International Journal of Ageing and Later Life

Volume 16, No. 1, 2022

Published with the support of the Swedish Research Council for Health, Working Life and Welfare (Forskningsrådet för hälsa, arbetsliv och välfärd 2018-01671)

ISSN 1652-8670 (www)
URL: http://ijal.se

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International Journal of Ageing and Later Life, 2022 16(1): 1–23 © The Authors
doi: 10.3384/ijal.1652-8670.3335

Expectations regarding aging among ethnically diverse undergraduates in Japan: a life course perspective on anticipated health and meaning in later life

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Abstract

This study explored expectations regarding aging among a diverse cohort of undergraduates in Japan. A concurrent mixed methods design was employed with online administration of the Expectations Regarding Aging scale (ERA-12), and open-format and demographic questions among 133 culturally diverse undergraduates in Tokyo. Independent samples *t*-tests, one-way analysis of variance (ANOVA), descriptive statistics, and thematic analysis were used to explore the data. ERA-12 scores and physical and cognitive function subscale results revealed negative perceptions about the aging process, while scores on the mental health subscale were significantly higher and positive. No significant differences emerged based on gender or cultural background. Qualitative data analysis revealed student awareness of lifestyle influences on health in later

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life, concerns about current health and risk factors, and potential to transcend negative physical changes by finding meaning in other aspects of life. Understanding expectations regarding aging among younger cohorts may inform gerontological education and public health promotion to support a life course approach to healthy aging.

Keywords: health expectancy, healthy aging, life course, young adults.

Introduction

Japan leads the world in population aging and has been referred to as a super-aged society due to rapid declines in birth rate and a demographic shift toward older ages (Muramatsu & Akiyama 2011). Within the next 50 years, up to 41% of Japan's population will be aged 65 years or older, which will have major impacts on public health services, social security, and intergenerational relations (National Institute for Population and Social Security Research 2017). At the same time, Japan's population is also becoming more diverse as younger adults from overseas take up new educational opportunities and fill employment vacancies, resulting from Japan's changing demographic structure (Hashimoto 2017). In the last decade, for example, there has been a 10% annual increase in university enrolments among international students, with nearly 500,000 currently in Japan and 37 universities offering government-funded bilingual education programs (Japan Student Services Organization 2019). To ensure that the increasingly diverse and aged population of Japan lives a healthy and active life, it is necessary to understand and promote health across the life course. This is because the majority of diseases that drive morbidity and mortality in Japan and similarly developed nations have their origin in behavioral and environmental factors from early adulthood, including poor diet, inactivity, tobacco use, and others (Lynch & Smith 2005). In this context, investigations of younger adults' expectations about aging can be useful as these may influence long-term behavioral and health outcomes.

The theoretical rationale for investigating younger adults' expectations about aging comes from the Life Course Perspective (Bengtson & Allen 2009). The Life Course Perspective asserts that the experience of aging is closely tied to perceptions, behaviors, life chances, and sociocultural

conditions that have cumulative impacts over one's life (Bengtson & Allen 2009). In the last two decades, there has been growing interest from health researchers and clinicians concerning the relationship among early life perceptions, behaviors, and environmental/cultural factors that ultimately influence morbidity and mortality outcomes in later life (Karmali & Lloyd-Jones 2013; Li et al. 2009; Wethington 2005). Expectations regarding aging is the operational concept for the present research, which describes perceptions about the capacity to achieve and maintain high levels of physical, mental, and cognitive functions in later life (Sarkisian et al. 2005). Importantly, expectations about aging not only are related to general conceptualizations about others or the current generation of older adults but also include an individual's self-referential projections about their possible future physical, mental, and cognitive health states (Faudzi 2019; Sarkisian et al. 2005). This is an important concept from a Life Course Perspective as expectations for physical and mental declines in old age may foreshadow disengagement from health-protective behaviors in early and midlife or reinforce negative stereotypes about the capabilities and roles of older adults (Herman et al. 2014; Hirvensalo & Lintunen 2011). This is relevant given recent epidemiological data that show widespread reductions in healthful lifestyle behaviors and increases in obesity among younger adults in Japan, which portends poorly for health in middle and later life (Matsushita et al. 2004; Tomkinson et al. 2019). It has also been reported that the early biomarkers of cardiovascular disease and other chronic health concerns have been observed among young adults, which suggests the need to consider lifestyle-related morbidity as a life course issue (Karmali & Lloyd-Jones 2013). To date, most studies of expectations regarding aging have been undertaken with cohorts over 45 years of age (Beser et al. 2012; Joshi et al. 2010; Kim 2009; Li et al. 2013), with comparatively less evidence reported among younger adults.

The Expectations Regarding Aging scale (ERA-12) is the most widely applied measure of health-related perceptions of aging, which has been validated in English, Chinese, Korean, and Turkish (Beser et al. 2012; Joshi et al. 2010; Kim 2009; Li et al. 2013; Menkin et al. 2017; Sarkisian et al. 2005). Research that utilizes the Expectations Regarding Aging construct (and the ERA-12 as a measurement tool) is most commonly undertaken within the disciplines of preventive medicine and clinical gerontology,

where the focus is on understanding potential precursors of long-term health-protective or health-risk behaviors or facilitating improved clinical service delivery for older adults (Davis et al. 2011; Joshi et al. 2010; Menkin et al. 2017). Studies of older and middle-aged adults using the ERA-12 have frequently identified negative expectations for aging on the overall scale as well as constituent physical, mental, and cognitive function subscales (Beser et al. 2012; Joshi et al. 2010; Kim 2009; Li et al. 2013). Among these cohorts, ethnic, gender, and occupational differences in expectations have also been reported (Davis et al. 2011; Menkin et al. 2017). Notably, only a cohort of middle-aged physicians from North America have shown comparatively high and positive expectations across physical, mental, and cognitive domains (Davis et al. 2011), which may indicate an important role for health knowledge in moderating expectations. Across all studies and cohorts, physical health and cognitive function expectations have been reported as considerably lower than expectations for mental health (Beser et al. 2012; Davis et al. 2011; Joshi et al. 2010; Kim 2009; Li et al. 2013).

Beyond research undertaken with middle-aged and older adults, two North American studies have explored the specific concept of health-related expectations regarding aging among younger people using the ERA-12 measure. These two studies employed modest samples of undergraduate gerontology and postgraduate medical students (Silver et al. 2016; Wiese et al. 2014). The results of these studies showed that younger adults held higher baseline expectations regarding aging than older adults, although the overall and subscale scores for expectations remained negative (Silver et al. 2016; Wiese et al. 2014). While studies of health-related expectancies related to aging are relatively scarce among younger adults, research into the more general construct of attitudes to aging is more common. The difference between the aforementioned concepts is that expectations regarding aging are self-referential (referring to personal anticipations about future self and experiences) in addition to providing general conceptualizations about older adults and aging and focused specifically on components of human health, whereas attitudinal studies are often oriented toward perceptions of others or society and address a broader range of psychosocial issues (Sarkisian et al. 2005).

The general construct of attitudes toward aging has been defined and measured in at least 10 different ways within the psychological and sociological literatures (see the Attitudes to Aging Questionnaire/AAQ, Anxiety about Aging Scale/AAS, Aging Perceptions Questionnaire/APQ, Aging Semantic

Differential/ASD, Kogan Scale, and others) (Barker et al. 2007; Kogan 1961; Laidlaw et al. 2007; Lasher & Faulkender 1993; Rosencranz & McNevin 1969). In contrast to expectations about aging (as measured using the ERA-12), the concept of attitudes to aging typically extends well beyond health to include such matters as fear of older people, physical appearance changes, wisdom development, received respect, stereotypes, matters relating to agism, and other issues (Iwasaki & Jones 2008; Kogan 1961; Lasher & Faulkender 1993; Rupp et al. 2005). Attitudes toward aging have been shown to vary considerably by country and culture, yet negative perceptions are often reported across a wide variety of domains and age cohorts (Holroyd et al. 2009; Löckenhoff et al. 2009). International comparative studies of younger adults have shown that, with the exception of a small number of geographic locations, there appears to be prevailing negative consensus regarding age-related reductions in attractiveness, capacity for everyday tasks, and capacity for learning (Löckenhoff et al. 2009). While attitudes to aging research provide a complementary area to expectations regarding aging, the latter concept is arguably more useful for elucidating specific health-related perceptions. Moreover, a recent systematic review of studies about perceptions of aging (broadly defined) identified the ERA-12 as among the top two (of 12 evaluated measures) most psychologically robust measures with a unique health-related construct in aging research (Faudzi et al. 2019).

Drawing on the Life Course Perspective and the current literature regarding aging expectations and attitudes, this research had two main objectives: 1) to explore health-related expectations regarding aging using the valid and reliable ERA-12 scale among a diverse cohort of university undergraduates in Japan and 2) to reveal subjective themes that potentially explain younger adults' expectations about later life and the aging process. The present research extends the existing literature on aging expectations in four important ways: 1) it represents the first time that the health-related concept of expectations regarding aging has been reported among cohorts in Japan; 2) it is one of only a small number of international studies to address expectations regarding aging among younger adults – assisting the development of a global evidence base; 3) it employs a concurrent mixed method approach that incorporates both quantitative and qualitative data – providing a more comprehensive perspective on perspectives about aging; and 4) it offers reliability and validity estimates for the ERA-12 with younger adult populations.

Methods

Design

A concurrent mixed methods design (QUAN-QUAL) was employed in this study (Creswell & Creswell 2017), which incorporated a valid and reliable scale augmented with open-format questions. This design permitted the collection of multiple data types, triangulation of findings, and an in-depth examination of the research issues (Creswell & Creswell 2017; Torrance 2012). An online survey methodology was employed to gather data from cohorts of undergraduate health students in Tokyo as this mode was considered to be both efficient and acceptable for technologically savvy younger adults. Data were collected using Google Forms, which respondents accessed during their discretionary time via a password-protected instance of Moodle 3.5 educational software.

Setting and Sample

The target sample included all undergraduate students (all subjects sampling; N = 202) who were enrolled in an English-language health science course at a bilingual Japanese university. The target university is one of only two completely bilingual tertiary institutions in Japan, so sampling the entire cohort of students enrolled in a compulsory health science course provided a relatively high level of representation of the growing number of students who participate in bilingual education. The setting was also chosen as enrolments included a relatively even split of English-speaking individuals who were born and educated in Japan and those who were born and educated in other countries. The unique composition of the program allowed the research to control for country of birth and prior education, potentially highlighting variations in aging expectations between Japanese and international students who have experienced a diversity of sociocultural conditions. The focus on bilingual and international students was also undertaken to reflect the changing demographics of Japanese society, particularly among younger age cohorts. All students who were enrolled in the course were invited to participate in the study between 2018 and 2019, and surveys were completed voluntarily (i.e. survey completion was not linked to course grade). Students were informed

of study aims and notified that submission of the online survey represented consent for the reporting of anonymized data. All respondents had native level or high English-language competence. This study was reviewed and approved by an institutional human research ethics committee (reference number 2017-23).

Measures

The ERA-12 scale was the primary data collection tool in this study. This measure was originally developed and administered by Sarkisian et al. (2005) in the United States. It has demonstrated acceptable reliability (α = 0.89) and validity (content, concurrent, and construct) among older and younger adults from several countries (Joshi et al. 2010; Sarkisian et al. 2005; Silver et al. 2016; Wiese et al. 2014). The ERA-12 contains 12 statements about aging and three subscales addressing physical, mental, and cognitive functions (Sarkisian et al. 2005). Each scale statement expresses negative sentiment about aging (e.g. *Having more aches and pains is an accepted part of aging; It is normal to be depressed when you are old*; and *Forgetfulness is a natural occurrence just from growing old*) and is scored on a four-point Likert-type scale (1 = definitely true, 2 = somewhat true, 3 = somewhat false, and 4 = definitely false). Following survey completion, students were asked a series of follow-up open-format questions to elicit more comprehensive understanding about their expectations. The questions were worded as follows: *In a few sentences, please describe what you expect that your health and life will be like when you are aged over 65 years*; *How, if at all, do you think you current lifestyle or behavior may affect your future health*; and *Is there any other information that you can provide that could explain your health-related expectations about aging?* Demographic information was also collected from respondents, including age, gender, undergraduate year-level, country of birth, and location of previous educational institution.

