the shops opposite, created a relationship with the outside world for residents which Southam and Eastview did not provide.

Contacts with the community organisations which visited the homes to provide entertainment occurred only on a group basis. Staff made arrangements for school children, church groups, and social clubs to visit the homes. There were no observed individual relationships between the visiting volunteers and the residents. At Southam, residents could not escape easily from the organised entertainment, which tended to take over the residents' lounge area. At Eastview and Northfield House, alternative lounges provided more private spaces for those who did not wish to participate.

Residents who were able to come and go independently into the outside world were physically active, with disabilities (memory loss and 'confusion') which did not restrict mobility. For example, Mrs. Maisie Freane at Southam, (discussed in Chapter Eight) retained the demeanour of her former role as a boarding school matron, but was apt to visit the village shop ten times in one day asking for the same items over and over, then find herself unable to remember the way back to the home. Despite being confused, she successfully perpetuated her life course identity of quiet, genteel authority. Visitors to the home and local villagers initially mistook her for a member of staff. Mr. George Urquhart, an Eastview resident, regularly visited the long-stay mental handicap hospital

where he had been a patient for over thirty years, and where his woman friend still lived. He successfully maintained his attachment to the institution which shaped his life course.

Few residents wrote letters because of failing eyesight and arthritic fingers, and because of the diminishing circle of close relatives or friends left alive in the world outside. The telephone could have provided a link with the outside world, but organisational policies limited its potential. One public pay phone per home was provided for residents, but each phone was located in a public alcove or corridor. Conversations were not likely to be private. For example, Mrs. Hazel Hill at Southam was overheard on the telephone complaining at length to her son about her pain and suffering. No residents had telephones in their rooms. Because of failing eyesight and hearing, and unfamiliarity with telephones generally, relatively few residents used the telephone. None of the public telephones provided in the communal areas of the homes were technologically advanced. Old models were in use which prevented arthritic fingers from dialling, and made it difficult for residents with sensory impairment from seeing the numbers or hearing the person at the other end of the line.

Few residents developed close personal relationships with other residents. They turned to their relatives for intimacy and expression of feeling (discussed below). Preserving links with remaining relatives who were part of their life course experiences was important. Most residents felt that they were in touch with family members - brothers, sisters, children, grandchildren, nieces and nephews, corroborating Jerrome's overview (1990, 1993, discussed in Chapter Three) of studies of inter-generational relationships within British families. Nearly all the residents were dependent on relatives coming to visit them. Concern about the health of family members was expressed by all the residents who were dependent on relatives visiting them for their contacts. This was because their younger generation relatives were already middle-aged or elderly themselves and beginning to experience ill health. For example, Mrs. Iris Rowlands, a 93 year old resident of Eastview, worried that her 67 year old son-in-law might not be able to continue driving and therefore would not be able to bring her daughter to visit.

The life course experiences of residents provided clues to the kinds of links with relatives which were feasible and which were actively sought. For example, the social mobility which had brought many residents into East Anglia from other parts of the country, and which shaped their identities as émigrés or as Londoners successfully transplanted (discussed in Chapter Eight), also dispersed the younger generation of relatives, leaving many elderly parents without any relatives living nearby. Some residents' relatives were inaccessible, having emigrated to Canada, the USA, and Hong Kong. Some relatives had moved away from the local area to another part of Britain. Some residents, in effect, had no relatives left. These were not only the ones who had never married or who were childless, but also those whose children were dead.

The charts below illustrate the residents' views of their links with relatives and friends.

FIG 42 Southam Residents: Keeping Contacts

Name	Contacts	Importance of Keeping in Touch	How Contacts are Maintained	Difficulties of Keeping in Contact
Mr. Leslie Atkins	Friends in the village *(where Southam is located)*; the publican.(former contacts). No relatives left.	*(No direct response)* I entertain the staff and people in the home with tales and stories.	I go to see them.	I used to belong to a club in the village - my arthritis makes it difficult - now too frail. I used to have a good old mate. He lived with me. He's dead now.
Mrs. Annie Baker	My daughter Jill and sister-in-law Hazel visit twice a week. My other daughter Rose visits sometimes, but she doesn't drive.	Fairly important.	They visit the home.	I don't like the phone - never had it till I retired. I'm a terrible letter writer, my hands are useless. Lack of mobility, both for me and my daughter Rose (no car).
Mrs. Florrie Dakins	my grandson; he lives 10 miles away.	*No response.*	He visits sometimes.	Too far - my old friends in Yorkshire are too old. My two husbands and two sons are dead.
Mrs. Irene Ellis	My daughter.	I'm independent with my own activities (gardening). I never thought it wise to get thick with neighbours.	Telephone.	It's not difficult to keep in touch.
Mr. Patrick Hillier	None.	I'd love to hear from my stepdaughter.	Not maintained.	No one left except cousins and a stepdaughter in the USA. She doesn't write.
Mrs. Lily Irving	My daughter Joan; my sister-in-law Elaine.	Very important.	Visits from my daughter. She takes me to visit Elaine; telephone.	My daughter Joan is not well.

Name	Contacts	Importance of Keeping in Touch	How Contacts are Maintained	Difficulties of Keeping in Contact
Miss Cissie Lawrence	My local family: niece, nephew-in-law, great-niece and nephew.	Important to know they're well, happy, and safe.	They phone and visit.	Don't think it's difficult. I'll find a way somehow. I used to write and phone when I lived away in a residential post.
Mrs. Cora Oliver	My daughter Ruth. My son is encouraged to keep in touch by Ruth.	It's good for me, really.	Ruth visits and takes me out.	Nothing.
Mrs. Kathleen Perkins	A nephew lives 10 miles away, but I don't claim him as a contact.	Very important.	*Not clear if she has regular contact with nephew; her confusion mounted over this line of enquiry.*	The distance is too far from Glasgow. You can write letters but I'm not a good correspondent.

At Southam, although most of the interviewed residents said they were in touch with family and friends, the influences of the life course, the organisational relationships of the home, and their own frailty affected the continuation of these relationships. For example, Mr. Lesley Atkins cited his arthritis and the death of his former friend; Mrs. Kathleen Perkins and Mrs. Florrie Dakins, both emigrées, were too far away from old friends, family, and familiar neighbourhoods to keep in touch.

FIG 43 Eastview Residents: Keeping Contacts

Name	Contacts	Importance of Keeping in Touch	How Contacts are Maintained	Difficulties of Keeping in Contact
Mr. Henry Clifford	Never see much of my brothers and sisters; they live 10 miles away.	Not important.	*No response.*	Oldest sister now dead. She used to write once a week. I never worry about it.
Mrs. Sally Cooper	Friends, relatives, step-children and step-grandchildren. They live nearby.	Very important.	Letters. Visits from relatives.	Don't like phoning; can't see well enough to make calls. Nothing makes keeping contacts difficult. A wretched past might make it difficult.

Name	Contacts	Importance of Keeping in Touch	How Contacts are Maintained	Difficulties of Keeping in Contact
Mr. John Davis	Daughters, sons-in-law, grandchildren.	Very important. I rely on them. They bring what I want from outside.	They visit once a week.	Nothing. My son-in-law is 67 and retired. He moans. *(implies his dependenceon continuing good health of son-in-law for family visits).*
Mrs. Olga Frederick	Friends, sisters and brothers.	I like to keep in touch with those I like.	Letter-writing, phone.	I have glaucoma - can't read or write letters.
Mr. Richard Llewellyn	Old friends and relatives in Wales. Step-sister, daughters, niece who live 10 miles away.	I like to keep in touch.	Letters, birthday cards (I had 20 cards from Wales). Visits from family who live nearby.	Don't know.
Mrs. Molly Nabbut	One friend, Miss Sansom, who used to live with me.	Very important. The thing that matters most, having people around who used to know you.	She visits me.	Miss Sansom is disabled and can't walk well. She comes by bus and taxi. Phoning is difficult.
Mrs. Iris Rowlands	No one left to keep in touch with except daughter and son-in-law.	*No comment; accepts the loss of old friends through death.*	Daughter and son-in-law visit by car.	Can't write or phone; eyesight too poor. son-in-law may not be able to drive much longer. My son is dead. My old friends are dead.
Mrs. Bertha Tarrant	Daughter, grandchildren, nieces, my brother's wife.	Yes - because they're family.	They visit sometimes; I can phone.	Not difficult
Mrs. Polly Towell	My brother who lives nearby; my son in Canada	Very important.	My brother visits three times a week. My son writes from Canada.	Distance. Death of old friends, relatives.
Mr. George Urquhart	My girlfriend *(at mental handicap hospital in same town, where he used to live).*	Don't mind. Keeps me company. I packed up with old friends who tormented me.	I go to see her.	*No response.*

Name	Contacts	Importance of Keeping in Touch	How Contacts are Maintained	Difficulties of Keeping in Contact
Mrs. Miriam Youens	My daughter. My sister-in-law from Sheffield rings once a week.	Very important.	Phone, visits.	They *(staff)* won't allow me to get in touch.
Mrs. Betty Zander	Old friends. My nephew looks after my finances.	Not important but I like to hear from them.	Visits.	Can't see to write letters, failing eyesight, difficulty walking and hearing. Estranged from my son.

At Eastview, eight out of twelve respondents were in touch with a close relative, and of those, five were visited regularly by a daughter, one by step-children and grandchildren, one by a brother , and one by a nephew. Several residents who felt themselves to be emotionally close to their relatives were prevented by distance and infirmity (both theirs and the relatives') and lack of money from maintaining regular contact through visits. Mrs. Polly Towell's son was in Canada. Mrs. Molly Nabbut's sister lived in Norwich. As noted earlier, Mrs. Nabbut, who was a childless widow, was visited regularly by her friend of fifty years, Miss Sansom, herself disabled. Mrs. Nabbut still perceived herself as being in touch with local contacts and relatives in the county town, ten miles away, where she had lived all her life. Her faithful friend, Miss Sansom, preserved this life line for her.

Some Eastview residents perceived themselves as still being part of, or rather retaining their identity with, a community outside the residential home. They based their relationships on their life course experiences. Mrs. Betty Zander felt she was still part of the community of the Spiritualist church, although her actual contact was limited. Her relationship with her son was hostile and non-existent, but she found a sense of belonging within Spiritualism. Mr. Richard Llewellyn mentioned his many birthday cards from relatives in Wales, even though he had left his Welsh mining village fifty years before. Mrs. Sally Cooper, the only respondent at Eastview who had lived in the town where Eastview was located, was still in touch with friends, although she was over 90. Her relationship in fact was with the community as a whole - knowing the landmarks of the town and its physical features. Mrs. Muriel Young, at Eastview, although visited regularly by her daughter, perceived nearly all her relationships, both present and past, negatively as a result of childhood deprivation (discussed in Chapter Eight). Only one respondent at Eastview, Mr. Henry Clifford, seemed completely isolated, despite having lived all his life in a nearby local community and having many brothers and sisters. He never married, lived with his parents, and was their carer until they died. His only relationships with others seemed to be those of being cared for by his parents, and in turn, caring for them. His parents had met his needs in the past, and the residential home met his need to be cared for in the present. Here again the clues for understanding Mr. Clifford's lack of interest in forming relationships lay in his life course experiences (Chapter Eight).

Mrs. Rowlands (discussed above and in Chapter Eight) spoke dispassionately about the life and death of her son, who had retired at 65 and died soon after. The links that once were strong and significant for her - with friends, neighbours, church, operatic societies, and gardening clubs - had faded away. Her eyesight had failed, she entered care, and she

became dependent on the organisational relationships and routines of the home. She had developed a philosophy of dispassionate objectivity so that her morale was sustained even when recounting these series of losses.

FIG 44 Northfield House Residents: Keeping Contacts

Name	Contacts	Importance of Keeping in Touch	How Contacts are Maintained	Difficulties of Keeping in Contact
Mrs. Violet Batty	Brother and sister-in-law. Mrs. Merton (a former neighbour).	If they don't come, I ring up and ask, "are you all right?"	They visit, I phone, I don't write.	I don't hear from old neighbours now *(bitter)*. I can't visit them, no means of transport, they live some distance away.
Mrs. Ruth Beckett	Two great-nieces and their families.	Important to have someone (a relative) to turn to if you have a problem *(doesn't see staff or other residents as meeting this need)*.	Relatives visit.	Frailty. My hearing is poor. I don't like too much of a crowd so I don't think I'll have a family birthday celebration this year. I'm 103. My generation is dead.
Mrs. Frieda Grantham	My sister, daughter, some former neighbours live locally, my husband is with me in the home.	I like to keep in touch.	They visit and phone. I phone them.	Nothing causes difficulty. I phone every Thursday.
Mr. Kenneth Grantham	Friends. Relatives. *(doesn't mention his wife specifically)*	Very important.	Visits out with son and daughter. Visits of relatives. Phone calls.	No difficulty.
Mrs. Fannie Hewitt	Daughters and granddaughters.	Very important.	Still live at home *(a short stay resident)*. I visit them. I don't write or phone.	Don't know. Most of my friends are dead; my other daughter lives away, doesn't write or phone.
Mrs. Enid James	Daughter and neighbours.	It's nice to have letters.	They visit.	I don't write any letters. My daughter does that for me. No real difficulty.

Name	Contacts	Importance of Keeping in Touch	How Contacts are Maintained	Difficulties of Keeping in Contact
Miss Julia Jessop	Brothers and sisters.	Very important.	I write to my brothers and sisters once a month and they write to me. One brother visits once a fortnight.	I can't hear well enough to use the phone. I lack transport. No old neighbours or friends visit me.
Mrs. Flora Needham	Family - my children.	I look forward to seeing them.	They visit.	Being here - I don't keep in touch - they do.
Mr. Albert Quinton	My daughters.	Not very important.	They visit every week.	Nothing makes it difficult.
Mrs. Connie Redmond	My school friend, my children *(became confused and distressed).*	Very important.	They visit me. *(distressed).*	Nothing.
Mrs. Ivy Verity	*Too distressed to respond.*			
Mr. Walter Verity	Still at home (short-stay resident); daughter and granddaughter; a good neighbour.	Very important.	They visit and phone.	Can't write or drive anymore.

At Northfield House, "being here", as well as residents' frailty, was given as a reason for the difficulty of keeping in touch, presumably referring to the institutional regime of the home and its distance from their previous neighbourhoods. Nevertheless, relatively more Northfield House residents, compared to the residents in the other two homes, were able to keep in touch with the local community. Perhaps this was because of the home's location on a council estate across from the shops, and with a bus stop opposite. The home's Day Centre activities, which drew people from the local community to participate with residents, were another contributory factor. It would seem logical to presume that the more recent a resident's admission to the home, and the more physically and mentally active the resident, the more likely that contact would be maintained. Specific examples showed that personality and retaining physical and mental health were more important than the recent arrival in the home, once the initial visiting of relatives was taken into account. For example, Mr. and Mrs. Grantham were relatively fit, active residents who were able to visit old acquaintances in the local community where they had lived all their lives, and so their contacts were maintained despite having lived in the home for some years. In contrast, Mrs. Connie Redmond and Mrs. Enid James, despite being new residents, said that all their friends were dead. Mrs. James claimed to receive visits from friends, but did not have any visitors (according to staff), except her daughter. Both of these new residents were experiencing memory loss and confusion.

9.3 Anticipating and Coping with a Changed Life Course

Entering residential care involves the loss of familiar environmental contexts developed throughout the life course. Because it imposes change in every aspect of daily living,

entry into care is a stress-inducing event (Holmes and Rahe, 1967, discussed in Chapter Three). Residents reluctantly acknowledged the changes in their life courses caused by entry to care. The changes were impossible for most to comprehend before the event. Despite their changed life courses, most residents felt that they possessed an inner self, a core personality, which remained intact despite the different context of their environment. Residents' accounts revealed that most of them felt obliged to adapt to the new organisational requirements of residential living. Increased frailty in old age was perceived as the key negative change which had prompted their entry to care. Most residents were reticent about discussing negative changes arising from the move to residential care. Positive examples of change, such as gaining social skills and tolerance through living in a group context, were acknowledged. The following chart illustrates the personal changes acknowledged by the residents who were interviewed.

Fig. 45 Changes noted by residents who were interviewed

(Note: the numbers indicate how many responded).

Home	Positive changes in Self since Entering Care	Negative Changes in Self since Entering Care	Not Sure; Can't Say	No change Since Entering Care	Total Numbers of Residents Interviewed
Southam	2 Mrs. Cora Oliver: I' m more friendly, less neglectful of daughter - she can go out now. Mrs. Kathleen Perkins: I'm less choosy and set in my ways because of living together, I realise I can't change people and must be more tolerant.	1 Mr. Leslie Atkins: age - slowed me up.	-	6	9
Eastview	2 Mrs. Olga Frederick: I'm beginning to be more tolerant. Mrs. Iris Rowlands: I'm less solitary and shy because of group activities.	2 Mrs. Sally Cooper: I had to change because residents changed, all the old ones have died. Mr. George Urquhart: I got used to different routines.	-	8	12

Home	Positive Changes In Self Since Entering Care	Negative Changes in Self Since Entering Care	Not Sure; Can't Say	No Change Since Entering Care	Total Numbers Of Residents Interviewed
Northfield House	4 Mrs. Frieda Grantham: I've changed for the better - happier. Mr. Kenneth Grantham: I'm kinder to old people. Miss Julia Jessop: I've learned to stick up for self. Mr. Albert Quinton: I' ve joined the group.	3 Mrs. Violet Batty: unhappy relationships, lack of privacy here. Mrs. Flora Needham: It's opened my eyes to disability. Mr. Albert Quinton: I've aged.	3	3	13

At Southam most residents interviewed did not think they had changed since entering care. Mr. Leslie Atkins mentioned ageing as a negative change, but Mrs. Cora Oliver and Mrs. Kathleen Perkins mentioned a positive change of increased sociability: "My relatives think I'm more outgoing - I never used to go out of the house"; "I'm not so choosy"; "I'm more friendly"; "I can walk better."

At Eastview, the majority of residents felt that they had not changed since coming to live there, but two who felt they had changed, Mrs. Olga Frederick and Mrs. Iris Rowlands, saw the change as positive. They had become more tolerant of others and more socially skilled due to living in groups. On the negative side, Mrs. Sally Cooper, who had lived in the home for ten years, said she did not know how she had changed, but the deaths of many residents over the years had affected her.

At Northfield House, relatively more residents who were interviewed (seven) said they had changed. Northfield House residents were more likely to admit that they had changed, or otherwise would avoid responding to the question. Their reactions raised questions about the extent to which the Unit design and small group living arrangements influenced residents' relationships and identities. The strong personality of Mrs. Black, the Officer-in-Charge, might have been a factor inhibiting some from responding, as well as their own individual perceptions. On the negative side, Mr. Albert Quinton said he had aged (but he also perceived his joining the group as a positive change). Mrs. Violet Batty said she had "changed a lot due to the lack of privacy, but underneath I'm the same". Mrs. Flora Needham said in a shocked way: " It's opened my eyes to disability." Positive comments included: "learned to stick up for myself"; "changed for the better - no longer depressed"; "kinder to old people".

9.4 Talismans and Roles

The first stage of establishing relationships in residential care was to assert identities based on life course experiences, and confront the changes in life style caused by entering residential care. Next, the residents had to decide whether to form new relationships which went beyond the initial stage of 'becoming known'. Some residents began to

display 'talismans', which denoted their individuality and life course events, as devices for getting acquainted. For example, Mrs. Olive Jenkins at Southam carried the same large print novel with her everywhere she went. The novel served as an invitation to begin a conversation about her choice of reading. Mrs. Gladys Garrett at Southam carried in her handbag a photograph of herself as a bride, and a later photograph of herself at the age of 63 when she worked as a store detective. She showed these to every new acquaintance. Mr. George Urquhart at Eastview carried a small portable radio, and invited other residents to listen to particular programmes with him. Mrs. Xavia Kelly, also at Eastview, carried her rosary beads as a talisman. Mrs. Enid James at Northfield House carried a small album of photographs of herself as a child, then as a young wife and mother.

As discussed in Chapter Eight, the relationships were primarily social ones. Residents developed these new relationships by adopting roles towards others, becoming social actors (Matthews, 1979, discussed in Chapter Three) influencing the interactions of daily life. Some of the roles, such as Queen Bee, Quasi-Staff Member, Venerable One, Old Hand, and Helper involved the use of power and influence in a reciprocal relationship with other residents. Other roles, such as Puzzle-Master, Clown, Comedian, Group Mascot, and Sufferer, were used for dramatic display before an audience of peers. The following charts illustrate these roles. A more detailed discussion of the specific roles follows.

FIG 46 Informal Roles Adopted by Southam Residents in their Relationships

Name	Queen Bee	Quasi-Staff Member	Venerable One/Old Hand	Clown/ Comedian; Puzzle-master	Group Mascot	Sufferer
Mr. Lesley Atkins			√ Resident for 12 years.	√ Entertaining stories, played part of the bride in Royal Wedding scenario.		
Mrs. Bessie Carr	√ Dominates downstairs lounge, turns TV on and off.	√ Helps with washing up.	√ Resident for 12 years.			
Mrs. Alice Edwards		√				
Mrs. Irene Ellis	√ Dominates upstairs lounge.	√ Informs staff of residents' needs.	√ Resident for 11 years.			
Mrs. Maisie Freane					√ Lived in Argentina, confused wanderer.	
Mrs. Hazel Hill						√ Had attempted suicide, now disabled and in pain.

Name	Queen Bee	Quasi-Staff Member	Venerable One/Old Hand	Clown/ Comedian; Puzzle-master	Group Mascot	Sufferer
Mr. Patrick Hillier				√ Entertains with spiritualist impersonations and revelations.		
Mrs. Lily Irving				√ Tells entertaining stories and anecdotes.		
Mrs. Olive Jenkins		√ Helps other residents.				
Mrs. Kathleen Perkins						√ Homesick for Glasgow, misses her former room mate in the home.
Mrs. Teresa Sanders					√ Has a mental illness, institutionalised since 1926.	

FIG 47 Informal Roles Adopted by Eastview Residents in their Relationships

Name	Queen Bee	Quasi-Staff Member	Venerable One/Old Hand	Clown/ Comedian; Puzzle-master	Group Mascot	Sufferer
Mr. Bert Arthur					√ Periodic violent outbursts of uncontrollable behaviour.	
Mrs. Maggie Askew					√ Talisman of one bottle of Scotch per week for evening night-cap, bought by daughter.	
Mr. Henry Clifford						√ Isolate.

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Mr. Henry Clifford						√ Isolate.

Name	Queen Bee	Quasi-Staff Member	Venerable One/Old Hand	Clown/ Comedian; Puzzle-master	Group Mascot	Sufferer
Mrs. Sally Cooper	√ Has protégés amongst newer male residents.		√ Local resident of town; lived in the home for 10 years.			
Mr. John Davis		√ Representative on Residents' Committee.				
Miss Evelyn East-wood					√ Has mental and physical disabilities; in institutions most of her life.	
Mrs. Olga Freder-ick						√ Double amputee, struggles to walk with artificial limbs.
Mrs. Kitty James					√ Has maintained voluntary silence for years.	
Mrs. Xavia Kelly					√ Carries talisman of Roman Catholic rosary beads.	√ Only black resident, from Sri Lanka originally.
Mrs. Laura Low-ther				√ Tells jokes, puzzles, funny riddles.		
Mr. Robert Martin					√ Has a learning disability, much younger than other residents.	
Mrs. Molly Nabbut					√ Nervous affliction evokes attention and sympathy from others.	√ Trembles and shakes with nerves since sister's death.

Name	Queen Bee	Quasi-Staff Member	Venerable One/Old Hand	Clown/ Comedian; Puzzle-master	Group Mascot	Sufferer
Mrs. Abigail Quinn				√ Interrupts group activities with loud, repetitious phrases.	√	
Mrs. Iris Row-lands			√ Integrated, balanced point of view, respected by other residents and staff.			
Mrs. Bertha Tarrant						√ Hates being in the home, depressed.
Mrs. Polly Towell	√ Dominates upstairs lounge.	√ Helps staff and residents.				
Mr. George Urquhart			√ Resident for 13 years.	√ Sets puzzles, carries talisman of own radio.	√ Has a learning disability, has been institutional-ised most of his life.	
Mr. Frank Young					√ Has a learning disability.	
Mrs. Miriam Youens						√ New resident, deprivedand self-pitying.

FIG 48 Informal Roles Adopted by Northfield House Residents in their Relationships

Name	Queen Bee	Quasi-Staff Member	Venerable One/Old Hand	Clown/ Comedian; Puzzle-master	Group Mascot	Sufferer
Mr. Joseph Archer			√ Resident for 25 years.		√ Institutional-ised in workhouse during childhood, continued living in institutions all his life; possible learning disability.	√ Dying.
Mrs. Ruth Beckett			√ Resident for 12 years.			
Mrs. Violet Batty		√ Helps other residents.				√ Hates living in the home.
Mrs. Frieda Gran-tham		√ Helps the staff.	√ Resident for 3 years, but lived in locality all her life.	√ Life and soul of the party.		
Mr. Kenneth Gran-tham						√ Often too weak to get out of bed.
Mrs. Enid James				√ Uses talisman of photos of self in younger days to gain attention.		
Miss Julia Jessop			√ Resident for 10 years, lived locally.			
Mr. Albert Quinton			√ Resident for 3 years, lived locally.			
Miss Edith Reed					√ Has a learning disability, entered home when her mother died.	
Mrs. Thelma Simp-kins				√ Likes to joke.		

Name	Queen Bee	Quasi-Staff Member	Venerable One/Old Hand	Clown/ Comedian; Puzzle-master	Group Mascot	Sufferer
Mrs. Ivy Verity						√ Had two strokes, emotionally labile.
Mr. Walter Verity				√ Tries to entertain.		
Mr. Hugh Wylie					√ Has a learning disability, institutionalised most of his life.	

In the lounge of each residential home, there was an observed unofficial leader amongst the residents, a Queen Bee who influenced the others with powerfully expressed opinions and views. The Queen Bee dominated the lounge in which she sat. For example, at Eastview, Mrs. Polly Towell controlled the heating and lighting. As long as no strong complaints were made by other residents, the Queen Bee carried on, unimpeded. The Queen Bees were women who were mentally alert and physically active. They saw themselves as helping others. In their life courses these women (for example, Mrs. Polly Towell at Eastview and Mrs. Irene Ellis at Southam) had experienced depression before admission and there was some evidence of emotional deprivation. Admission into care helped them to find themselves and become powerful for the first time in their lives. They reported incidents of concern about the well-being of individuals to the staff and were generally respected. The staff recognised this dynamic of group life, but did little to curb their unofficial power. Interestingly, the residents (including one unofficial leader, Mrs. Irene Ellis at Southam) in each of the three homes were reluctant to acknowledge the existence of unofficial roles. Residents tended to deny that there were any leaders (other than staff) and did not admit that they themselves played any particular role in the group. They may have been unable to recognise these group dynamics, or perhaps felt that it was safer not to acknowledge the existence of unofficial power and influence. It was noticeable that each woman (and it was always a woman) who assumed the role of Queen Bee appeared very happy and fulfilled within the group environment, in contrast to her life course experiences before admission to care. Each admitted her happiness, at the same time downplaying her role. Further research would be required to explore whether an awareness of former life experiences would make it possible to predict which residents would be likely to become Queen Bees and Quasi-Staff Members, but it is suggested that the following characteristics are important:

female gender;
earlier deprivation, successfully overcome;
relatively active both physically and mentally;
entry to care after a depressive illness/crisis caused by bereavement;
survival in care over a period of time;
not seeking a close personal relationship within the home; and
belief that residential care offers refuge and help.

The men's leadership styles were less involved with individual relationships and decision-making, but were more concerned with becoming known and accepted. They became 'well-known' through membership of a Residents' Committee of the home, or a

Social Club where these existed. For example, at Eastview, Mr. John Davis took great pride in his role as representative on the Residents' Committee.

The role of Quasi-Staff Member was sometimes but not always combined with that of the Queen Bee. Like the Queen Bee, this role carried with it a great deal of power which was tacitly accepted by the staff as long as it was convenient for them to do so. The Quasi-Staff Member, unlike the Queen Bee, exerted influence beyond the territory of the lounge, and was active in helping the staff with tasks, such as laying the tables or washing up. For example, Mrs. Alice Edwards at Southam dried the cutlery after every meal, but did not assume the role of Queen Bee in her lounge. When the two roles were combined, the Quasi-Staff Member role focused on some aspect of the personal care needs of another resident. She might advise staff on the bathing needs of certain residents, and supervise other residents, rather than assisting with household tasks. Mrs. Polly Towell at Eastview, who combined both roles, was observed telling staff, "When you bathe Mrs. Maude Baker, be very careful of an inflamed area near the groin."

