International Journal of Ageing and Later Life

Volume 7, No. 1, 2012

IJAL

International Journal of Ageing and Later Life

Volume 7, No. 1, 2012

Published with the support of the Swedish Council
for Working Life and Social Research
(Forskningsrådet för Arbetsliv och Socialvetenskap, 2011–1917)

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

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Table of Contents

Articles

Book Reviews

International Journal of Ageing and Later Life, 2012 7(1): 7–32. © The Author

The fight-to-die: older people and death activism

By NAOMI RICHARDS*

Abstract

This article explores the activities and convictions of older right-to-die activists who belong to a small but very active interest group based in Scotland, UK, called Friends at the End (FATE). The analysis presented here is based on knowledge gained through seventeen months of ethnographic research with the organisation. While FATE activists currently campaign for a legal right to a medically assisted death, many are also open to taking matters into their own hands, either by travelling to the Swiss organisation Dignitas or by opting for what is known as "self-deliverance". FATE members' openness to different means of securing a hastened death contrasts sharply with the more limited demands of the UK's main right-to-die organisation, Dignity in Dying, and highlights their specific orientation to freedom, which, it is argued here, results from the organisation's older demographic.

Keywords: right-to-die, euthanasia, activism, social movements, end-of-life, autonomy.

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Introduction

In the public imagination, activism is often associated with youth. This assumption is perhaps based on an idea that older people have dwindling energy and less passion than younger people, both of which qualities are required to organise collectively. Barbara Macdonald (1985: 28), for example, in her collection of essays on ageism and older women, recounts an incident on a Reclaim the Night march, where one of the organisers singles her out for not "keeping up" with the other demonstrators. At sixty-five years of age she is seen as an anomaly in a demonstration consisting almost entirely of younger people. Although older people's continuing civic and productive engagement (e.g. Burr et al. 2002; Martinson & Minkler 2006; Morrow-Howell 2000), volunteerism (e.g. Choi 2003; Warburton & McLaughlin 2005) and participation in policy processes (Barnes 2005) have all been examined, research into the active involvement of older people in new social movements or direct action is lacking. Equally, the preponderance of older activists in the right-to-die movement in the UK also remains under-explored, within both the gerontological and the death studies literature. This could be due to the fact that it is only in the last decade that right-to-die activists have garnered the requisite media attention to make their collective voice heard, including, perhaps, by academics. The reasons for the increase in media coverage are multiple and various, and I will explore some of them in this article. Another possible reason for a seeming reluctance to explore the connection between older age and death activism might be linked to a more general aim to dissociate older people from death and dying. This has been attributed to a desire to break the "naturalised" link between death and old age and/or to prioritise positive images of ageing unencumbered by references to deterioration and death (Lloyd 2004: 243).

It is argued here, however, that there remains much to be gained from a sustained enquiry into the passion and conviction of this small but vociferous and relentless campaigning force. This article sets out to determine what is distinctive about the involvement of older people in a highly contentious debate in the hope that it will illuminate both the motivations of those involved and the broader ethical dimensions of the UK right-to-die movement. Participation in the right-to-die movement as a whole is not limited to an older demographic, nor are the parameters of the debate defined by its demographic. However, older activists are drawn to the cause not just as a result of personal identification, as Gilleard and Higgs argue (2000: 71), but also because of their social identity as older people. It is the intersection of old age and death activism that this article seeks to explore through an examination of the activities and convictions of a group of right-to-die activists, based in Scotland, called Friends at the End (FATE). I do not intend to focus on arguments for and against assisted dying, as this is a well-rehearsed debate. Instead, I describe older activists' perspectives in order to draw theoretical conclusions about the existence and form of their activism and its relationship to the wider debate about assisted dying.

First, I give a brief summary of FATE's origin and activities. I then briefly discuss why older people are likely to join FATE. One of the common motivations is fear of a "bad death" – for themselves and/or others – and so what constitutes a bad death, as activists envisage it, is important in order to grasp the nature of their activism. I will then go on to compare FATE's raison d'être with that of the UK's main national organisation, Dignity in Dying, which campaigns for a legal right to a medically hastened death. This comparison will highlight FATE members' specific orientation to freedom, which, I argue, owes something to the demographic of the organisation. The average age of FATE's members is 68 years, and 74% of the members are more than 60 (Judd & Seale 2011). I suggest that the age of members gives their collective activism a sense of urgency in that they have started to think pragmatically about their mortality, and also an air of non-conformity in that they are less interested in maintaining corporate structures and hierarchical modes of governance, both factors setting them at odds with the more "professionalised" campaigners at Dignity in Dying. FATE members' frank discussions about the mechanics of dying and their descriptions of different bad death scenarios might sound morbid or obsessive to outsiders. Yet for FATE activists, acquiring knowledge about how to prepare for and plan for death helps to assuage their fears arising from the uncertainties surrounding the dying process. Their involvement in the right-to-die movement also gives members a sense of purpose and collective spirit as they fight to bring discussions about dying into the public arena.