Analyses

Quantitative data were initially cleaned, and the distribution was investigated using the Kolmogorov–Smirnov statistic to determine the appropriateness of tests of significance. Internal consistency (Cronbach's alpha)

and construct validity (Principal Component Analysis factor loadings) were checked to ensure that the results conformed with internationally reported reliability and validity estimates. Scores were recoded based on the ERA-12 scoring protocol (Sarkisian et al. 2005). The protocol requires that an overall score (out of 48) and subscale scores (out of 16) be recoded into scores out of 100. Total ERA-12 and subscale scores were determined based on existing scoring protocols and previous research publications (Sarkisian et al. 2005). Independent samples *t*-tests were used to explore potential differences in overall and subscale scores related to cultural background and gender, while descriptive statistics were used to report other sample characteristics. A one-way analysis of variance (ANOVA) with post-hoc tests (Turkey HSD) was undertaken to identify potentially significant differences at the subscale level. The significance level for determining potential differences between groups was set at $p < 0.05$. All statistical analyses were conducted using SPSS (version 25).

Responses to the open-format, qualitative questions were analyzed thematically using QSR NVIVO software (version 12) and coresearcher collaboration (Lofland et al. 2006). A four-step analysis procedure was undertaken as follows: 1) categorical coding (organizing student comments into basic descriptive categories), 2) analytic coding (grouping categorical codes based on latent or underlying themes within the data), 3) memo and theme development (development of rich thematic descriptions of the emergent ideas), and 4) coresearcher verification of thematic descriptions and exemplar quotations. This process was based on other published reports of qualitative health research (Annear & Lucas 2018) and is often described in the literature as inductive thematic analysis (Annear & Lucas 2018; Lofland et al. 2006).

Results

In 2019, 133 health science students (66% response among 202 eligible students) completed the ERA-12, open-format interview questions and demographic questions. After cleaning and evaluation of the dataset (five duplicate cases were removed), ERA-12 responses were found to conform to a normal distribution (Kolmogorov–Smirnov = *ns*). The ERA-12 displayed acceptable internal consistency reliability ($\alpha = 0.80$) and construct (factorial) validity. Data from the PCA verified the presence of three

components (subscales) with eigenvalues exceeding 1.00, explaining 32% (physical health), 12% (mental health), and 10% (cognitive function) of the variance (54% cumulative variance), respectively, and corresponding to the originally published scale (Sarkisian et al. 2005). Loadings for component one (physical health) subscale ranged from 0.49 to 0.74. Loadings for component two (mental health) ranged from 0.51 to 0.75. Finally, loadings for component three (cognitive function) ranged from 0.43 to 0.84. Beyond the scale data, all participating students provided qualitative statements about their expectations regarding aging in answer to the open-format questions, which provided a large set of subjective data (≈5000 words of textual data). Among the sample, there were more female respondents consistent with enrolments at the target university. Slightly more than half of all students were born and educated in Japan. Demographic characteristics and ERA-12 scores are summarized in Table 1.

ERA-12 Scale and Subscale Scores

Across the diverse student sample, the mean ERA-12 overall score was 44.84 out of 100, indicating relatively negative health-related expectations regarding aging. Mean subscale scores were also computed, and only the mental health subscale showed comparatively positive expectancies regarding aging with large differences observed in relation to scores on the other two subscales. The data showed relatively positive sentiment in relation to expectations for mental health items (depression and loneliness in later life), but more negative expectations in relation to physical health (expectations for pain and functional impairment) and cognitive function (expectations for memory problems). The results of a one-way ANOVA confirmed that there was a statistically significant difference between the three subscales, and post-hoc testing revealed a large difference between the mental health subscale and the other two (physical and cognitive subscales), F (2, 398) = 78.364, $p < 0.001$, $\Pi^2 = 0.28$ (large effect) (see Table 1 for subscale means and standard deviation [SD]). At the item level, highest scores were identified in relation to the statement concerning time with loved ones, with majority of respondents holding the comparatively positive expectation that they will spend more time (not less) with family and friends as they age (M = 3.02; SD = 0.84). Lowest scores were related to the statement concerning physical breakdown (physiological entropy), with a

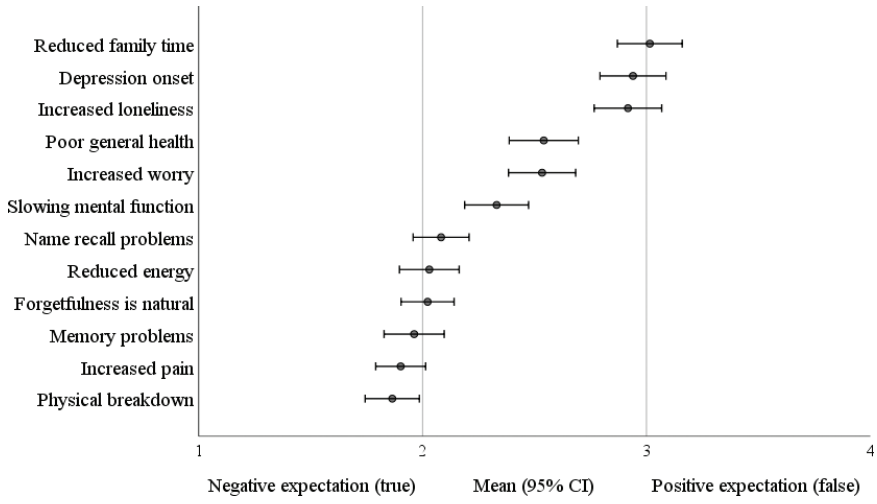
Table 1. Respondent demographic information and ERA-12 scale scores (N = 133)

Mean age (SD) and range	19 years (1.89); 11 years (17 – 28)
Gender, *n* (%)	Female, 87 (65%)
	Male, 46 (35%)
Birth country, *n* (%)	Japan, 74 (56%)
	USA, 28 (21%)
	China, 8 (6%)
	Other, 23 (17%)
High-school location, *n* (%)	Japan, 69 (52%)
	USA, 32 (24%)
	China, 9 (7%)
	Other, 23 (17%)
Academic year level, *n* (%)	First, 121 (91%)
	Second, 8 (6%)
	Third, 2 (1.5%)
	Fourth, 2 (1.5%)
ERA-12 scores (mean and SD/100)	
Total score	44.84 (14.70)
Mental Health Subscale (items 5–8)	61.71 (20.85)
Cognition subscale (items 9–12)	36.65 (18.55)
Physical health subscale (items 1–4)	36.15 (17.58)

majority of respondents holding the comparatively negative expectation that their body will inevitably wear out over time like a piece of machinery (M = 1.86; SD = 0.70). Item level scores are summarized in Figure 1.

Independent samples T-tests were conducted to evaluate potential differences in expectations based on gender and cultural backgrounds. These analyses revealed no significant differences between students who were born or educated in Japan and those who were born or educated outside of Japan in relation to either total ERA-12 score or subscale scores, $t(131) = -0.28$ to -1.62; p = ns. There were also no significant differences in terms of male and female students in relation to ERA-12 scores and

Figure 1. Mean ERA-12 item scores and confidence intervals (*N* = 133)



subscale scores, $t(131) = -0.27$ to -1.59; p = ns. These data indicate a relatively stable and consistent set of expectations regarding aging on the basis of both gender and cultural backgrounds. Age and year level were relatively similar across the cohort (88% of the sample were aged between 18 and 20 years and 91% were first year students), so tests of significance were not conducted with these variables.

Qualitative Statements

Students' subjective comments about their expectancies for health and life after the age of 65 revealed their underlying perceptions of the aging process. Following analytic coding and coresearcher verification, three themes emerged: 1) *lifestyle awareness*, 2) *health challenges and risks*, and 3) *transcendence of the physical body*. No negative or conflicting cases were identified during the analysis. Thematic explanations and exemplar student quotations are outlined later.

Lifestyle Awareness

Students within the sample expressed an understanding of the connection between health in later life and their current lifestyle behaviors. They considered factors such as personal knowledge, lived experiences, and regular habits as positive influences on their current health and held expectations of continued wellness as they age – so long as these behaviors were maintained through the life course. Moreover, some students also wrote about the importance of vicarious experiences of healthy aging from older role models, typically parents or grandparents, who showed that higher levels of physical and mental function are possible at older ages. Exemplar quotations from these students include the following:

> *I feel that I am going to be a relatively healthy person even when I age. From a relatively young age, I have been trying my best to practice habits that will keep my body in a healthy condition, including regular participation in sports and exercise.* (#90, Male, 18 years)

> *I want to remain active every day when I am older. I have seen two ends of the spectrum when it comes to aging, but I have certainly seen from my grandfather that moving about and doing something daily helps him stay mentally and physically healthy and less prone to illnesses.* (#111, Female, 18 years)

> *I plan to continue eating the healthy diet that I was raised on and have a regular habit at the gym. My dad is a personal trainer and nutritionist, so [because of his example and instruction] I am comfortable that I know how to live a life that will lead to good health in my old age.* (#103, Female, 18 years)

Health Challenges and Risk Factors

Some students within the cohort expressed negative expectations about their future health based on their current personal circumstances, family history of disease, or exposure to health risk factors. These issues were considered as limiting current health behaviors or creating future morbidity or mortality risks. Student viewpoints related to this theme were relatively frank and nihilistic in places, and references were again made to the power of familial experiences in shaping expectations about health in later life. Example statements from student participants included the following:

> *My family has a history with diabetes and thyroid issues. I currently have Hashimoto's Disease (my body is attacking my thyroid) and I know a big part of this came from my depression phase after my parents divorced.* (#48, Female, 21 years)

I think I will have been diagnosed with lung cancer by [65] because I [am exposed to] second-hand smoke a lot from my father, who has been a very heavy smoker for a long time. (#35, Female, 18 years)

I believe that I will succumb to the hereditary brain disease that runs in the males in my family and die at around 50–60 years old. I do expect to be relatively healthy mentally and physically until that age. If I do live to be older than 65, I believe my mental health will be in good condition, but my physical condition may be worse. (#89, Male, 18 years)

Transcendence of the Physical Body

While expecting inevitable declines in physical function to different degrees, some students expect to reorient their attention toward emotionally and psychologically rewarding experiences and behaviors associated with close relationships, hobbies, or education/learning activities. In some cases, students assigned more priority to psychological and emotional wellbeing in later life compared to maintaining health and mobility. These students articulated their personal and broad conceptualization of health that included loving and supportive relationships in the context of accepting physical limitations, pain, or illness. Student quotations that embody the concept of transcendence of the physical body include the following:

I hope to be a happy old man even though I may be suffering from some physical pain…To me, being socially and psychologically healthy is much more important than keeping myself physically healthy. (#129, Male, 19 years)

As I am not active, my body will probably be in poor health in later life…However, I have many hobbies, so I will hopefully continue to enjoy doing the things that I love even if I have health complications. I have no idea if I will ever get married, but if I do, I hope I will continue to have a healthy relationship with my partner even after I am old. (#59, Female, 18 years)

I expect my life as an older person to be as exciting as it is now. I think that growing old is part of a great adventure that we are all experiencing. At age 65, there is still a lot to learn as well as do whatever situation life brings me. (#97, Female, 18 years)

Discussion

The Life Course Perspective asserts that experiences in later life are closely linked to accumulated perceptions, behaviors, and sociocultural

conditions that begin early in life (Bengtson & Allen 2009). It is important to understand the expectations regarding aging that are held by younger adults as these may influence future morbidity, mortality, and quality of life via behavioral pathways (Lynch & Smith 2005). Such understanding may also inform the development of educational interventions, gerontology courses, and public health promotion that aim to increase knowledge about healthy aging and human life course. In this section, the results of the ERA-12 survey and open-format questions are discussed with reference to current literature and theories of aging. Research limitations and implications for gerontological education and health promotion are also considered.

Among the student sample, overall scores on the ERA-12 scale were slightly negative, which indicates that on balance, respondents generally perceive old age to be a difficult period of the human life course. Scores were consistent across gender and cultural background among the student cohort (i.e. no significant differences were observed), which suggests that there was homogeneity of expectations at least within the present sample. Overall ERA-12 scores were broadly similar to results reported in studies of graduate medical students and undergraduate gerontology students in the United States (Silver et al. 2016; Wiese et al. 2014). For example, Silver et al. (2016) and Wiese et al. (2014) reported ERA-12 mean scores of 45.86 (SD = 9.05) and 41.20 (SD = 13.70), respectively, among their student samples compared to an overall score 45 in the present study. However, the overall score identified in the present study was considerably higher compared to mean scores from studies of middle-aged and older adults from other countries, which have typically ranged from 23 to 38 (Beser et al. 2012; Joshi et al. 2010; Kim 2009; Li et al. 2013; Sarkisian et al. 2005). The similarity of overall score between the present cohort and studies of North American students suggests a possible trend for age-related declines in expectations regarding aging. It is possible that as people experience more health problems or functional declines with age that they reevaluate and revise their expectations for aging. It is equally plausible, however, that students in health-related education (including gerontological and medical and health science courses) may hold greater awareness or knowledge of the capacities of older adults, and this may explain higher expectancies compared to general cohorts of middle-aged and older adults.