These combined roles were successful and fulfilling because they bridged the gap between social relationships and organisational relationships. The Quasi-Staff Member sometimes organised other residents to assist with the tasks of setting tables, clearing the tables, and washing up. At Eastview, Mrs. Polly Towell and Mrs. Sally Cooper were Quasi-Staff, but only Mrs. Polly Towell was Queen Bee as well. At Southam, Mrs. Alice Edwards and Mrs. Bessie Carr were Quasi-Staff, but only Mrs. Irene Ellis was also Queen Bee as well as Quasi-Staff. At Northfield House, Mrs. Frieda Grantham was the Quasi-Staff and Queen Bee. A lesser role than that of Queen Bee or Quasi-Staff member, but one which shared some of their characteristics, was that of Helper - usually of one or two other residents. Some men adopted this role, but the women predominated, and this gender choice could be linked to gender differences in socialisation and earlier life course experiences (Gilligan, 1982, discussed in Chapter Two).

Other residents adopted the roles of Venerable One or Old Hand, acquired through length of residence and personality characteristics, in which they demonstrated expertise in the ways of living in residential care. These Old Hands often were residents who survived long enough in care to accumulate a history of life course experiences within the home. At Eastview, for example, Mrs. Sally Cooper was known as 'Old Sally' to denote this role. At Northfield House Mrs. Ruth Beckett, known as 'Granny Beckett', who had been a resident for twelve years, had won similar recognition, although she was in fact childless.

Certain residents adopted the role of Clown or Comedian. Mrs. Thelma Simpkins at Northfield House defined her role as "I like to make them laugh". Most unusually, Mr. Leslie Atkins at Southam had been selected by the staff to act as the bride in a mock royal wedding staged as a pantomime at the home at the time of the wedding of the Prince and Princess of Wales in 1981. He clearly was proud of his costume and showed photographs of himself dressed in a wedding gown.

Mr. George Urquhart adopted the role of Puzzle-Master at Eastview, involving everyone he met in puzzle solving. He posed a series of riddles and word games to confound and entertain his audience, a role made more significant by his life course experience in a hospital for people with learning disabilities. His life course prompted him to show his cleverness despite the label of learning disability. Some 'confused' residents functioned as Group Mascots, a role which ensured recognition from others. Behaviour included wandering into social events and conversations, repeating a motto over and over like a signature tune and making an impact on social routines. For example, at Eastview, Mrs. Abigail Quinn repeated during a bingo session, "I want to get up" in a loud and insistent voice which assured her of attention.

Others adopted the role of Sufferer. Mrs. Hazel Hill, at Southam, positioned herself in a chair in the hallway so that all visitors to the home had to pass her chair. She looked drawn with pain. In response to their enquiries, she told passers-by about her suffering and torment from a spine injury when she attempted suicide after the death of her husband. At the same time she enjoyed the attention which enabled her to share her angry and grieving emotions.

The links between residents' identities formed throughout their life course experiences and the roles they adopted within the home were most evident in the case of the Sufferers, most of whom had been Deprived; and in the Group Mascots, some of whom had been institutionalised previously because of disability, and some whose confusion was of long standing duration.

Whatever the role might be, its function was to provide an opportunity to share emotions and win attention.

9.5 The Changed Contexts of Life Courses: Group Relationships in Residential Care

The residents' views on how well they related to others within the group environment reinforced the significance of their own life course experiences, the organisational relationships (the regime, the design of the home), and the frailty and confusion of residents. Despite the importance of adopting roles as a strategy for forming relationships, many residents denied the significance of the personality and personal power of any particular individual. Residents were relatively reluctant to recognise or admit the existence of leadership in the groups, or of individuals playing a particular part in group life. Many examples of leadership roles were observed (especially the role of Mrs. Polly Towell at Eastview), but the respondents either did not want to acknowledge this aspect of group living or else did not recognise group dynamics and relationships. The responses given were circumspect. For example, Mr. Patrick Hillier at Southam; Mrs. Polly Towell, Mr. Richard Llewellyn, and Mr. John Davis at Eastview; and Mrs. Frieda Grantham and Mrs. Violet Batty at Northfield House stated that they were "Helpers" of the staff and residents, but only Mrs. Towell and Mr. Davis portrayed themselves as leaders. Mrs. Irene Ellis at Southam denied her leadership role altogether, although it was plainly evident from observation and acknowledged by staff. At Southam, Mrs. Lily Irving, and at Northfield House, Mrs. Frieda Grantham and Mr. Walter Verity portrayed themselves as the "life of the party" and "telling jokes", in pursuance of roles they had adopted throughout their life courses.

The instrumental value of residents' roles to the staff and to the maintenance of institutional life was emphasised. Because they were being asked about the nature and use of unofficial power, it was not surprising that residents sought to throw a smoke screen over this aspect of their lives out of fear of retaliation from management. As discussed in Chapter Seven, there were no internal placement policies and no right to occupy a particular space within the home. Staff could move residents from one bedroom to another, and break up an established group dynamic or close paired relationships. It was in the interest of residents to maintain silence about their relationships with each other. If the relationship dynamic was too intrusive and dominant, or perceived by staff to be harmful, then the relationship could be dissolved.

In the charts below, the residents' perceptions of group relationships are presented.

FIG 49 Perceptions of Group Relationships: Southam

Name of Resident	Positive perceptions: what helps a group to get along with each other	Negative perceptions: barriers to getting along with each other	Own role in group	Other residents' roles in the group
Mr. Leslie Atkins	Most pair up.	One or two are awkward; all have different things wrong with them.	I don't mix in with group, except with Irene *(Mrs. Ellis) (as a pair).*	One or two lead; Mrs. Irene Ellis and Mr. David Brooks stand out.
Mrs. Annie Baker	I don't take notice of the group.	I share a room with someone who is confused - can't talk to her. Don't know what causes problems; can't make relationships here.	No role.	No leader; but Mrs. Hazel Hill stands out.
Mrs. Florrie Dakins	Never fallen out with each other; we talk together.	Can't answer; not my affair.	No role; haven't been here long; used to play violin in church, but not here.	No leader; all are treated the same here.
Mrs. Irene Ellis	All right; new people are all good. We have a tradition of getting along with each other here.	Some people talk a lot.	I'm quiet but active, not the leader.	Everyone's different; I know them well *(echoes staff's statement).*
Mr. Patrick Hillier	Very well; we never question each other about anything.	No problems but I get no visitors.	I help three ladies; I can walk, I lead them into the dining room.	Mrs. Olive Jenkins leads the lounge group; she puts the TV on and off.
Mrs. Lily Irving	Don't know how the group gets along.	A lot find fault with each other and complain about everything.	I ignore arguments and pretend to be asleep; don't find fault; I'm happy as long as I'm left alone; make a joke and have a natter.	One or two are leaders, especially Mrs. Irene Ellis. That poor soul in the corner is totally disabled *(Mrs. Dora Turner).*
Miss Cissie Lawrence	All right; don't know what helps.	Sometimes people get mixed up in their head.	Just an ordinary role; not wise to find fault in a community.	No one leader in the group stands out.

Name of Resident	Positive perceptions: what helps a group to get along with each other	Negative perceptions: barriers to getting along with each other	Own role in group	Other residents' roles in the group
Mrs. Cora Oliver	Very well	One lady (Mrs. Teresa Sanders) in my bedroom keeps me awake; I wouldn't report her even though I said I would.	No role; I'm no trouble.	No leaders.
Mrs. Kathleen Perkins	Very well; fear that you've got to behave and can't step out of line helps the group to get along.	No outlet for saying this or that.	No role; thought it would be strict, lucky to be in a home as nice as this.	No one leads; all are the same.

At Southam, life course experiences which shaped relationships in the past influenced current relationships. For example, Mrs. Annie Baker, who had experienced Deprivation and could not trust, felt she could not make relationships with the group. Mrs. Lily Irving drew on her life course experiences to make jokes and "natter" as a means of forming relationships. Mrs. Irving, who attended the home once a week for Day Care and also intermittently for short stay residential periods, was more outspoken than other residents. In keeping with her life course personality, she said that residents "find fault with each other." Miss Cissie Lawrence drew on her life course experiences as a teacher and boarding school matron to justify the need to preserve harmony within the group. Most Southam residents felt that they got along well with each other. Their responses indicated awareness of institutional living. They mentioned, as well as staff, the food as a positive aspect of group living, but the "routine" and "fear of stepping out of line" as negative aspects. Southam residents mentioned the role of staff more positively than residents of the other two homes. (This was the smallest home with the longest serving staff). The greatest problem in getting along was said to be 'confusion' and disability in certain residents.

Fig 50 Perceptions of Group Relationships: Eastview

Name of Resident	Positive perceptions: what helps a group to get along with each other	Negative perceptions: barriers to getting along with each other	Own role in group	Other residents' roles in the group
Mr. Henry Clifford	Group gets along all right, *no reason given.*	Some talk a lot and get on my nerves.	No part in group; I sit and listen; I'm happy on my own.	Don't know of any leaders.
Mrs. Sally Cooper	Group gets along quite well, *no reason given.*	Don't know; I feel the *(group)* atmosphere; some people don't.	No particular part.	Don't know; not really any one who stands out.

Name of Resident	**Positive perceptions: what helps a group to get along with each other**	**Negative perceptions: barriers to getting along with each other**	**Own role in group**	**Other residents' roles in the group**
Mr. John Davis	No arguments, pretty good atmosphere, we all muck in.	Arguments in lounges; some fuss and complain.	I don't complain; I'm a leader on the Residents' Committee.	Got to keep an eye on others - one man nearly set fire to the sitting room through smoking; some people don't know where they are *(confused)*.
Mrs. Olga Frederick	They manage pretty well; some lounges are better than others.	Some people are greedy, don't have good manners.	I like one or two here, they're not yet friends; I don't go in a group.	No one leads; one *(Mrs. Kitty James)* called "the Witch" used to steal.
Mr. Richard Llewellyn	Very good; I spend a lot of time in my bedroom *(a single room which he uses as a bed-sit)*; bingo, church activities help.	No problems.	Not a lot; I help.	One tall fellow with a bad foot *(Mr. John Davis)* is a leader; can't speak about other individuals.
Mrs. Molly Nabbut	All right; kindly residents help.	No problems; my room mate used to be difficult to get on with, but is back from hospital, I hope she's improved.	Don't know; listener.	We'd be lost without the help and leadership of Mrs. Polly Towell.
Mrs. Iris Rowlands	A single room helps; we get along in the upstairs lounge, we realise we're all more or less the same.	No problems.	No part - I do as I'm told.	Mrs. Polly Towell helps. Mrs. May Orville's health is a worry; Mrs. Molly Nabbut needs help.
Mrs. Bertha Tarrant	All right.	Don't think so; don't know.	Play no part; only say my piece when I want to; no one puts me down.	Don't take notice.

Name of Resident	Positive perceptions: what helps a group to get along with each other	Negative perceptions: barriers to getting along with each other	Own role in group	Other residents' roles in the group
Mrs. Polly Towell	Quite a few get on all right.	Don't know; just bad days, a word or two; new residents are more difficult to look after.	I suppose I'm the leader; it keeps me going. I do what I can to help.	I see them as individuals. Mrs. Molly Nabbut has a nervous affliction caused by her sister's death.
Mr. George Urquhart	All right; they like each other, but two's company, three's a crowd.	Residents ask too many questions; I don't like that.	Don't know.	No leaders; some people stand out *(but would not name them).*
Mrs. Miriam Youens	*No statement made, too angry.*	Others don't speak unless I speak, I don't know my room mate's name, she's stand-offish.	Nobody wants me.	They've got their own visitors, and don't bother with me.
Mrs. Betty Zander	Very well, except for new admissions; bingo, activities, meeting together help the group relationships.	One new admission sat in the wrong chair; some people want to rule the roost - won't fit in.	No role in group - doing knitting for Oxfam.	Several leaders, don't know who; we're all individuals, Mrs. Polly Towell helps others.

Eastview residents also drew on their life course experiences for forming current relationships. For example, Mr. Henry Clifford, who had never married and had lived an isolated life except for his relationships with his parents, spoke of talkative residents "getting on my nerves". Mrs. Miriam Youens, who had experienced Deprivation and an unhappy marriage, mentioned a "difficult" room-mate. Mrs. Olga Frederick, who presented a genteel personality, objected to "greediness" at the dining room table. More residents at Eastview than at the other homes mentioned each other's role: "choosing each other", "kindness of another resident", "asking for what you want". Some said they either "didn't know", or felt "excluded" in response to questions about group living. Eastview residents mentioned "activities" and "the standards of the home" as positive aspects. These statements acknowledged the importance of organisational relationships, and supported the therapeutic claims of activity theory (Havighurst, 1963; Cavan et al, 1949, discussed in Chapter Two). At Eastview those residents who had their own single room (for example, Mr. Richard Llewellyn) were apt to feel more satisfied with the groups in which they were placed at the dining room table and in the lounges. Their ability to choose a measure of privacy encouraged tolerance of the enforced togetherness in public areas (echoing Willcocks et al, 1987, discussed in Chapter Four). Several residents mentioned specific difficulties with 'confused' residents.

FIG 51 Perceptions of Group Relationships: Northfield House

Name of Resident	Positive perceptions: what helps a group to get along with each other	Negative perceptions: barriers to getting along with each other	Own role in group	Other residents' roles in the group
Mrs. Violet Batty	All right; we get along as best we can.	I can't knit; it's best to be in own single room; one resident *(Mrs. Enid James)* interferes and "yaps."	I help the staff.	I'm in charge of helping others.
Mrs. Ruth Beckett	All right, others aren't very talkative.	One new resident takes my chair in the lounge. New residents leave me behind. *(i.e. I'm the survivor when others arrive and eventually die).*	I can't hear others, I'm deaf. I don't argue with any one.	*No comment.*
Mrs. Frieda Grantham	Having fun, bingo activities; they get along very well.	Some like TV, some don't; one woman keeps coming in my room.	I help with the food, peel potatoes, I'm life of the party.	No leaders, the staff lead. Some residents sleep a lot.
Mr. Kenneth Grantham	Get along pretty well, laughing, talking, being with each other; coffee mornings.	Some arguments about TV, opening windows in the lounge.	I don't do anything, I like watching TV.	No leader, all more or less the same.
Mrs. Fannie Hewitt	Very well, friendliness helps.	Nothing.	I go along with the group.	No leader, no one stands out.
Mrs. Enid James	*No comment.*	I can't get on with one person *(Mrs. Violet Batty)* in the Unit; she keeps needling, takes the micky out of me, I can't go home and do what I want as before.	I did the same to her *(retaliation)*; I enjoy my life.	No leader, but one in the Unit is in charge *(refused to specify name).*
Miss Julia Jessop	All right, bingo activities.	One resident interfered, came in my room, took over my visit with my brother.	No particular role.	No leader, we're all together.

Name of Resident	Positive perceptions: what helps a group to get along with each other	Negative perceptions: barriers to getting along with each other	Own role in group	Other residents' roles in the group
Mrs. Flora Needham	Don't know.	Don't know.	Don't want to stir up trouble, I'm very quiet.	Don't know.
Mr. Albert Quinton	Pretty well, we're all together, working class.	Don't know.	Not much of a role.	No one leads, no one stands out.
Mrs. Connie Redmond	Very well, make the best of it, only choice we have.	No problems.	Just be one of the group, no good being off-hand.	No leader.
Mrs. Ivy Verity	*No comment.*	*Angry when husband (also in group) loses his temper; concerned with keeping up appearances.*	*Apologises for being silly.*	*No comment.*
Mr. Walter Verity	Yes, my wife and I get along in the group.	No problems; some arguments, but there's always some of that	I tell "clean" jokes, entertain.	No leaders.

At Northfield House, the residents were less positive about group living than in the other two homes. As noted above, at Northfield House, the combination of small group living structured without an internal placement policy to achieve a measure of compatibility, and the powerful presence of Mrs. Black, the Officer-in-Charge, resulted in less open responses and less satisfaction. Either specific problems were more openly admitted in this home, or else residents said they "didn't know". Problems were attributed to arguments about TV choice, opening windows, interfering with relatives' visits, etc., thus echoing the findings of Willcocks et al (1987) that these are the features of residential life which really matter to residents. Only two out of twelve respondents, Mrs. Frieda Grantham and Mrs. Fannie Hewitt, said they got along "very well" without qualification. Mrs. Redmond also said "very well", but added the stoic comment "we make the best of it". (One who responded "very well", Mrs. Fannie Hewitt, was experiencing memory loss.) The rest said "pretty well" or "all right except for one person." (Mrs. Violet Batty and Mrs. Enid James commenting about each other in all probability).

It was interesting to note in all three homes the tacit admission by residents that the reciprocal roles which they adopted towards each other were most significant in determining the nature of group living. Despite their disavowals of personal power and leadership, their comments took into account the realities of organisational relationships and structures.

9.6 Reciprocity of Relationships

The concept of reciprocity is essential for defining the nature of a meaningful relationship. The discussion in Chapter Three suggested that reciprocity is an attractive concept because of its implied balance of power within relationships, which supports the goal of empowerment (Solomon, 1976). Homans (1958, 1974) and Titmuss (1970),

both discussed in Chapter Three, explored concepts of exchange of services, giving and getting, and mutual benefit. In all three homes, exchange of services, giving and getting assistance, and the use of power by unofficial leaders in each residents' group were observed. Rather than a balance of power, the most obvious examples of reciprocity were the relationships of the Queen Bee and Quasi-Staff Member (discussed above) with other residents, where power was wielded by one resident on behalf of others. Another example is Pairing (discussed below) between room-mates, where a more physically and mentally active room-mate assisted the frailer room-mate.

As discussed in Chapter Six, residents were asked to express their own understanding of reciprocity. Although the discussion was carefully phrased in non-technical language, and was preceded by an explanation of the concept, my initial reaction to the results was that the method seemed less successful than I had hoped. The topic may have been too conceptual and the elderly respondents growing tired at the end of the interview. Alternatively, they may have avoided the topic because, in reality, it exposed a power imbalance and involved the admission of leadership amongst the peer group. Responses appeared nearly all concrete and trivial, indicating that the respondents did not understand the questions as they were intended. Yet, on reflection, some responses were significant in the context of life course events.

Life course experiences shaped residents' understanding of reciprocity. For example, Mrs. Annie Baker at Southam said she would like to give "trust - but I can't." She had been emotionally scarred by a childhood in which she had been abused by her father. A resident at Eastview, Mrs. Iris Rowlands (discussed in Chapter Eight), who had adopted a philosophical and objective view of life, said "I've given freedom to my daughter" (by entering the home and relieving the burden of caring which had been her daughter's task). Mrs. Muriel Young at Eastview, the resident who was "always miserable", responded by saying "I'd like to give money to children" - perhaps an indication of the poverty and childhood deprivation which she revealed in her life history.

Residents expressed the concept of reciprocity when they asserted that it was their own and others' responsibility to 'break the ice', form social relationships, and become acquainted. The kindness of other residents was valued. Most respondents hoped to give and get friendship. The women who had taken the role of Helper mentioned giving help and reassurance to other residents. The loss of memory and 'confusion' of many residents were seen as impeding any expectations of receiving anything back from other residents.

The following charts illustrate the residents' views of reciprocity of relationships.

FIG 52 Southam Residents: Reciprocity of Relationships

Name	Perception of Reciprocity	I would like to give:	I would like to get:	I give to others:	I get from others:
Mr. Lesley Atkins	*Reciprocity is shared enjoyment in a social situation, impeded by confusion of other residents.*	I talk to one or two at night downstairs.	Can't get nothing. Half don't know - they've lost their memory.	A laugh.	A laugh.

Name	Perception of Reciprocity	I would like to give:	I would like to get:	I give to others:	I get from others:
Mrs. Annie Baker	*Reciprocity cannot be practised within the home because she cannot trust enough to share with others.*	I'd like to share with someone I could trust - but not here, gossiping to others.	Trust.	Not much these days.	Don't get much trust these days with the things you hear.
Mrs. Florrie Dakins	*Reciprocity is giving freedom to her carer and not causing trouble in the home in return for fair treatment and release from worries.*	Fairness to everyone.	They're all nice here in the home - I could have stopped with my grandson for good, but I said no.	I never caused any trouble, I settled here like that.	Don't know - I've got no worries here.
Mrs. Irene Ellis	*Reciprocity is expressed as appreciation and thankfulness for the safety given by the home.*	No. Nothing. I was upset when I lost my sister.	Understanding.	*No comment.*	Help in bereavement; I'm very lucky to be here, I feel safe; the food's good, and the garden's lovely. It's very expensive to live outside now.
Mr. Patrick Hillier	*Reciprocity is part of a close personal relationship with relatives, but he is realistic about his lack of opportunity for this kind of relationship.*	Kindly thoughts.	The same - kindly thoughts.	As much as I possibly can. I don't have any relatives in England and I don't get any visitors.	Very little.
Mrs. Lily Irving	*Reciprocity is based on shared friendships, with good conversations; residents are either not capable or not interested in giving these.*	Strong faith; good friendship.	Same as I give.	Friendly chat, good sense of humour.	Can't answer that; there's good in everyone of us, but I don't want to sit with the poor souls who are confused. I'm a natterer.

Name	Perception of Reciprocity	I would like to give:	I would like to get:	I give to others:	I get from others:
Miss Cissie Lawrence	*Reciprocity is part of group living and helping others within the home*: I touch the hand of that poor soul who mutters to herself.	Kindness.	The same amount of kindness.	Thoughtfulness - that's how you can help them here.	Kindness.
Mrs. Cora Oliver	*Reciprocity is giving freedom from the carer role to her daughter in return for past acts of caring.*	Freedom to my daughter. I want to give her my things.	I don't want anything. I'm happy here. I came here off my own bat.	Friendship with everyone.	Friendship, companion-ship.
Mrs. Kathleen Perkins	*Reciprocity is part of a close personal relationship, and she has lost all her close personal relationships.*	Sharing feelings.	The same - sharing feelings.	*She became upset*: Jean's dying. *(her former room mate)*. My husband died - dropped dead after only three years. I'm out of touch - I don't know if my parents are alive or dead *(confused)*. *I changed the subject and calmed her.*	*No reply - then a philosoph-ical comment*: it's a path we all have to take *(i.e. loss of loved ones and approaching death.)*

FIG 53 Eastview Residents: Reciprocity of Relationships

Name	Perception of Reciprocity	I would like to give:	I would like to get:	I give to others:	I get from others:
Mr. Henry Clifford	*No real concept of reciprocity because of his lifelong role as an isolate.*	You could tell me.	You could tell me.	You could tell me.	I'm reasonably content.
Mrs. Sally Cooper	*Refused to respond.*	Don't know.	Can't answer.	Can't say.	No - can't say.

Name	Perception of Reciprocity	I would like to give:	I would like to get:	I give to others:	I get from others:
Mr. John Davis	*A realistic view of his dependence in old age and his role within the home.*	Make them happy, talk about their troubles.	Don't want a lot, a smoke, friendships, a drink now and then, say when you're old you've got to expect these things. Money doesn't interest me. What can I spend it on here?	I never want for nothing.	They like to see me happy. This is my home now. I wouldn't be able to look after myself. I can dress myself though.
Mrs. Olga Frederick	*Reciprocity is about wishing for others what you don't have yourself and hoping to receive what is perceived as missing.*	Good health	Kindness	It's hard to think - I don't think about this	Criticism - plenty!
Mr. Richard Llewellyn	*Life-long self-reliance and adherence to a strict moral code reduce the likelihood of reciprocity*	Don't know.	Nothing at all. I can manage.	I help as much as I can. I don't talk about anything *(gossip).*	Not much.
Mrs. Molly Nabbut	*Reciprocity is only possible with a close friend from outside the home.*	Don't know.	True feeling. I hope they feel friendly towards me.	When you've been a friend so long, she *(her friend Miss Sansom)* can talk to me about anything She can say, "do you remember?" You don't make new friends so easily.	A lot to do with the past. Share memories and past experiences. TV helps bring memories back.

Name	Perception of Reciprocity	I would like to give:	I would like to get:	I give to others:	I get from others:
Mrs. Iris Rowlands	*Reciprocity within the home is a series of processes which are dependent on the willingness of the staff and the more active residents to empower the residents.*	Depends on the person and what they want. I'd like to give my daughter a special doorbell - she's in an upstairs flat.	Sincerity.	We share sweets. We give money to young people to get us things from the shops. We give presents to staff who leave.	There's a mixture of residents and staff here - the good and bad together. The staff vary. The Officer-in-Charge is friendly yet aloof, but she does remember. It must be a big job for her. Mrs. Towell gets cards for us to send for relatives' birthdays. She puts on the tapes, runs the TV and radio for us.
Mrs. Bertha Tarrant	*Reciprocity is not possible without knowing others.*	Advice about problems.	I'd like the other residents to stick up for themselves.	I don't know the others well enough yet.	Nothing.
Mrs. Polly Towell	*Reciprocity is mainly about helping others and receiving inner satisfaction from assuming the roles of Queen Bee and Quasi-Staff Member.*	More reassurance to Mrs. Molly Nabbut; I don't know if she'll ever recover from her shock *(of losing a close relative).*	Never thought about it.	I help where I can. I help Mrs. May Orville. Her hands are arthritic. I cut up her meat.	Friendliness.
Mr. George Urquhart	*Reciprocity is understood as concrete exchanges of gifts.*	Presents. What I can afford. Can't pay too much now.	Presents.	Presents.	I got this watch from my girlfriend.
Mrs. Miriam Youens	*Reciprocity is perceived as giving to children to compensate for her own perceived childhood deprivation, and paying back the debt of care to her sister.*	I'd like to give things to children who visit the home.	There's nothing I want - except sociability from others.	I wouldn't ask anyone for anything. I wish I could pay my sister back for her help.	I wish my daughter would fetch me for the weekend. My sister from Sheffield rings once a week. She cares.

Name	Perception of Reciprocity	I would like to give:	I would like to get:	I give to others:	I get from others:
Mrs. Betty Zander	*A cynical view of others' ability to reciprocate suggests a negative view of relationships.*	I'd help as much as I could.	Truthfulness.	I give as much help as I can either mentally or physically.	A lot of baloney!

FIG 54 Northfield House Residents: Reciprocity of Relationships

Name	Perception of Reciprocity	I would like to give:	I would like to get:	I give to others:	I get from others:
Mrs. Violet Batty	*Bitterly disappointed that reciprocity between neighbours no longer functions now that she is living in a residential home some distance away from her former village.*	I share a lot and give things.	I don't get much from others. I'd rather give.	I try to help others. I've always been a generous person. Too much so sometimes. They don't visit - the people I've helped. That hurts more than anything. I didn't send any cards this year.	Nothing much. My former friends and neighbours don't visit. I didn't get much for my birthday this year.
Mrs. Ruth Beckett	*Not able to respond to every question but indicated that she is careful to act according to the rules rather than spontaneously - this is the reciprocity required of residents in return for care.*	*No comment.*	*No comment.*	I do knitting for the Officer-in-Charge.	*No comment.*
Mrs. Frieda Grantham	*Reciprocity is based on a friendly relationship with other residents.*	Conversation. Friendly interest.	Being friendly with me.	Buy presents for others.	Talking to me.
Mr. Kenneth Grantham	*Reciprocity is based on friendly relationships in the home, and especially with staff.*	Be friendly.	Friendliness.	I used to give sweets. They *(the girls/staff)* got fat, won't have them now. I laugh.	Happiness.

Name	Perception of Reciprocity	I would like to give:	I would like to get:	I give to others:	I get from others:
Mrs. Fannie Hewitt	*Reciprocity is about maintaining generally friendly relationships.*	Anything I could.	Friendliness.	Friendliness.	Friendliness.
Mrs. Enid James	*Her responses half-revealed her disappointment about the mutual dislike of another resident, but she clung to a childhood maxim about reciprocity.*	The same to everybody.	The same as I to them. You can tell if anyone doesn't like you.	Lend me their papers. Helping me out.	Be kind to others and they'll be kind to you, Granny said; otherwise ignore them.
Miss Julia Jessop	*Reciprocity is not fully understood. A life-long reluctance to be dependent on others is revealed. Friendship in the social sense is valued.*	Don't know. I don't have anything like that.	Don't want anything from anybody. Just go without. Just the way I've always been. Independent.	Don't know. Take it as it comes.	Friendship. Everyday happy-go-lucky all round.
Mrs. Flora Needham	*Reciprocity is seen as being against the rules of the home.*	We mustn't help people here - I said, leave her to do it on her own.	*No comment.*	Nothing.	Don't know.
Mr. Albert Quinton	*Comments are inhibited by awareness of the institutional relationships of the home.*	Give and take.	The same.	It's not so bad here.	It's not so bad here.
Mrs. Connie Redmond	*Reciprocity is about earning help. Friendship is secondary.*	I don't really know. I worked with them in the fields.	All I could - you've got to work for what you get.	Only friendship.	Now and again I get help. Have to work for it the same as others. Always been used to working.
Mrs. Ivy Verity	*Too upset to respond.*	*No response.*	*No response.*	*No response.*	*No response.*
Mr. Walter Verity	*Reluctant to respond and began to give orders.*	A helping hand.	Nothing.	Drink your tea!	At times, helping hands.

9.7 How the Residents Form Relationships: Anticipation and Previous Acquaintance

Asserting identities, assuming roles, recognising the impact of change in their daily environments, and coming to terms with group relationships represent adjustment strategies which individual residents cannot avoid. Adjustment strategies draw heavily on past life course experiences. The individual resident relies on the past in order to deal with the present. Inevitably, residents must confront the next stage of their changed circumstances. They begin to realise that the residential home is now their home and the people who live there are their most frequent sources of contacts. Relatives, friends, and former neighbours are no longer close at hand, even if they still survive. Those who recognise that the residential home is their final resting place and that they will leave only when they die are more reconciled to being there. At this point, some individual residents may seek consciously to form new relationships with their peers in the home. Others may remain psychologically rooted in the past and pursue the most superficial of relationships with their new neighbours. The residents' views on how they form relationships in the home, their expectations of friendship, intimacy, and expression of feelings move beyond the social relationships and identities by which they first established themselves.

Most residents had not planned their admission to care; it was not a positive choice (Wagner, 1988, discussed in Chapter Four). In each of the three homes, the majority of the residents interviewed stated that prior to their admission they had not thought about how they would form relationships within the home or how they would get acquainted. This reaction is linked to their failure to anticipate the changes which entering residential care would impose on their lives.

In each home there were some residents who had made the conscious decision to seek admission, rather than to accept it grudgingly and regretfully as the only possible solution to a crisis caused by health, social, and personal factors. Those who had made a conscious decision to enter care were more apt to make an effort to form relationships. The most commonly admitted reason for admission as a positive choice (Wagner, 1988) was the desire to relieve the burden on their carers. Residents who had transferred from other residential homes, or who had been short stay residents elsewhere (with the exception of a few residents at Northfield House who had moved from a private home which had raised its fees) tended to be more satisfied with their current situation than the majority, perhaps because they felt they had exercised more choice.

The personality and social skills of the individual residents, developed over their life courses, were important factors in forming relationships, and were acknowledged strongly by the residents. Nearly all the respondents felt that it was their responsibility to get acquainted by being "sociable." Nothing else had prevented them from forming relationships. As noted, few mentioned the staff assisting in the process. Ways of getting acquainted included "helping others"; "activities" (especially at Northfield House where there was a scheduled activities programme); "talking" and "joining in" (the routine). Of those who denied or doubted whether they had developed any relationships in the home, their own proclivity for being 'loners' or not mixing well was cited. They also blamed the extreme old age and confusion of the other residents and their own frailties: "I don't mix well", I'm selective," "my poor eyesight", "you can't speak to everyone or like everyone", "I have off-days".

The organisational relationships of the homes and their range of services influenced residents' initial relationships. Recognising the possibility of forming new relationships in residential care depended on the extent to which admission into permanent care followed a planned sequence of short-stay care and attendance at Day Centre activities at the home. Northfield House was the only one of the three homes studied which provided

a full range of services which might have eased the transition into care. In addition, it drew its residents from the surrounding rural areas rather than from further away. These features of its organisational relationships facilitated the residents' initial relationships. Another aspect of its organisational relationships (the lack of a coherent placement policy in the small group Units) offset the advantages gained. In the case of new residents, knowing some of the residents already did not ensure that these previous relationships would deepen into intimacy or close personal attachment, although previous acquaintance did help them feel more at ease socially in their new environment.

Residents in all three homes became acquainted with their fellow residents through the daily routine. The internal placement policy (or rather, the ad-hoc decisions) operated by the staff determined where residents slept, sat and ate. Proximity to other residents was established by these internal placement decisions. Proximity provided opportunities for getting acquainted but also limited choices. 'Getting acquainted' was viewed by many residents as "getting used to the routine" and "knowing your place in the home" rather than getting to know other people.

The residents' thoughts about getting acquainted are presented in the charts below. These illustrate the influences of life course experiences, organisational relationships, and the extent of frailty. Data about whether admission was their own choice, how they formed relationships, whether they had a special friend in the home, and whether they felt others in the home really knew them, are included. The data are organised home by home, with residents' names in alphabetical order. A more detailed discussion of the findings follows each chart.

FIG 55 SOUTHAM: Getting Acquainted

Name of resident	Previous thought about getting acquainted	Admission: choice or no alternative	How acquaintance-ships formed; whether others know them as they really are	Any special friend within the home	Other relevant information
Mr. Leslie Atkins	No.	Just came twelve years ago.	I think people here know me; another resident, Mr. Jocelyn, showed me round, took me to clubs in the village; I used to help in the garden.	Mrs. Irene Ellis.	Mrs. Ellis and I have the same interests, been to same places; she is also a long-term resident for many years.
Mrs. Annie Baker	No; never thought I'd end up here.	Following two strokes, I entered the home of my own accord to spare my daughter *(her carer.)*	People here don't know me, but they think they do; can't make relationships here; lack of private space; I'm a loner but not unfriendly.	One close acquaintance who is not a friend (Mrs. Hazel Hill); she talks to me; I don't ask about her family.	I'd like to trust, but I can't; *experienced deprivation and parental abuse in early years.*

Name of resident	Previous thought about getting acquainted	Admission: choice or no alternative	How acquaintance-ships formed; whether others know them as they really are	Any special friend within the home	Other relevant information
Mrs. Florrie Dakins	No.	I came here of my own accord; here for good - to die.	People here know me because I'm not afraid to reveal myself; I talk to everyone; make friends with everyone.	No.	*Two husbands dead; both sons dead; émigrée from Yorkshire.*
Mrs. Irene Ellis	No.	My daughter brought me here.	I don't know if anyone knows me here; I get along with everyone; I try to help everyone out; weekly exercises do everyone good and help people get along.	Mr. Leslie Atkins.	We share the same interests; both resident in home for a long time.
Mr. Patrick Hillier	No.	I entered from hospital; this is the best place to be.	Nobody here knows my private life; I mucked in with everyday life together; the servants *(staff)* are very good; all are friendly here.	Mrs. Hazel Hill; she likes companion-ship.	*He uses spiritual belief to establish identity; was a Rolling Stone.*
Mrs. Lily Irving	No.	My daughter Joan is friendly with Matron who arranged it to relieve my daughter *(carer).*	Matron knows me, but it's hard to get acquainted; I was introduced by daughter; Matron said I have a good sense of humour.	No.	*Short stay resident and Day Care user.*
Miss Cissie Lawrence	Yes; I made up my mind I was going to settle even if I was unhappy as hell.	To relieve burden on my niece *(carer)* who had a stroke.	Fortunately I've settled; getting up and saying good morning; there are only about five people I can talk to *(others are confused, or too ill or deaf.)*	Not so far; age and infirmity prevent friendships, I may make a special friend.	*A new resident; her sociability ensures that people know her as she really is.*

Name of resident	Previous thought about getting acquainted	Admission: choice or no alternative	How acquaintance-ships formed; whether others know them as they really are	Any special friend within the home	Other relevant information
Mrs. Cora Oliver	No.	I first came for respite care to relieve my daughter; I'm here for good till they carry me out in a box.	People know me because I can be sociable with anyone; striking up conversations; I'm friends with anyone.	No.	My walking has improved since entering the home.
Mrs. Kathleen Perkins	No.	*No clear understanding of why she is in the home.*	Few people here know me as intimately as friends in Scotland. My room-mate, Miss Jane Norris, helped; I lost my own problems as I shared hers.	Miss Jane Norris.	Now I'm separated from my room-mate; her life is ebbing away.

At Southam, there were no reported instances of previous acquaintances amongst those interviewed. (Southam's catchment area included the county town and a new development area with a transient population, so that most of the residents had grown up, worked, and lived in different areas from one another.) One of the Officers at Southam had collected insurance from a resident, Mrs. Alice Edwards, twenty years before when they both lived in the same community. This provided a bond of social recognition for Mrs. Edward's life course. Unlike the other residents, there was acknowledgement from staff that Mrs. Edwards had existed as an individual outside the context of the home. At Southam (the smallest home with only twenty-five beds and a stable, long-serving staff group), the majority of the residents felt that people in the home knew them. Those Southam residents who considered themselves to be 'loners', and who defined friendship as a social rather than a personal relationship felt that people did not know them. Eight out of nine residents interviewed at Southam said they were acquainted. Nearly all of those interviewed felt it was their responsibility to be sociable and reach out to others. Only Mrs. Baker felt acted upon and passive, waiting for others, usually the staff, to take the initiative. She did not really want to be at Southam. She had experienced deprivation and abuse in her early family relationships, so that she felt she could not trust others. Most Southam residents reported that although no particular hindrance to getting acquainted was put in their way, no particular help was given either. Two residents, Mrs. Perkins and Mr. Atkins, felt that they were encouraged by other residents (Old Hands) acting as mentors to become part of the group.

An example of a resident who had made an active choice to enter care was Miss Cissie Lawrence, an 87 year old retired schoolteacher, who decided to enter Southam to relieve the burden of caring which fell on her 71 year old niece. Miss Lawrence was observed using her considerable social skills gained throughout her life course experience. She chatted to the staff and other residents in an outgoing manner shortly after her arrival. "I was determined to settle" said Miss Lawrence. Similar reactions from residents who had made a conscious choice to enter care were observed in the other two homes.

FIG 56 EASTVIEW: Getting Acquainted

Name	Previous thought about getting acquainted	Admission: choice or no alternative	How acquaintance-ships formed; whether others know them as they really are	Any special friend within the home	Other relevant information
Mr. Henry Clifford	No.	Didn't like coming; no alternative, couldn't walk, doctor advised it.	I think people know me; not acquainted yet, don't mix well.	No.	I've been a loner all my life; reasonably content.
Mrs. Sally Cooper	Yes; had visited people I knew in home previously.	Thankful to get here; but if I could have got more home help, I'd have stayed in my own home; I said if I come here I come for good.	Don't know if people know me; I talk to people in lounges; only three are left; all the rest have died; few staff are left of original ones.	No.	*Has friends outside in local community; lived in home for many years.*
Mr. John Davis	No; didn't know anyone here.	Came because of arthritis in legs, couldn't get up the stairs or go out.	People here know me because I'm not confused and they seek me out; no trouble to get acquainted; newspaper interviewed me, in a few days I knew everybody; I'm the only one you can hold a conversation with, others are deaf and hopeless.	They're all friends, but no-one in particular.	*Known for his former work role as fireman in London Blitz.*
Mrs. Olga Frederick	Yes; heard about home through my cousin, Mrs. Amanda Rogers, who is a resident.	Looked around several homes; some not clean enough; this one was lovely.	Don't know if people know me; we're thrown together here and have to make the best of it; I think they like me, I'm a tryer.	No. *Sharing a room with her cousin was a disastrous experience.*	*Dislikes staff calling her "dear" and expecting her to call them by their forenames.*

Name	Previous thought about getting acquainted	Admission: choice or no alternative	How acquaintance-ships formed; whether others know them as they really are	Any special friend within the home	Other relevant information
Mr. Richard Llewellyn	No.	I tried another home for one month before coming here; doctor arranged it.	People are getting to know me; it's all right; I treat them as they treat me; I get along well with the "girls" *(staff)*.	No female acquaintances; friendly with several fellows; we help each other out.	Being a Christian is important when seeking a friend.
Mrs. Molly Nabbut	Can't remember coming here.	I was shocked at sudden death of my sister; I developed body tremors and palsy.	Don't know if people know me; they *(staff)* say: sit here and you sit; that decides who you get acquainted with; I knew Mrs. Frederick at school.	No special friend, but Mrs. Towell and Mrs. Rowlands are helpful.	*Has a close friend, Miss Sansom, who visits her regularly.*
Mrs. Iris Rowlands	No.	I was at a short-stay home for few days; then transferred to Eastview.	People know me, I'm no different; gradually got acquainted; hard to see staff, as eyesight is poor; can get on with most people.	No, but Mrs. Polly Towell is a help; another resident and I entered the home on the same day.	*Critical in a detached way, she is well-liked by other residents.*
Mrs. Bertha Tarrant	No.	Only came here because my daughter can't have me; wouldn't be happy in any home.	People here know me; some people are too old or too senile to get acquainted, don't want to be with old people all your life.	No; never one for bothering with friends.	*New resident; unhappy in home.*
Mrs. Polly Towell	No.	Transferred from another residential home; I wasn't happy there; cooking there not good; I had clashes with room-mate over plants in room.	People know me; used to play bingo with staff; two residents (Mrs. Hooper is one) very kind; but some short-stay residents make me sick.	Mrs. Mary Hooper; also Mrs. May Orville and Mrs. Molly Nabbut (latter two at dining table and in upstairs lounge.)	*An acknowledged Queen Bee and Quasi-Staff member who found happiness in her new roles.*

Name	Previous thought about getting acquainted	Admission: choice or no alternative	How acquaintance-ships formed; whether others know them as they really are	Any special friend within the home	Other relevant information
Mr. George Urquhart	No	My Welfare Officer got me here *(from mental handicap hospital).*	People know me; I spoke to people, told them where I was from; *uses radio as talisman.*	No; I visit my "girlfriend" who lives at the hospital.	*Had lived many years in a mental handicap hospital.*
Mrs. Miriam Youens	No	My daughter Sylvia made arrangements with the doctor for me to come.	People know me now; I knew Mrs. Iris Rowlands previously from a club I belonged to; no friends here; they've all got their own friends.	No.	*Deprived childhood; new resident; unhappy at being in the home.*
Mrs. Betty Zander	Yes; I was used to running that place in Finchley *(was a cook in an NHS hospital for 72 patients).*	I heard a good report of this home; asked to come here; couldn't see to do cooking or to walk.	No-one knows me; I knew some people before I came; have nothing to say; they keep away from me because of my Spiritualism and truthfulness.	No; acquainted with a few who sit at my table.	*Critical of residents whining for attention; thinks some residents should be in a mental hospital.*

At Eastview, Mrs. Molly Nabbut and Mrs. Olga Frederick knew each other previously because they had attended school together many years ago - an almost random occurrence. (Eastview's catchment area was the county town almost ten miles away, a growing transient area with population moving in from East London.) At Eastview there were two first cousins living in the home (one of whom was Mrs. Frederick.) Mrs. Amanda Rogers had been a resident for some years when her cousin, Mrs. Frederick, a double amputee, came to live at Eastview attracted by her relationship with her cousin. They shared a room for a while, but differences developed and they were separated. The Officer in Charge at Eastview, Mrs. Olds, said she had grave misgivings about placing the two women together, because they had not really known each other well enough to guarantee their compatibility in a shared bedroom. Mrs. Frederick said "I was a bitch - I rattled my trolley at night and played my radio loudly to upset her. Now I'm afraid she'll tell everyone and no-one will want to know me. She has everyone on her side." This account illustrates the difficulties of transforming a social relationship, even one founded on kinship, into a close personal relationship in a restricted living space with little privacy. The penalty paid for such a failed relationship was expressed by Mrs. Frederick as loss of social esteem within the wider context of social relationships in group living. This account also demonstrates the importance to residents of achieving satisfactory social relationships in the residential setting.

Eastview was a much larger home than Southam, with a more transient staff group, but because it had more single rooms there were more opportunities for privacy. A majority of Eastview residents said they felt that people knew them. There was a sense of progression and change implied in the responses, with the unstated premise that developing relationships takes time. For example, Mrs. Iris Rowlands said, "Yes - now", and Mrs. Olga Frederick (a new resident) said, "No, but I've got a lot to learn". A resident who denied that other residents knew her was Mrs. Betty Zander, the Spiritualist widow who stated that she kept apart from the others because they might not understand or tolerate her Spiritualist beliefs.

Nine out of twelve Eastview residents interviewed reported that they had become acquainted with other residents. Mrs. Olga Frederick reported that she had looked around and compared homes before seeking admission. Mrs. Betty Zander based her expectations on her previous life course experience when she worked in a geriatric hospital. The communal lounges at Eastview provided opportunities for social relationships and for joining a group rather than for close personal relationships. Intimate relationships, when they developed, were based on the experience of being room-mates. One or two residents at Eastview specifically mentioned that the power of the staff who determined their internal placement within the home subsequently affected their opportunities for getting acquainted. Mrs. Frederick at Eastview felt that all the residents were "thrown together" and that she was forced to call staff by their forenames, a custom she could not accept. She saw the dropping of titles of 'Mr.', 'Mrs.', and 'Miss' as part of the rules of the establishment with which she had to comply. On the other hand, Mr. John Davis liked the informal style and camaraderie of the staff, feeling that this helped him get acquainted. This contrast in the reactions of two residents in the same home to an aspect of the organisational relationships illustrates the difficulty of establishing a policy which would satisfy all the residents' expectations. Yet if the staff had recognised Mrs. Frederick as an individual, and learned of her desire for a more formal form of address, her preference could have been accommodated. They could have learned more about her if they had recognised the importance of residents' life course experiences in shaping expectations of care.

FIG 57 NORTHFIELD HOUSE: Getting Acquainted

Name	Previous thought about getting acquainted	Admission: choice or no alternative	How acquaintance-ships formed; whether others know them as they really are	Any special friend within the home	Other relevant information
Mrs. Violet Batty	No.	I didn't want to be in home; my brother and the social worker arranged it while I was in hospital.	I don't know and don't care whether people know me; don't speak to others; some speak, some don't.	Mrs. Clara Marshall in same Unit is my special friend. *Dislikes Mrs. Enid James, also in her Unit.*	Mrs Enid James yaps and intrudes when my visitors come.

Name	**Previous thought about getting acquainted**	**Admission: choice or no alternative**	**How acquaintance-ships formed; whether others know them as they really are**	**Any special friend within the home**	**Other relevant information**
Mrs. Ruth Beckett	No.	Between devil and deep blue sea following death of my niece; couldn't expect great-nieces to give up jobs to look after me.	*Unable to say whether people really know her;* others are all right; can't hear others' conversation because of deafness; seen new residents come and go *(die).*	No.	*Entered home in 1978; spent twelve years in home; now 103.*
Mrs. Frieda Grantham	No.	I entered home from hospital following suicide attempt; *subsequently refused rehabilitation to own home.*	They know me now - I make them laugh; helping others, doing jobs; knew one or two others previously.	No.	*Husband in same home.*
Mr. Kenneth Grantham	No	*See above*	Yes, I think they *(staff)* know me; talking to others; everyone is friendly; knew one or two others previously	No.	*Wife in same home.*
Mrs. Fannie Hewitt	No.	Doctor ordered me to this home; I liked it from the start.	Yes, people know me; settled in; I knew several others from school days; friendliness of self and others.	No.	*Day Care; short stay.*
Mrs. Enid James	No.	I entered for my daughter's sake *(her carer).*	People don't really know me; I fell in with the routine; talked to others; helped with cleaning, wiping dishes; *uses photographs as talismans.*	Mrs. Violet Batty lends me her paper, is kind.	*Her mutual antagonism with Mrs. Batty was nevertheless a relationship which Mrs. James valued.*

Name	**Previous thought about getting acquainted**	**Admission: choice or no alternative**	**How acquaintance-ships formed; whether others know them as they really are**	**Any special friend within the home**	**Other relevant information**
Miss Julia Jessop	Forgot; too long ago.	Two lady doctors got me here ten years ago when I was ill.	I hope people know me; got to know others through communal living under previous Matron; activities *(basket-work)* helped; now activities are much improved.	Mrs. Thelma Simpkins, my room-mate, has become a special friend.	Deafness prevents me from becoming fully acquainted; I have my off-days which pass.
Mrs. Flora Needham	No.	Had been in Tontell Lodge Private Home, but relatives said fees were too expensive.	I never mix well; others take initiative in striking up conversation; it was hard at first; *avoids saying whether people really know her.*	I feel close to one other resident who had also been in Tontell Lodge.	*Unhappy in home and in the area; still a Londoner at Heart.*
Mr. Albert Quinton	No.	Arthritis caused entry.	Don't know if people know me; hard to make friends.	No.	Being working class is important.
Mrs. Connie Redmond	No.	Day care, short stay.	People know me and we get on well together; same as always; I talk to others; some you can talk to, some you can't.	No.	*Somewhat confused about where she lives, whether in her own home or in care.*
Mrs. Ivy Verity	No.	I had a heart attack and stroke; for daughter's sake.	*Too upset to say whether people really know her*; regular attendance at Day Centre; friendly chats; others' pleasant manners.	No.	*Husband also a short-stay resident; did not mention husband's health and role as carer.*
Mr. Walter Verity	No.	I was wife's carer; then I had a stroke.	Some people know me; my wife was here first; speaking to others.	No.	*Wife also a short-stay resident.*

At Northfield House, three of the eleven residents interviewed already knew people who were resident and this helped them to settle. (As noted above, previous acquaintance was most likely at Northfield House, because of its localised catchment area in a rural setting with a stable population. Its Day Centre and short stay care programme brought local elderly people to the home before they entered the home as permanent residents.) The residents at Northfield House (which, as noted above, provided Unit living, and whose Officer-in-Charge, Mrs. Black, had a dominant leadership style) were more evasive than those in the other homes. Fewer residents said that people knew them, and others said they "didn't know" or they "hoped so". One respondent, Mrs. Ivy Verity, burst into tears at this point and the interview had to be abandoned. It could be argued that Northfield House residents should have had more opportunities to establish their identities and develop significant relationships because of living in small groups and because some already knew each other before admission. Their reticence and sense of strain reflected the tensions of small group living in residential care, exacerbated by the lack of an internal placement policy to ensure measures of compatibility (Willcocks et al, 1987, discussed in Chapter Four).

Paradoxically, all twelve Northfield residents interviewed felt acquainted, despite their denial of being known. Northfield House's programme of coffee mornings was targeted at the nearby sheltered housing units, enabling tenants to attend by sending a mini-bus to collect them. Prospective residents became acquainted before admission. Mrs. Frieda Grantham, the outgoing, active resident at Northfield House (discussed in Chapter Eight), served as an unofficial public relations officer on these occasions, showing tenants her room and speaking enthusiastically about the home. The Officer-in-Charge at Northfield House, Mrs. Black, was blamed by one resident, Mrs. Violet Batty (discussed in Chapter Eight), for preventing her from taking an active role which would have helped her form relationships: "she won't let me help others." Mrs. Batty (who was unhappy and felt forced into care by her brother and social worker following her hospital admission caused by a fall at home) also expressed disappointment that the social worker who had visited her before admission did not visit again once she become a resident. She did not want to sever all her links with her previous life course experiences.

9.8 Summary of Discussion

In the preceding sections, the influences of life course experiences, organisational relationships, and residents' frailty on their relationships were evident. Residents retained their own individuality formed throughout the life course, even if the homes' organisational regimes did not recognise this aspect of themselves. The residents who had made a positive choice (Wagner, 1988) to enter care made more effort to get acquainted. The relationships sought were social relationships, and the means to achieve these was through adopting Talismans and Roles. The most fulfilling and successful roles were those of Queen Bee and Quasi-Staff Member. These roles involved helping other residents, often with considerable unofficial power exercised through the role. The residents' frailty, mentioned frequently as a limiting factor in relationships, often led to helping relationships with an unequal power balance. The residents felt that the responsibility for forming relationships lay with themselves. The organisational relationships of the homes defined the limits of what could be achieved within relationships. The homes' regimes imposed patterns of change on the residents. Residents felt, for the most part, that they were obliged to adapt. Some residents mentioned increased social skills as positive changes. The staff were not viewed as playing much part in helping the residents form relationships.

Residents were reluctant to admit the existence of any leadership or powerful roles from within their own ranks, even though observation revealed these roles be clearly evident. Perhaps this was because there was no official provision for the roles within the

organisational relationships of the homes. Residents found it difficult to comprehend or acknowledge the concept of reciprocity, but there was observed evidence of its existence in their relationships. Residents appreciated each others' efforts to welcome them, enter into relationships, and offer help to each other. Most residents felt that they were in touch with their relatives, but not all residents had relatives who were easily accessible.

The next sections present the residents' perceptions of their personal relationships, including friendship, intimacy, expressing feelings, and pairing within the homes.

9.9 The Extent of Friendship

As discussed in Chapter Three, friendship is a difficult concept which does not fit neatly into clearly defined categories of social, personal, and organisational relationships. Friendship is equally applicable to the concepts of personal and social relationships. The research attempted to gain a picture of residents' concepts of friendship; of whether they viewed friendship as a basis for forming personal relationships and attachments, or simply as another kind of social relationship.

The charts below illustrate the views of residents on what makes a person a friend. Life course experiences shaped residents' views. Residents who had formed few particular attachments in their lives, and who looked for or were content with a general level of sociability, gave non-specific responses and could not articulate their concepts of friendship. These tended to be those who had experienced Deprivation. Those who both currently and in the past enjoyed close friendships, or who were seeking friendship of a more intimate type, gave more precise responses. The precise comments were all made by women. Comments of a more general kind, indicating criteria of social standing and group membership boundaries, were made by some of the men. The differences supported Gilligan's argument (1982, discussed in Chapter Two) and Jerrome's comments (1993b) of the gender differences in relationships.

FIG 58 Southam Residents: Defining Friendship

Name	What Makes a Person a Friend	Analysis, Comment
Mr. Leslie Atkins	Talking to one or two - then get to know them.	*Long term resident, no relatives, closest to Mrs. Irene Ellis.*
Mrs. Annie Baker	Don't know.	*Said she could not trust others because of childhood abuse and deprivation.*
Mrs. Florrie Dakins	Sitting and talking to people nearby - I'll talk to anyone.	*Does not see friendship as a personal relationship.*
Mrs. Irene Ellis	Don't know *(mentions shared activities in the home).*	*Denies own Queen Bee role and relationship with Mr. Atkins.*
Mr. Patrick Hillier	Ordinary friendship, companionship.	*No close relatives or children; seeking a personal relationship with Mrs. Hazel Hill.*
Mrs. Lily Irving	Sincerity, humour, faith *(Salvationist)*, seeing others' point of view.	*Day Care and short-stay resident; sociable, observant, considers herself not really part of home yet.*
Miss Cissie Lawrence	When you're young - shared interests; now, not sure.	*Comments on frailty preventing expression of former interests and activities.*
Mrs. Cora Oliver	Don't know, can't explain.	*Detached, divorced from husband, past deprivation and separation from children.*

Name	What Makes a Person a Friend	Analysis, Comment
Mrs. Kathleen Perkins	Sharing, understanding how they feel about something, love - you've got to have this.	*Widow, no children, had formed close personal relationship with room-mate, Miss Jane Norris.*

The precise comments of Mrs. Kathleen Perkins and Mrs. Lily Irving, both of whom had enjoyed close personal relationships, can be contrasted with the vague, non-committal responses of Mrs. Cora Oliver and Mrs. Annie Baker, who had each experienced Deprivation in their life courses. Their responses illustrate the influence of the life course on relationships, yet it must be acknowledged that some who were non-committal had not been deprived.

FIG 59 Eastview Residents: Defining Friendship

Name	What Makes a Person a Friend	Analysis, Comment
Mr. Henry Clifford	Couldn't tell you, always looked after my parents; a neighbour, Mrs. Stone, was very good to me.	*An isolate, never had a friendship or close relationship apart from parents.*
Mrs. Sally Cooper	I don't know, any more than I know how people choose husbands and wives.	*Cynical, annoyed, disillusioned because she has lost her protégé ; hinted at past unhappiness in her marriage.*
Mr. John Davis	I help a man here who's deaf.	*Sees himself as a Helper, leader, more capable than others who are confused; seeks social relationships.*
Mrs. Olga Frederick	Honesty, truthfulness.	*Frank, open, used the interview to reveal her feelings.*
Mr. Richard Llewellyn	Being a Christian.	*Looks for similar values, seeks social relationships only.*
Mrs. Molly Nabbut	An inner feeling that they're friendly to you.	*Sincere, has a close personal relationship with Miss Sansom, a friend who visits regularly.*
Mrs. Iris Rowlands	Sincerity; don't like people who dodge about from one to another	*Distinguishes between social and personal relationships; enjoys good social relationships in home but does not consider any resident to be a friend.*
Mrs. Bertha Tarrant	Never one for bothering with friends; only close to daughter and mother.	*New resident, angry because of entry to care, only wants a personal relationship with her daughter.*
Mrs. Polly Towell	All are friendly except for Mrs. Ida Plumpton; we talk; I help them.	*Contented and fulfilled with the social roles of Quasi-Staff Member and Queen Bee.*
Mr. George Urquhart	When you like someone; some people are nice, some are not; people are not all the same.	*Lived in a mental handicap hospital for 35 years; closest to his 'girlfriend' who is still in the institution.*
Mrs. Miriam Youens	Sharing experiences and talking together if you're straightforward.	*New resident, unhappy at entry to care, estranged from daughter, deprived childhood.*

Name	What Makes a Person a Friend	Analysis; Comment
Mrs. Betty Zander	Truthfulness; I can diagnose it, that's why they stay away from me.	*Denies personal relationships, estranged from son, widowed twice, Spiritual Belief is a source of strength.*

Eastview residents (Mrs. Zander, Mr. Llewellyn, Mrs. Rowlands, Mrs. Nabbut, Mrs. Frederick) who gave precise responses which defined the personal qualities they would seek in another were those who had reached a level of integration (Erikson et al, 1986, discussed in Chapter Two) in their life courses, in contrast to the vague responses of those who felt their relationships to be lacking currently as well as in the past. The integrated responses were not indicative of current close relationships but of a sense of acceptance of their relationships over the life course. Mrs. Frederick, although falling out with her cousin, showed self-knowledge of her faults and presented herself with honesty.