At the subscale level, the pattern of response among younger adults in Japan exhibited both similarities and important differences compared to other age, regional, and professional cohorts who have completed the ERA-12. Specifically, significantly higher expectations for aging were found in relation to the mental health subscale (addressing items related to anxiety, loneliness, and depression) with a positive mean score of 62. These findings are distinct from other studies that have been conducted with younger adult cohorts in North America. For example, in the previous two studies that employed the ERA-12 among younger adults, mental health subscales scores were both in the negative range, with Silver et al. (2016) reporting a mean value of 48.86 (SD = 12.02) and Wiese et al. reporting 37.00 (SD = 17.50) (Silver et al. 2016; Wiese et al. 2014). In the present study, responses on the mental health subscale were the only result that showed relatively high and positive expectations. Comparatively lower and negative, expectancies were observed for the physical health and cognitive function subscales, which is consistent with responses reported in other populations – both younger and older (Joshi et al. 2010; Sarkisian et al. 2005; Silver et al. 2016; Wiese et al. 2014). Higher and positive scores on the mental health subscale identified in the present study are a novel finding that suggests that younger adults in our sample do not perceive a strong connection between aging and the onset or worsening of anxiety, depression, and loneliness. This result accords with other health research, which shows that across the life course mental illnesses are amenable to successful intervention and management (Windle et al. 2010; Wuthrich & Rapee 2013), and other findings that older adults are no more prone to mental health problems than other age cohorts (Kessler et al. 2010). Outside of a single middle-aged health professional cohort (Davis et al. 2011), our study was the only one to show comparatively high and positive expectations on any of the ERA-12 subscales.

Students' qualitative comments augmented and extended the quantitative ERA-12 results. In their response to open-format questions, many students wrote about their awareness of the connection between lifestyle behaviors and long-term health. In particular, students who had active and healthy parents or grandparents often reported positive expectations for their own future aging experiences, which suggests that family relationships, upbringing, or childhood environment may influence appropriate lifestyle behaviors and desirable quality of life outcomes. These positive

expectancies were balanced, however, by comments from other students who indicated that they were living with long-term health problems or that they have a family history of chronic disease or exposures to known risk factors (e.g. second-hand smoke associated with parental tobacco use), which they expected to reduce their health-related quality life as they age. Nihilistic perspectives about physical aspects of the aging process were commonly articulated, which supported negative sentiments identified in the quantitative ERA-12 data (i.e. comparatively low and negative scores on the physical health and cognitive function subscales). Across both the *Lifestyle Awareness* and *Health Challenges and Risks* themes, students indicated that familial factors influenced their health-related expectations, both positively and negatively. This aligns with social ecological theory and research on health behavior, which suggests that family relationships play a critical role in determining the health outcomes and behaviors of younger people via a range of pathways (e.g. role modeling health behaviors, passing on genetic risks, or creating a healthy or unhealthy home environment) (Sallis et al. 2015; Stokols 1992).

Beyond their expectations about the aging body, students also wrote about their anticipation of positive psychological experiences of later life regardless of their physical condition or functional declines. These students considered that their experience of aging could *transcend the physical body* and depend to a larger extent upon such factors as close relationships, meaningful hobbies, or educational activities. This perception reinforced results from the ERA-12 survey, wherein students exhibited high and comparatively positive scores on the mental health subscale (addressing issues of depression, anxiety, and loneliness). This is the first time that such results have been reported among a cohort of younger adults and corroborated across both quantitative and qualitative measures. Such perceptions are not commonly identified among younger adult cohorts, but they align with certain psychosocial theories of aging that emphasize the importance of reframing notions of self and individual capabilities away from physical attributes or function. Potentially related theories of aging include Gerotranscendence (Tornstam 2011) and Selective Optimization with Compensation (Baltes & Dickson 2001). Gerotranscendence is a gerontological perspective that is seen mostly among older adults as they transition from a materialistic and rationalistic conception of life to a more transcendent viewpoint where meaning,

relationships, and ego reduction become more important in daily life (Tornstam 2011). Selective Optimization and Compensation posits that successful adaptations to aging rely on accepting the limits of physical and mental resources, while reallocating personal resources and capacities in the pursuit of other meaningful goals (e.g. selecting social or educational opportunities due to functional losses and committing more personal resources to the pursuit of adapted or new interests that align with these selections) (Baltes & Dickson 2001). In support of both perspectives, students wrote about reorienting behaviors and interests to better accommodate expected functional or health declines, for example, optimizing one's time and energy on less demanding hobbies, learning opportunities, or relationships following some anticipated physical or cognitive declines. Thus, it appears that even with expectations for declining physical or cognitive function, younger adults in Japan are able to conceptualize a meaningful and rewarding experience of later life that is supportive of their mental health. Such perspectives hold promise for gerontological courses or life course health promotion strategies that seek to facilitate age positive views about the experience of growing older in developed societies.

Limitations and Future Research

While the present sample was not large enough to permit generalizability beyond the target site, the pattern of ERA-12 results (particularly the overall score) corresponds closely with international studies involving other age and regional cohorts. A larger follow-up study should be undertaken with a representative sample of younger adults from Japan, which could include the development and application of a validated Japanese-language version of the ERA-12 (which does not currently exist). Considering our unique findings for comparatively high and positive expectations for mental health and qualitative results concerning the transcendence of bodily challenges, follow-up qualitative studies of younger adults' perceptions about mental health and aging in Japan may be useful. For example, it may be helpful for future research to pose questions about how Japanese society potentially supports psychological adjustment to old age and whether there are any unique protective factors related to lifestyle or culture. Finally, as international administration of the ERA-12 expands

to different age and ethnic cohorts, it may be appropriate to conduct a meta-analysis to examine absolute differences in effects across diverse groups once an adequate quantum of data is available. If such differences are verified via meta-analysis (in relation to expectations about physical, mental, and cognitive health), it would provide powerful rationale for further global targeting or refinement of gerontological education and public health marketing strategies.

Implications for Health Promotion and Gerontological Education

Gerontological education and health promotion in aging societies like Japan should include content on experiences of aging from a number of perspectives, including physical, cognitive, and mental health. Considering the comparatively low and negative expectations concerning physical and cognitive health reported in the present study (and some other international reports), it is advisable to include balanced content about the physiological capacities and potential of older adults as related to the concept of normal aging. It is well known, for example, that major cognitive decline in later life is related to disease processes (such as Alzheimer's Disease), rather than changes attributable to normal aging (Andersen-Ranberg et al. 2001). The promotion of lifelong health in Japan among younger cohorts should also demonstrate evidence for the connection between lifestyle behaviors and reduced risk of chronic disease, disability, and frailty, which has been well established in the international literature (Chodzko-Zajko et al. 2009; Fries et al. 2011). While many students are aware of this connection, others hold negative and nihilistic views about aging and their future health state based on their present and familial experiences, which should be challenged through education. A focus on emotional and mental health should also support a holistic and transcendent view of aging, which emphasizes how later life can be a positive experience even in the context of declining or changing health.

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International Journal of Ageing and Later Life, 2022 16(1): 25–48 © The Authors
doi: 10.3384/ijal.1652-8670.2234

Perceptions of a good life for the oldest old living at home

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Abstract

An increasing number of people are growing older and living longer in their homes. This study aims to describe key stakeholders' (politicians, managers, and professionals) perceptions of a good life for single-living oldest old persons living at home with extensive needs for support. Interviews with stakeholders were analysed with content analysis. The analysis resulted in the theme: An incongruence between intentions and actions in promoting a good life for the oldest old. Our findings show a gap between intentions and actions, which caused feelings of powerlessness in the key stakeholders. To promote a good life for the oldest old persons, a congruence is needed between individual awareness and the prerequisite of promoting a good life. Developing methods that identify and bridge gaps between intentions and actions could support the abilities of organisations to promote a good life for the oldest old persons with extensive needs for support.

Keywords: ageing in place, capabilities approach, caring, homecare, oldest old.

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Introduction

The number of people in Europe aged 65 years and older is expected to increase until 2060 (Rechel et al. 2013), and the number of people aged 80 years and older (often referred to in the literature as the oldest old) in Sweden will increase from half a million in 2018 to one million in 2040 (Statistics Sweden 2017). Even though it is important to note that the oldest-old age group is characterised by a high degree of within-age variability (Stone et al. 2017), conditions related to outcomes such as low physical activity, slowness, exhaustion, weight loss and weakness are considerably more prevalent in the 80+ age group compared to the entire group of 65+ community-dwelling older adults (Collard et al. 2012). Furthermore, belonging to the oldest-old age group is associated with an increased risk of adverse events such as falls, institutionalisation, disability and compromised mobility, which constitute a major concern for the individual as well as society (Buckinx et al. 2015).

The ageing population imposes higher demands for better and more effective health and welfare systems (World Health Organization 2012). Providing possibilities for older persons to remain in their homes as long as possible is one strategy to meet the demographic challenge and reduce the cost of institutional care. Therefore, the concept of ageing in place is central in ageing policy and favoured by many older persons (World Health Organization 2007). In Sweden, elderly care has been provided by larger institutions since around 1950 and in small-scale, home-like environments since around 1990 (Brink 1990). Since the 2000s, policies have been gradually developed towards providing the opportunity to age in one's own home (Vasunilashorn et al. 2012).

The development of the policy towards ageing in place is not just about meeting the demographic challenge and reducing costs. It has also been described as supporting the older persons' well-being through the sense of belonging the home can entail (Almevall et al. 2022; Board & McCormack 2018; Vasunilashorn et al. 2012; Wiles et al. 2012). Being able to remain in one's own home has been described as related to independence, autonomy, security, connection and familiarity (Wiles et al. 2012). It has been argued that the home contains the most central aspects of human life (Kelly 1975).

The home is considered to contain physical, social, behavioural, cognitive and emotional aspects (Oswald & Wahl 2005) and has been described as a symbol of the self, a place where social and cultural identities become stated and stabilised (Dovey 2005). Nevertheless, expectations to remain at home despite increased frailty can be challenging and difficult (Iwarsson et al. 2007), especially for older persons with complex health problems and an extended need for support. The need for home modification and support, as well as a sense of isolation, has been pointed out by older persons as barriers to remaining at home and ageing in place (Martin et al. 2019). It has also been described that in relation to younger people, older people have fewer demands in the process of requesting care (Gautun & Grødem 2015) and may lack the opportunity and choice to decide where to live (Wiles et al. 2012), which can be crucial when health problems and care needs are increased.

In Sweden, the Social Services Act (2001) regulates the responsibility of municipalities regarding the older persons right to well-being and independence, with access to an active and meaningful existence in society with others. Older persons can apply for assistance from home help services funded by the municipality and carried out either by private or municipality-based carers. The extent of assistance is based on assessments of need and can cover all hours of the day. This means many older persons with extensive need for care can remain in their homes throughout life (Swedish Institute 2021). Examples of extensive needs for support at home include assistance with mobility, personal hygiene, food preparation, medication, oral care, social interaction, as well as more advanced interventions that carried out by healthcare staff. The older person in the focus of this study needed support from home care staff, with at least four and up to eight visits every day, evening and/or night.

The consequences of the demographic situation affect politicians (Evertsson & Rosengren 2015; Finnbakk et al. 2012) and top managers (Finnbakk et al. 2012), who express worries about the possibility of providing good elderly care based on individual needs in the face of scarce resources. A study of decision-makers' assumptions, norms and priorities found that assumptions regarding needs in different life phases risked the allocation of resources, affecting how resources were used, rather than the needs of the older persons (Finnbakk et al. 2012).

Gautun and Grødem (2015) showed that arguments should be made more explicit about older persons needs in different life phases.