FIG 60 Northfield House Residents: Defining Friendship

Name	What Makes a Person a Friend	Analysis; Comment
Mrs. Violet Batty	Mutual feelings of liking.	*She seeks a close personal relationship.*
Mrs. Ruth Beckett	*Did not comment.*	*Confused by too precise a question.*
Mrs. Frieda Grantham	Others' friendliness; sharing a laugh.	*Her husband is resident in the home with her.*
Mr. Kenneth Grantham	The way they act.	*His wife is resident in the home with him.*
Mrs. Fannie Hewitt	Friendliness; outgoing person.	*She seeks social relationships.*
Mrs. Enid James	Someone you can turn to for help; someone who helps you.	*Still playing her life course role of 'adored child', seeking help.*
Miss Julia Jessop	Tolerating each other's ways; shared experiences.	*A measured view; has both social and personal relationships; a long term resident.*
Mrs. Flora Needham	Don't know; they all look after themselves, mind their own business.	*Not seeking a personal relationship.*
Mr. Albert Quinton	Being working class like me.	*Frail and isolated.*
Mrs. Connie Redmond	People who are good company.	*Seeking social relationships.*
Mrs. Ivy Verity	How people speak to you; their voices; how they treat you.	*Husband with her in the home.*
Mr. Walter Verity	Shared experiences over time; feelings of liking, caring.	*Wife with him in the home.*

Northfield residents who either had experienced or were seeking a close relationship also gave more precise replies than those whose previous relationships had not been satisfactory.

In the charts above, the findings resonate with the definition of friendship developed by Sarah Matthews (1983b, discussed in Chapter Three) in which she contrasts friendship based on shared interest, with friendship based on shared experience. Both types of friendship were present. There were other variations of Matthews' themes. The shared

experience of friendship grew out of new shared life course experiences in the homes, rather than from earlier life course experiences. Entering care on the same day, surviving for many years in care beyond the expected span, sharing a room, sharing the same views about the staff - these were the kinds of experiences which might lead to friendship. Some friendships were based on roles adopted towards each other, such as taking an active role in helping others (the Quasi-Staff Member) or sharing some common activity. Some residents in each home determined friendship on the basis of qualities to be found in the other person. These were the ones who had formed or who were seeking close personal relationships, or who had reached a stage of integration in their life course. Some residents didn't have any expectations of friendship because of their lack of success with friendships in their past life course experiences.

FIG 61 Residents' Concepts of Friendships

	Residents who conceive of friendships as based on personal attributes	**Residents who conceive of friendships as based on roles**	**Residents who conceive of friendships as based on shared experiences**	**Residents who have no expectation or concept of close relation-ships**
How Relation-ships are formed	Appreciating qualities found in other persons: honesty, sincerity, etc.	Helping others, being helped.	Entering care at the same time, participating in activities, sharing a room.	Do not know how to form relationships, little previous experience of friendships in the past, or now too confused or feeble to have any expectations or concepts.

At Southam Miss Cissie Lawrence said she felt that shared interests were important criteria for forming a friendship, but these were more important for youth. When asked what would be the basis of friendship in old age, she did not know. Also at Southam, Mrs. Kathleen Perkins (who had found a close relationship with Miss Jean Mills) gave precise comments to define friendship, "understanding, sharing feelings, and love." Another respondent at Southam, Mrs. Lily Irving, said "sincerity, tolerance, humour, and faith."

At Eastview, shared experience was also mentioned. Mrs. Olga Frederick said, "honesty", Mrs. Iris Rowlands, "sincerity", and Mrs. Betty Zander and Mrs. Iris Rowlands "truthfulness".

At Northfield House Miss Julia Jessop felt that shared experience, through living together in the same Unit, was important. Group membership criteria were important to Mr. Albert Quinton at Northfield House who mentioned "being working class". Mr. Richard Llewellyn at Eastview also mentioned group membership when he said "being a Christian" was important.

The research also asked residents to discuss their actual friendships, not just their concepts of friendship. Most of the residents in all three homes said that they had formed friendships in the home. On closer examination of their responses, it became evident that friendship was interpreted by some as "being on friendly terms with most people" and "being known by most people" - related more to concepts of sociability, acquaintanceship, and

social relationships on the one hand, and with concepts of personal and social identity on the other, rather than to dyadic personal attachment. The responses given could be re-interpreted to yield only a minority of positive responses. There was the possibility also that this was a threatening question, calling into critical examination the foundation of their self-esteem. In each residential home, despite my careful development of contact over a period of time to gain acceptance and trust before asking such a direct question, some half-hearted and non-committal responses may have been an attempt to block accurate but perhaps emotionally painful responses. As Erikson et al (1986, discussed in Chapter Two) suggested, residents may omit painful episodes in a search for integration. The new close attachments which developed were with other residents and were based on either sharing a room, or on reciprocal transactions of giving and receiving help. The influence of the life course experience was acknowledged as a motivation or as a disincentive for forming new relationships.

The residents' detailed views of their friendships are presented in the charts below.

FIG 62 Southam Residents' Views of their Friendships

Name	Friendship in home not developed	Reason why friendship was not developed	Friendship in home developed	Reason why friendship was developed
Mr. Leslie Atkins			√ With Mrs. Irene Ellis.	We share same interests: cycling, outdoors, gardening.
Mrs. Annie Baker	√ Only an acquaintance with another resident.	It's just one of those things, I don't enquire about her family.		
Mrs. Florrie Dakins			√ But with no particular person.	I talk to others nearby.
Mrs. Irene Ellis			√ Friendly with everyone and Mr. Atkins.	Shared interests, both long term residents.
Mr. Patrick Hillier			√ Mrs. Hazel Hill.	She has an illness, she likes company.
Mrs. Lily Irving	√	They're all 'palled' up together; I'm new. I have to sit in a particular chair.		
Miss Cissie Lawrence	√	Too soon, I'm a new resident; weakness *(frailty)* may prevent friendships being formed.		

Name	Friendship in home not developed	Reason why friendship was not developed	Friendship in home developed	Reason why friendship was developed
Mrs. Cora Oliver	√ But friendly with all.	*No explanation given.*		
Mrs. Kathleen Perkins			√	Rather not say *(referring to former room mate Miss Jane Norris, whose identity she revealed later.)*

At Southam, Mrs. Kathleen Perkins, claimed that she had formed a close relationship (with her former room mate, Miss Jane Norris) and Mr. Atkins and Mrs. Ellis noted their special friendship. The others said they were "friendly with all".

FIG 63 Eastview Residents' Views of their Friendships

Name	Friendship in home not developed	Reason why friendship was not developed	Friendship in home developed	Reason why friendship was developed
Mr. Henry Clifford	√	Always been a loner, was close to my parents.		
Mrs. Sally Cooper	√	I have friends outside the home *(a local resident of the community.)*		
Mr. John Davis			√ But no one in particular.	We all muck in, say "all right, Bill" !
Mrs. Olga Frederick	√	I'm a new resident, I think they like me, I'm a tryer and don't give up easily.		
Mr. Richard Llewellyn			√ Not very many, friendly with several fellows, no female acquaintances.	We help each other.
Mrs. Molly Nabbut			√ Mrs. Iris Rowlands.	I sit near her and she's friendly.
Mrs. Iris Rowlands	√ Not particularly	My blindness; three friends are dead, all my old friends are dead, but Mrs. Polly Towell is a help.		

Name	Friendship in home not developed	Reason why friendship was not developed	Friendship in home developed	Reason why friendship was developed
Mrs. Bertha Tarrant	√	I'm new in the home, I don't like it.		
Mrs. Polly Towell			√ Mrs. Mary Hooper at my table, Mrs. May Orville, and Mrs. Molly Nabbut.	Proximity and opportunity to help them.
Mr. George Urquhart	√	*No answer.*		
Mrs. Miriam Youens			√ I know Mrs. Iris Rowlands.	*Knew her before entering the home through the social club in sheltered housing.*
Mrs. Betty Zander	√ Except for one or two.	Those that sit at my table.		

At Eastview, only three out of twelve respondents said they had formed specific friendships with other residents. Mrs. Polly Towell, who had assumed the roles of Queen Bee and Quasi-Staff Member with a small group of residents in the upstairs lounge, responded affirmatively, naming three residents, Mrs. Mary Hooper, Mrs. Molly Nabbut, and Mrs. May Orville, as friends. Mrs. Miriam Youens and Mrs. Molly Nabbut mentioned Mrs. Iris Rowlands as a friend. Conversely Mrs. Rowlands did not mention them when she was asked, saying instead that her blindness prevented her from forming close relationships. Their different responses perhaps revealed their different concepts of friendship. The life course experiences of Mr. Henry Clifford, an isolate, and Mrs. Sally Cooper, a local, helped to explain their responses.

FIG 64 Northfield House Residents' Views of their Friendships

Name	Friendship in home not developed	Reason why friendship was not developed	Friendship in home developed	Reason why friendship was developed
Mrs. Violet Batty			√ Mrs. Clara Marshall.	I look after her; she's on her own, doesn't have many visitors.
Mrs. Ruth Beckett	√	Deaf; many residents have died while I've been living at the home.		
Mrs. Frieda Grantham			√ Friendly with all.	Friendliness of others; I make them laugh.

Name	Friendship in home not developed	Reason why friendship was not developed	Friendship in home developed	Reason why friendship was developed
Mr. Kenneth Grantham			√ All of them.	Everyone is friendly.
Mrs. Fannie Hewitt	√ But I like them though.	*Short stay resident.*		
Mrs. Enid James			√ Mrs. Violet Batty; all of them.	I treat them right; she lends me her paper.
Miss Julia Jessop			√ Mrs. Thelma Simpkins.	My room mate; we have different ways; we don't interfere with each other.
Mrs. Flora Needham			√ One lady from the home where I used to be.	I knew her before I came here.
Mr. Albert Quinton	√	No reason.		
Mrs. Connie Redmond			√	I socialise every day, no one stands out.
Mrs. Ivy Verity			√	Friendly with all; how people speak and treat you is important.
Mr. Walter Verity	√	New in the home; wife accompanies me.		

At Northfield House, nine residents said they were "friendly with everybody but with no-one in particular". Only four Northfield House residents interviewed, Miss Julia Jessop, Mrs. Flora Needham, Mrs. Enid James, and Mrs. Violet Batty, said they had formed specific friendships. Mrs. Batty and Mrs. James had developed a mutual antagonism which was nevertheless a significant relationship for each, which Mrs. James viewed more positively.

9.10 Moving Beyond Friendship into Intimacy

Intimacy is a feature of some, but not all friendships. Intimacy is an essential aspect of close personal relationships or attachments, which is sometimes, though not always, an aspect of friendship (Bowlby, 1951, 1986, discussed in Chapter Three). Most of those studied had lost many of their life-long intimate attachments because their parents, spouses, siblings, and in some cases, their children, had died before the residents entered the home. Few of the relationships which they developed with other residents deepened into friendship and intimacy. Most residents remained, in spirit if not in actuality, close to the residue of their relatives and friends living outside the home. Their life course experiences remained with them and if only in memory, provided the focus for intimacy in relationships. Most respondents designated someone outside the home as the person to whom they felt closest. The data suggested that intimacy is an attribute of kinship for

most and is not dependent on daily contact. It is the feeling of being close which matters rather than seeing someone every day. Few of the respondents had gone beyond the level of social relationships, of getting along with the group as a whole, in their interactions with each other in the home. Previous close friendships, or the mutual obligations of kinship, had included shared experiences, responsibilities and fun. These intimate, long standing relationships determined the choice of most. Those few residents who did mention another resident as an intimate friend had formed reciprocal relationships which exchanged need and power, helping and being helped. These aspects of reciprocity satisfied the need for intimacy, and echoed Jerrome's view (1993b) of reciprocity as a key concept in relationships, although not in this instance, inter-generational relationships..

The residents' views of intimacy are illustrated in the charts below.

FIG 65 Southam Residents' Views on Intimacy

Name	Overall, feels closest to:
Mr. Leslie Atkins	Mrs. Irene Ellis *(resident).*
Mrs. Annie Baker	Daughter.
Mrs. Florrie Dakins	What a funny thing to ask - *(avoided answering).*
Mrs. Irene Ellis	Daughter.
Mr. Patrick Hillier	Stepdaughter in USA.
Mrs. Lily Irving	Daughter.
Miss Cissie Lawrence	Niece and nephew-in-law (my niece was like a daughter to me).
Mrs. Cora Oliver	Daughter; also Anne, my former neighbour before I entered the home.
Mrs. Kathleen Perkins	Miss Jane Norris, former room mate *(resident).*

At Southam, six out of the eight respondents chose a woman relative outside the home: a daughter, a niece, a step-daughter. The remaining two chose a woman resident in the home. Mrs. Kathleen Perkins said of Miss Jane Norris, "She needs me". Mr. Lesley Atkins said of Mrs. Irene Ellis, "We share the same interests". He had no close relatives left, and so designated Mrs. Ellis, but she mentioned her daughter rather than him.

FIG 66 Eastview Residents' Views on Intimacy

Name	Overall, feels closest to:
Mr. Henry Clifford	Nobody, I keep myself to myself.
Mrs. Sally Cooper	Various friends outside the home, no one inside the home.
Mr. John Davis	Daughters and grandchildren.
Mrs. Olga Frederick	Myra, my sister.
Mr. Richard Llewellyn	Daughters.

Name	Overall, feels closest to:
Mrs. Molly Nabbut	Miss Nora Sansom, my friend who visits regularly. Fairly close to Mrs. Polly Towell *(resident).*
Mrs. Iris Rowlands	Daughter.
Mrs. Bertha Tarrant	Daughter.
Mrs. Polly Towell	Brother, who visits regularly.
Mr. George Urquhart	Susan, my girlfriend (who lives in a mental handicap hospital).
Mrs. Miriam Youens	No one *(angry with daughter).*
Mrs. Betty Zander	Nobody in particular; I'm a loner, but not lonely.

At Eastview, six respondents named a relative (sister, brother, daughter). Two named specific long-term women friends in the community. Mrs. Sally Cooper mentioned "friends" in the community, but not in the residential home, without being specific. Three (Mrs. Betty Zander, Mrs. Miriam Youens, and Mr. Henry Clifford), all of whom had experienced difficulties in their previous relationships, said they did not feel close to anybody. Mrs. Betty Zander said "I'm a loner but I'm not lonely". Seven Eastview residents did not feel close to anyone in the home. Two of the male residents (Mr. Richard Llewellyn and Mr. John Davis) said "I like them all". No one named each other in an example of reciprocal feelings. This was also true of Southam.

FIG 67 Northfield House Residents' Views on Intimacy

Name	Overall, feels closest to:
Mrs. Violet Batty	Brother. Friend *(resident)* Clara Marshall.
Mrs. Ruth Beckett	Great-nieces.
Mrs. Frieda Grantham	Husband *(also in the home).*
Mr. Kenneth Grantham	Wife *(in the home).*
Mrs. Fannie Hewitt	Daughter and grand-daughter.
Mrs. Enid James	Daughter.
Miss Julia Jessop	Sister Caroline.
Mrs. Flora Needham	Children.
Mr. Albert Quinton	Daughters.
Mrs. Connie Redmond	Parents *(who are dead).*
Mrs. Ivy Verity	Husband *(also in the home).*
Mr. Walter Verity	Wife Ivy *(also in the home).*

At Northfield House, all the respondents named a close relative (wife, husband, children, brother, sister). Only one out of twelve named a specific resident. The husbands and wives in each case named each other in an example of reciprocal feelings, but these derived from the life course not from the experience of living in the home.

9.11 Expressing Feelings as Part of Close Personal Relationships

Expressing feelings is an expected feature of close personal relationships, of intimacy, and probably of many friendships. Three factors inhibited the residents' expression of feelings. First, life-long cultural traditions formed throughout the life course of not expressing one's feelings to others remained in force, inhibiting disclosures. Secondly, the frailty, sensory deprivation, and confusion of many residents inhibited open disclosure of feelings. Thirdly, the organisational relationships in each home were extremely powerful inhibitors. Residents were reluctant to express feelings openly because of their relatively powerless situations in the regimes. In each of the three homes, the majority of residents felt it was not easy to express their feelings in the home. There was a shared view that it was not culturally acceptable to express their feelings openly. Their preferred way of expressing feelings was to "keep it to myself", conforming to a life-long cultural response. Living in a residential home, with its lack of privacy, simply deepened this perception of proper behaviour and communication in their social world. Good feelings were expressed by sharing the company of others, by helping other residents and by saying "thank you" for help given. Difficulties in expressing feelings were attributed to the demands of group living, of "being frightened to speak out" or "being misunderstood by staff." The frailty of other residents was mentioned: "loss of memory and speech loss in others".

The charts below illustrate their comments.

FIG 68 Southam Residents' Views on Expressing Feelings within the Residential Home

Name	Easy for residents to express feelings, and reasons why	Difficult for residents to express feelings, and reasons why	How I express my good feelings	How I express my negative feelings
Mr. Leslie Atkins	No.	I don't know what half of them are saying. One sits at my table and takes all the cakes and eats corn flakes with her knife.	How would I know? I always have a joke ready. I'm pretty well liked in the village - a character, they say.	You could be in a much worse place than this.
Mrs. Annie Baker	Sometimes, when they rile each other up, but they get over it.	It's not easy to express feelings. You need your own private space but don't have it here.	Keep them to myself.	Keep them to myself.

Name	Easy for residents to express feelings, and reasons why	Difficult for residents to express feelings, and reasons why	How I express my good feelings	How I express my negative feelings
Mrs. Florrie Dakins	No. I've never been that way, but the "girls" *(staff)* couldn't be nicer.	People don't express feelings much, don't know why not.	I don't talk about it. I remember my two late husbands *(good memories).*	They're in my mind *(loss of two husbands).*
Mrs. Irene Ellis	Yes, we all get on well.	No difficulties.	I try to get along.	I keep things to myself.
Mr. Patrick Hillier	Yes. The "nurses" are helpful, they have firm control, and prevent or sort out arguments.	No difficulties so far.	Never get excited, keep calm and quiet.	Don't get many of these - keep even quieter.
Mrs. Lily Irving	Not everyone can. A lot don't; individual personality helps.	Others' personalities and characters can make it difficult.	I'm not a cuddly, "kiss-y" person. I say hello to the group.	I like things out in the open - not sure how to answer.
Miss Cissie Lawrence	No.	I don't think residents want to; I wouldn't think of it.	I keep them to myself.	I have negative feelings but try to suppress them or shake them off.
Mrs. Cora Oliver	Yes. Being friendly.	If you're kept awake at night by my room-mate, Teresa Sanders.	I'm not one to interfere. When I'm relaxed, I can.	I can't. I wouldn't be unkind and report my room-mate.
Mrs. Kathleen Perkins	Yes. I've chosen my few friends well.	Not paying attention to others' needs; over-zealous people.	Try to raise a laugh when my partner, Miss Jean Mills, is down. Being kindly.	Haven't had these. Can't talk about that.

At Southam, opinion was evenly divided between those who felt that expressing feelings was possible only with a few close relatives and friends outside the home, and others who, lacking outside contacts, felt that expressing feelings was not desirable at all, given the social nature of group living. Southam residents used humour to express positive feelings. Only the short-stay resident at Southam, Mrs. Lily Irving, said "I like things out in the open." Her life course experiences and subsequent approach to relationships were extraordinarily forthright, clearly defined and dominant although these could be interpreted as indications of behaviour which was not yet institutionalised.

FIG 69 Eastview Residents' Views on Expressing Feelings within the Residential Home

Name	Easy for residents to express feelings, and reasons why	Difficult for residents to express feelings, and reasons why	How I express my good feelings	How I express my negative feelings
Mr. Henry Clifford	Couldn't tell you.	Couldn't tell you.	I don't express my feelings.	I suffer 24 hours a day in pain silently.
Mrs. Sally Cooper	Yes. Can't say why.	Can't say.	Wouldn't know.	I try not to.
Mr. John Davis	They seem to get on together. If you have confidence, the other person understands.	Loss of memory. There's only one man I can hold a conversation with. They can't talk properly. Some argue. Some residents always want attention. Some staff think these residents are the only ones here.	Talk, laugh; play dominoes.	I stammer when I'm over-excited. No good moaning, best if you don't say anything.
Mrs. Olga Frederick	No.	Having to live together.	*Did not answer.*	Sometimes keep it to myself. It doesn't always work - I like to let feelings out occasionally.
Mr. Richard Llewellyn	I could do. You live close to people here. People aren't difficult.	There are gangs of people. I'm not in a group.	Younger ladies say, "You're always smiling". We've got to get on with each other.	I get a bit nasty at times.
Mrs. Molly Nabbut	Don't know. People don't talk about feelings much. I can express feelings to my friend, Miss Sansom, who visits me.	You can move about and sit next to someone else *(can get away from the difficult ones but can't get close to others).*	I depend on my friend Miss Sansom visiting me.	I bottle it up; haven't thought about it.

Name	Easy for residents to express feelings, and reasons why	Difficult for residents to express feelings, and reasons why	How I express my good feelings	How I express my negative feelings
Mrs. Iris Rowlands	I can. People don't have much trouble expressing feelings.	People take it as we say it.	People take it as we say it.	You don't want to be misunderstood by staff or have them take it the wrong way. I like strong tea, but the staff say that residents can't digest strong tea so I don't get it. My friend from the sheltered housing unit (where I used to live) was found dead and was only 74 *(expressing her feelings of shock and sorrow).*
Mrs. Bertha Tarrant	Don't know.	They're frightened to speak out.	I tell others how I feel.	If I don't like a person at first meeting it's no good.
Mrs. Polly Towell	Don't know; perhaps.	If they have a bad night, they talk about it. Some residents are difficult.	Doing helpful things.	I was glad when staff put Mrs. Ida Plumpton on another table - she's a complainer and can be nasty.
Mr. George Urquhart	No.	Don't know.	I'm good company; I tell riddles and puzzles.	I tell the staff when I'm down in the dumps.
Mrs. Miriam Youens	No. Nobody wants to bother with you.	I talk to myself: what have I done wrong to deserve this, Lord?	I go to the Communion service here. I'm always happy when I talk to God Almighty.	I always feel miserable. *(Note that she claimed to be always happy and always miserable).*

Name	Easy for residents to express feelings, and reasons why	Difficult for residents to express feelings, and reasons why	How I express my good feelings	How I express my negative feelings
Mrs. Betty Zander	Yes. They just talk to one another.	I don't know.	I don't talk much.	I don't need to. I have my contacts 'on the other side' *(Spiritualism)*. They tell me what to do.

At Eastview, although there was a reluctance to be open, a few more respondents did feel that it was possible to express feelings because of the positive aspects of "living close together"; "having confidence that the other person understands" (i.e., is not 'confused'.) A resident of Eastview, Mr. Richard Llewellyn, described the demands of having to live in a group environment: "I have to get on with others and always keep smiling." Two Eastview residents with learning disabilities, Mr. George Urquhart and Mr. Robert Martin, were more open in relating how they expressed their negative feelings - Mr Martin saying, "I tell other people", and Mr. Urquhart: "I'm nasty at times." An Eastview resident, Mrs. Betty Zander, expressed her negative feelings by speaking to her "spiritual contacts on the other side." A newly arrived Eastview resident, Mrs. Muriel Young said "I never have any good feelings and I'm always miserable", but she expressed positive feelings about her relationships with God. (She had expressed long-standing feelings of inferiority and told of life course experiences of Deprivation, discussed in Chapter Eight.)

FIG 70 Northfield House Residents' Views on Expressing Feelings within the Residential Home

Name	Easy for residents to express feelings, and reasons why	Difficult for residents to express feelings, and reasons why	How I express my good feelings	How I express my negative feelings
Mrs. Violet Batty	Don't know.	I mustn't take notice of her, and try not to answer her *(Mrs. Enid James)* back. I accused her of pinching two of my night-gowns. She interferes and takes over my visits from my brother.	I'm good to Clara *(Mrs. Marshall)* and get on with her.	If I said what I really think, she *(Mrs. James)* would report me. I keep quiet.

Name	Easy for residents to express feelings, and reasons why	Difficult for residents to express feelings, and reasons why	How I express my good feelings	How I express my negative feelings
Mrs. Ruth Beckett	No comment.	I'm always left behind *(the survivor when others die).* That one *(un-named)* takes my chair.	I never argue with anyone.	When my relatives come, they're never offered a cup of tea. I tell the residents and Officers, "You've got to obey the rules here."
Mrs. Frieda Grantham	Yes. I'm always helping.	I don't know. I don't see much of the others.	I'm always happy.	No; it's not often I get down.
Mr. Kenneth Grantham	I suppose they do.	There's a man I get on with but I can't understand a word he says - he shakes.	Friendship.	Someone who's deaf or can't speak.
Mrs. Enid James	Yes. Very nice except one.	Can't tell.	*No response.*	I just don't speak. I stay up until the last person goes to bed.
Miss Julia Jessop	I suppose they do sometimes.	Can't tell you, it's private. There's a clique in the lounge - 3 people not talking to each other.	I'm always happy - take things as they come.	Here in my group *(the Unit)* we all have moments of rum feeling. Everyone has their problems. The next day the sun shines and all is well.
Mrs. Flora Needham	I hear them talking to each other - it's nothing to do with me. I don't interfere.	Don't know. Less said the better.	I don't.	Keep it to myself.
Mr. Albert Quinton	No. It would be better for them to join in. Mucking in together helps.	According to who you are and who you're with.	*No comment.*	If you're unhappy, you just cope with it.

Name	Easy for residents to express feelings, and reasons why	Difficult for residents to express feelings, and reasons why	How I express my good feelings	How I express my negative feelings
Mrs. Connie Redmond	I think so. I'm not here all the time.	Don't know.	I go home to my husband at night *(confused; she is a widow)*. Just join in and be happy. Only thing you can do.	Keep ourselves to ourselves. Don't express feelings.
Mrs. Ivy Verity	*No comments, too over-whelmed with emotion.*			
Mr. Walter Verity	Should do; personality helps.	Don't know.	I say thanks.	By looks, I suppose.

At Northfield House, where Unit living created more opportunities for close relationships, the residents, once again, were more ambivalent and guarded in their responses. Miss Julia Jessop, who had lived in the home for a number of years, said "I suppose I can express my feelings - sometimes". Northfield House residents gave a more expansive picture of their negative feelings than the residents of the other homes.

9.12 Pairing

In each residential home a greater incidence of pairing amongst the residents was observed than they themselves reported. Participant observation, together with the spontaneous comments of staff and residents, revealed the extent of pairing. These were sometimes male/female pairing, but more often the members of the pair were of the same gender. The relationships of each member of the pair to the other could be analysed in two different dimensions: either the power and dominance of one member of the pair over the other, and the gains or losses for the other person; or the bond of shared experience within the home (echoing one of Matthews' definitions of friendship [1983b] as discussed in Chapter Three). Motivations sprang from the life course experience within the home, and what had happened in the individual life course before entering the home. Residents who had experienced close relationships, who were subsequently bereaved, and had no children or other close relatives left, were likely to seek out another resident and form a pair. For example, a more active resident might befriend a frail resident and offer physical help. This happened most frequently amongst room-mates. The staff were not always happy about pairing and often tried to break up pairs which they perceived as detrimental to the regime. The staff also discouraged pairing because they feared bereavement reactions when one of the pair died, leaving a grieving resident.

At Southam, as previously noted, Mr. Leslie Atkins and Mrs. Irene Ellis were an unlikely yet close pair, illustrating the importance of shared experience. Mrs. Ellis was a quiet reserved widow of a civil servant. Mr. Atkins had worked as a farm labourer, and had never married. They shared the experience of living in the home for over ten years, longer than any of the other residents, and each enjoyed sitting together in the garden in the summer exchanging memories of cycling in the countryside in their youth. Their longevity in the home as Old Hands became part of their shared life course experience,

and it created a bond. In another example of shared experience, Mr. David Brooks and Mrs. Queenie Xaviour sat side by side in the upstairs lounge at Southam and kissed each other good night every evening. Both were confused, and as a consequence they muddled the sequence of time and were not entirely oriented to present day events. Their attachment developed from having entered the home on the same day, and they did not forget this bond of shared life course experience, despite their confusion.

At Eastview, Mrs. Sally Cooper, the 91 year old widow (an Old Hand) who had been resident in the home for over ten years, formed a number of successive alliances with the incoming male residents. She helped Mr. Bert Arthur become acquainted when he arrived by taking him under her wing as her protégé. She was hurt when he broke free from her powerful influence to find other friends. Her life course experience led to assuming an identity as a Local which she expected would give her power and influence in forming relationships with new residents.

Only one or two residents preserved a close link with friends in the outside world who had been part of their life course experiences. Mr. George Urquhart, the 78 year old single man with learning disabilities, sustained a relationship with his 'girlfriend', a single woman of 71, also with learning disabilities, who lived in a nearby long-stay hospital (discussed above). Mrs. Molly Nabbut, an Eastview resident, and Miss Sansom (discussed above) who lived in a flat ten miles away, were a devoted pair who had once lived together. Miss Sansom visited Mrs. Nabbut regularly, travelling over twelve miles via bus, train, and taxi, to be with her friend each week, despite having a disability which restricted her mobility.

At Northfield House, there were three married couples, each of whom had been married over forty years. One couple, Mr. and Mrs. Grantham (discussed above) entered Northfield House following a suicide pact which failed. Mrs. Grantham was the dominant partner, busying herself with duties and activities in the home. She had a relationship of rivalry and competition with another married couple, Mr. and Mrs. Clarke, who lived in the same Unit. Following the sudden death of Mr. Clarke, Mrs. Grantham made efforts to help his widow. Mrs. Clara Marshall and Mrs. Violet Batty became a pair at Northfield House, united in their discontent and dislike of the home. They began to spend time in each other's rooms. (Each had a single room.) The staff became uneasy about this alliance because of what they perceived as the shunning of the other six residents in the Unit. They tried to put pressure on the pair to sit in the communal lounge rather than in each others' rooms, feeling that the group atmosphere in the Unit was deteriorating as a result of the exclusiveness of the pair.

The chart below portrays the extent of pairing which was revealed. Excluded from the table are the married couples living at Northfield House: Mr. and Mrs. Grantham, Mr. and Mrs. Verity, and Mr. and Mrs. Clarke.

FIG 71 Pairs within the Residential Homes

Residential Home	Pairs	Explanation
Southam	Mr. Leslie Atkins and Mrs. Irene Ellis.	*Survivors; shared experience of long stay in home; interests in cycling, gardening.*
" "	Mr. David Brooks and Mrs. Queenie Xaviour.	*A social relationship; shared the experience of entering the home on the same day; sit next to each other in the lounge.*
" "	Mrs. Kathleen Perkins and Miss Jean Norton.	*A close personal relationship; had been room-mates; no children or close relatives.*

Residential Home	Pairs	Explanation
Southam	Mrs. Hazel Hill and Mr. Patrick Hillier.	*Mr. Hillier had no close relative or friends, offered help to Mrs. Hill, a new resident who entered care after a recent experience of loss and attempted suicide.*
Eastview	Mrs. Bertha Tarrant and Mrs. Miriam Youens.	*Shared experience of entering the home together as new residents. Both deprived, bitter, estranged from daughters. Both heavy smokers.*
" "	Mrs. Sally Cooper and Mr. Bert Arthur.	*A disrupted relationship, because his interest shifted away from her. She, a long-standing resident of many years, offered him guidance as one of her protégés when he entered the home.*
" "	Mrs. Olga Frederick and Mrs. Amanda Rogers.	*A disrupted relationship. Cousins who shared a room when Mrs. Frederick entered the home, attracted by her cousin's residence there. Quarrels followed, and they were separated.*
Northfield House	Mrs. Violet Batty and Mrs. Clara Marshall.	*Mrs. Batty, a childless widow, seeking a close personal relationship with Mrs. Marshall as an alliance against the staff.*

9.13 Summary of Discussion of Friendships, Intimacy, and Pairing

The preceding sections presented the residents' perceptions of personal relationships and their related activities. Residents' concepts of friendship varied according to their life course experiences of friendship. Those who were looking for, or who had already enjoyed friendships, defined friendship as a close personal relationship rather than as a social relationship. Most residents viewed friendships in the homes as acquaintanceships and part of 'being known'. Closer relationships developed from the experience of sharing a room or from reciprocal transactions of giving and receiving help. Most residents reserved their feelings of intimacy for their relatives, because these were the relationships which had been established throughout the life course. They did not find it easy to express feelings within the homes because of the inhibiting factors of powerful organisational relationships, confusion in other residents, and cultural taboos on self-disclosure. In each home, there were incidences of pairing, often on the basis of shared life course experience within the home, and the need, arising out of the whole life course experience, to find a close personal relationship within the home. Most pairs had an unequal power balance, with a dominant partner. Staff were uneasy about the pairing of residents, suspecting a power alliance which could disrupt the organisational relationships. Staff feared grief reactions of the survivor when one member of the pair died.

9.14 Summary of the Chapter

This Chapter explored a kaleidoscope of the residents' views and experiences of relationships. The personality, interests, and motivations of the individual resident, developed throughout the life course, were important influences on relationships. Few residents had given prior thought to the relationships they would form within care. Those who had planned their admission and made a conscious decision to enter the home were apt to make more effort to form relationships with other residents. The organisational relationships of each home, including its daily routine, and its formal and informal internal placement policy, determined the opportunities for relationships. Consequently, forming relationships was interpreted by residents as accepting the home's routine and regime. Staff were not perceived as especially helpful in assisting residents to form relationships. Joining in activities and helping others were perceived as ways of

getting acquainted. The confusion, frailty, and sensory impairment of some of the residents were hindrances.

Most relationships sought were social relationships, characterised as acquaintanceships. When these on occasion deepened into friendship, intimacy, or a close personal relationships, it was as a result of sharing a bedroom, giving help, or sharing life course experiences in a significant way. Friendship was characterised by residents as a generalised social relationship, rather than as intimacy. The residents felt closest to their remaining relatives. The ease of remaining in contact with relatives depended on the organisational relationships of the home, and the mobility, availability, and proximity of relatives. Most residents felt they had changed as a result of living in the home, some for the better, citing the necessity to become more sociable, outgoing, and tolerant as a result of group living. Social relationships were built on the identities presented when residents entered the home, and were initiated by the use of talismans. The relationships also developed through assumption of roles such as Clown, Queen Bee, and Quasi-Staff Member. Some roles (for example, Quasi-Staff Member) gave certain residents power over other residents. As long as this role was perceived as helpful to the staff, the individual was permitted to function within it. The pairing of residents was not always encouraged, either because pairing was viewed either as seditious, or else emotionally damaging because the intimacy of the pair would all too soon by disrupted by death.

The influences of the residents' life course experiences, the homes' organisational relationships, and residents' mental and physical frailty were evident in each separate exploration of relationships. These three influences were inter-related. Although I argue that they should be considered together as part of an integrated view of the nature of relationships within residential care, this happened only rarely. Staff and residents acknowledged residents' mental and physical frailty, and the organisational relationships of the home. They did not acknowledge overtly the influence of the life course experiences of residents. The connection of all three influences to relationships was not widely recognised.

Relationships of Elderly People in Residential Care

Chapter Ten

Discussion and Summary of the Findings

10.1 Introduction to the Findings

Did the research succeed in achieving its aims? To answer this question, it is necessary to recall the aims discussed in Chapter One to discover whether the findings fulfilled the initial expectations of the research. The aims are summarised below:

The study of relationships provides an opportunity to understand the residents' points of view of what it is like to live in a residential home. Relationships provide a key for understanding Fourth Age experiences lived in a particular setting. Relationships are important for residents' well being. Relationships express the emotions and feelings of residents. Knowledge of relationships will contribute to the development of good practice within residential care. Relationships are part of professional values. Practice, including management of care, should be based on therapeutic relationships between residents and workers. This study will dispel or confirm some previously held assumptions about old age (that it is devoid of relationships); about residential care (that residential homes are emotionally depriving institutions); and about relationships (that relationships are intrinsically good and necessary for well-being).

Before addressing these aims, two points about the research process need to be made. First, the research only partly succeeded in understanding the views of the residents, because of their inhibitions about stating their true feelings. I experienced the same doubt which Booth (1985) expressed about the ability of research to gain and understand the opinions of old people. Residents shared a surprising amount of information, but only in a few instances were they really interested in talking to me. Throughout the process I suspected that what they said was merely what they thought I wanted to hear. I felt more confidence in their accounts of their own life histories than in what they told me about their relationships. Secondly, although I used participant observation to get to know residents who were too ill or too confused to contribute to an interview, I relied on the life histories and interviews to understand each individual. (Participant observation was more useful for understanding the regimes of the homes). My findings therefore were limited by the restricted range of residents whom it was possible to interview. The selection of residents for the life histories and interviews was not representative of the population of the homes, because many residents were not able to take part in the interviews. The findings accordingly apply primarily to the mentally alert residents.

The questions posed in Chapter One were used only as a starting point to trigger the research. The findings were not intended to be used to 'prove' the truth or otherwise of the initial questions. In particular, the findings could not establish that the presence or absence of relationships is crucial as an indication of the well-being of elderly people in residential care, as Question Six (p. 15) asked. With these problems acknowledged, the research findings do assert the importance of relationships for the well-being of elderly people in residential care. The findings establish that relationships of elderly people in residential care do exist and are related to individual life histories. The relationships turned out to be rather different from what was expected. The findings revealed the importance of social relationships within what may be designated as a Post-Attachment phase of relationships. They also emphasised the recognition that personal relationships are linked to the past, and that relationships are used to express power. The findings noted how aspects of change, loss, bereavement, the life course perspective, institutional processes, and staff roles have influenced relationships. Each of these aspects will be discussed in turn. The Chapter will

discuss the unexpected puzzlements which emerged, and the findings which converged with, or diverged from previous research. The particular issues illuminated by the research which contribute to knowledge are reviewed. The discussion includes a summary of events within residential care which occurred since the research began, and how these affect the research findings. The conclusion of the Chapter appraises the successes and failures of the aims of the research.

10.2 The Residents' Points of View: The Importance of Social Relationships within a Post-Attachment Phase

From the residents' point of view, residential homes provided a sense of security, but resulted in a loss of personal power. The research shows that despite attempts to improve the standards of residential care, life in care was lived in settings which provided little privacy. Residents were grouped into communal environments. Meals were taken with groups of other residents. Leisure activities were group activities. Each resident spent much of the day in communal areas. Relationships were played out on a social stage where there were dangers in revealing too much of one's inner self amongst strangers, but also dangers of losing personal identity within the institutional environment. Given these circumstances, it is not surprising that social relationships, intended to achieve recognition and acceptance in social situations, were the most important relationships for residents. The initial challenge for all residents was how to present themselves as individuals to the groups of residents within the home. Relationships were based on establishing individual identities and becoming known and recognised. Residents used their life course experiences to present identities based on Locality, Work Roles, Spiritual Belief, and Deprivation. They also used Talismans such as photographs and books to denote their own individuality established over their life courses. These presentations of identity helped individuals to stand out from the anonymity of the group without risking too much of their inner private selves.

These were the initial relationships formed. Later, residents had a choice. Would they build on their established identities and adopt a social role within the home, or would they attempt to find a close personal relationship with another resident? Most residents sought an extension of their initial social relationships based on their previous life courses, and developed social roles within the home, such as Queen Bee, Quasi-Staff Member, Entertainer, and Helper. All of these roles were played out in front of groups of residents and staff. Residents formed social relationships for self-fulfilment, not just for utility value purposes. The most influential and satisfying role for residents was to combine the two roles of Queen Bee and Quasi-Staff Member. These dual roles gave residents power, social approval, and recognition both by staff and other residents. Residents needed to be physically active and socially skilled in order to fulfil these roles. Because of the high incidence of physical frailty and confusion, only certain residents were able to play these roles. Woman residents were more likely to undertake these dual roles. Male residents assumed roles of Social Leaders acting as representatives on Residents' Committees. In this way, residents re-enacted gender roles adopted in earlier life, where men assumed organisational leadership and women took on domestic caring roles. Yet the women acknowledged that their current roles were different in part from earlier life roles, because they had assumed more powerful leadership roles (as Quasi-Staff Members) than the roles assumed by the male residents.

The dominance of social relationships suggested that residents' need for new relationships had moved beyond attachment as characterised by Bowlby (1951, discussed in Chapter Three) into what I would describe as a Post-Attachment phase, in which they established their identities in a social setting. The Post-Attachment phase differs from many of the developmental perspectives reviewed in Chapter Two. Most theories of development view

the intimate attachment between parent and child as the most significant relationship. For example, Freud (1953, 1976, 1986 editions) underestimates the value of adult relationships, regarding them only as echoes and reworkings of childhood relationships. Developmental theorists who recognise the possibility of change and emotional growth in adulthood (Jung, 1969, 1982, 1989 editions; Erikson, 1950, 1986; Gutmann, 1987) come close to identifying the Post-Attachment phase, but they do so implicitly. Erikson concentrates on intimacy in preference to social relationships. Bowlby (1951, 1986), for example, does not consider old age as a Post-Attachment phase because his interest in attachment causes him to look for evidence of attachment in old age as a continuation of earlier relationships. I would argue that the preoccupation with relationships of attachment and intimacy has prevented the recognition of the importance of social relationships in old age, particularly within an institutional setting.

10.3 The Residents' Points of View: Personal Relationships as Links with the Past

Close personal relationships remained, of course, very important for residents. Personal relationships were likely to be acknowledged openly, in contrast to the social relationships which were only half acknowledged. The close personal relationships were, for the most part, past relationships with family members who had shared their life courses over the years. Residents named adult children and siblings as the individuals to whom they felt closest. They sometimes mentioned parents and spouses who were now dead. These personal relationships were rooted in the past. Although present contacts with family members might have been limited, personal relationships were psychologically important to residents' sense of self and identity. The feeling of being close mattered more than the actual level of contacts. These relationships lived on in their present-day consciousness and sustained their present lives even if the relationships had been severed by death or distance from their families.

The residents who were likely to form new close personal relationships with another resident were those who previously had enjoyed close relationships, but who had not resolved the emotional loss of these relationships through death or separation. Their painful feelings of loss and bereavement still troubled them. They were more likely to seek out another, more frail resident who also was emotionally needy, and seek to develop a deeper relationship which could become a close personal relationship. Mrs. Kathleen Perkins at Southam and Mrs. Violet Batty at Northfield House were both examples of residents who sought a close personal relationship with another resident, rather than a social relationship. They each formed a pair with another resident who was more frail than they. This kind of intimate pairing was marked by reciprocal relationships of helping and being helped. Each member of the pair needed the other. Pairing occurred not only when residents had no close relatives, or had not succeeded in resolving the pain of bereavement. It could also arise from shared life course experiences in care with a companion survivor who also had lived longer than the average number of years in care. Mrs. Irene Ellis and Mr. Leslie Atkins, who had survived over ten years in care, were an example of this kind of pair, which was a less intimate pairing than those based on unresolved loss.

Residents recognised friendships within the home mainly as social acquaintances rather than as intimate relationships. Friendships were acknowledged as part of the social relationships of the home. This gave residents the opportunity to claim that they had many friends or were "friends with all". Sustaining friendships with former neighbours and friends proved difficult because living in the home removed residents physically from neighbourly opportunities for contact. Their friends from the world outside were mainly contemporaries who were either dead, disabled, or lacking the means of transport to visit the home. There were a few exceptions, for example Mr. George Urquhart and Mrs.

Molly Nabbut at Eastview, who both kept contact with a close friend who lived outside the home. Their impetus for sustaining contact was based on the initial closeness of the relationship, which was in each case an intimate personal relationship of attachment rather than a social relationship. Significantly, each of these residents previously had shared accommodation with their faithful friends, and it could be argued that the friends had become Quasi-Family Members. Keeping contact was possible because Mr. Urquhart could walk to the hospital where his girlfriend lived, and Mrs. Nabbut's friend, Miss Sansom, was able to visit the home using taxis and public transport (although Miss Sansom herself was disabled).

10.4 The Residents' Points of View: Relationships as Expressions of Power

I noted that residents' own views about their relationships reflected their need to exert power within an environment which tended to make them powerless. For example, residents claimed power for themselves when they asserted their responsibility for managing their own relationships. Residents were not willing to abdicate their own responsibility for forming relationships. They did not blame the organisational relationships of the home for any disappointments they might have felt about their success or failure in forming relationships. They asserted that it was their own personal responsibility to get acquainted and that little either prevented them or helped them. They said that opportunities for expressing feelings (one of the ways in which relationships can develop) were limited by frailty, sensory deprivation, confusion, and cultural traditions of "keeping myself to myself" rather than by the organisational relationships of the home. Preserving the right of choice over forming relationships is a way of asserting power in the new environment. Residents tacitly admitted that the routine of the home (including its provision of social activities) influenced opportunities for social relationships. This admission was evident when they identified "learning the routine" as important. Even if their power and choices were in fact limited by the homes' organisational relationships, the residents' positive perceptions of their own ability to control their relationships were significant expressions of power.

Similarly, residents asserted power through their attitudes to staff. They treated the staff in an instrumental, detached manner. Residents were ambivalent about staff roles. The staff were perceived as providing necessary physical care. Staff were valued when they did this well, but rarely were recognised by name. Residents did not sentimentalise their relationships with the staff. Unlike the staff's perception of the residents, the residents did not view their relationships with staff as analogous to an child/adult relationship. The Officer-in-Charge was the one exception to the anonymity of staff. Residents perceived the Officer-in-Charge as powerful, recognised her by name, and discussed her management style in relation to residents. She was acknowledged because of her power in the hierarchy.

Residents used power in their relationships with each other. Hierarchical levels of organisational relationships operated amongst the residents, in imitation of the levels of relationships in the world outside. Although some residents wielded power over other residents, most residents were reluctant to admit that they might be subject to, or exert power within, their relationships with their peers. The power of the Quasi-Staff Member was only partly acknowledged by residents and by staff. It was in the interest of residents to remain silent about these unofficially powerful relationships because of the staff's ability to disrupt existing relationships by moving residents from one bedroom, Unit, or dining room table to another. The reciprocal relationship between residents playing the roles of Helper and Helped One demonstrated a power imbalance. To acknowledge this openly would involve admission of leadership and resident power. Acknowledgement was

avoided or deliberately misunderstood because the real power lay with the staff. Residents' power could not be claimed openly because it could be removed by the staff with no warning or right of appeal. By disguising their power, residents sought to retain as much of it as possible. They were circumspect, discreet, and rather hesitant to reveal the extent of power within relationships and their own roles. Cultural inhibitions also played a part in residents' reluctance to discuss or share their views. In addition, residents perceived no purpose in expressing their views because none of the homes had a clear policy for enabling critical opinions to be expressed. Instead, residents instinctively feared retribution and punishment if they expressed disagreement.

Most residents claimed that they remained essentially the same as an individual, and although not willing to discuss negative changes arising from the move to residential care, they admitted that they had been obliged to adapt to the regime and to their own increased frailty. They found it easier to acknowledge the positive aspects of the organisational relationship rather than the negative aspects. For example, some residents expressed satisfaction with being safe and cared for in the home, indicating that organisational relationships were important for their well-being. Other residents cited welcome changes such as gaining more social skills and greater tolerance of others as a result of living in the home. Reluctant entrants to care were likely to be less satisfied and to become less involved in relationships in the home, echoing Wagner's recommendation (1988, discussed in Chapter Four) that admission to care should be a positive choice. New residents who were angry at being in care (Mrs. Batty at Northfield House) or who had a strong grievance against staff because of a new, current loss (Mrs. Perkins at Southam) did not hide their disillusionment and frustration. Their relationships with staff and with other residents were often angry and demanding. They projected power through their demands for attention.

Residents' acknowledged perceptions of personal relationships with each other tended to be positive and conventional. Precise definitions and more detailed discussions of relationships were given by residents who had developed successful close personal relationships previously outside the home and currently within the home. Residents whose past and present relationships were unsatisfactory or rather distant were vague in their replies. Residents recognised the existence of pairing between residents when it was based on male/female pairing arising out of shared life course experiences in the home. They were less likely to acknowledge same-gender pairs who were motivated by a need for intimacy. Their reluctance may have been due to negative social attitudes about suspected homosexuality and lesbianism (Jerrome, 1993b, discussed in Chapter Three). These less conventional aspects of sexuality were not raised by the residents or by the staff throughout the research. I noted that Erikson's pseudo-integration (1986) may have served as a psycho-social mechanism prompting the sometimes elusive replies of residents.

Residents' ability to exercise power depended on their retention of physical strength and mental alertness. Residents acknowledged that impaired health limited communication, and that opportunities for developing relationships depended on their ability to communicate with each other. The most disliked and feared condition was confusion in other residents, echoing Jerrome's assertion (1986, discussed in Chapter Three) that confused elderly people are either ignored or laughed at in the club culture. I observed similar reactions in the residential homes. The mentally alert residents were intolerant of the confused residents. Loss of memory was viewed as an impediment to relationships. Residents distinguished between residents who had grown more confused whilst in care and those who had entered care in an already very disorientated state. Residents whose social relationships in the home had been established before the onset of confusion were viewed more sympathetically, because they were perceived as individuals whose current deterioration aroused pity. Residents whose confusion prompted their entry to care could

not establish an identity based on their previous life courses. They were less likely to be perceived as individuals, and they were treated less sympathetically.

10. 5 The Theme of Change

In reviewing the findings, an emergent theme is the influence of change on relationships in residential care. Changed structures and contexts needed to be taken into account in studying these relationships. Entering care caused relationships to change because of the change in the individual's environment. It was impossible for most residents to comprehend this change before the event. Since many relationships formed throughout the life course had been lost through death and disability before entering care, residential care provided opportunities for new relationships over and above "learning the routine". The potential for forming relationships in residential care depended to a great extent on residents' belief in change as a positive opportunity for personal and social development (echoing the arguments of Henderson et al, 1980, and Gottlieb, 1985, in Chapter Three about belief in social support). Residents also needed to believe that personal and social development continued to be possible in old age (affirming the argument of Baltes, 1979, in Chapter Two about the possibility of psychological and social development in adulthood). These aspects are important for the researcher who, because of unrecognised ageist attitudes, may overlook the newly formed social relationships and roles of the elderly residents. Elderly residents themselves were often disappointingly ageist, and discounted possibilities for forming new relationships. Some residents, whose relationships were marked by integration and the acceptance of self and others, were able to view change positively. Mrs. Iris Rowlands at Eastview (discussed in Chapter Eight) was an example of such a resident.

10.6 The Theme of Loss and Bereavement

The influence of loss and bereavement (Parkes, 1972; Kubler-Ross, 1973; discussed in Chapters One and Three) was a second theme running throughout the findings. Loss and bereavement led to admission to care and affected subsequent relationships. The residents all had experienced the death of a close family member: spouse, siblings, parents, and in some cases, their own adult children. Geographical distance and strains on carers often resulted in disrupted family relationships. Friendships had ended through death or gradual neglect, and also because of geographical distance and infirmity. The high turnover of residents, because of the number of deaths in a relatively short period of time, inhibited the development of relationships. Residents were reluctant to form new relationships because they feared additional bereavement. Forming a close personal relationship in the home raised the risk of a further loss through the death of one of the pair, or a disruption of the relationship because of personality clashes. The stormy relationship of Mrs. Olga Frederick and her cousin Mrs. Amanda Rogers at Eastview is an example of a relationship which failed. Their incompatibility emerged when they became room mates and were obliged to develop a closer relationship than they had maintained in their previous life courses. They were separated by the Officer-in-Charge when the relationship broke down in hostility. Mrs. Frederick, the newer resident, claimed that she had lost not only the relationship itself, but also social esteem within the wider group context because of Mrs. Rogers' better established social alliances as a long standing resident of the home. Mrs. Frederick also acknowledged her own contribution to the breakdown of the relationship, which displayed clarity and honesty about herself.

I speculated whether some elderly people whose relationships had been impaired in earlier years by Deprivation might be more likely to enter care. I surmised from the life history accounts that some residents who had experienced childhood deprivation had not formed sufficiently close and satisfying relationships in adulthood with their spouses or children to

withstand the strains and crises of needing care in old age. Mrs. Annie Baker at Southam and Mrs. Miriam Youens at Eastview were examples of this possibility, but more research would be required to establish a clear connection. The ways in which loss and bereavement had been resolved, and whether their emotional effects had been worked through at all, affected the kinds of relationships in residential care. Loss and bereavement caused some residents to search for intimacy but some residents to turn away from it. A cycle of self-neglect resulting in admission to care could be set off by bereavement reactions. Mrs. Olive Jenkins and Mrs. Bessie Carr at Southam were examples of self-imposed neglect. Both became depressed after the death of their husbands. Mrs. Jenkins lived in dirty conditions and failed to eat, while Mrs. Carr attempted suicide. In both instances, their reactions to loss led to their entry to care.

10.7 The Influence of the Life Course Perspective on Residents' Relationships

The influence of the life course perspective on residents' relationships was the pivotal issue of the research. The findings established that residents had to use their life course experiences to gain recognition as individuals. Residents acknowledged that their personality formed over the life course was a factor in forming relationships in the home. Establishing individuality was essential for avoiding submersion into batch living routines (Goffman, 1961) and being overwhelmed by the groups of strangers with whom they were now expected to live. As discussed above, residents used their identities established throughout their life courses to form relationships in the homes. The thrust behind the development of relationships in residential care was to become known in a socially acceptable way which would ensure respect, attention and acknowledgement from staff and other residents. This was the essence of the Post-Attachment phase of relationships. The discovery of a shared life experience in the past, whether based on Locality, Work Role, or Spiritual Belief, led to shared reminiscences in the home and possible new relationships. I noted that residents who had been institutionalised because of learning disabilities or mental illness for most of their lives, or who had lived very restricted lives at home with their parents for the same reasons, were less able to present identities which could be used to form relationships. Their limited experiences and relationships across their life courses hindered their ability to develop present-day relationships in the home. The attitudes of many of the other residents towards them were not helpful. Mr. George Urquhart at Eastview was an exception, because of his extrovert personality, his physical strength, and the possibility that his learning disability was not as severe as that of other residents.

I was surprised that residents did not recognise historical time as important within their life courses. Residents acknowledged the influence of world events only in a half-hearted manner. The First World War and the Second World War were mentioned, but did not appear as important as I had expected. This downgrading of importance may have been due to the predominance of women, whose lives had centred mainly on family events. Residents accepted the events of their life courses without recognising the influence of history even though they had lived through two World Wars. Many of the residents had lost a parent or a sibling at an early age because of illnesses which were then prevalent but which now are no longer life-threatening, but they did not comment on this historical change. Their employment patterns reflected social change. Many of the women had left domestic work for factory work, and their families had moved from areas of high unemployment to the South-east in search of work, but the significance of these happenings within the wider historical context was not recognised by the residents themselves.

The rising economic prosperity of the country over their life courses had enabled most residents to achieve a greater level of prosperity than their parents. Residents' accounts

suggested that Deprivation experienced early in the life course could be overcome when it was material rather than emotional deprivation or abuse. Some residents whose deprivation resulted from abuse and lack of parental attachment needed to share their life course with me. They demonstrated a search for understanding, for sharing and telling their story of what happened in the past as a resolution of previously experienced pain (Coleman, 1994, discussed in Chapter Eight). In contrast, I also encountered the reaction of Pseudo-integration (Erikson et al, 1986, discussed in Chapter Two and above), in which residents omitted or denied significant, often painful past events, when sharing their life course experiences.

Psycho-social analysis (Freud, 1953, 1976, 1986 editions, discussed in Chapter Two) helped me to understand the progress of individual life courses. I noted particularly the repetition of certain patterns of behaviour and relationships when previous losses of close relationships resulted in unresolved bereavement reactions, as in the example of Mrs. Kathleen Perkins at Southam, Mrs. Miriam Youens at Eastview, and Mrs. Frieda Grantham at Northfield House. Integrity (in the Eriksonian sense, 1986) was achieved by residents who had let go of the past and coped with change successfully at various stages of their lives, for example Miss Cissie Lawrence at Southam and Mrs. Iris Rowlands at Eastview.

Life course experiences shaped residents' understanding of reciprocity in relationships. Residents who had previously helped others and who had experienced being helped within caring relationships were more likely to articulate the meaning of reciprocity and to demonstrate reciprocal actions. The most significant act of reciprocity acknowledged by residents was the decision to enter residential care in order to relieve the burden of caring on a close relative - giving a loved daughter or niece their freedom in return for help given over the years. Again, Miss Cissie Lawrence and Mrs. Iris Rowlands provided examples of their personal decisions to enter care because of their concern for their carers.