There are different models and definitions of a good life. Nussbaum's capability approach holds areas about what a person should be granted access to in order to live a good life. The approach (Nussbaum 2011) describes ten capabilities all humans, regardless of age, function, cognitive disability or gender, need to access in order to live a good life. They address the importance of being able to live to the natural end of one's life, having good health, maintaining integrity and the ability to move from place to place. They also highlight the significance of being able to use one's senses, imagination and thinking (including enjoying pleasurable experiences), and having emotions and emotional attachments to things and people outside oneself. The capability approach stresses the necessity of having access to the use of practical reasoning, being able to engage in critical reflection about planning one's life and maintain social affiliations that are meaningful and respectful. Finally, they stress the importance of being able to live with concern for other species and nature, having opportunities to laugh, play and enjoy recreational activities, and having control over one's material and political environments (Nussbaum 2011).

According to the Nussbaum's capability approach, a good life requires that a person is able to be and do things according to what he or she wants in life. A good life is connected to equality, well-being and justice and contains capabilities considered central for a good life. Furthermore, the capability approach has been suggested for political planning (Nussbaum 2011), such as in social welfare (Evans 2017). The capability approach has been used in research regarding ageing in place (Grove 2021), informal caregiving for older persons (Horrell et al. 2020), person-centred care (Entwistle & Watt 2013) and for persons with dementia living in their own homes (Tellez et al. 2016). The capability approach has also been found appropriate to use by those who deliver care in local elderly care settings to promote dignity in the persons receiving care (Pirhonen 2015) and the care of persons with dementia (Melander et al. 2018).

Compared to younger age groups, persons aged 80 and over living at home with support often have a reduced network of friends and family. Therefore, the needs of the oldest old persons may also include different or additional areas compared to younger counterparts. The oldest old persons also often depend on more social services and providers.

Municipalities are responsible for the social services and care of older people at home, and politicians, managers and professionals in the municipality are obligated to provide support to older persons in accordance with the Social Service Act. As such, they can be considered key stakeholders in enabling a good life for the growing group of oldest old persons living at home with extensive needs.

To our knowledge, there are no studies on how key stakeholders perceive a good life for persons aged 80 and over living at home with support. Therefore, the aim of this study is to describe key stakeholders' perceptions of a good life for single-living oldest old persons living at home with extensive need for support.

Methods

Design

This study has a qualitative design. Focus group interviews (FG) were used for data collection (Morgan 1997), and data were analysed by a qualitative content analysis (Graneheim & Lundman 2004).

Participants

This study was conducted in a municipal organisation for elderly care in a medium-sized city in the north of Sweden. The participants were key stakeholders at different levels in the organisation: politicians responsible for opinion formation, exerting influence over public decision-making; managers responsible for assistant nurses in home care service; social service officers assessing the need for support for people in home care; district nurses responsible for nursing in home care; and physio and occupational therapists responsible for rehabilitation.

A purposive sample of 28 key stakeholders participated in this study. Inclusion criteria were at least 2 years of experience in the municipal organisation for elderly care and a willingness to participate. An administrator in the organisation served as a contact person for recruiting the participants and distributed verbal and written information about the study and the information letter to those who met the inclusion criteria. All persons asked agreed to participate. An overview of the focus group

Table 1. Overview of participants in the focus groups

Focus group	Age (Y)	Experience (Y)	Number of participants	Key stakeholder
District nurses	35–47	2–11	5	Patient care
Occupational therapists and physiotherapists	48–62	3–20	7	Patient care
First-line managers	31–59	4–12	7	Management
Social service officers	47–59	10–22	5	Management
Politicians	59–69	6–10	4	Political

participants is presented in Table 1. The participants were key stakeholders at three organisational levels: political, management and care practice.

Focus group interviews

Data were collected by focus group interviews in order to generate rich data through group interaction in a permitting climate (Morgan 1997). Focus groups were conducted to generate broad data and insights on the specific phenomenon by using the interaction in the group (Morgan 1997). The participants were divided into five focus groups, with four to seven participants in each group. Four focus groups were divided by profession, except the fifth group which consisted of a mixed group of occupational therapists and physiotherapists (Table 1).

According to Morgan (1997), three to five groups are generally sufficient for data saturation, as more groups seldom provide new insights. Furthermore, he states that the number of participants is determined by their level of knowledge of the topic, and he recommends four to six participants in each group. In our study, all participants were experienced in providing care to older persons at home, and the number of participants in each FG was considered sufficient. The groups were designed to create the conditions for in-depth understanding, which is recommended when participants have a lot of experience to share (Krueger 2014).

As for the researchers carrying out the FG, one had experience in clinical work in home health care and strategic work within the organisation. The others researchers came from outside the

organisation and had clinical and research experience in various contexts of care. The mix of researchers being based inside and outside the elderly care organisation provided conditions for a critical approach to pre-understanding and inside knowledge. To increase the dependability of data, the first author moderated all focus groups, the other authors took turns participating in the FG to assist and provide summaries of the interviews. An interview guide was utilised to ensure the same questions were asked in all five focus groups. However, new aspects of the subject can occur during the data collection process in this type of research and influence follow-up questions (Graneheim & Lundman 2004). The researcher encouraged the participants to discuss the given topics freely rather than following a chronological order of the interview guide (Morgan 1997).

An interview guide (Table 2) was used based on the capabilities approach (Nussbaum 2011). The interview guide was developed by the research group and tested on two occasions. The capability approach was used as a tool to expand the discussion about what a good life for older people meant to the key stakeholders. Initially, the participants and researchers presented themselves. Before the focus group began, the researchers introduced the concepts: oldest old person, single-living, extensive need for care and the capability approach.

First, a broad question was asked: "Please, tell us your view of the conditions demanded for the single-living, oldest old with extensive need for support in order to live a good life at home". Thereafter, questions related to the capabilities were asked, such as having basic needs met, showing and receiving love and gratitude, discussing and reasoning with others, and engaging in activities that are interesting and fun. Clarifying questions were asked to enhance the dialogue, including "Give an example", "What do you think about that" and "Tell me more about it". Some capabilities of the oldest old persons, such as discussing and reasoning with others and being able to be creative, spontaneously arose without needing prompting from the interview guide.

The interviews were conducted in Swedish. Each focus group discussion ranged from 81 to 94 minutes and was digitally recorded and transcribed verbatim by the first author.

Table 2. Focus group interview guide

Opening question
Please share your views of the conditions demanded for single-living older adults with extensive need of support, in order to be able to live a good life at home
Topical question themes
• Life and basic needs
• Integrity and safety
• Creativity and thinking
• Emotions and close relationships
• Love and gratitude
• Planning one's life
• Fellowship with others
• Living in relation to animals and nature
• Enjoying activities and having fun
• Control over one's own environment
Follow-up questions were asked, such as *Give an example* and *Tell me more about it*

Data analysis

Data were analysed using qualitative content analysis with a deductive approach (Graneheim et al. 2017) and uploaded into the qualitative analysis software package NVivo (QSR International 2014).

The transcribed interviews were read several times to get a sense of the material as a whole. Meaning units (words in a sentence or several sentences) related to the aim were extracted and condensed, that is, shortened without loss of the core message. The condensed meaning units were coded and compared regarding differences and similarities in several steps and sorted into categories, which constituted the manifest content.

Since the FGs were organised to catch possible similarities and differences between the various types of key stakeholders, the codes between the groups were compared, as were the identified categories. However, the findings turned out to be similar regardless of whether

the interview data represented expressions from the political, management or care practice level of the organisation. Therefore, it was decided not to go any further with the analysis related to organisational representation in the groups and continue to analyse the deconstructed material as a whole.

The categories were then further analysed guided by the capability approach. This resulted in four subthemes. The subthemes expressed the content of the categories at a higher interpretative level. Thereafter, the subthemes were discussed several times amongst the authors, and a theme was formulated expressing the researchers interperetative meaning of the subthemes (Graneheim & Lundman 2004; Graneheim et al. 2017).

Study context, selection, characteristics of the participants and the analysis process have been described in order to facilitate transferability. During the analysis process, the connection between data and findings was confirmed by going back to the original text to verify that no content was missing, which improved dependability. Finally, the findings were compared and discussed with all authors until consensus was reached in order to strengthen the credibility and confirmability of the findings (Graneheim & Lundman 2004).

In the findings, quotations are used to illustrate original statements and strengthen dependability (Graneheim & Lundman 2004). The quotes are labelled with a number, as are the key persons (e.g. P1 and FG1) to show that quotes represent all five FGs and various persons.

Ethical consideration

This study was approved by the Regional Ethical Board in Umeå, 2015-10-12 (No. LTU-2706-2015). Participants received written and verbal information about the aim of the study and approach. They were informed that their participation was voluntary, and that they could withdraw from the study at any time without disclosing why. The participants were assured confidentiality. All participants were instructed to contact the researcher if they had questions or concerns. Grouping FGs by profession would allow for open discussions with others with similar experience and prevent discussions from being inhibited by eventual hierarchical structures.

Table 3. Overview of the identified theme and subthemes

Theme	Subthemes
An incongruence between intentions and actions in promoting a good life for the oldest old	Striving to promote integrity whilst being occupied with handling unfulfilled needs
	Striving to promote meaningful relationships whilst being aware of loneliness
	Strengthening identity through activity whilst ensuring safety and security
	Striving for support adapted to the older persons needs whilst dealing with shortcomings in accessibility

Findings

The findings consist of one theme and four subthemes (Table 3) describing key stakeholders' perceptions of a good life for the single-living oldest old persons living at home with extensive need for support.

An incongruence between intentions and actions in promoting a good life for the oldest old

The participants described a good life for older persons as promoting integrity, familiarity, strengthening identity through activity and being offered adapted support. They described their own and the organisation's intentions to promote a good life for older persons. In contrast to these intentions, contradicting descriptions related to daily challenges were revealed, such as caring actions being dominated by dealing with limitations, loneliness, uncertainty and lack of accessible support in the daily life of the older persons with the highest level of home care. The contrasting descriptions in the results are interpreted as an incongruence between intentions and actions to promote a good life for oldest old.

Striving to promote integrity whilst being occupied with handling unfulfilled needs

Participants described that promoting integrity was a vital part of a good life for older persons. Integrity was considered to be promoted when the

older person was given opportunities to feel self-confident, valued and confirmed as a person. The participants emphasised the significance of paying attention to each person's life story and inner abilities, such as courage, motivation and attitude, to support their integrity. However, they described that the older persons were not always adequately acknowledged by staff and society, which could hinder them from feeling appreciated and valued.

When numerous professionals gave support, the participants felt that the self-reliance and integrity of the older persons were threatened. Numerous professionals visiting could create feelings of insecurity and unease for the older person, which sometimes affected their opportunities to participate in decision-making concerning their need for support.

> P2: Someone [from the staff] who sees the older person and confirms them can lead to feelings that someone is interested in them, which is important. I do not think that the staff is uninterested in the older person's life, but they do not have time to do more than just the most necessary things. The older person gets stressed as the staff's visit has to go hastily instead of them feeling acknowledged and having time with the staff. (FG 3)

Participants described opportunities to keep caring for the home and continue with previous routines as important for the integrity of the older person. Small support efforts were considered crucial for the older person's independence as well as for maintaining and improving their abilities. Providing opportunities for the older person to take care of their home together with staff was described as contributing to their self-confidence and influence over their daily life. However, the participants described that the opportunities for independence sometimes collided with the need for help in daily life, which was perceived as an obstacle to maintaining a good life.

Participants described that the opportunity to make decisions about everyday life was part of a good life. Decision-making was considered difficult, as the older person sometimes lacked the ability to express their needs, due to, for example, hearing- or cognitive impairment. This leads to difficulties in finding a balance between supporting the older person in making decisions and deciding for them. Allowing the older person to make all decisions was regarded as leading to a lack of safety for them.

P1: Relatives have told us that we have to go in and fix this [medication] because they think she [their mother] cannot handle it…However, when we checked the drug list, everything was correct. It is often the relatives' worries that make us go in and take over.

P3: Relatives' fear.

P5: Yes, it is clear that it is about being confident that nothing will be wrong. Maybe it is both about protecting the older person and ensuring that we have a responsibility, as they are acting as if it is a kind of uncertainty.

P2: I had a case where a man had a pill organiser and went over the dosage package, as he took medicine several days in a row. Then family members wanted us to lock it in… The man became furious and broke it, as he wanted to take care of his medicine himself, so we went back to the pill organiser, and then it worked well. (FG 5)

Striving to promote meaningful relationships whilst being aware of loneliness

The participants described a good life for the oldest old as having meaningful relationships. The relationships with staff provided attention and closeness, which created an opportunity for the older person to feel love and happiness, which, in turn, created a sense of meaning. Pets were also emphasised as providing closeness and joy. The opportunity to shift between solitude and togetherness was described as part of a good life. Participants described that healthcare providers could play an important role in supporting and encouraging the older person to enjoy fellowship with others. However, they expressed concerns for the older person who lacked families and friends and those who did not want to socialise in groups.