The lives of residents continue while they are in the home. Although those studied gradually lost touch with their community in the world outside because of their length of residence in care, they acquired life course experiences within the home which helped to offset these losses. Their life courses in care were comprised of shared experiences with other survivors. The residents who were survivors in care had outlived the average time span of residence. They became well known to staff and to other residents because they acquired a reputation as Old Hands, for example, Mrs. Sally Cooper at Eastview, Mrs. Irene Ellis at Southam, and Mrs. Ruth Beckett at Northfield House. They were experts in the art of living in residential care. They had seen Officers-in-Charge and other staff come and go. They outlived most of the other residents, watching others enter care and later die. They were keepers of the collective memory of the homes and helped to preserve the homes' culture. They were not usually Queen Bees or Quasi-Staff Members, with the exception of Mrs. Irene Ellis. These residents were not valued particularly within the homes' organisational relationships, although they could have been recognised as elders within the community of the aged. Their survival had won them power which made the staff uneasy. The relative neglect of their potential contributions reflects the values of a society which does not respect the wisdom of elders (Coleman, 1994).

10.8 The Influence of Organisational Relationships: The Importance of Process

Despite residents' outward denial, the organisational relationships of the home exerted a powerful influence on residents. Organisational relationships of the home affected the opportunities for both social and personal relationships. Even when the organisational relationships were concerned with provision of finite resources of space, design, and

location of the home, the processes which managed the use of these resources could be enhancing or detrimental to relationships. The organisational relationships which affected residents most were the admissions process; the absence of a placement policy; the sizes, designs, and locations of the homes and the decision-making processes governing these; the management of the mix of short stay care, day care, and permanent residents; and the actual life courses of the homes.

The admissions process did not help residents to keep existing relationships or to form new relationships. Frequently, new residents entered the home with 'unfinished business' because they had not succeeded in resolving their feelings of loss, bereavement, and crisis. 'Unfinished business' needed to be finished properly so that residents could accept the events of the past without undue pain and be free to develop new relationships. Little was done to help them. The homes had no strategy for developing ongoing practice which would encourage relationships. The social workers who had visited the applicants and gathered the life course information necessary for admission, ceased contact soon after residents entered the home so that the threads of their life courses were lost. As discussed earlier in the Chapter, residents found it impossible to foresee the changes resulting from entry to care. The social workers' preparatory visits were of limited value, and needed to be followed by subsequent visits to help residents develop new relationships.

The homes lacked an internal placement policy to fulfil the potential for more satisfying relationships. Placement decisions were functionally based, and did not note individual personalities with their own likes and dislikes and preferences for a particular location. The power of the Officer-in-Charge to move residents from one bedroom to another either disrupted established relationships with other residents or led to the development of new relationships. Placing confused residents together in a separate Unit was viewed as desirable by residents and staff, but this policy was difficult to sustain. Lucid residents became confused as health deteriorated. Moving to another Unit or home could add to the disorientation of the confused resident. Some residents who had worked previously in organisational settings such as hospitals or residential schools accepted the need for managerial decisions to place the residents who were confused. (Their reactions illustrate the influence of life course experiences on relationships, because these residents were more tolerant of the necessary limitations of institutional living).

Private space within each home was limited. Eastview and Southam still had four-bedded rooms which provided little privacy. Unit living at Northfield House facilitated more relaxed, less institutional meal time routines, but did not ensure harmonious or closer relationships between the residents. Northfield House's Unit design prompted more of its residents to admit that they had changed, in contrast to the reactions of residents at the other two homes. Significantly, Northfield House's Unit design did not incorporate the bed-sitting room concept. Double bedrooms as well as single bedrooms were in use, and Northfield House residents were not encouraged to use their bedrooms as sitting rooms, although they could have been if the Officer-in-Charge had possessed greater vision. These factors detracted from the potential of Unit living to encourage relationships. (In contrast, Eastview had a relatively large number of single bedrooms, which residents were encouraged to use during the day for private relaxation.) In another example of the modifying effect of processes on relationships, the interventions of Northfield House's powerful Officer-in-Charge permeated every corner of the home. Because she stifled residents' initiative, her involvement tended to negate the beneficial effects of Unit living, although her efforts were intended to combat its negative effects on relationships. From this observation, I noted that aspects of size and design which were apparently beneficial for developing and sustaining relationships needed to be matched by facilitative management processes.

In the three homes I studied, processes which encouraged relationships were counterbalanced by less beneficial processes. For example, the homes' potential for using short-stay residential care and day care in place of full-time residence, or gradually to introduce future residents to the homes, was not fully realised at Southam and Eastview. The juxtaposition of permanent and short term residents in the same lounge at Southam was disruptive to permanent residents' established relationships. Short stay residents found it difficult to form new relationships because of their interloper status within an established social milieu. Even when space was limited, sensitive management processes could have supported residents' relationships more positively. One example of this was observed when the Officer-in-Charge at Southam made the effort to re-arrange seating in the lounge with the least possible disruption to a very confused and disabled resident.

It was difficult to determine whether the size of the homes, measured by their maximum capacity of resident numbers, made a difference to residents' relationships. Much depended on how the internal design made private space available within the context of residential groups and how the groups were encouraged to make use of the space. Southam's upstairs communal lounge was small enough to enable all the residents who sat there to hear and communicate with each other. In contrast, one of the downstairs lounges at Eastview was so large and rambling in shape that individual residents were isolated within it. Yet Eastview, which was a relatively large home, provided more privacy with its larger number of single rooms (which were well furnished with a comfortable chair for use as a bed sitting room) than Southam, whose bedrooms were very cramped and sparsely furnished. The location of a residential home, including its accessibility by public transport, was seen to be important for sustaining relationships with relatives and old acquaintances. Two of the homes studied, Eastview and Southam, were not conveniently located. Yet it might have been possible to organise the homes' mini-buses to collect those relatives who were prevented from visiting by lack of transport.

As the research progressed, I noted that each home had its own identity, culture, processes and regimes which influenced the relationships of residents. One of the important findings of the research is that in addition to the individual life courses of residents, each home had its own life course. As discussed in Chapter Seven, the environmental and historical contexts of the homes set cultural patterns which affected their organisational relationships. Southam's routine, for example, echoed the traditions of a country home, while Eastview was run like a factory.

10.9 The Influence of Organisational Relationships: Staff Attitudes, Roles, and Practices

The influences of organisational relationships were most evident in the staff's attitudes, roles, and practices, yet they themselves might have denied the importance of their roles. They were well meaning but unaware of their own power. Staff held a negative view of old age. They did not want to live in a residential home when they themselves became old. Staff perceived new residents entering care as more confused and physically more frail than the residents who had entered care some years previously. This perception led to negative expectations of the kinds of relationships which could be developed. Both residents and staff colluded in basing their expectations of residential care on workhouse traditions, with their inbuilt power imbalance between staff and residents. Staff recognised that size, staffing, design, and the effects of frailty and confusion were important influences on the daily routine, but they lacked knowledge of group dynamics, organisational processes, and awareness of how their own roles might influence the relationships of residents. Only a few of the staff recognised the impact of individual personalities of residents and the power of certain residents over others. The care staff did not admit any interconnection between institutional size and design, management styles, care practices, residents' frailty, and

residents' relationships. (Only one of the Officers-in-Charge, Mrs. Olds at Eastview, had made this explicit connection.) Like the Officers, the care staff drew on their mothering experience, using the analogy that caring for residents is like caring for children, or less frequently, that caring for residents is like caring for one's own aged parent or grandparent.

The Care Assistants' roles provided an interesting parallel to the residents' own roles within the organisational relationships of the home. Although residents exercised power in the ways they perceived and conducted their relationships, as a whole residents were powerless against the staff. Instrumental, non-sentimental attitudes towards the staff prevailed amongst the residents. The Care Assistants exercised power over the residents, but were powerless within the wider organisational relationships of residential care. Staff, in turn, were encouraged to adopt instrumental and non-sentimental attitudes towards the residents. The Care Assistants were motivated not by altruism but by convenience. They were all mature women with dependent families, who chose to work in residential care for pragmatic reasons of location and the ability to fit part time employment with family relationships. They had few other employment opportunities and little chance of career advancement. Their own institutionalisation in part-time non-career manual jobs created loyal dependency on the regime and made them unquestioning of the bureaucracy. Self-interest and a desire to preserve the enterprise (Estes, 1979) were more influential than thoughts of developing relationships with residents as part of value-centred practice.

The limited interpretation of the Care Assistants' role led to uncertain relationships with residents and with each other. A task-centred rather than a resident-centred culture predominated. The Care Assistants were not provided with opportunities to gain a sense of the individuality of residents. Because residents were not perceived as individuals with life courses which extended before and after their admission to care, their relationships were not recognised. It was unusual for a Care Assistant to read the admission file of each resident, and when this was done, it was "to find out what's wrong with them". The daily routine did not include asking the individual resident to share aspects of their life course. Key working failed because it was neither linked to care planning nor to any over all aims of practice. The Care Assistants who were given roles as key workers were not able to facilitate purposeful experiences for individual residents. The absence of care planning and regular reviews of residents' well-being meant that residents' health needs, including hearing and eyesight, were not monitored. (As discussed above, the deterioration of hearing and eyesight has a detrimental affect on forming and sustaining relationships). Care Assistants did little to curb the power of the residents who were Quasi-Staff Members, calling into question whether some of the weaker residents' needs were identified and met appropriately.

The part time nature of their employment reduced the continuity of the Care Assistants' relationships with residents. The staff-resident relationships I observed were impersonal on an emotional level, but conscientious at the level of the performance of physical tasks. The staff's chief role was to offer physical care and to carry out the routines of getting the residents up in the morning and putting them to bed in the evening. Extending this role to include developing relationships was not imagined. They interacted with residents only in a perfunctory way, exchanging a few bantering remarks whilst carrying out the daily routine. Separating residents who became attached to each other was seen as necessary to protect both residents and staff from bereavement reactions. Detachment from excessive emotional involvement was advised for staff and for residents. They feared the emotional pain of death and dying. Deaths were frequent so that no one could fail to be affected by feelings of bereavement and loss. Keeping an emotional distance from one another provided protection from over-involvement and subsequent depression. Denial of death and bereavement was part of a survival strategy for staff and for the residents, but it did not always succeed. Lacking any training or supervision, the Care Assistants' informal model

of care was to treat the residents like their own children or like their own mothers. But this model could cause emotional pain. Staff who began to feel personal involvement with residents were vulnerable to feelings of grief when particular residents died, just as some residents grieved for the loss of a room mate.

Officers-in-Charge, like the Care Assistants, had no clearly identifiable professional role, other than to draw on workhouse and institutional nursing models. Officers-in-Charge were powerful within the home, but lacked power in the wider structure of organisational relationships outside the home. Officers-in-Charge perceived organisational issues affecting relationships in the home as beyond their control. They were preoccupied with external threats rather than with internal issues which they themselves could resolve. I saw their actions as aspects of their own institutionalisation and helplessness within the bureaucracy. Officers focused on vocational and administrative issues rather than professional issues. They fostered relationships based on their own life courses, using parent/child analogies as the basis of care. The Officer-in-Charge's pragmatic leadership was most important in establishing relationships within the home, but this was a weakness. Too much depended on the personality of Officers who perceived themselves as powerless in the wider structure. The Officers' failure to recognise their own power provided an excuse not to change aspects of the routine which inhibited residents' relationships. It was interesting to note that the Care Assistants, Officers, and residents were predominantly white working class women. All the care staff (except for one male Care Assistant at Northfield House who retired soon after the research began), all the Officers, and most of the residents were women, as has been established. In culture and race, residents and staff were almost entirely white and British born. The race, gender, and class implications of the perceived use and availability of power within organisational relationships of residential care could be explored further with a different mix of residents.

Both residents and staff noted that the way to form relationships was to "get to know what the routine is and join in". On the positive side of organisational relationships, residents mentioned the activities run by staff as sources of stimulation. Activities encouraged a positive community spirit. Residents drew attention to their need for fun and enjoyment. Activities, especially social events, provided this. Not all residents joined in, some residents preferring to remain on their own. Northfield House had a well-resourced activity programme which took place in its own separate room with specially appointed staff. Northfield residents were attracted to take part in activities, in contrast to Eastview staff's struggle to persuade residents to attend the afternoon Bingo sessions held in the dining room. Eastview's makeshift setting for activities and lack of specialist activities staff detracted from the potential appeal of activities. At Southam, activities such as musical movement took place in the downstairs lounge where there was a piano. The problem for Southam residents was how to avoid the activities if they did not wish to take part, since most bedrooms were not furnished for use during the day. Perhaps the most popular activity was the bar and Social Club run by staff at Eastview in the evenings for residents. Staff replicated a Working Men's Club setting in one corner of the dining room. Residents could buy a drink and chat. Some residents disapproved of the bar. This was an example of the impossibility of pleasing all residents when routines and staff practices were organised on a communal basis. In another example, whereas Mrs. Olga Frederick at Eastview said that she did not like staff to use her first name, Mr. John Davis, also at Eastview, took the opposite view, saying that he liked to be called by his first name.

Organisational relationships should take account of the need for multiple regimes (as discussed by Booth, 1985) for managing the range of residents' mental and physical frailty. Multiple regimes can encourage personal and social relationships if steps are taken to individualise care practice. Staff did not recognise multiple regimes explicitly, although there was evidence of their existence. Nor did they recognise the need to manage multiple

regimes constructively. As I have established, institutional care practices and more positive care practices occurred side by side. Practices were neither co-ordinated nor consciously formulated. Regimes were not accountable because they were not subject to systematic review. Activities were valued, but were not seen as part of a wider set of aims. The layers of bureaucracy within the Social Services Department removed policy decisions from the Officer-in-Charge, and this I felt was one of the reasons for the lack of individualised care practice.

10.10 Ignoring the Importance of Relationships for Residents' Well being

In principle, good residential care practice accepts the professional values assumption that relationships are necessary for individual well being. However, residential care practice does not always view the very old, frail dependent people living in institutions as fully human and capable of the same emotions as people who are not so old and not institutionalised. The residential homes failed to acknowledge the possibility of psychological and social change in the residents (the 'weak' form of development, Baltes, 1979, discussed in Chapter Two). As a result, residents' relationships were ignored. Staff and residents recognised the importance of organisational relationships, but failed to see the value of personal and social relationships.

'Practice' as a therapeutic intervention which promotes relationships and residents' individuality was not developed within the homes. The homes had no clear aims for practice, other than to provide ongoing care until death. Advisory guidelines for staff valued relationships only for their utility value in resolving problems. The Officers-in-Charge viewed themselves (and were viewed by residents) as managers, not practitioners. Even when an Assistant or Deputy Officer happened to be professionally qualified in social work or nursing, their designated roles did not include responsibility for developing individual practice.

Good practice itself was not conceptualised to any degree. Most of the models of care reviewed in Chapter Four promote goals and values for residential care which are intended to facilitate individual relationships. These models of care, however, are vague on the methods by which practice can be developed to fulfil the desired aims. The exception is group care practice (Ainsworth and Fulcher, 1981), which is more specific in the way it draws attention to the characteristic importance within group care of complex networks of relationships between staff and clients and between individuals and groups (CCETSW Expert Group, 1992). The concept of the 'good' relationship needs to be explored further, because although satisfying relationships with other residents were capable of promoting individual well being, relationships within a group environment could also cause distress because residents lacked a means of escape when relationships foundered. As we have seen, the loss of relationships through death or separation was emotionally damaging.

It is best to be pragmatic rather than ideological in criticising or defending care practices. So many factors were interlocking. A 'good' care practice was made less effective by lack of attention to other linked concerns. For example, the research showed how the use of key workers for bathing residents provided an opportunity to develop trust and continuity between key workers and residents because of the private and intimate nature of the task. Unfortunately, the key worker role was limited to brief periods of time to avoid attachments developing. The key workers' interventions were restricted by the boundaries set on their role.

Because often there was little evidence of close personal relationships developing within the homes, I could have concluded that no significant relationships existed and that relationships were not important so long as residents' physical needs were met. However,

I have argued that residents' relationships suggested that they had entered a Post-Attachment phase of their life courses, in which their social relationships were important for establishing self-esteem and social acceptance within the residential homes. Residents valued feeling safe and cared for, but they also needed to ensure that their identities as individuals were asserted. Relationships helped them to break through the limitations of batch living (Goffman, 1961), and for this reason, they are important. The 'good care practice' movement needs to consider how to manage the organisational relationships which inhibit personal and social relationships. Professional social work models of practice have assumed that residential care practice should be based on therapeutic relationships between residents and staff, but such relationships were not observed or recounted to me. This in fact is a misguided principle for residential care, because it ignores the more appropriate staff role of facilitating diverse relationships. Perhaps it is a mistake to envisage the relationships of staff to residents as being ideally close and therapeutic. It may be more suitable for staff to play a facilitating role which promotes relationships between residents, and between residents and their relatives.

10.11 Unexpected Puzzlements

The first unexpected puzzlement (and the biggest disappointment of the research) was the continuing pervasiveness of batch living practices in the organisational relationships of the homes. Over thirty years have passed since the dissemination of Goffman's findings (1961) and other examples of the literature of dysfunction, yet routines continued to keep relationships at bay. The organisational relationships of the home had not been changed in any way to take account of residents' individuality through care planning, key working, or recognition of the contribution of the life histories of residents. The homes' day-to-day routines did not reflect any awareness of the value of individual relationships. For example, it was easier to spend vast amounts on redesigning the use of space than to influence the staff/resident relationships.

The second puzzlement was my discovery that professional values and training had made little impact on the staff's day to day work. Few of the staff had been offered any training. There was no obvious career progression for the women staff, most of whom were hourly paid Care Assistants. The staff who had been trained often decided they could not change organisational practices because the other staff would not co-operate, or the bureaucracy was too pervasive. Once they gained a professional qualification, they tended to leave residential care for better paid field work positions. Social Services Training Officers sometimes have been known to blame Care Assistants for not taking time to talk to residents. My research showed that this was too simple a perception. The care staff, all women, were institutionalised by the regime and by the nature of their employment as manual workers. Their purpose was defined as offering physical care. They were not encouraged to learn about the residents' life courses. They were not offered systematic staff support and supervision. They were prevented from acting as key workers except in a temporary capacity which defeated the aim of key working. I had expected to find that the staff/resident relationship would be very important. Instead it was the least significant relationship. Staff were regarded as instruments by residents. Staff were not supported by the organisational regime to develop their relationships with residents because of fear of their reactions to the frequent deaths of residents. The second reason why staff/resident relationships were discouraged was because relationships were perceived as being associated with professional values. Care Assistants are not employed as professional staff. If they were to adopt professional values and practices, they might claim more training, a higher status, better working conditions, and more money. The economic implications of professionalising care staff are expensive. Practices which are linked with professional views are not promoted wholeheartedly as a result. The gender and class

implications of the use of power in resident-staff relationships raised additional issues for further exploration.

10.12 Convergence With and Divergence From Previous Research

The findings established that relationships are important for the well being of residents, but that relationships receive a low priority from the staff. The influence of organisational relationships (including staff practices) on residents' personal and social relationships has become clearer than previous research has shown. Relationships are influenced by environmental contexts and by individual motivation.

Many of the theoretical perspectives on ageing, relationships, and residential care reviewed in early Chapters were borne out. The nature of residential care and of the elderly residents themselves modify the applicability of previous research. The perspectives of biological ageing (Strehler, 1977), which suggest that relationships in old age will be a continuation of earlier relationships, were not helpful. Their emphasis on the continuance of close intimate relationships formed in childhood discounted the potential of new social relationships occurring in old age. My research findings point to the importance for elderly people of social relationships within a Post-Attachment phase of relationships. Although residents designated their relatives and old friends as their closest and most intimate relationships, these designations did not take into account the disruption of their previous relationships because of their own survival in old age beyond most of their contemporaries, and by their entry to care.

Psycho-social views on attachment (Bowlby, 1951, discussed in Chapter Two) took a similar view of relationships, valuing close, intimate relationships formed in childhood, and undervaluing the importance of social relationships. Bowlby (1951) asserted that a friendship relationship (in the social sense of relationship) could not be a substitute for attachment. This statement failed to take account of the positive contribution of social relationships (including friendship as 'acquaintanceship') to individual well-being in residential care. Freud (1953, 1976, 1986 editions) portrayed new adult relationships as replacements of previous relationships founded in infancy and childhood, and as echoes and re-working of childhood relationships. Rather than finding that current relationships repeat the patterns of past relationships, I found that in certain instances (discussed above) where residents had experienced Deprivation or unresolved bereavement, they sought to fill the emotional emptiness in their current lives through forming new kinds of relationships. They searched for completion in their present relationships.

This helps to explain, in part, why Eastview resident Mrs. Polly Towell became a Quasi-Staff Member and Queen Bee. Each stage of Mrs. Towell's life had been marked by some sense of personal guilt in relation to a loss. She experienced painful angry relationships with her father and blamed him for her illness in young adulthood but also felt guilty about her mother's unhappy marriage. When she worked for a steamship company during the Second World War, she booked evacuee children on the liner *Benares* which subsequently was torpedoed with the loss of the children's lives. Her husband had several children by his first marriage in Canada with whom he had no contact. Later she was involved in a dispute with her mother's second husband over the inheritance of property after her mother's death. A childhood accident, caused by a pot of boiling water tipped over in the kitchen, scarred her three-year old son. She blamed herself for these painful relationships and events. Her son, when grown, emigrated to Canada, leaving her alone. Her roles as Quasi-Staff Member and Queen Bee gave her an opportunity to make up for failed incidents of caring in the past when she perceived that her relationships caused pain. Now she received public acknowledgement from other residents that she was a helpful, caring person who eased others' pain.

Erikson et al's view of ageing (1986) suggests that the final stage of maturity is a dialectic between integrity and despair. According to Erikson, elderly people whose intimate relationships of the past have been satisfying will be more likely to achieve integrity if they can overcome bereavement reactions. One could see evidence of this in the relationships of Mrs. Iris Rowlands at Eastview, but Mrs. Towell's integrity in old age was due, I felt, to more than her need to compensate for the intimate personal relationships of the past. Her personality as an individual, and her willingness to embark on new social experiences in old age were equally important.

Weiss (1973, 1974) argued that attachments are not the only form of close relationships or the only bond of emotional significance in adults. My research establishes the importance of social relationships in the Post-Attachment phase of relationships, and so affirms Weiss's argument. Weiss's provisions (1973, discussed in Chapter Three) are useful for considering relationships of elderly people in residential care, and are applicable to old age and to the context of residential care. Social support (Cobb, 1976; Gottlieb, 1978) was an important aspect of social relationships in residential care. Residents' social relationships affirmed status, in a greater degree than personal relationships. The social relationships of residents with each other provided aid, affirmation, and affect, identified by Kahn and Antonucci (1981) as key elements of social support. Affect was provided in greater measure by the personal relationships which occasionally formed between residents. Aid was supplied primarily by the organisational relationships of the home.

Although Ishii-Kuntz (1990) claimed that elderly people may worry about being a burden and so find peer relationships a greater source of support than their relatives, I did not find this to be so because of the residents' clamour for attention within the homes. The continuing prevalence of batch living (Goffman, 1961) meant the residents had to compete with each other for attention. Age itself did not create a bond other than residents' admission that "we're all in the same boat here". Differences in previous life courses and personalities were greater than any communality of old age. This supports the continuity perspective of ageing (Victor, 1987, 1994; Hughes, 1990) which recognises heterogeneity in elderly people. Physical and mental dependency made self-centredness the motivating force in many of the relationships within residential care. Residents' self-centredness was not helped by the lack of care planning and the continuance of batch living. Levinson's view (1978) that the most significant relationship in old age is with the self, and that development can occur as the individual comes to terms with approaching death, was affirmed.

When elderly people entered residential care, they brought with them their life course experiences shaped by previous environmental contexts, but they needed to preserve their identities from being overwhelmed by the institutional context of residential care. Their strategies for forming relationships illustrated their resistance to institutional contexts. Their resistance supports Bronfenbrenner's argument (1979) that environmental contexts influence individual personality. Although Gutmann (1987) claimed that both men and women may deny loss of close relationships in old age, I found that rather than denying their loss, residents kept relationships which had been lost through death and separation alive in their accounts of their life course experiences. Past intimate relationships were sustained in memory.

Age stratification theory (Riley et al, 1972), by implication, argues that residential homes which bring an age cohort together may provide opportunities for new relationships and shared concerns. Subculture theory (Rose, 1965) suggests that positive affinity in old age leads to shared group consciousness and shared activity. Reciprocity and exchange theory (Dowd, 1975; Homans, 1958, 1974) suggest that the power imbalance between old age

and middle age removes opportunities for reciprocal activity. I found that reciprocity and exchange (echoing Jerrome, 1993b, discussed in Chapter Three) underpins many of the relationships between residents in residential care. Stronger residents help the more frail residents, and the frail residents repay the stronger residents with appreciation and acknowledgement of their usefulness. Within the residential homes, I found that certain residents exercised covert power and domination over other residents. Although it could be argued that wealthier elderly people could buy better care in higher quality private settings, the covert power within a home was not based on economic wealth but on personality, leadership skills, and most importantly, on greater physical and mental capacity in relation to others. In contrast, the political economy view of ageing (Walker, 1980, 1983) argues that power is based on economic wealth, and that elderly people's loss of wealth and economic status is related to the powerlessness of old age. Both reciprocity theory and political economy theory overlook the heterogeneity of elderly people.

Hockey (1983, 1990) argued that residents clung to identity, hope and trust in a wider pattern of meaning, accepting the present hardships of the regime and the loss of the past. I found that residents' identity was important, but they did more than cling to it. They used identity to establish themselves in a new environment. My view of the residents' relationships recognises their strategies for gaining status and power rather than hope and trust. I also query Hockey's view (1989) that women residents lose more than men when they enter care because they lose their caring role. As my findings indicate, many women residents were successful in assuming leadership over other residents in the caring role of Quasi-Staff Member. I found few examples of the views of Jung (1969, 1982, 1989 editions), Gutmann (1964, 1979, 1987), and Gilligan (1982) about the change in gender differences in relationships of old age, when men may become more caring, and women more powerful. The women residents who became leaders followed traditional patterns of caring, developing emotional closeness and taking on physical tasks in relation to other individuals, while the men assumed social leadership on committees or as raconteurs and authorities on technical matters.

As discussed above, I found that many residents claimed friendships with other residents, but they defined these as social acquaintanceships. Jerrome (1979), in an early piece of research, argued that proximity in an institution creates opportunities for helpfulness but not friendships, and that friends (in the sense of intimate personal relationships) are those previously known individuals outside the institution. I found this to be generally true, even when death had ended the previous intimate relationship. Acquaintanceship prevailed within the homes. Only on occasion did helping opportunities develop into attachment relationships, particularly with room mates.

Social integration was important in group settings. Acquiring a helping role towards other residents facilitated successful relationships which were based on friendly acquaintanceship rather than intimacy. Residents who entered care on or near the same date and subsequently survived together in the home developed shared life course experiences within the home itself. Relationships grew from these shared experiences in care. Keith (1990) claimed that egalitarianism is a feature of residential relationships because the residential group is outside the power systems of society. I argue that the group seeks to replicate the power systems which residents have known in society. Residents are all too aware of the power of the staff at the top of the hierarchy.

Willcocks et al (1987) argued that small group living in Units does not offer an alternative lifestyle because of organisational and structural constraints, and that most residents wanted more control over their physical environment in preference to increased activities. I judged that small group living in Units might have worked better if it had been supported by a thoughtful internal placement policy and more conscious group work skills practised by

staff. If Units had been comprised of single bed sitting rooms, the alternative life style advocated might have been achieved. I found that most residents valued activities and did not want to choose between activities and more control over their environment. They wanted both, not one or the other. I agree with Willcocks et al's argument that lack of privacy affects opportunities for meaningful relationships in residential care. Willcocks et al stated their dislike of the mix of day care and permanent residents, but this problem was successfully overcome by the design of Northfield House. Its Day Care Unit had a separate entrance for Day Care users, but permanent residents could participate in the activities. The provision of a clearly demarcated social activity room which did not double up as a lounge or dining room gave permanent residents a venue for enjoyment in a location which was part of the home and yet separate. Sophistication of design overcame possible intrusions of privacy.

The life course perspective (Sugarman, 1986; Riley, 1979) helped me to view residents' relationships as part of their life course experiences. I agreed with Pearlin and Schooler's argument (1978) that elderly people develop coping resources and coping responses to change. Phased admissions, which occurred only at Northfield House, helped residents through their transitions to residential care. Placement decisions, both external and internal, are crucial factors in the failure or success of the transition process and in fostering or inhibiting the development of new relationships, yet my observations revealed that placement decisions rarely considered the individual's need for both continuing and new relationships.

The dimension of historical time (Neugarten and Datan, 1973; Hareven, 1982) was not as useful for understanding the social processes of ageing as I had expected. Important historical events had affected the life courses and relationships of the elderly residents, but residents showed little awareness and acknowledgement of these influences in their accounts.

Middleton (1983) drew attention to the continuity of relationship skills in old age, and the sometimes negative influence of lifelong culturally-based inhibitions on forming new relationships. I found this to be only partially true, because some residents drew attention to positive changes in themselves, such as growth in tolerance and sociability, arising from the experience of living in a group environment, but some of my findings supported Middleton (the cultural unwillingness to reveal feelings).

10.13 Particular Issues Illuminated by the Research: Contribution to Knowledge

Both the processes and the findings of the research illuminated issues in ways which make a contribution to knowledge. The research processes were responsible for developing different applications of the life course perspective, and new conceptualisations of both values and relationships as tools for developing practice. The research findings established that relationships of elderly people in residential care do exist, and are related to individual life histories. The findings identified the under-recognised importance of social relationships, the specific roles adopted by the residents to assert their identities, and the emergence of the Post-Attachment phase of relationships. Specific practice-related issues illuminated by the findings include the importance of establishing an external and internal placement policy for residents entering and already living in residential care. The most important practice-related finding to emerge from the research was that practice which promotes only a single solution for problems which involve a diverse, shifting range of personal, social, and organisational relationships will fail. The research highlights the need for an integrated approach to practice to tackle the different factors which can affect relationships.

The research links the life course perspective to the study of relationships in residential care. Combining these concepts provided a new approach for exploring residents' individuality. Instead of using the life course perspective only for reminiscence or for resolving specific relationship problems, it provided a means of developing good care practice in the collective sense as an aid for a more enlightened management approach. Gathering life histories helped me to understand residents' current behaviour. The life histories enabled residents to share the nature of their past and present relationships. The life histories recognised residents as individuals with clear identities. The life course perspective approach ensured that the impact of the homes' organisational relationships on individual identities was not ignored. As well as this fresh use of the life course perspective with individual residents, another broader application of the life course perspective emerged. It became apparent that each residential home had a life course of its own, in which its past history, previous role and use, location in a particular community, and relationship to that community created a distinctive culture of care which affected residents' relationships. In order to develop good care practice, the life course of the home itself needs to be taken into account.

The research had characterised the three perspectives of the social world and the social interactions which underpin practice with elderly people as three Values Concepts (discussed in Chapter Five). (These are Values Concept One, the belief in the worth of the individual; Values Concept Two, the belief in change and development in adult life; and Values Concept Three, the belief in the reciprocal influence of the environment on the individual, and the individual on the environment). The three Values Concepts proved appropriate for developing the research, but also demonstrated their potential usefulness for developing care practice, because of the way they combine the concepts of individuality, change, and the environment.

The research explored relationships within the dimensions of personal, social, and organisational relationships. By bringing together these three dimensions of relationships, the diversity of relationships (which the CCETSW Expert Group, 1992, argues is the essential characteristic of residential care) was acknowledged. This conceptualisation also provides a new tool for the development of good care practice.

One of the most important new insights highlighted by the findings of my research is the shift in perception of the relationships of elderly people away from a preoccupation with close personal relationships towards a recognition of the greater role of social relationships. This is what I have termed the Post-Attachment phase of relationships. It is not just that elderly people in residential care have more social relationships than personal relationships; social relationships play a hitherto under-recognised role in maintaining the residents' sense of well being. Social relationships are necessary to establish individual identity and individual acceptance within residential care. Residents establish their own individual identity and acceptance through presentation of certain aspects of their life course experiences. Residents drew on dimensions of Locality, Work Roles, and Spiritual Belief to win acceptance. A powerful yet uneasy identity was projected through the dimension of Deprivation. Residents adopted roles in relation to each other, such as Helper, Entertainer, Puzzle Master, and most significantly, Queen Bee and Quasi-Staff Member, which helped them to establish new relationships in care. Many of these roles involved the use of power. Residents used power in their relationships with staff and with each other. Sometimes they disguised their feelings and views in an attempt to preserve the little power they had over their relationships; sometimes they asserted their own responsibility for making relationships and demonstrated this in their distant relationships with staff and in their roles towards other residents. Booth's warning (1985) about the reluctance of residents to reveal

their true opinions, and my own expressed frustrations about their unwillingness to share information with me, was now more easily understood as part of this power strategy.

I identified the lack of a coherent placement policy, both for external placements in a particular home and for the internal placements of residents within a home, as a significant yet hitherto unrecognised factor affecting opportunities for relationships. Recognising the importance of where residents are placed at the dining table, in a communal lounge, and in a Unit or a shared bedroom (although no perfect solutions can be provided to please all individuals) would result in more sensitive decision-making within practice.

Although aspects of previous research are echoed within my findings, other researchers presented views of relationships which were part of their findings rather than their central concern. They mostly studied relationships with younger cohorts of elderly people who were not institutionalised. Their findings did not connect the issues which are central to relationships as this research does. For example, my research has suggested that because Care Assistants are themselves institutionalised by the organisational relationships of care, they cannot be expected to form relationships with residents merely by being admonished to "talk to residents more". The organisational relationships of the home need to provide a structure to support the development of relationships with residents.

The lack of a clear strategy for individualised care practice exercised a negative influence on residents' personal and social relationships. My research suggests that positive caring practices with the potential to enhance relationships were counterbalanced by other practices which inhibited relationships. Earlier research on issues of relationships (reviewed in Chapter Three) tended to take a single issue and promote a single solution, for example, the use of space and design or activities. My research argues that one of the issues for relationships of elderly people in residential care is how to achieve coherence and integration of many of the positive caring practices which could make a difference to the recognition of residents' individuality. Reasonable, pragmatic achievable goals to promote relationships need to be developed. Unless care practices are individualised and integrated, residents' personal and social relationships in residential care, which are important for their well-being, will struggle for survival rather than thrive within a supportive framework. Further discussion of individualised and integrated care practice is developed in Chapter Eleven.

10.14 New Events in Residential Care and How These Affect the Findings

Care in the Community legislation was implemented in 1993 after this research began. Residential care continues as a major provision of Community Care, despite efforts to increase the range of alternatives to care. Although the policy is still in its beginning stages, the new legislation demands more accountable care management at the point of initial entry to care than was previously required. Elderly people seeking financial assistance for the cost of residential care are now required to have their needs assessed by a social worker prior to entering care, together with an exploration of community-based alternatives to entering care. When the problems are complex, needs-led assessments are meant to be jointly conducted by NHS staff and by Social Services. Good Community Care practice is intended to provide choice, partnership with carers, and empowerment of clients. It seeks to change the traditional professional worker/client relationship, in which the professional retains the power, to a more democratic, shared balance of power.

Quality assurance and quality control of residential homes have become tighter in principle. Inspection and registration of residential homes have been extended to local authority homes. Yet Inspection and Registration Officers find to their frustration that they have not been given a developmental role to promote good practice. Their only roles are to inspect

and register homes, or in extreme case to close those homes which flagrantly breech regulations. In-service training through work-based National Vocational Qualifications in Social Care has been made available to an increasing number of Care Assistants in residential homes, but there is still no comprehensive provision of training for residential care. The increasing use of private and voluntary care homes gives more power to the Officer-in-Charge, in principle, to improve care practices and promote relationships. This is because she or he is likely to be an independent owner/manager rather than the employee of a large bureaucracy which can be blamed for perpetuating institutional practices, although whether the Officer-in-Charge actually will make use of this power in a positive way will depend on improvements in training.

The requirements of the National Health Service and Community Care Act (1990) should result eventually in care practices which focus more on the individual needs of residents, including their relationships, but the current cash shortage in the local authorities responsible for administering Care in the Community (Means and Smith, 1994) has inhibited progress. Community Care's initial attention has focused on the purchase of service through needs-led assessment, rather than on the provision of service (Means and Smith, 1994). Currently there is no widely used tool for discovering the views of residents about the actual provision of care. The views about Community Care which are expressed tend to be seen in terms of management and finance, despite requirements to consult carers and clients. Owing to pressure of work in making initial assessments, regular reviews of residents' progress in residential care do not take place as often as they should.

The difficulty of individualising care practices in residential care has been documented throughout this study of relationships. This difficulty continues under Care in the Community, partly because the diversity of the organisational, social, and personal relationships in residential care frustrates efforts to bring about this positive change, and partly because of the lack of resources. Core skills for residential care staff working in the 'provider units' which offer residential care for elderly people need to be developed in order to provide good care practice and opportunities for enhanced relationships (Stevenson and Parsloe, 1993). My research establishes the importance of relationships within good care practice. The recommendations of this research as well as the Caring in Homes Initiatives (Brunel University, 1989, discussed in Chapter Four) need to become part of the mainstream of Community Care and to be followed by other similar initiatives. Until provision of service develops further, relationships will remain a low priority.

10.15 Reviewing the Aims of the Study of Relationships and its Concepts

I chose a little-recognised subject area for this research which was relevant to practice, under-researched, and values-related. My goal was to identify and understand the relationships which exist in particular situations with particular individuals in particular groupings - the relationships of elderly people in residential care. From this understanding I hoped to develop new teaching and practice strategies. At the beginning of the Chapter, the aims of the research were summarised as:

> The study of relationships provides an opportunity to understand the residents' points of view of what it is like to live in a residential home. Relationships provide a key for understanding Fourth Age experiences lived in a particular setting. Relationships are important for residents' well being. Relationships express the emotions and feelings of residents. Knowledge of relationships will contribute to the development of good practice within residential care. Relationships are part of professional values. Practice, including management of care, should be based on therapeutic relationships between residents and workers. This study will dispel or confirm some previously held assumptions about old age (that it is devoid of relationships); about residential care (that residential homes are emotionally depriving institutions); and about relationships (that relationships are intrinsically good and necessary for well-being).

Chapter One portrayed 'relationship' as a fairly neutral concept which could be interpreted and expanded in a number of ways, and could be used as a basis for enquiry without causing so much emotional pain that responses would not be elicited. These arguments remain cogent in broad terms. Relationships did provide a key for understanding Fourth Age experiences within residential care, as long as the diversity of relationships was taken into account. Relationships were not one-dimensional, but were inter-related. Studying relationships as personal, social, and organisational provided separate dimensions which were useful so long as one recognised that the separate dimensions frequently merged and overlapped. For example, residents' relationships were developed both for utility value and for self-fulfilment, with the same relationship frequently serving both purposes.

The aims show the idealism of my initial expectations and my preoccupation with close personal relationships. I had higher expectations of discovering attachment relationships than were borne out by the findings. In Chapter Three, I surmised that new attachments in old age would develop only when residents had freed themselves psychologically from the loss of their previous life course attachments. I found that attachments were more likely in just the opposite situations, when residents had not successfully resolved their painful losses of previous attachment relationships. Residents did not become attached to staff. The kind of attachments which were most prevalent were to the home and the regime, which provided a positive role for the Queen Bee and the Quasi-Staff Member. Instead I found different sorts of relationships: social relationships which were used purposefully by residents to assert their identities, act out useful and entertaining roles, and win recognition and self-esteem in institutional settings. Old age in residential care was not devoid of relationships, but the relationships were different from what I expected. I was not able to discover any differences in the relationships formed in residential care by residents who had been widowed and residents who were never married. The limited scope of the research did not permit me to explore any real differences between the perceptions and experiences of relationships of the short stay and day care users, and the permanent residents. The staff/resident relationships were not as important as I thought they would be. It was disappointing to discover that residential homes are still emotionally depriving institutions, but I discovered ways in which good care practices (for example, effective key working and care plans) could promote residents' relationships. The life course perspective gave coherence to the research. The life course also provided a potential structure for affirming the residents' individuality through their relationships.

The research supported the notion that relationships are intrinsically but not exclusively good. Relationships are both good and bad. It was not possible for me to establish or prove in this kind of research that relationships are necessary for well-being. I encountered evidence of destructive relationships between residents. The research showed that when organisational regimes try to control or deny residents' relationships, the relationships do not disappear but survive in a surreptitious manner. The goal for residential care should be to enable residents to enter into relationships which resemble ordinary relationships, some good, some not so good, but which can be pursued and acknowledged without fear.

10.16 Conclusion of the Chapter

This Chapter's overview analysed the findings of the research. It reviewed the aims of the research in the light of the relevant findings. The unexpected puzzlements were discussed, as well as the findings' convergence with, and divergence from previous research findings. The research establishes that the relationships of elderly people in residential care do exist and are related to individual life histories. The research's illumination of particular aspects of relationships provided the basis of new knowledge about relationships. These aspects include new applications of the life course perspective and conceptualisations of both

values and relationships as tools for developing practice, the under-recognised importance of social relationships, the specific roles adopted by the residents to assert identities, and the emergence of the Post-Attachment phase of relationships. Specific practice-related issues include the importance of establishing an external and internal placement policy for residents. The most important issue is the inadequacy of single-issue care practice because it does not address the diverse range of personal, social, and organisational relationships. The research identified the need for an integrated and individualised approach to practice which takes account of the diversity of relationships.

The Chapter discussed events affecting residential care since the research began. The initial aims of the study of relationships and even the concept of relationships were modified as a result of the findings. Finally, the discussion affirmed the importance of relationships for residents' well-being despite the recognition provided by the research that the actual relationships in residential care are limited in scope and depth. Recommendations based on the research findings will be presented in the next Chapter. These recommendations will suggest ways of individualising residential care through integrated care practice and integrated service delivery in order to support and sustain residents' personal and social relationships.

Relationships of Elderly People in Residential Care

Chapter Eleven

Recommendations Arising from the Research

11.1 Introduction: the Need for Integrated Care Practice

The previous Chapters established that relationships are important for the well-being of residents. Personal and social relationships provide the means through which residents can express their individuality and combat the institutional effects of batch living in residential care. Good residential care practice should enhance residents' individuality. In order to achieve this aim, it must promote their relationships. Good residential care practice needs to recognise the characteristic diversity of relationships in residential care, in which complex organisational relationships can easily overwhelm individual personal and social relationships. The purpose of this research is to develop and disseminate recommendations for good care practice which enhance residents' personal and social relationships. The recommendations argue the need for integrated care practices, supported by integrated service delivery policies within each home, in order to support and sustain residents' relationships and promote their individuality. The recommendations take account of the continuing institutional nature of residential care. For most residents, residential care remains a second best choice to independent living in the community. Residential care is not likely to disappear in the near future, so these recommendations are offered as partial mitigations of the effects of institutionalisation.

Individualising residential care for elderly people through a focus on their relationships is a desirable goal. Integrated practice is needed to achieve this goal. The use of life histories is the first of five essential elements for integrating social care practice within residential care. The four subsequent elements are key working, care planning, support for loss and bereavement, and group work skills. The discussion emphasises a practice perspective rather than a service delivery perspective of residential care. It argues that service delivery policies must support integrated care practices, and not be substituted for them. It introduces the concept of integrated practice within residential care.

11.2 Distinguishing Between a Service Delivery Perspective and a Practice Perspective

The perspectives of service delivery and practice delivery differ from each other. Service delivery is concerned with a co-ordinated approach which is efficient, effective, and well-managed. To achieve effective service delivery, managers deploy a work force of social care workers to carry out clearly defined tasks, backed up by professional expertise. Organisational relationships predominate in service delivery. The arguments for this approach are well known (Sinclair, 1990) and do not need reiteration here.

Practice delivery, in contrast, is concerned with how services actually are delivered by individual workers for, to, and on behalf of individual residents. Practice delivery requires individual interpretation of and individual decision-making on a range of service requirements and provision. It is based on individual knowledge of the uniqueness of each elderly person in care. Practice delivery requires the worker to do more than carry out clearly defined tasks, but to integrate tasks into over-all practice. This will include thinking through the practice implications of such values as respect for individuality, and intervening on that basis. This practice delivery supports a professionally derived values and skills approach for residential staff to a much greater extent than the service delivery perspective.

Practice delivery ascribes greater importance to personal and social relationships than to organisational relationships.

The thrust of residential care development has been towards the achievement of satisfactory service delivery rather than a concern with practice delivery. This factor explains in part why residential care has not been individualised sufficiently to promote relationships and to meet the criteria of a good standard of care. Both the perspectives of service delivery and practice delivery accept individualising services as one of the criteria for achieving a good standard of care. Both perspectives are needed to make progress towards achieving the goal of good care, but the neglect of practice delivery hinders progress in attaining the goal.

11.3 Review and Discussion of the Factors which underpin Individualised Services

Individualising services for elderly people in residential care depends on recognition of the following factors:

First, the need for individualised practice in order to promote relationships and meet the criteria of a good standard of care.

We have seen that individualisation of services, in the sense that services are tailored to fit the needs and wishes of the consumer, is now a recognised part of the criteria of a good standard of care (Wolfensberger, 1982; Booth, 1985; Atherton, 1989). Individualising services for elderly people is an accepted principle of good care practice (Goldberg and Connolly, 1982; Home Life, CPA, 1984; Wagner, 1988) as it is for other client groups. In principle, when elderly people seek help from Social Services under the National Health Service and Community Care Act 1990, they are offered a needs-led assessment rather than a service-led assessment in order to tailor the provision of services to their individual requirements. Professional training for nurses, social workers, and occupational therapists includes the recognition of the individual's needs and rights for therapeutic relationships (Biestek, 1958, 1973; Perlman, 1957; Hollis, 1972); knowledge of ageism (Townsend, 1986; Johnson and Bytheway, 1993); and awareness of the destructiveness of institutionalisation (Goffman, 1961; Townsend, 1962).

Secondly, the nature and reality of residential care (i.e. its institutional nature, and the failure to provide sufficiently individualised care.)

We have seen that services for elderly people have not always reflected the principles of good practice (including individualised services and the importance of relationships) which are part of professional social work (Barclay, 1982). Provision of services for elderly people in Britain has been dominated by residential care, which traditionally has not individualised its care of residents because of the lingering influence of workhouse traditions (Longmate, 1974; Means, 1986; Townsend, 1986).

Two schools of thought about residential care have emerged (Booth, 1985). One, the literature of dysfunction, expresses the view that all residential care is oppressive and damaging to individual well-being (Bowlby, 1951; Goffman, 1961; Townsend, 1962; Morris, 1969; Jones, 1967; Miller and Gwynne, 1972). The other school of thought argues that the development of good care practice in residential homes can mitigate the damaging effects of institutionalisation (Atherton, 1989). Those whose views support the literature of dysfunction deny that it is possible to achieve individualised services in residential care which promote relationships and so develop good care practice. The mitigation view encourages development of good care practice. The models of good care which have developed over the last fifteen years assume that institutionalisation can be

mitigated by good practice (Atherton, 1989; Brearley, 1990). Estes' definition (1979) of the enterprise of care (service providers who are motivated by self-preservation motives rather than by altruism) is an appropriate although cynical analysis of why certain groups sought to develop good care models.

By adopting concern for developing good care models in residential care, professional social work designated residential care for elderly people as an area of practice for colonialisation. Although some progress in individualising care is noted, professional social work's contribution is most noticeable in supporting residential care's continuing existence through the belief that good care practice will provide a solution for what is wrong. The outcome of good care practice is likely to be more modest than a total reversal of the features of institutionalisation, achieving instead a softening, blurring, and amelioration of some of the more institutionalised practices which prevent expression of individuality.

Thirdly, the likelihood and necessity of residential care remaining as a major part of service delivery.

The principal form of social services for elderly people remains residential care. Despite the literature of dysfunction (Townsend, 1962; Bowlby, 1951; Goffman, 1961; Miller and Gwynne, 1972), more and more old people's homes have opened in successive decades, helped by government funding patterns which boosted the growth of private residential care (Sinclair, 1988). Care in the Community legislation (NHS and Community Care Act, 1990) is intended to slow down the growth of residential care and provide alternatives to institutional care. Henwood (1992) rightly claims that residential care is a reality which cannot be eradicated, notwithstanding the ideologies of Community Care (Griffiths, 1988).

Fourthly, the dependence of individualising services on an integrated approach to practice supported by integrated service delivery.

As it is unlikely that residential care will disappear, residential managers and care workers should offer residents as individual a service as possible within residential care in order to support residents' personal and social relationships. Services can move towards individualised delivery when they are integrated through multi-professional and multi-disciplinary provision and appropriate management strategies. The integrated approach to practice needs to be supported by a framework of integrated services. Integrated practice is a micro-approach, combining five essential elements which can be delivered by a multi-professional, multi-disciplinary team. Because the aim is to individualise services, the role of the individual worker relating to the individual resident becomes more prominent in integrated practice than at service delivery level. Both integrated services and integrated practice are needed to manage the characteristic diversity of relationships in residential care in order to promote the individuality of each resident.

The professional values of individuality and respect for persons promote relationships and help to achieve good standards of care. Values, as free-standing entities, cannot achieve good standards on their own. As we have seen, too often workers in residential care are presented with lists or exhortations of the things or values which are meant to develop good practice. They remain no more than worthy intentions because the various practice initiatives have not been integrated. The steps for achieving practice delivery, as compared to service delivery, have not been well defined. Residential staff need to address actual practice situations and apply their values appropriately through integrated practice. Relationships will benefit from this approach.

Integrated practice in residential care starts with the first essential element, the taking of a life history of an individual client, when then facilitates the successive four essential elements of integrated practice: key working, care planning, support for loss and bereavement, and group work skills. Each element depends on the concurrent implementation of the others taking place concurrently. The elements cannot be effective when offered in an isolated manner. For example, a key worker cannot put into practice an individualised service without knowing the individual resident very well. The life history helps to bring about this knowledge. The key worker has no real focus for individual practice without agreeing a care plan with the individual. Providing an individual service as a key worker to an elderly resident involves forming a relationship with an individual who will probably die during the progress of the relationship. Support for loss and bereavement reactions which affect staff morale as well as residents is essential in order for staff to sustain their relationships in their roles as key workers. Since residents live in a group setting, group work skills for key workers are required so they can reconcile the conflicts and competing demands of members of the groups.

Fifthly, the essential role which the life course perspective can play in facilitating integrated practice.

The life course perspective (Butler, 1974) can provide a unifying focus for promoting relationships and achieving integration of practice. It facilitates integration of practice because it focuses on the individual's own biography as told by the individual. Taking a life history is different from a needs-led assessment (considered part of good practice for Care in the Community) because the structure of a life-history is not dependent on identifying needs. It is also different from a social and medical history taken by a nurse or social worker because the categories of meaning are defined by the individual who is the subject of the history rather than by the professional worker.

The next section discusses the five essential elements of integrated practice, and establishes their appropriateness for individualising care and promoting relationships.

11.4 The First Essential Element of Integrated Practice: Using Life Histories

A **life history** provides a means of learning about the life course experiences of residents and understanding their individuality expressed through their social and personal relationships. It starts and ends with a self-told story of relationships, events, and meanings. It reveals that residents' personal relationships are rooted in their past life course experiences. Sustaining psychological closeness is as important as maintaining actual contact. Integrated practice can use this aspect of personal relationships to find ways of sustaining residents' desired psychological closeness from the past, through discussion, counselling, and appropriate reminiscence as well as visits from relatives and friends.

The life history establishes the importance of new and on-going social relationships in residential care and the social nature of friendships. Residents have entered into the Post-Attachment phase of their life courses. The goals of residents' social relationships in residential care are to achieve recognition of individual identity, respect, and acceptance. Sharing socially acceptable aspects of life course experiences with other residents is the preferred way of asserting identity and becoming known. Integrated practice can support the development of these new relationships within residential care by recognising residents' identities and roles. Helpful roles adopted by residents ought to be recognised more overtly. Potentially destructive roles should be prevented from causing psychological harm to more vulnerable residents. The difficulties that residents who had been institutionalised

previously in long stay hospitals incur in sharing their limited life course experiences with other residents would be recognised through the use of a life history approach.

Sensitive handling of the admission process is required to resolve the 'unfinished business' of the crises which prompted entry to care. When used sensitively, the life history approach can assist the resolution of admission crises because it links past, present, and future relationships of residents. Social workers who visit residents prior to admission need to continue to visit until a key worker relationship is established within the homes. The importance of life course experiences within care should be recognised. Survivors in care (the Old Hands) relate life histories which contain accounts of their relationships whilst in care. Staff need to recognise the life course events which occur in care and create a bond of communality between residents. For example, two residents entering care around the same time will share a significant life course experience and could develop a relationship with each other which draws on this shared experience.

Few of the recent guidelines (Kelleher and Peace, 1993) for developing good residential care succeed in drawing out the individual views of elderly people themselves, which is the starting point of good practice. Knowledge of residents' individual life course experiences provides the key for effective individualised practice to mitigate the worst effects of batch living. The use of a life history approach for recognising the individuality of residents before and after the point of admission into care is recommended, provided the resident is willing to share and participate. Life histories can facilitate the empowerment of the resident by involving him or her as an equal partner in activities and decisions based on mutually shared knowledge. Obviously the permission of the resident will be needed, and the principle of confidentiality maintained. The use of such information needs to be agreed and clearly understood. In some instances the residents may wish to have a copy of their life history to give to their relatives, thus affirming to the subsequent generation the individuality of their elders' life courses. Staff would need to develop appropriate knowledge, understanding, and skills in life history taking.

11.5 The Second Essential Element of Integrated Practice: The Key Worker

The appointment of a continuously serving **key worker** (Elliott, 1980; Mallinson, 1987; Dant and Gearing, 1993) for each resident is important for developing integrated practice. The key worker role should be used as a means of encouraging a resident-centred culture rather than a task-centred culture. The key worker should be responsible not only for bathing the resident, but also enabling the resident to participate fully in whatever organisational, social, and personal relationships which are possible for the resident and desired by him or her. To achieve this, the key worker needs to maintain regular records, convene regular reviews, manage a care plan, and most of all, consult regularly with the resident to whom she is assigned.

Residents do not wish to view the staff as their children or as their parents, or to be viewed by staff in that way. Although the parent/child analogy may provide the initial motivation for staff to undertake their caring roles, it is not appropriate as a foundation for ongoing staff/resident relationships. In designating the role of the key worker, the instrumental nature of staff/resident relationships needs to be recognised. The staff are there to facilitate residents' relationships with other residents and with relatives, not to develop close relationships with residents themselves. For example, they could help to provide transport for relatives and friends to enable them to remain in contact with their elderly relatives in the home. This differently defined staff relationship with residents needs to be incorporated into the focused staff role of key worker.

Key workers need to know how ageism limits the recognition of the elderly individual's potential for positive change and development. Lowered expectations of the potential for forming relationships can became self-fulfilling prophecies. If staff expect the potential for relationships to be present, they will look for it, find it, and develop it according to the wishes of the individual.

11.6 The Third Essential Element of Integrated Practice: The Care Plan

Forming and implementing a mutually agreed **care plan** (Brandon, 1993), in which the key worker draws on residents' life course experiences shared through life history taking, is essential for each resident. The care plan provides a vehicle for integrating practice rather than concentrating on a single issue to overcome the effects of batch living. Its purpose is to achieve individualised care. The care plan should aim for enlightened use of organisational relationships to enhance personal and social relationships as part of the strategy of individualising care. Care planning should begin as soon as the admission process begins. Care plans can help to make entry to care as positive a choice as possible. They can plan phased entry and gradual, supported transitions to care.

A care plan can use specific philosophies and practices to stimulate relationships. For example, the most positive aspect of residential care is its ability to meet residents' needs to feel safe and cared for. This should remain a top priority in the care plan. Health needs, especially sensory impairment, should be monitored, and suitable help provided so that residents can communicate with each other as effectively as possible. Positive aspects of activities for fun and enjoyment need to be part of a care plan, as long as the individual resident shares this perception and is not a reluctant participant. The care plan might include the provision of a one-to-one volunteer programme of regular visitors for isolated residents who would benefit from and agree to such a programme. Individual volunteers would provide new relationships and improve the self-esteem and status of residents who feel less well regarded by others because they have no visitors. Another use for volunteers might be to act as independent advocates for the residents. Teaching telephone skills to residents who are uneasy with the telephone might enable them to take the initiative in communicating with relatives. Siting the public telephone in a private area ought to become standard policy.

Concepts of empowerment and self-determination should permeate the care plan. Residents have to see a purpose in discussing or sharing their views. They should not fear retribution if they express their feelings. Expression of their views needs to become culturally acceptable. Residents should be reasonably confident of a positive hearing. The care plan provides a means of enabling individual views to be heard, but the care plan would not be sufficient on its own to empower residents. The care plan needs to be backed up by other care practices, including a Residents' Committee; clearly articulated aims, objectives, and philosophy for the home; a Residents' Handbook; a Complaints Procedure; and an Independent Advocate system. These are examples of integrated practice supported by integrated service delivery.