P15: But just to have something to look forward to, so that the older person knows that they have something planned for the week…To have fun, and not just be at home where nothing else happens other than the visits by home service.

P13: Also, for the relatives, it is important to know that their older family members can enjoy and have something to do and not just sit there alone in their apartment day in and day out.

> P17: Absolutely, it matters; they feel better from social interaction. Just to help them go somewhere, meet others, do things with others and break up this grey, everyday life is very important for recovery and capability. (FG 1)

Participants described feelings of powerlessness when the older person lacked family, friends or other close relationships. The participants wished they could give older persons the opportunity for social interactions and time with staff or the opportunity to find new relationships outside the home. Not being able to do this meant they felt unable to promote meaningful relationships amongst those who lived alone and lacked contacts outside the home.

> P17: I think that for the older persons who are sitting alone at home, the staff is their whole world, while the staff may see the visits as short work efforts. (FG 2)

Strengthening identity through activity whilst ensuring safety and security

Participants perceived a good life for older persons with extensive needs as retaining the older person's identity through continuing with previous activities. With its associated relationships and interests, the home and neighbourhood were a prerequisite for maintaining activities the older person had done throughout their life. Household chores, playing cards, socialising with peers or maintaining the home were considered vital for a good life.

The possibility to go outside and experience nature, visit city surroundings, stores and/or healthcare facilities was perceived as important for a good life. The participants described that it was important for older people to live in a familiar environment that supports their identity, personality, relationships and life history. A good life for older persons was described as one in which they can have fun and be active. Participants stressed the importance of the older person having events and experiences to look forward to, which could maintain and increase a positive sense of ageing. Activities for older persons were described as important, but participants described a lack of resources in the organisation to support this.

> P28: I have an example from an older person with paralysis of one side of his body. He had home help service, and the staff said that they could not be held responsible because he risked falling in the home, so the relatives wrote a power of attorney that they take responsibility if something happens to him. He lived the rest of his life at home. The relatives said that if he had been forced into a nursing home, he would have lost his life, his freedom.
>
> P27: Can the home help service say that they can take care of the older person but not take responsibility? Was the home not adapted for his needs?
>
> P28: As the facilities were not so modern, they [staff] washed him and his clothes in the sauna. He got food deliveries every day, and he actually had everything he needed. (FG 4)

The home and neighbourhood were described as a place where activities were available on the terms and interests of the older person. The home was described as essential for continuing with previous activities. However, the home and neighbourhood were also described as unsafe and associated with a potential risk of injury for those with declined ability. Simultaneously, the participants stated that it was important to follow the wishes of the older person and accept possible hazards at home.

Striving for support adapted to the older person's needs whilst dealing lack of accessible support with shortcomings in accessibility

Participants described that a good life for older persons required being offered support adapted to their needs. This was facilitated by flexible assessments of the home environment, the possibility to be spontaneous in activities and being involved in the support given to them. This adapted support could also prevent the older person from the feeling of being a burden to others. However, the participants perceived that the older person's wishes to demonstrate independence during assessments by exceeding their actual everyday capacity could hinder an evaluation that would provide adequate support. Participants described feelings of shame and frustration when the conditions were not adapted to the needs of the older person as they felt that they as key stakeholders should do better to provide good conditions.

According to the participants, a good life for older persons meant having access to a diverse team of professionals who understood their complex needs and worked together accordingly. Support needed to be appropriate and sustainable to provide safety, which was created through cooperation and the professional's individual responsibility. Adapted and adequate support was only possible when there was access to staff who reacted quickly to changes in the health status of the older person. A lack of communication between professionals regarding the older person's needs was perceived as hindering a good life for them.

> P10: You see how intertwined everything is and that everyone has to go hand in hand and work in teams in order to support the older person. (FG 5)

A good life for older persons was described as including support to relatives. In the planning of support, participants stressed the importance of relatives who knew the person well. However, they also described relatives as sometimes demanding different supports than the older person wanted. To give support based on older persons needs, participants stated that staff needed to increase their knowledge about diseases and how they affect the health of the older person. Increased competence amongst the staff could facilitate their ability to understand the significance of adapted support for the older person.

> P22: Home service makes visits six times a day, but there is no continuity of staff. I do not know how many different staff the older person meets in a week. If they have a cognitive disability, it is chaos for them… just the feeling of knowing somebody is coming into their home, but not knowing who it is, and if it is someone they recognise. (FG 3)

In order to enhance the feeling of security for the oldest old, the participants expressed that adapted support should be provided according to the timetable by staff familiar to the older person, which is not the case today.

Discussion

This study explored key stakeholders' perceptions of a good life for single-living older persons with extensive needs living at home. From the participating key stakeholders' perspective, a good life for older persons was understood as promoting integrity, familiarity, strengthening identity through activity and being offered adapted support.

The key stakeholders had a clear view of a good life. On the one hand, they described an intention to promote a good life; on the other hand, they described an organisation preoccupied with handling unfulfilled needs, loneliness, a shortcoming in accessibility and insecurity at home. This expressed duality was interpreted in the result as an incongruence between intentions and actions, a clash between the ideal and the real. The findings reflect a situation where home care for those with the most extensive need and support, out of necessity, mostly focused on basic needs, hence limiting possibilities to promote a good life for older persons.

Our findings show that a good life for older persons was seen as related to a sense of meaningful relationships. However, key stakeholders described how older persons often lacked close relationships and the possibility to shift between solitude and togetherness. Loneliness as a hindrance to a good life for older persons was also described in a study of nurses' perceptions that shows the importance of establishing long-term relationships and balancing the need for independence with a feeling of loneliness (Carlson et al. 2014).

Tuominen & Pirhonen (2019) showed that close relationships were important for a good life for older persons, whilst loneliness was described as imprisoning and an overwhelming feeling of emptiness. According to Nussbaum (2011), people live with and for others, and life without this is not a worthy life. In our study, key stakeholders felt powerless when unable to support and enable social interaction and closeness for older persons, which we interpret as an inability to support what Nussbaum refers to as affiliation.

According to key stakeholders in our study, another aspect of a good life was integrity related to opportunities for older persons to make independent decisions about their everyday life. Findings illustrate difficulties in balancing and promoting the older persons' own decision-making and the perceived need to decide for them. Continued independence in

chores and activities was recognised as key to the older persons daily life. This balance was described in the presence of identified risks associated with living alone. Similar perceptions have previously been described amongst physiotherapists, occupational therapists and social workers (Hjelle et al. 2018).

The expressed perceptions about decision-making in this study could be related to Nussbaum's capability of practical reasoning (Nussbaum 2011), which entails the capability to form a conception about the good and critically reflect on decisions about one's life. In some cases, the key stakeholders' actions limited the older persons possibilities to take these steps. However, the key stakeholders had to choose between actions where neither of them fully supported the self-government of the oldest old when it could entail potential risk for danger and self-harm. Key stakeholders expressed that the independence of the elderly often needed to be negotiated to fulfil the organisation's responsibilities for older persons safety.

The identified incongruence between intentions and actions in this study indicates deficient conditions for promoting a good life amongst older persons. In situations with deficient conditions, Nussbaum (2011) suggests supporting two specific capabilities that promote other capabilities: affiliation and practical reasoning.

Affiliation is related to the capability of living together, showing concern for others and being part of social interaction and friendship. Practical reasoning is related to the ability to be engaged in planning one's life (Nussbaum 2011). Related to the findings in our study, it seems that the capabilities of affiliation and practical reasoning are involved in several of the identified aspects of a good life.

The incongruence that is central in our study can be interpreted as the key stakeholders being confronted with a tragic choice (Nussbaum 2000; 2011), which has been referred to as a way of understanding various caring situations for older persons (Horrell et al. 2020). A tragic choice occurs when no present alternative agrees with a person's moral values. The person will then need to either ignore or acknowledge that such a choice has to be made. The nature of a tragic choice is that all available options involve a moral conflict.

By acknowledging a tragic choice, the focus is maintained on the fact that one is acting against their moral values in the current situation,

but this acknowledgment can have the potential to create conditions for future actions. To create such change in conditions, supportive capabilities must be possible to add to the scarce resources available (Nussbaum 2011).

In our findings, the incongruence between intentions and actions in promoting a good life for older persons seemed to reveal a stalled process in distinguishing the threshold between the most supportive capabilities and, by doing so, identifying the best course of action. By developing an understanding of affiliation and practical reasoning as supportive capabilities, a good life amongst the oldest old with extensive need for support could better be facilitated.

The capability approach has been suggested to strengthen the focus on human well-being in social work (Evans 2017) but is also noted as being excessively optimistic about what society can do for its citizens (Hugman 2008). Our findings show a gap between intentions and actions, which seemed to release feelings of powerlessness in the key stakeholders. The feelings of powerlessness were prominent, regardless of whether participants worked at a political level, as managers or in patient care.

The incongruence in this study shows similarities with a study of social workers' professional ideals (Hendriks et al. 2016). Findings in this study show an incongruence between the ideal and the real, and in Hendriks et al. (2016) findings, amongst others, a powerlessness connected to the professional ideals and the hindrances that surround it.

Powerlessness has been described as the expectancy or probability that one cannot determine the outcome one is striving for (Seeman 1959). Sharing perceived powerlessness is important for the process of dealing with value conflicts (Grönlund et al. 2016). The importance of inter-professional support to cope with ethical issues is common in clinical care (Molewijk et al. 2008). Relating to the findings in this study, ethical support could be reasonable to implement in care settings within municipalities involving politicians, managers and care personnel. Such interventions could be used to support reasoning towards a new, common understanding to increase the ability to identify the best place for action and thereby promote a good life for older persons.

Our findings of key stakeholders' perceptions of a good life for older persons include integrity, familiarity and identity as well as facilitating

adapted support, all relating to different aspects of living at home. Living at home relates to the concept of ageing in place and is part of ageing and welfare policies in many countries. Ageing in place refers to the ambition to provide opportunities to grow old in one's home and community instead of in residential care (Davey et al. 2004). The meaning of ageing in place is considered important for security and familiarity (Wiles et al. 2012). A disadvantage of an ageing-in-place policy might be that older persons are expected to remain at home despite their possible frailty and need for care (Iwarsson et al. 2007).

Our findings show that it is important to learn more about the organisation giving support to older persons with extensive need for support and to develop methods that promote a good life for them. Such methods should not only consider basic needs but also evaluate capabilities and prerequisites for a good life, and, of course, the care organisation's possibilities to promote the good life. This knowledge can increase the opportunities for older persons to enjoy the benefits of being at home and age in place and prevent the physical home from turning into an experience of homelessness, with dimensions of detachment and captivity (Zingmark 2000).

Conclusion

This study reveals an incongruence between intentions and actions in promoting a good life for oldest old. The incongruence causes feelings of powerlessness amongst key stakeholders at different levels of the organisation. To promote capabilities and a good life for older persons with extensive needs, a congruence is needed between the key stakeholders' individual awareness and the prerequisite of promoting a good life and the organisation's ability to support this endeavour. In the case of older persons with extensive need for support at home, it seems essential to identify methods to promote a good life for them. Such knowledge is important for both the older person and the organisation to identify and bridge the gap between intentions and actions in the promotion of a good life.

Acknowledgements

We would like to thank all participants for their contributions.

Ethical approval

This study was approved by the Regional Ethical Board, Umeå, Sweden 2015/338-31Ö.

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International Journal of Ageing and Later Life, 2022 16(1): 49–73 © The Authors
doi: 10.3384/ijal.1652-8670.3540

A home, an institution and a community – frames of social relationships and interaction in assisted living

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Abstract

Assisted living facilities are presented as the older person's home but, at the same time, defined by institutional and communal characteristics. Using Goffman's (1974/1986) concept of frame, we aim to find out how home, institution and community frames define social roles and shape social relationships and interaction in assisted living facilities. Directed content analysis was used to analyse the data consisting of observations, one group discussion and ten individual interviews with residents in an assisted living facility. We found that the home frame was characterised by meaningfulness, spontaneousness and informality of social relationships and interaction, whereas the institution frame by indifference and formality of them. Acknowledging and tolerating other people was not only central in the community frame but also dissociating oneself from some people. Frames can shed light on how different interpretations of the

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multifaceted social environment of assisted living affect homeliness of the facility and well-being of the residents.