It was noted in the research that self-centredness often appeared to be the motivating force behind residents' behaviour and relationships with each other. Self-centredness is an instinct for self-preservation in an institution where residents have to compete with each other for attention. Care planning which mitigates the effects of batch living would help to reduce self-centredness because residents would be less likely to compete with each other for attention.

11.7 The Fourth Essential Element of Integrated Practice: Support for Loss, Mourning and Bereavement

Recognition of the impact of **deaths** of residents, subsequent **loss, mourning and bereavement** (Worden, 1982; Parkes, 1986) in both residents' and workers' relationships is an important element of integrated practice. Support and consultation need to be provided both to care workers and to residents. Individual life histories bring workers face to face with the impact of death, loss, and bereavement on the lives of residents. This affects their own lives as carers of elderly people who, on average, survive no more than eighteen months in care before they die. Integrated practice should provide therefore regular **support and consultation** for workers in the areas of **bereavement, loss, and mourning** to enable them to continue to relate to elderly individuals who are so near to death.

Staff need knowledge, understanding and skill in responding to bereavement reactions in particular residents, so that residents are supported through periods of crisis. They should recognise the importance of change and transition in residents' relationships, especially the disruption to relationships caused by entering care. They should acknowledge residents' reluctance to form new relationships because of the likelihood of encountering new loss, and fear of losing social esteem if a new relationship founders. Staff need to be able to recognise the symptoms and causes of complicated bereavement which may affect residents' relationship needs. This will include helping residents to resolve unfinished business, e.g. painful and unresolved loss and mourning.

Support for staff who experience the death of the residents on a regular basis is essential. When integrated practice is adopted, more frequent contacts take place between the staff member and the resident. The staff's customary defence against loss - distancing themselves from the residents - is destroyed. Staff are vulnerable and subject to stress as they respond to residents' physical and mental deterioration and inevitable death. A staff member qualified to provide counselling and support would help the staff to respond to their own feelings and those of residents.

11.8 The Fifth Essential Element of Integrated Practice: Group Work Skills

Recognition of the impact of group dynamics within group living, and the need for workers to recognise and use **group work skills** (Mullender and Ward, 1991; Brown and Clough, 1989; Douglas, 1976) in practice is the fifth essential element. The individual life history will bring about workers' increased awareness of different personalities. It makes individual wishes and requirements more evident. In order to balance the needs of the individual within the competing demands of the group, workers' practice should reflect **knowledge and skill in group work principles and dynamics.**

Group dynamics, including informal leadership, group roles, and group norms, are important because age itself does not create a bond between residents. Residents' individuality over-rides the communality of age to a great extent, leading to rivalry and incompatibility at times. Because so much of residential life is lived in groups, enhancing the positive aspects of social relationships is important. This includes regular provision of activities to support group solidarity and social relationships. Disability and sensory impairment which prevent relationships from developing because of communication difficulties should also be taken into account.

Group work would recognise the power of elderly residents in relation to each other. Residents' power is based on personality, skills, motivation, and physical and mental capacity, and also on the willingness to co-operate or not. The reciprocal relationship of

caring/being cared for is a power relationship. The most satisfying relationship role for residents is caring for others and assuming power as a Quasi-Staff Member. Group work skill are needed to protect vulnerable residents when they are dominated oppressively by other residents, and to recognise residents' assumption of their own responsibility for forming relationships and their belief that this responsibility is in their own control.

11.9 Summary of Discussion of Integrated Practice

The life history approach is the pivotal first element which facilitates integrated delivery of the subsequent four essential elements of integrated practice in residential homes, namely key working; care planning; support for loss, mourning, and bereavement; and group work skills. Integrated practice provides a strategy for developing good residential care practice which promotes residents' individuality, and in so doing, facilitates their relationships.

These essential elements, including the life history approach, mitigate the effects of institutionalisation. They cannot eradicate the institutional nature of residential life. But because residential care will remain as a major social care provision, it is both worthwhile and a moral imperative to take action in full recognition that in reality no more than limited improvements will be achieved. When considered individually, the essential elements of integrated practice are not particularly new, but the separate elements have lacked an integrated approach. Usually they have been implemented in a piecemeal fashion, if at all. Without an integrated approach they will not succeed in achieving an acceptable mitigation of institutionalisation, promoting residents' individuality, and enhancing their relationships. My recommendation is that integrated practice, facilitated by a life history approach as the first of five essential elements, will help to individualise residential care for elderly people, promote their personal and social relationships, and so mitigate the effects of institutionalisation.

Integrated care practice needs to be supported by integrated service delivery policies within each home and within the hierarchy of any wider management structure responsible for the home. Like the care practices discussed above, many of these are not new policies. They also need to be integrated as part of an over-all strategy about relationships. The service delivery policies include use of space and design, management structures and staff roles, admission and placement policies, staff development policies, and use of resources.

11.10 Integrated Service Delivery Policies: Use of Space and Design

The concept of 'space' includes external space, the community in which the residential home is located. The research established that each home has a life course of its own, with a distinctive culture based on its history and relationship to its surrounding community. Integrated service delivery policy should recognise the importance of the home's culture for developing its organisational relationship with the community. The stigma which often is associated with residential care can be avoided by promoting a positive image of the residential home based on its culture. For example, Southam projected the image of a country house to which the community responded by participating in social events in which residents shared. Residents benefited from the positive relationship of the home to the community. Eastview's factory-like building projected a negative image which meant that it would have to use a different strategy to avoid stigma, perhaps by emphasising its provision of single bed sitting rooms.

The location of residential homes is important for preserving contacts with relatives and friends and ensuring that personal relationships survive in actuality and not just in memory. Homes need to be easily accessible by public transport. If this is not possible, the home needs to provide a mini-bus shuttle service to assist relatives to visit at regular intervals.

The provision of clearly signposted visitors' rooms in homes which have double bedrooms would provide privacy for visits. Receiving visits from close relatives in a public lounge inhibits intimacy and may lead to intrusion from other residents who are eager for attention. It is preferable to have single rooms both for greater privacy and for receiving visitors. These should be furnished as bed sitting rooms with their own private bathrooms, and would benefit from being located in a small group Unit, but with access to a designated Activity Area. The Unit design would ensure that some communal activity (meal times) could be managed on a more personal and individual basis, but that residents could enjoy the privacy of their own single rooms. A purpose-built Activity Area located away from the bedrooms and communal lounge/dining areas would attract more residents than a makeshift area in a corner of a dining room. A positive image of activities would be projected. A guest bedroom for visitors who have travelled a distance, available (through payment) on a hotel basis, would also help to preserve existing personal relationships.

The residents' relationships with staff, shown to be largely instrumental, would be enhanced by the provision of large print name tags for all staff, so that residents could learn the names of staff. Residents can find the size of the larger homes overwhelming; this feeling could be mitigated if they were helped to know the names of the staff and other residents. The residents' names should be sign posted in large print on their bedroom doors so that their identity and location are more easily established. The provision of aural loops in each bedroom, dining area, and communal lounge would help residents' efforts to communicate with each other.

It must be remembered that the beneficial factors of size and design need to be accompanied by good factors of other aspects of integrated service delivery.

11.11 Integrated Service Delivery Policies: Management Structures and Staff Roles

The management of the home needs to develop clearly stated aims, service delivery and practice outcomes, and a philosophy of care which includes the goal of developing and maintaining relationships. Without clearly stated aims, as we have seen, each home develops its regime from the personality of the Officer-in-Charge and the traditional workhouse influenced expectations, without any systems to note achievements and resolve problems. Relationships may be overlooked or abused unless they are part of the homes' stated aims and outcomes.

Residents' rights need to be communicated clearly, in large print and also on cassette tape so that those with sensory impairment are not excluded from obtaining information. This is necessary because often residents hesitate to ask staff to do what they perceive as special favours, such as writing letters. A Residents' Handbook, explaining in simple language the rights of residents (including establishing and maintaining relationships), the home's aims and outcomes, its placement policies, and its care management systems should be developed. Residents' Committees need to be established with clear roles and boundaries for resident representatives' decision making. The extent of power sharing needs to be made explicit. Models for these aspects of practice are to be found in some of the projects with people with learning difficulties, based on normalisation principles (Wolfensberger, 1972, 1982, discussed in Chapter Four).

The recommendations for integrated practice do not assume that all workers in residential care need to be professionally qualified as social workers, nurses, or occupational therapists. Implementation of integrated practice can be carried out by unqualified workers (Care Assistants). The distinctive roles of professionally qualified workers (the nurse, the

occupational therapist, or the social worker) are to provide support, training, consultation, and supervision for unqualified workers. In a typical residential home, at least one Officer with a professional qualification should be responsible for developing integrated practice which other staff would implement. He or she could be designated as ' Manager of Integrated Practice'.

This role would differ from that of the Officer-in-Charge, but would be accountable to the Officer-in-Charge. Officers-in-Charge should be accountable for the over-all service delivery/practice requirements of the home. They would supervise staff in specialist roles, such as the Manager of Integrated Practice and also the Activities Organiser responsible for activities programmes. It should become the policy for decision-making to be delegated by the Officer-in-Charge to other staff, as long as clear systems of accountability are set up. Greater role clarity in professional decision-making for the Officer-in-Charge would moderate the less desirable effects of individual personalities on the regime. This would counter the institutionalisation and sense of helplessness which is often felt by Officers-in-Charge, and instead would help them recognise the extent of their own power and enable them to use it positively. The Officer-in-Charge needs to develop a professional role, not just a bureaucratic role.

Both residents and staff would benefit from the creation of a suggestions and complaints system. Issues could be raised without fear of retribution. Changes could be introduced after participatory discussions. Most of all, management structures and staff roles need to recognise the diversity of relationships in residential care and how factors of organisational relationships such as size, design, and residents' frailty inter-connect and influence personal and social relationships. The multiple regimes which are so characteristic of residential homes, but which are seldom overtly recognised, should receive more attention. These diversities of relationships comprise the central issues of which management needs to take account and for which it must be accountable.

11.12 Integrated Service Delivery Policies: Admission and Placement Policies

Each home needs to have a clearly stated Placement Policy for both the external and internal placements of residents. The Placement Policy should support the aims, outcomes, and philosophy of the home regarding relationships. It should take note of individual preferences, personalities, and relationships. A residential home's intake area should be as local as possible. Placements should be made within an area which comprises a recognised community and locality, so that relationships with family, friends, and community can be maintained more easily.

External Placement Policy should eliminate emergency ad-hoc admissions and admissions direct from hospital whenever possible, as these often give residents little opportunity to think through the changed nature of their relationships once they enter care. Elderly people can be so taken up with bereavement and shock of crisis that they do not become aware of the implications of the permanent placement until it is too late. These residents may have difficulty in relating positively within the home. Phased admissions through the use of well-managed respite care or short term introductory periods in care can help elderly people to develop their new relationships gradually and recognise the changes in their existing relationships.

Internal Placement Policies should also be developed as a means of developing and maintaining relationships. This aspect of service delivery policy is one which has not been discussed elsewhere, as far as I can discover, yet I believe it is important for good practice. The policy should not be one of simply filling beds. The internal Placement Policy should

consider the matching of room-mates, dining room table companions, the grouping of residents in a Unit, and residents' seating in a communal lounge, with a view to compatibility and sharing of interests.

Residents should retain the right to their own room and bed and to their own place in the lounge and dining room, rather than be liable to upheaval and movement within the home because staff wish to re-assign residents' rooms. This should be a principle and right for every resident, unless there are strong valid reasons for intervening in the existing relationships. These reasons should be stated explicitly, with residents having the right to challenge the staff's internal placement decisions. Internal Placement Policy needs to be aware of the need to protect, at times, a weak and dependent resident from dominance by another resident. This would constitute a reason for re-assignment of a bed following a careful gathering of facts.

Confused residents should be placed in a separate Unit, but those who become confused should not be moved unless confusion results in marked and prolonged disruptive behaviour to other residents. A separate Unit within each home for those residents who are highly confused may be more beneficial to other residents' relationships. There are difficulties in implementing this practice. It is not always clear who is 'confused' and to what degree. The deterioration of residents over time and the increasingly advanced ages at which they are admitted would make strict segregation impossible. It would be ethically unacceptable to transfer a deteriorating resident from one environment to another simply to achieve administrative tidiness. There is also a danger that a policy of segregation would pander to negative stereotypical views about confusion and its effects.

11.13 Integrated Service Delivery Policies: Staff Development Policies

The ageist attitudes of staff should be challenged but within the context of improved staff support. They need to acknowledge the importance of residents' relationships. They need to develop relationships with residents which will be facilitative rather than close and personal. Staff training for integrated practice should include knowledge and skills for the life history approach, the key worker role, care planning, loss and bereavement, and group work interventions. Their staff development should be internally organised, probably linked to a National Vocational Qualifications system, and supported by regular supervision. The home's aims, outcomes, and philosophy should underpin staff development strategies.

An Induction Programme for new staff and for new residents would help staff and residents develop their relationships to each other and to the organisational structure of the home. Recognition of long service and of specific staff achievements could take place once a year to boost morale and build positive organisational relationships.

11.14 Integrated Service Delivery Policies: Use of Resources

Inevitably, changing practice and service delivery to promote relationships will require increased resources. More staffing hours will probably be needed, so that staff can develop their roles as key workers, operate care plans, and facilitate the relationships of residents. This may mean more Care Assistant hours or more Officer hours, or a combination of both. Staffing is one of the most important resources. The use of space and design is also important for promoting relationships. I agree with Willcocks et al (1987) that single bed sitting rooms should be provided.

Other resources are more specific: the provision of assistance with fares and transport for close relatives and friends who otherwise may be unable to visit; regular health checks and

the provision of correct spectacles and hearing aids to assist communication; and private, easy-to-use telephone facilities with amplification, touch button dials and large lettered panels rather than one old-fashioned dial telephone in a public corridor.

11.15 The Need for Additional Research

This research explored the nature of the relationships of elderly people in residential care. The findings serve as building blocks for further research which can illuminate these relationships further. In particular, practice considerations suggest that the importance of residents' personal and social relationships for their well-being needs to be affirmed in additional research.

The influence of the life course experience on relationships was the pivotal issue of the research. The extent to which relationships in residential care are determined by the resident's past experiences, especially the effect of deprivation, would be interesting to explore further. A more extensive study could investigate the influences of life course experiences on the kinds of relationships sought in residential care. The question of whether certain types of personalities and certain life experiences are more likely to result in admission to care could be studied at a deeper level. The links between life course experiences, reasons for admission, and the subsequent relationships experienced could be investigated further. The differences in the relationships of day care users, short-term residents, and permanent residents, and the extent to which their residential status influences their relationships, could be explored, but the influence of their residential status would be difficult to establish in the face of so many other influences. More research is needed to determine what kinds of relationships are feasible and evident for residents who have experienced severe memory loss and are confused. Gender differences and roles and their effects on relationships could be explored. The applicability of the recommendations and findings to independent sector homes could be the basis of a further project.

An important finding of the research is that residents' relationships have entered a Post-Attachment phase. Further research on this theme might be to seek to replicate the findings on the importance of social relationships within residential care, and to expand understanding. Residents' use of power could be explored further. A focused study could explore the roles of the Queen Bee and Quasi-Staff Members and their use of power and influence. The extent and nature of new attachments in residents' relationships, and the reason for them, are worth exploring.

This research drew on the views and behaviours of a predominantly white, working class group who were mainly women. Because of the location of the homes in East Anglia, neither staff nor residents reflected the broader cultural and racial mix of people in other areas of Britain. Further research needs to consider the influences of race, ethnicity, and culture on relationships in care.

The most important recommendation for practice is for integrated practice and integrated service delivery. This recommendation needs to be piloted in practice. A further aspect for future research might consist of an experimental design for action research in which the essential elements of integrated practice, accompanied by integrated service delivery policies, are adopted within one or more residential homes. The subsequent outcomes for residents' relationships could be contrasted with outcomes for relationships in homes which did not adopt integrated practice. The diversity of relationships in residential care would make this a complex undertaking. A less ambitious project might consist of a comparison of two homes, one with clear aims and outcomes which include the development and support of relationships and one with no clearly defined aims. Another possible direction for future exploration is to revisit the same residential homes to discover

what changes in care practices have resulted from the implementation of the NHS and Community Care Act (1990) and whether these practices make a difference to the relationships. These comparisons would provide an interesting exercise, but it is my view that unless practices are integrated, one good care practice will be neutralised by another practice which is less good. The less ambitious research projects may not be able to offer any further findings on the importance of relationships to residents because their scope would be limited to the consideration of only one aspect of practice. The same would be true of any research which sought to explore a single issue about relationships.

11.16 Summary and Conclusions

One of my purposes in undertaking the research was to inform the teaching of social work practitioners and social work students about residential care for elderly people, management strategies, and social work values and attitudes. The research has succeeded in enabling me to achieve this purpose, and to design appropriate curricula for both social workers and nurses.

The research has ranged widely over a number of conceptual issues about ageing, relationships, and residential care. The research topic considered many aspects of practice which are in the process of change. New legislation, the purchaser/provider split, and the issuing of many new practice and quality assurance guides are some of the changes which have occurred. Many local authority residential homes for elderly people have been upgraded in their design in order to meet new regulations, or have been sold to independent providers. The 60-bedded home may disappear. Alternative forms of care are being developed, such as Resource Centres which combine residential care with day care and sheltered housing. Inspection is being extended as a quality control measure. Elderly people who will need residential care in ten years time may have different, more positive expectations than those who live in residential homes in the mid 1990s.

Despite the changes in policies, organisational structures, and legislative frameworks for residential care since the research began, the issues raised by the research about the relationships of elderly people in residential care remain current. The research is about how we perceive elderly people in residential care, value their individuality, and mitigate the effects of institutionalisation; and about how they perceive themselves. The findings of the research affirm the importance of relationships for residents' well-being. 'Relationship' has been studied as a concept which subdivides into three dimensions of personal, social, and organisational relationships, and so expresses the diversity of residential care from the perspectives of the residents themselves rather than from the perspectives of management. This supports the importance of relationships for developing practice which empowers residents. The changes in residential care which have taken place since the beginning of the research recognise the need to empower residents. Currently, plans are under way to write a new code of practice for residential care which goes a step further than Home Life (CPA, 1984) by giving equal weight to the perspectives of carers and users of service as well as to service providers. It is my recommendation that the recognition of the importance of relationships should be a central concern of the new code of practice.

As I conclude, it is important to remember that this exploration of relationships in residential care was, in effect, more concerned with how professional values and attitudes can be translated into practice than about the specific design aspects of the homes themselves, which is a subject in itself. The challenge of implementing values into practice will remain a relevant issue in the caring professions and certainly with regard to the relationships of elderly people in residential care. This research makes a contribution which broadens understanding of this issue.

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Appendix One (Chapter Six)

Introductory Letter to the Staff and Residents

TO: THE STAFF AND RESIDENTS:

I teach social work at the Essex Institute of Higher Education in Chelmsford. Many of my students work in residential homes like this one.

I am interested in getting in touch with people who live and work in an elderly person's home to find out what it's like. That's why I'm spending some time here. I hope you'll get to know me, and I you.

I'd like to talk one-to-one to you about your life, your experiences, and about the people, both past and present, who have meant the most to you. Perhaps you will be interested in talking to me. I'd appreciate any help you can give.

Eventually, I shall need to write about my findings. The written account will be for a course of study at Cranfield Institute of Technology, and will not be given to the home.

Yours sincerely,

PAT HIGHAM
Telephone: 0245 493131 ext. 245

Appendix Two (Chapter Six)

Interview Guide / Schedule
(for Life Histories)

Introduce SELF; explain purpose and role. Assure that there are no "right answers".

Confidentiality, tape recorder and notes.

Name of Residential Home.

Name of Subject. D. O.B.

Life Story: (Triggers)

Childhood.

Family Life.

School.

Friends.

Work.

Marriage.

Children.

Who did you feel closest to?

Interests.

Activities.

Friends.

Significant Events.

Memories.

Now: When and why entered home?

Questions:

Who do you spend most time with?

Who would you turn to if you had a problem?

If you could choose, who would you like to spend the most time with?

Would you describe yourself as: a "loner" or "sociable"?
having "acquaintances" or a "circle of friends"?

Appendix Three (Chapter Six)

Draft Interview Guide

Relationships of Elderly People in Residential Care

Name of Respondent: Residence:

Date of Interview: Date of Birth:

Expectations of New Relationships

1) Before you came here, how did you suppose you would get acquainted with the people here?

2) How did you get acquainted?

3) What helped?

4) Has anything prevented you from getting acquainted as well as you might like?

5) Have you developed any friendships whilst here?

6) Who with?

7) How has this come about (or not)?

8) What makes a person a friend to you?

Keeping old Relationships

9) Have you found it possible to keep in contact with old friends, neighbours and family members?

10) Who with?

11) How?

12) How important is it to you to keep in touch?

13) What makes it possible to keep in touch?

14) What makes it difficult?

Establishing Identity

15) Do you think people here know you as you really are?

16) How do people living here get attention or get noticed?

Group life

17) How does the group get along with each other?

18) What causes problems in getting along?

19) What helps the group to feel good about being here together and creates a good atmosphere?

20) What part do the staff play in helping the group to form relationships?

21) Who leads the group?

22) What part do you play in the group?

23) Are there any notable characters in the group?

24) Tell me about them. What makes them notable?

Expressing Feelings

25) Is it easy for people here to express their feelings towards each other?

26) What makes it easy or difficult?

27) How do you express your good feelings? Your angry feelings?

Effects of the Home on Relationships

28) Do you feel that you have changed towards people since being here?

29) If so, what has caused the change?

30) How have you changed?

31) How would you describe your relationships with others here?

Attachments

32) Who do you feel closest to, not just in the home?

33) What about here?

34) Why is this person so special to you?

Reciprocity

35) Relationships are about give and take. In the past you probably did not think about this. What about now?

36) What would you like to give to others?

37) What would you like to get from others?

38) What do you get from others?

39) What do you give?

Conclusion

40) Is there anything which I have left out that you would like to share with me?

Appendix Four (Chapter Six)

Interview Guide (Final Version)

Relationships of Elderly People in Residential Care

Name of Respondent: Residence:

Date of Interview: Date of Birth:

Expectations of New Relationships

1) Before you came here, how did you suppose you would get acquainted with the people here?

2) How did you get acquainted?

3) What helped?

4) Has anything prevented you from getting acquainted as well as you might like?

5) Have you developed any friendships whilst here?

6) Who with?

7) How has this come about (or not)?

8) What makes a person a friend to you?

Keeping Old Relationships: Introduce and explain new Section.

9) Have you found it possible to keep in contact with old friends, neighbours, and family members?

10) If no, why?

11) Who with?

12) How?

13) How important is it to you to keep in touch?

14) How do you keep in touch?

15) What is the way of keeping in touch that you prefer?

16) What makes it difficult?

Establishing Identity

17) Do you think people here know you as you really are?

18) How do people living here get attention or get noticed?

Group life: Define what is meant by the group: the group where you sit in the lounge; the group at the dining room table; in your Unit, or in your bedroom.

19) How does the group get along with each other? (Specify group in turn)

20) What helps the group to feel good about being here together and creates a good atmosphere? (Specify group in turn)

21) What causes problems in getting along? (Specify group)

22) What part do you play in the group? (Specify group)

23) Who leads the group? (Specify group)

24) Are there any people who stand out? (Specify group)

25) Tell me about them. What makes them stand out?

26) What part do the staff play in helping the group to form relationships? (Specify group)

Expressing Feelings

27) Is it easy for people here to express their feelings towards each other?

28) What makes it easy?

29) What makes it difficult?

30) How do you express your good feelings?

31) Your negative feelings?

Effects of the Home on Relationships

32) Do you think that you have changed towards people since being here?

33) If so, what has caused the change?

34) How have you changed?

35) How would you describe your relationships with others here?

Attachments

36) Who do you feel closest to, not just in the home?

37) What about here?

38) Why are these persons so special to you?

Reciprocity

Explain: relationships are about give and take. Perhaps you have not thought about this before. I'd like you to think about it now. When I say "giving" I don't mean giving things.

39) In your relationships, what would you like to give to others?

40) What would you like to get from others?

41) What do you get from others?

42) What do you give?

Conclusion

43) Is there anything which I have left out that you would like to share with me?

44) Additional probes based on material emerging.

Appendix Five (Chapter Six)

Interview Guide (for Staff)

Name of Respondent: Residential Home

Date of Birth: Date of Interview:

Expectations of New Relationships

1) Before a resident comes to live here, do you suppose he or she gives much thought to how they'll get acquainted with the other people here?

2) How do they get acquainted?

3) What helps?

4) Does anything prevent them from getting acquainted as well as they might like?

5) Do the residents develop any friendships while they're here? Give examples.

6) Who with (staff, other residents)?

7) How has this come about (or not)?

8) What makes a person into a friend, as far as the residents are concerned?

Keeping Old Relationships: Introduce and explain new section

9) Do residents keep in contact with old friends, neighbours, and family members?

9a) If "no", why not?

10) Who with?

11) How?

12) How important is it to them that they keep in touch?

13) How do they keep in touch?

13a) What is the preferred way of keeping in touch?

14) What makes it difficult to keep in touch?

Establishing Identity

15) Do you think the residents here know each other as they really are?

16) How do people living here get attention or get noticed?

Group Life: Define what's meant by the group: the group in the sitting room, the group at the dining room table, in the bedroom (pairs).

17) How does the group get along with each other? (Specify group)

18) What helps the group to feel good about being here together and creates a good atmosphere?

19) What causes problems in getting along?

20) What part do the staff play in helping the group to form relationships?

21) What part do you play in the residents' groups?

22) Who leads the group of residents?

23) Are there any notable characters in the group?

24) Tell me about them.

Expressing Feelings

25) Is it easy for residents here to express their feelings towards each other?

26) What is it that makes it easy?

26a) What makes it difficult?

27) How do residents express their good feelings?

27a) Their bad feelings?

The Effect of the Home on Relationships

28) Do you think the residents have changed in the way they relate to people since being here?

29) If so, what has caused the change?

30) How have they changed? (Give examples)

31) How would you describe the relationships which exist here?

Attachments

32) Who do residents feel closest to, not just in the home?

33) What about here?

34) Why are some individuals so special and close to some of the residents?

Reciprocity
(Explain: Relationships are about give and take. Perhaps you've not thought about this before. I'd like you to think about it now. When I say "giving", I don't mean giving things)

35) In their relationships, what would the residents like to give to others? (Specify others: staff, residents, family.)

36) What would they like to get from others?

37) What do they get from others?

38) What do they give?

The Home Itself

39) How important is the location of the home and its relationship to the local community for the residents?

40) What is the home's relationship to the local community?

41) How important are the presence or absence of relationships as a factor for admission to the home?

42) How does the administrative management of the home affect residents' relationships?

43) How does the design of the home affect residents relationships?

Sensory Impairment

44) How does hearing loss of residents affect relationships?

45) How does loss of vision affect relationships?

Conclusion

46) What can you tell me about the relationships of the residents?

47) What about the staff's relationships with the residents?

48) What about your own relationships with residents?

49) Is there anything I've left out which you'd like to share with me?

50) Additional probes based on material emerging.

Appendix Six (Chapter Seven)

The Constellation of Reasons for Admission to Care

Note: each resident was admitted with a number of reasons noted in the Social Work Report. The following information records the incidence of each factor.

Bereavement and Lack of Relationships: Number of times noted.

	Southam	Eastview
Afraid of being alone	8	10
Depression following bereavement	10	5
Anxiety and fearfulness	6	1
Complex bereavement	4	7
Hospital admission following mental breakdown	3	4
Unsettled after move to new area	4	3
Poverty, Homelessness, Self-Neglect		
Poverty	2	3
Poor housing	3	3
Homelessness	2	13
Alcoholism	3	1
Self-neglect	6	8
Factors Relating to Family and Carers		
Estranged relationships with carers	11	16
Insufficient care from relatives	5	3
No relatives	1	4
Relatives unable to provide care/own poor health	1	11
Physical and Mental Health		
Inability to care for self	4	10
Memory loss	12	10
Physical dependency/illness	8	41
Accident	4	8
Mental illness	1	1
Learning disability	-	3
Long term institutionalisation (physical disability)	-	1

Appendix Seven (Chapter Seven)

Length of Stay:

An Overview taken from permanent residents' files, May, 1989

	Southam	Eastview	Northfield House
Admitted 1970-1979	6	4	2
Admitted 1980-1985	5	16	12
Admitted 1986-1989	12	36	28
Total	23	56	42

Note: Each home reserved certain beds for short-term residents whose stay was limited to two weeks. These residents entered the home for temporary periods of respite care usually in order to enable their carers to have a holiday or a break from the daily routine.

Appendix Eight (Chapter Seven)

Gender of Residents

	Men	Women
Southam	5	19
Eastview	17	46
Northfield House	9	32