Keywords: assisted living, frame analysis, home, social interaction, social relationships.

Introduction

Population ageing and the high costs of institutional long-term care have resulted in a growing commitment in many Western countries to ageing in place policies that allow older people to stay at home as long as possible (Genet et al. 2011; OECD 2005). The care of older people has therefore increasingly shifted from institutional settings to private homes or other home-like environments. This shift has also been evident in Finland where home care, informal care and housing services have increased at the expense of institutional care (Anttonen & Karsio 2016). In 2000, 12.6% of the Finnish population aged 85+ lived in nursing homes, and by 2019, this share had dropped to 1.5%. At the same time, the number of clients in sheltered housing with 24-hour assistance rose from 3.6% to 15.9% (National Institute for Health and Welfare 2021).

Assisted living – also called sheltered housing or service housing – consists of many different ways to organise housing and care services for older people. In Finland, *assisted living with 24-hour assistance* provides housing and care services for older people with the greatest care needs, such as those with dementia. Skilled care staff is available 24 hours a day, and residents' needs are similar to those in institutional care. *Ordinary assisted living* is intended for those older people who have less care needs but who, due to deteriorating health and/or functioning, are unable to live in their private homes. However, the care needs of older people also in this type of housing have become more and more intensive, calling for 24-hour assistance. Residents in both these types of services have their own rented apartment or room in the facility and pay separately for services they require. (Kröger 2019.) *Service centres*, then, can provide ordinary assisted living and assisted living with 24-hour assistance and also offer some of their services to (older) people living outside the facility. Such services include, for example, meals, guidance from a care professional, and events and social activities in the facility. The facility in focus in this

study falls under the service centre category, but for clarity, we use the more general term assisted living facility (ALF).

The main distinguishing feature of ALFs compared to such institutions as nursing homes is their home-likeness: ALFs have a less medical and institutional appearance than nursing homes (Roth & Eckert 2011). ALF residents can, for example, bring their own furniture and other belongings to their apartment or room. ALFs are also supposed to uphold the self-determination of residents and to provide more person-centred care than institutional settings (Pirhonen 2017). As ALFs, at least in policy papers, are considered to provide home-like environments, it is also necessary to approach social relationships differently than in traditional institutional environments. More attention must be given to how social relationships are structured by the socio-physical environments of ALFs. Research shows that social relationships are critical to the way that residents perceive ALFs (Cutchin et al. 2003; Lewinson et al. 2012; Roth & Eckert 2011). Roth and Eckert (2011) point out that although ALFs are formally designed as home-like environments, it is the residents and the staff who shape the facility into what it actually is. For example, private spaces in the facility become contested and redefined when staff freely enter residents' private apartments. A similar observation can be made about visitors to ALFs: if an ALF were an older person's home, the resident should have control over who has access to them and who can come into their home. However, this is not always the case (Bennett et al. 2017). Although social relationships very much affect what kind of places ALFs are and become, it is equally true that the physical and organisational setting of ALFs affects how social relationships in these environments can develop. The relationship between the environment and social relationships in the ALF is a two-way street.

As social environments, ALFs are hybrids of a home and an institution. On the one hand, ALFs are portrayed as private homes, and their purpose is to offer home-like living for older people. On the other hand, ALFs offer health care and social services for residents, and at the same time, they are workplaces for care and other professionals and, therefore, have institutional characteristics (Cutchin et al. 2003; Eckert 2009). Importantly, however, ALFs (particularly service centres) also organise various services, events and activities not only for residents but also for other (older)

people living in the neighbourhood. These ALFs aim to bring older people together, to act as a meeting place for a wider community and, thus, promote the social participation of older people living both in and outside the facility. From the perspective of social relationships, these ALFs also involve characteristics of a wider community and represent an arena of interaction between community members that exceeds the boundaries of the facility (Johansson et al. 2022). In other words, social relationships in ALFs are simultaneously framed by the characteristics related to those homes as private homes, institutions and local communities. Such a multifaceted environment sets certain rules for social relationships and interaction that individuals need to understand and interpret when attending different social situations. Erving Goffman's (1974/1986) theory of frames explains how individuals come to understand these rules in varying social situations.

In his book *Frame Analysis*, Goffman (1974/1986: 10) studies "basic frameworks of understanding that are available in our society for making sense of events" and the vulnerabilities of these frameworks, such as *keyings*, *fabrications* and *frame breaks* – ways in which these frameworks are subject to transformations and disruptions. He argues that when attending any current situation, often involving other individuals and not necessarily restricted to face-to-face gatherings, individuals face the question "What is it that's going on here?" (p. 8). The answer to this question defines the situation and, thus, determines the expectations for action. To define a situation, then, key factors are the "principles of organization" (p. 10) that govern social events and individuals' involvement in them. Goffman calls these principles of organisation as *frames*. In other words, to answer the question "what is it that's going on here?" we need to contextualise the events and understand the norms and rules that control the interaction (Persson 2019). We can do that by employing the culturally constructed "schemata of interpretation" (Goffman 1974/1986: 21) – frames – that are shared by the members of the community.

The idea of frames relates well to ALFs as the members of these communities can be seen to share similar ways of understanding and interpreting social situations in the facility. Especially, central for these interpretations is, we argue, the different distinguishable characteristics of ALFs: the characteristics of a home, an institution and a community. Drawing from Goffman's theory of frames, features of a home, an institution and

a community can be understood as interpretative schemata that are employed in making sense of social events and defining social situations in ALFs. The aim of this study is to find out how these three frames define social roles and shape social relationships and interaction in ALFs.

Studies by Harnett and Jönson (2017) and Gjernes and Måseide (2019) represent examples of the ways in which frames can be used to empirically study everyday situations of care facilities, and they can deepen our understanding of the functioning of everyday life in such facilities. Harnett and Jönson (2017) studied the framings of meal situations in a nursing home and found that an *institutional frame*, *private frame* and *restaurant frame* were employed in these situations. These different frames had implications for the actions of residents and staff members. For example, in the institutional frame, the staff members were in control of the situation, and the resident's role was that of a care recipient, whereas in private frame, staff members and residents acted as friends. In the restaurant frame, the staff members acted as waiters, considering the personal requests of the residents. Gjernes and Måseide (2019) found that in a day care centre for persons with dementia, the staff members guided and controlled the eating of the individuals during breakfast unnoticeably. By doing this, they framed the meals as "ordinary breakfast meals" instead of as meals arranged particularly for persons with dementia. This was done to display and maintain the older persons' dignity and normality. Both studies suggest that using the concept of frame in empirical research can reveal important details about the everyday social situations of care facilities that have implications for the well-being of the older persons.

Widening the view of frames in care facilities, our study aims to deepen gerontological knowledge of the use of the home, institution and community frames in the everyday social life of ALFs and the implications thereof for social relationships and interaction. This study contributes to our understanding of how the multifaceted social environment of ALFs affects well-being of the residents and staff members.

Materials and Methods

The data for this study was collected as part of a research project *Ageing and Social Well-being (SoWell)* conducted at Tampere University. The project explores older people's expectations, needs and activities regarding

their well-being and enjoyment of a good life in old age. The study protocol was approved by the Ethics Committee of the Tampere Region.

The data were drawn from one ALF (service centre) for older people in southern Finland. The facility is an outsourced service provider that provides both assisted living with 24-hour assistance (called group homes) and ordinary assisted living. In addition, the facility offers various services for (older) people living outside the facility. The facility consists of two joint apartment blocks located in a suburban area close to nature. The blocks comprise approximately 150 apartments, of which approximately half are in the group homes and half in the ordinary assisted living. There is a restaurant/café and are many common areas with sofas, armchairs, chairs and tables that the residents and visitors can use for socialising, reading, watching television and other activities. Recreation rooms are used not only for socialising but also for events and hobbies (e.g. handicrafts). There is also a gym and common saunas in the facility.

The data consist of observations, one group discussion and ten individual interviews with older people living in the facility. The observations were made, and the group discussion and interviews conducted in the facility's unit providing ordinary assisted living. The observations took place in the facility's shared areas, such as the restaurant, recreation rooms and the yard. The researcher observed everyday life in the facility, concentrating on social relationships and interaction, and interacted with residents and staff. Detailed field notes were written immediately after each observation session. The observation data consist of 35 hours of observations that were made during the spring and summer of 2018 by the first author.

All participants in the group discussion and the individual interviews were recruited with the help of staff. Residents with a cognitive disorder not allowing for informed consent were excluded; this was evaluated by staff members. The group discussion involved seven persons. The group met once to discuss well-being based on a semi-structured interview framework with themes and questions related to well-being. One researcher served as moderator of the discussion and another one observed the discussion, making notes and ensuring all topics in the interview framework were covered. The age of the group discussion participants ranged from 68 to 101 years, mean age being 86.6 years. Five of the participants were women and two were men. The group discussion took place

in the ALF in autumn of 2018 and lasted 1 hour 27 minutes. The audio recorded discussion was transcribed verbatim.

Five of the seven participants in the group discussion were later interviewed individually by the first author. An additional five participants were recruited with the help of staff. The individual interviews followed a similar semi-structured interview schedule as the group discussion. The participants' age ranged from 68 to 94 years, mean age being 82 years. Five of the interviewees were men and five were women. The length of residency in the facility ranged from approximately 5 months to 5 years. The interviews were conducted during late autumn of 2018 and early spring of 2019. The shortest interview took 38 minutes and the longest 1 hour and 56 minutes. Eight of the interviews took place in the participant's own apartment in the ALF and two in a recreation room. The audio recorded interviews were transcribed verbatim.

All participants in the group discussion and interviews were relatively independent in functioning. Some were able to move without any aids, others required a wheelchair or a walker. All participants lived alone in their own rented apartments in the ALF and used different services provided by the facility depending on their needs and preferences (e.g. health care, cleaning, laundry, restaurant and social activities).

Using the concept of frame (Goffman 1974/1986) as an analytical lens, we utilised a theory-driven approach, directed content analysis (Hsieh & Shannon 2005), to analyse the data. We divide our analysis into two phases. In the first phase, we read the whole data carefully and separated all sections of data including descriptions of social relationships and social interaction. By doing this, we created an initial understanding of the different topics related to social relationships and interaction in our data.

In the second phase of the analysis, we examined how our data extracts, identified in the first phase, are defined by the different frames (home frame, institution frame and community frame). We developed three questions to help us identify the different frames in the data: (1) what kind of relationships and interaction are enabled or ruled out in the situations concerned, (2) who or what defines the "rules" of interaction and (3) to what extent can residents control their own social interaction. We used these questions to identify different ways of framing social relationships and interaction in our data extracts. For example, we observed that in some extracts, the rules and practices of the ALF, such as mealtimes,

played a central role in interaction, pointing to the institutional frame. On the contrary, in some extracts, such rules played no or only a small role, pointing to home or community frames. To identify the frames, we read the data extracts carefully multiple times, reflecting on the three questions, and finally grouped each of the extracts under the applicable frame. The frames are elaborated in the sections below and illustrated with excerpts from the data. All names are changed for anonymity.

Results

The following observation excerpt illustrates residents' awareness of the existence of different frames in the facility's everyday life. The researcher is sitting with the residents in the restaurant:

> Another person sitting at the table asked: "Is that person over there a patient?," referring to a person sitting alone at another table. A person sitting in front of me said: "That's no patient, that's a customer." To that, a person sitting at a table behind us remarked: "No, that's a resident." The person sitting next to me and the person sitting in front of me said: "Exactly, a resident." The person under discussion did not react at all.

A resident is using the term "patient" to refer to another person. However, this resident is immediately corrected: the term "patient" is not correct in another resident's opinion, who calls the person a "customer." But another resident objects again: this person should be called a "resident." This term finally gains the approval of others. The residents are thus aware that their role in the facility might be understood in different ways: an ALF is a place where one might be seen as a patient (institution), a customer (community) or a resident (home). For the people involved in such a situation in such a place, finding the right term requires an understanding of the different frames that are applicable to the place and the situation. Using Goffman's (1974/1986) terms, what occurred in the situation was *clearing the frame*: the frame became clear for all participants after erroneous interpretations of the frame were corrected by other participants. The exchange over the most appropriate term demonstrates the residents' awareness that the ALF is a multifaceted place where the home, institution, and community frames influence everyday life. This example also illustrates the dynamic nature of frames: all these different frames

exist in the ALF at the same time and are invoked in different situations by different actors in different ways.

Next, we elaborate on how these three frames affect and define social relationships and interaction in ALF.

Home Frame

In the home frame, social relationships and interaction occurred on the residents' own initiative, and they were not determined by the rules or obligations of the institution or community frames. Thus, the relationships appeared casual or home-like, since they were determined by the residents' own preferences to be in contact with people they considered meaningful in their life. The participants had meaningful social relationships both within and outside the facility. Those most often mentioned as closest relationships were one's own children, grandchildren, their families and other relatives. Children and grandchildren were also often mentioned as one's most frequent visitors and the persons one visited, who took them out to see other people, and who helped with various everyday chores such as shopping and banking. Most participants also said they had meaningful social relationships inside the facility, and within the home frame, they described other residents as friends. Some participants said they had made good friends in the facility, and others indicated that they only had "acquaintances." Some said they spent time almost daily with friends from the facility, for instance playing cards in the common areas, eating together in the restaurant or sometimes visiting one another. Almost all participants mentioned having friends outside the facility, such as former colleagues, old friends from where they used to live or friends from hobbies. They usually talked to them on the phone but sometimes visited them or had them come to visit.

Social relationships and interaction appeared informal within the home frame. Some participants also counted staff amongst their friends and said they were close to them. Matti reflected in the interview on the kind of place that ALFs are and how his relations with staff affect his approach:

> Matti: Well here, in a place like this, in a way, as this is, kind of… even though this is our home, everybody's home, it's also a bit, maybe slightly like an institution, more or less. Because we're in contact with staff every day, more or less, but anyway, the thing with our relations is, we're told, we're on first-name terms, which is good, I think. Staff are

> on first-name terms with customers, I'm not sure if that's with everybody, but anyway, in some way it eases the personal relationship between staff and customer.

Matti describes an ALF as an institution, although it is also a home at the same time: he perceives his living environment as a combination of both these frames. The reason why he sees the ALF less as an institution and more as a home lies in the casual and not too hierarchical relationship with staff. Here, the home frame is invoked by the casual way the staff and residents talk to each other. Matti is aware that in the context of the institution frame, the relationship with staff members would be a more hierarchical one. Matti also uses the term "customer" when referring to himself and others living in the facility, and by doing so, he is highlighting the relationship being more relaxed than that between a patient and a care professional. Thus, the different frames overlap and residents themselves also consider how the use of certain frames affects different situations and life in the facility. The next observation excerpt describes an interaction situation between a nurse and a resident.

> A nurse came to a group of people sitting around a table to dispense medicines to one of them.
> Nurse: "I brought you some water because I thought you must be very thirsty" (hands a glass of water).
> Man (laughing): "Yes I am, but this water won't help with that."
> Nurse gives the pills and says: "Well, would these be of any help?"
> The person takes the pills and the nurse simultaneously puts a plaster on his upper back.
> Man (laughing): "Ugh, these pills taste terrible."
> Nurse (laughing): "I'm sorry but I haven't been able to influence their taste."
> Nurse leaves. The situation around the table continues normally: the people are reading magazines and occasionally someone comments on something they have read.

In this situation, a nurse approaches a resident sitting with other residents at a table to give him his medicines and to change a plaster on his back. This situation could be very formal: for example, the nurse could take the patient to a treatment room. However, in this case, the situation is framed differently. The dispensation of medicine and the treatment, which would normally belong to an institution frame, had the appearance of a casual encounter of friends rather than a hierarchical or formal care situation. The nurse and the resident are making friendly jokes and laughing, as if

they were just two friends chatting together. This way of interacting invokes the use of more relaxed home frame in the situation instead of the formal institution frame. The interaction is shaped by the overlapping of these two frames. Using Goffman's terms, this could be called *keying*: planting a frame inside another frame (Goffman 1974/1986).

Social relationships and interaction in the ALF were not always casual or meaningful. For example, nurses did not always act according to the rules of the home frame, but sometimes took a stronger role in determining the nature of interaction. Next, we show how social relationships and interaction appeared in the institution frame.

Institution Frame

Whereas in the home frame, social relationships and interaction were initiated and the rules of interaction were determined by residents, in the institution frame, those rules were determined by the institution, and residents had no control over their interactions. Furthermore, interaction was mostly limited to exchanges between residents and staff. In the next excerpt from the group discussion, Liisa is talking about the rules of the facility.

> Liisa: I would have wanted to do a book that's useful when you come to an old people's house like this. Whenever an old person is admitted, they'd be handed that book, so there's a person at the front door who will tell you where to go, where your room is and all those sorts of things. So the book has everything, your rights and your responsibilities. But right now, when I ask where to put my rubbish, they'll just say "I don't know, ask this or that person" and it'll be a week before I get an answer. – So I mean you have to have that kind of responsibility, and it's not the responsibility of whoever comes to the facility but who teaches that person the ropes.

Liisa is talking about the rights and responsibilities of the facility's residents and about "learning the ropes" when a new resident is admitted to the facility. She acknowledges that there are certain rules at the ALF, and that staff members, as representatives of the facility, should inform residents about these rules. Institutions have schedules that need to be followed. The most visible and obvious rules that became apparent during the observations at the ALF were the meals schedules. The next observation excerpt is from the restaurant:

> Next, I went to see whether there were more people downstairs in the restaurant. There were about fifteen persons around the tables. They weren't talking with each other, just sitting quietly and I was a bit curious as to what was going on. Occasionally someone at some table would say a few words, but otherwise it was very quiet. After a while staff started to enter the room and hand out dinners, and I realized what was happening: people were sitting there because they were waiting for their meals. Before this realization I thought it very strange that all these people had been sitting there side by side but not talking to each other. They hadn't come there so socialize, but to eat.

This situation – people sitting around tables without speaking – began to make sense when staff entered the room and started serving food: it was dinner time at the facility, and residents had turned up, or those in wheelchairs had been brought there, to wait for their dinner to be served. In other words, the facility's schedules affected when, why and how residents came together. When they were waiting for and having their dinner, residents did not seem to be interested in one another and their relationships appeared distant and indifferent. Mealtimes were not always as quiet as this, but it was clear that some of the diners were friends, laughing and talking with each other, whilst others hardly made any contact with others. Some residents, then, came to the restaurant to eat with their friends (home frame), whereas others just came to eat in the facility's restaurant because this was the scheduled mealtime (institution frame) (cf. Harnett & Jönson 2017). Following the schedules works as a cue for the institution frame and, thus, for certain kind of actions, but laughing and chatting with friends as a cue to abandon the institution frame and adopt the home frame in the meal situation instead.

In the institution frame, the residents' relationships and interaction with staff appeared to be more formal than in the home frame. Staff appeared as helpers and professionals. When talking about the help they received from the facility, some residents pointed out that they had to pay for this help – making it clear that the help they get from staff is different from the help they get from relatives. Family members help them because they care (home frame), and staff members help because it is their job (institution frame).

Many participants said they were content with the staff and with the help they received at the facility. Some, however, also told of bad experiences with staff members, saying they had not been helpful and took a long time to get things done. Some participants said they were concerned

about friends who did not have the help of relatives and had in fact intervened to offer help because they thought that staff were not doing enough. Some even felt that staff members had downplayed residents' concerns. In these descriptions, staff were seen as representatives of their occupation, and this was reflected in residents' expectations about the relationship. That is, for residents, staff appeared within the institution frame as care professionals who were expected to show helpfulness, compassion and efficiency. In these expressions of dissatisfaction with staff, residents' expectations of appropriate staff behaviour within the institution frame were not met.

Although staff were seen, within the institution frame, as care professionals who were expected to show professionalism, the multifaceted ALF environment meant that the position of staff was not always clear. In the next interview excerpt, Anna is talking about nurses entering her apartment in the facility.

> Anna: Yes, and really this homelike peace, sometimes when I first came here you might have had nurses, all of a sudden a nurse just came in with her/his own key, but there were lots of complaints back then, that we want to live here like all by ourselves, but there's also the policy that if someone doesn't answer the knock on the door or, you know, then you have to see if something has happened or something. So, it's a fine line again what the nurse can do.

Anna is reflecting on the most appropriate frame when interacting with staff. She feels that the home-like atmosphere of her home in the ALF has been violated by nurses who have entered her apartment without permission, using their own keys. In these situations, nurses have treated the resident's apartment not as a private home but as their workplace: entering the apartment without permission thus invokes the institution frame in the situation. As Anna admits, nurses must have their own keys and enter if the resident does not answer the knock on the door. After all, one expects nurses to come and check on their patients. However, as Matti pointed out, "*after all this is our home and you can't just barge in*". Nurses should treat the apartment as a private home: "*ring the doorbell, knock and wait for a while.*" Residents think that nurses should act according to the home frame, not the institution frame. Residents want to be able to decide when and how they interact with staff. Within the institution frame, residents are denied the right to make this decision, which

means this is not an appropriate frame for them. This situation involves a *frame break* (Goffman 1974/1986): the acts of staff differ radically from residents' expectations in the situation. The overlapping frames are at variance with each other because there is no clear, shared understanding of the appropriate frame. Thus, residents have a *negative experience* (Goffman 1974/1986) as they find that the frame they thought would be applicable in the situation, is not and they are uncertain of what rules apply in the interaction.

When the first author was conducting an individual interview in a resident's apartment, two nurses entered with their own keys to remind the resident about lunch. The nurses interrupted the interview but did not acknowledge the presence of the guest or apologise for the interruption. It was clear that the nurses did not think they were entering someone's private home, but rather their workplace. However, later in the interview, the resident said that having nurses check on him adds to his sense of security. Although residents are keen to live in a private home, they are also aware of their own vulnerability and, thus, are aware of their need for the institution frame. Like Anna reflected, there is a "fine line," how the staff should act in an ALF and also the residents' perceptions of the staffs' suitable behaviour vary. Nurses are thus expected to balance between the home and institution frames.

Community Frame

The community frame falls somewhere in between the home and institution frames: within this frame, residents could not decide who they wanted to interact with, but, nonetheless, had more influence over their interaction than in the institution frame. Another difference was that whilst in the home and institution frames, there was no ambiguity about the source of the rules of interaction, in the community frame, these rules were not determined by a single actor, but rather by the more abstract social codes of the ALF. Within the community frame, relationships and interaction included those with other residents, staff, ALF visitors and flexibly with the whole ALF community.

ALF residents cannot always choose their company in the same way as they could in a private home, but on the other hand, social life and activities in the facility are not entirely controlled by staff, as they would

be in an institution. Therefore, it is necessary for residents to make an effort to acknowledge and get along with other people. In the next group discussion excerpt, residents are talking about their sense of community in the facility.

> Liisa: But anyway, there are many people here with many infirmities, and yet they get along and exactly this, that there would be some kind of community spirit. That's so important.
> Researcher: Do you have that here?
> Liisa: Not really.
> Saara: There's no way that could happen here.
> Liisa: Yes, but you can't expect everybody to be the same, you can't expect that.
> Anna: I think the same that it's quite impossible to try to get that kind of community spirit because we're all different persons so we have different tastes in music, hobbies, and everything, so we'd need to be tolerant and not assume that everybody should think the same way as I do. It's a richness that we're all different and allow others to be different.
> Hanna: That's right.

Whereas in the institution frame, relationships and interaction with other residents appeared distant and indifferent and were determined by the rules of the facility, in the community frame, other people in the facility appeared as individuals who deserved to be treated with understanding and tolerance. Other residents were not necessarily friends with whom the participants had formed relationships by choice (home frame), neither were they just random people who follow the same rules of the facility and happen to be at the same place at the same time (institution frame). Other residents were those people who form the community around one's home and institutional practices; these were the people one needed to get along with when outside the familiar home and institution frames. The rules of interaction in the community frame are, thus, defined by the community's shared ideas of what is considered appropriate behaviour in such a context. On the other hand, the eagerness of residents to emphasise tolerance of diversity can also be seen as a reaction to tensions between the home and the institution frames, and the acknowledgement of diversity helps to protect the home frame from the harmonising effects of the institution frame. In other words, by emphasising the importance of tolerating diversity, the residents are protecting their own privacy and individuality as residents of the facility.

Other people are also more readily acknowledged and taken into account in an ALF than in, say, a normal apartment block. This is demonstrated by the following observation excerpt. A group of residents is sitting in the day room talking with the researcher about living in the facility:

> "We have quite accepted this as our home," said a person sitting in front of me. However, after a while, a person sitting next to me said: "Well, an institution is nevertheless always an institution," explaining that you can't just follow your whims there because you obviously have to take others into account as well.

One of the residents points out that the facility is not a home because you have to take into account of the other people living there. The fact that the place is an "institution" where people need to live together harmoniously prevents the place from being an actual home. The presence of others cannot just be ignored, but it affects the whole experience of living in an ALF. Thus, in the community frame, residents had some control over who they wanted to interact with, but, on the other hand, the participants are aware of the presence of others and its implications for their expected behaviour (e.g. expectations of social activity). At the same time, this constant awareness of other people in the facility was also considered to provide a source of security. The participants pointed out that the presence of other people, other residents and staff in the facility enhanced their sense of security and reduced their sense of loneliness.

ALF visitors became more visible during events organised at the facility that are open not only to residents but also outsiders. People visiting the facility to attend events and activities were not mentioned very often either in the group discussion or in the interviews. When they talked about acknowledging others and accepting diversity in the facility, the participants were mostly referring to other residents. It seems then that visitors attending events and activities or using services are not necessarily seen as part of the ALF community. Nonetheless, they are a visible part of the facility, as demonstrated by the following observation excerpt. People from the outside the ALF have come with their children to attend an event:

> I was rather annoyed by the other adults and their children on the same floor with me. The children could not concentrate but were wrestling and fooling around with each other. In addition, they shredded all the streamers along the corridors. After the show

> ended, they just left and left all the shredded streamers on the floor. Their parents did not comment on the wrestling or the shredding and did not tell them to clean up the mess they'd made.

In the situation described above, the visitors were standing in the corridors, close to the doors to the residents' apartments, but did not behave as if they were visiting someone's home or a care facility. The visitors' actions were determined by their understanding of the most appropriate frame for such a situation. The visitors did not frame the ALF as a home or an institution, but as a public space in which they may behave as they pleased and let their children fool around or assume that someone else will clean up after them. This frame was invoked by the event organised in the facility that made the facility seem for the visitors not as someone's home or as a care facility. They did not consider that the mess they left behind might be inconvenient for residents or the staff. In contrast to residents, then, they did not acknowledge the other people in the facility, but followed different rules that may not be explicit.

Another group of people missing from the participants' descriptions were those who lived in group homes. When talking about the ALF community, the participants sometimes referred to their circle of friends or people living on the same floor, but did not mention group homes or their residents; sometimes, it seemed they were actively excluded from the residents' community. When asked what kind of communities she thinks she belongs to, Anna described herself as an ALF resident but her community does not comprise the community as a whole:

> Anna: Because we're here in home-like circumstances and not in an institution. Sure there are these two floors, or are there three, where there are these closed wards, dementia wards, but I don't know much about them. Because there are so many different types, but in that sense I think it's good you can get it [more care] from here, if your health greatly deteriorates you can stay here in the same building. And you just move a bit to another place then.

Anna makes a point of her home-like living environment by saying that she knows very little about the *"dementia wards"* in the same building. She is making a point that these places are different form where she lives and distancing herself from the people who live there: they are different from her and her home-like way of life as an ALF resident. When the

institutional "dementia wards" are excluded, she can be seen as living in a home-like environment. Nevertheless, those places might become part of her life sometime in the future if her "*health greatly deteriorates*." In the next interview excerpt, Ida is making distinctions between herself as an ALF resident and others in poorer health.

> Ida: And I've been satisfied. If someone's being critical, they're being critical without a reason. We can live here as we would in any other rented accommodation. But here we have the security so that if anything happens, then… Although we're private residents and we don't belong to those service centre things at all. We can't get a doctor here or, there's a nurse only once a week.

Ida says that she and other residents like her are living in the facility as private residents. She seems to take the view that those who really "*belong to those service centre things*" need a lot care and other services from the facility. These people are different from her and other "*private residents*" in the facility. So, although we saw social relationships and interaction in the ALF appearing as constant acknowledgement and acceptance of others within the community frame, they also appeared as making distinctions between oneself and others in the facility.

Not only did ALF residents set themselves apart from others, but so did also outsiders visiting the ALF. One staff member said she had been told by some of these visitors that they do not like to be associated with the ALF because otherwise they too might be seen as old and frail. During observations of a group of people coming from the outside to attend activities, one of the participants said she has not dared to ask others if they lived in the facility. Apparently, she did not want to cause offence by assuming they might be living in the facility. It, thus, seems ALF visitors do not want to be seen as part of the ALF community.

Whilst the community frame is recognised and referred to by ALF residents, it is less distinct and structured than the home and institution frames. In the community frame, other residents are recognised as individuals who need to be acknowledged, but they are not regarded as personal friends or simply as fellow patients in the institution. The participants recognise that the ALF is a wider community that includes *"dementia wards,"* for example, demonstrating that this frame entails not only those in the individual's immediate proximity but also those who form the wider community. At the same time, however, the boundaries of this

frame become visible when distinctions are made between oneself and others in the facility. It seems that the determination of the circle of people who are involved in this frame is not fixed but negotiable. Furthermore, when considering the wider community of the ALF, the characteristics and the rules that govern interaction within this frame become unclear. In this sense, the community can even be described as a no-man's land where social relationships and the boundaries of action and interaction are not defined by the familiar rules of a home or an institution.

Discussion

We found that the way in which social relationships and social situations are structured in the ALF is influenced by the way the facility is framed and understood. Previous research shows that social relationships affect residents' perceptions of the ALF (Cutchin et al. 2003; Lewinson et al. 2012). Our study adds a new layer to this by suggesting that perceptions of the ALF also impact on social relationships. On this basis, we suggest that it is important to take into account of the multifaceted nature of the facility and its effects on social life when attempting to understand ALFs as social environments. Harnett and Jönson (2017) found institutional framings of meals in nursing homes so dominant that other framings, like home frame, were hard to find. This study adds to our knowledge of what kind of role institutional, home and community frames play in an ALF.

Different frames enable different kinds of social relationships and interaction in the ALF. In other words, what kind of social relationships and interaction are feasible is influenced by the way in which social situations in the ALF are framed. For example, the relationship and interaction between residents and staff is influenced by the frame adopted by the participants in the situation. Sometimes frames are not shared (*frame break*) by the participants, which may give rise to conflict and *negative experience* (staff enter residents' apartments without permission), but they can also be piled upon or planted within each other (*keying)* to purposefully create a shared understanding of the situation that differs from the expected one (making a treatment situation seem as two friends joking instead of an interaction between a care professional and patient) (Goffman 1974/1986). Thus, the relationship between the frames is dynamic, and they exist in the facility at the same time, being invoked by different

actors in different ways and eventually being accepted or rejected by the participants. Frames also define the nature of social relationships: other people in the ALF can be seen as friends, fellow patients, fellow residents, professionals or "others" who are intentionally left out. Frames play an important role in defining social relationships and interaction in ALFs and impact upon the smooth running of everyday life.

The provision of home-like housing and care services for older people is a central policy objective in Finland and elsewhere (Anttonen & Karsio 2016; Genet et al. 2011), and therefore, it is important to understand how social relationships and interaction affect residents' perceptions of the facilities and their home-likeness. Based on our findings, the presence of institutional features in social interaction in an ALF does not adversely affect the perceived home-like nature of the facility, so long as staff know how to use the home frame in situations that are meaningful to residents. As we saw, lack of control over social interaction, for example in situations where staff enter apartments with their own keys, diminishes residents' sense that they are living in a home-like environment. At the same time, however, residents appreciate that in some situations, staff need to enter apartments with their own keys. This implies that the interpretations staff make about different social situations and about their expected and appropriate behaviour in the ALF are important to residents' experience of living in a home-like environment. In their interaction with residents, staff need to balance between the home and the institution frames. Our finding supports earlier results on the key role of staff in enabling a home-like ALF experience and residents' well-being (Pirhonen & Pietilä 2015; Street et al. 2007; Williams & Warren 2009). Like in the study of Gjernes and Måseide (2019), the actions of staff members in framing meals as ordinary breakfast meals in a day care centre for persons with dementia maintained the older persons' dignity and normality, the actions of staff in framing social situations as home-like can maintain the feeling of home-likeness for the residents.

Although the sense of private space is important in the ALF, this importance has to do not only with physical aspects such as having beloved items and furniture in one's own room or apartment but also with social aspects that affect the way in which the space is defined (see Roth & Eckert 2011). Our findings suggest that having a home in an ALF is not only

about a private space and personal belongings but also about the power to determine one's social relationships. Anyone who has the power to determine their social relationships will also have the power to define their private space. In the institution frame, residents did not have this kind of power, in the home frame they did. In the community frame, the situation was less straightforward: residents did have some say over their social relationships and interaction, but at the same time, they were constrained by the facility's rules. Frames are, thus, important regarding residents' autonomy in the facility.

Our study also draws focus to the nature of ALFs as communities. We found that social relationships and interaction in the ALF were affected not only by the home and institution frames but also by the community frame, which falls somewhere in the middle ground between the former two. As our findings indicate, the presence of other people, mainly other residents, cannot be ignored in ALFs; indeed, it is an important feature of everyday life there. The home and institution frames do not in themselves fully cover all kinds of social situations in such places. ALFs are neither just a home nor just an institution but also places where residents live their private lives in a public space (Roth & Eckert 2011) that has its own rules for social relationships and interaction. This is supported by the existence of *restaurant frame* alongside institutional and private frames in nursing home meal situations (Harnett & Jönson 2017). The restaurant frame challenges the institutional arrangements of meals, but is also not private or home-like, but something in between.

The community frame in our study indicates that in addition to the clearer rules for social relationships and interaction posed by the home and institution frames, there are also more abstract social codes that define social life in ALFs. These codes or rules guide residents towards acknowledging and tolerating other people around them in the facility, but, at the same time, towards dissociating themselves from those people who might threaten the impression of their home-like living in the facility. It seems that the community frame serves as a placatory frame in between the home and the institution frames, in which it maintains residents' privacy and individuality, but, at the same time, recognises the communal characteristics of the place. The community frame indicates that an ALF is a home that is supposed to be communal, but not to the extent that it is too homogenising, as in an institution.

Visitors to the ALF, that is, people who do not live in the ALF but who attend its events and recreational groups, were not mentioned very often in the interviews or in the group discussion. This might indicate that their presence is not very meaningful to residents. However, the behaviour of these visitors demonstrated that outsiders might have their own way of framing the place. For these people, the home, institution or community frame did not seem appropriate, but they appeared to view the facility as a public space where they can behave as customers and are not obliged to acknowledge other people in the same way as residents felt they were within the community frame. More research is still needed to better understand the meaning of outsiders visiting the ALF and the ways in which they make sense of the facility and their role in different situations. Our findings suggest that non-residents did not want to be associated with the ALF because they feared they might be regarded as old and frail. However, ALF residents were equally reluctant to be associated with cognitively impaired or frail persons. In the words of Pirhonen et al. (2016), both visitors and residents viewed more frail older people as *ability others* and used this reasoning to maintain the impression of themselves as capable individuals and residents instead of patients of an ALF.

Our findings contribute to ongoing discussions about how the housing and care of older people should be organised in such a way that their autonomy and well-being are enhanced. If it is understood that all the individuals involved in ALFs interpret and make sense of social relationships and interaction through different frames, then it will also be easier to see how different expectations of interaction and action in different situations can lead to misunderstandings and conflicts. Successful social life in ALFs can be created and maintained when everyone involved in the ALF is able to recognise the ways in which they themselves and people around them make sense of everyday social situations in the facility. The idea of frames in the ALF could be used to educate both staff and residents about the multifaceted nature of ALFs and its implications for social interaction. Making frames visible in ALFs can lead to better communication and an enhanced sense of autonomy for residents as they are given the opportunity to decide for themselves about their social relationships and interaction. If ALFs cannot be totally private homes, the idea of frames could help to transform them into communities that allow all their members to have a say over what kind of place they are.

Acknowledgements

This work was supported by the Päivikki and Sakari Sohlberg Foundation and the Björkqvist Fund. The work was done in the framework of the Gerontology Research Center (GEREC) and the Centre of Excellence in Research on Ageing and Care (CoE AgeCare). We would like to thank all the people living and working in and visiting the ALF for giving us a window into their everyday life in the facility. We especially wish to thank staff members for helping us arrange the group discussion and interviews and all the residents who took part in them.

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