Methods

This article is based on knowledge gained through involvement with the activities of FATE over the course of seventeen months. The fieldwork was carried out as part of a broader anthropological study of the UK right-to-die debate, the general aim of which was to discover whether or not this contentious and high-profile "conflict of rights" represents a new way of anticipating and talking about death. In research with FATE, the ethnographic method was employed in order to observe directly and participate in the activities of the group and collect descriptive data about their actions, beliefs and attitudes (Bryman 2001). While the ethnographic method is often criticised, largely on positivist grounds, for being impressionistic and lacking reliability, engaging with participants in their ordinary activities in naturally occurring settings over a long time period is the only way to contextualise the meanings that they attribute to their social world (Brewer 2000: 10). The ethnographic data collection undertaken with FATE involved: participation in the activities of the group, including attendance at five thrice-yearly meetings and other one-off events; accompanying activists to two international right-to-die conferences in consecutive years; multiple semi-structured interviews with five key members and multiple phone conversations and email exchanges with those key members; and sustained informal contact with approximately 15 other members and affiliates. Those FATE members who were interviewed in-depth were selected through purposive sampling in a desire to find information-rich cases (Patton 2001[1990]).

Contact with Dignity in Dying was more limited, involving: attendance at two Annual General Meetings; attendance at one-off events including a meeting of the All-Party Parliamentary Group "Compassion in Dying"; a formal interview with the Human Rights Officer; and informal contact at public debates and legal hearings with the Chief Executive, the Head of Legal Strategy and Policy, and the Director of Campaigns and Communications. The research was undertaken between October 2006 and February 2009. Although interviews were also undertaken with both high-profile and grassroots activists who strongly opposed any form of legalised assistance to die, requests to undertake the same type of sustained ethnographic inquiry of the main opposition organisation, Care Not Killing, were declined. I am therefore unable to make a comparison between FATE activists and Care Not Killing activists in terms of the influence of age on the form their activism takes. Care Not Killing was newly formed when first approached for access, and it is likely that some initial disorganisation may have contributed to its reluctance to grant me access. It should also be noted that at the time of conducting the research, those advocating for a change in the law (FATE and Dignity in Dying) were more "active" than those defending the status quo; hence, there were more activities to observe and participate in than would have been available through ethnographic interaction with Care Not Killing.

All data sources – extensive and detailed field notes about events, meetings and interviews; formal interview transcripts; supporting documentary evidence such as newsletters and campaign literature – were carefully read and re-read and then coded according to key themes (Scott Jones & Watt 2010: 161) while the fieldwork was still ongoing. Identifying what was of significance to participants themselves was also part of this process. The ethnographic method has a distinctive openness (Katz 2001 [1983]: 202), which allowed me to direct the research purposively according to the need to flesh out the key themes arising. In the analysis stages, data from the different events, meetings and interviews were mined for their significance and then compared and contrasted in an iterative process. Data matrices were also created in order to cluster the evidence and draw connections between data (Scott Jones & Watt 2010: 162–172). The evidence cited in this article is taken from all of the sources mentioned above and is also grounded in a detailed knowledge of the right-to-die debate in the UK. As is customary in ethnographic writing, I move between descriptive accounts of FATE and Dignity in Dying, and theoretical propositions.

Maintaining neutrality as a researcher is difficult in such a contentious bio-ethical debate. As a researcher, my utility for right-to-die participants rested with my (assumed) ability to offer them a platform upon which to air their views. However, it also entailed the hope or even the assumption that the research would endorse their particular perspective. In order to divest campaigners of this view I was very clear at the start of each interview that I wanted to access multiple perspectives; that I was examining the debate "in the round"; and that, above all, I held a neutral position on the central question of whether assisting someone to die is "right" or "wrong". As anthropologists who have studied human rights activism have discovered, it can become problematic when researchers neglect or forsake their own ethical position in relation to the politics of the field in order to make their research more relevant to research participants (Jean-Klein & Riles 2005). In Garner's (n.d.) research into fox hunting in Britain, he found that activists expected him to have an opinion on the issue, and this led him to believe that neutrality is not a position that activists can either understand or accept. I also encountered this difficulty, in that activists on both sides of the debate would attempt to solicit and scrutinise my personal beliefs in order to penetrate what they assumed to be my guise of neutrality. Indeed, postmodern and feminist epistemological debates have centred on this very notion of whether pure objectivity when conducting research is either a worthwhile or an achievable aim, given the inescapable influence of researchers' values and personal beliefs on the data collected and analysis supplied. However, by being as self-reflective and as dispassionate as possible, along with reminding participants of my genuine agnosticism on the issue, I made attempts to minimise the "untrammelled incursion of values" (Bryman 2008: 25) into the research process. Had I assumed a position on the issue, it would not only have been dishonest, but would also have resulted in activists assuming certain knowledge and understanding on my part and key explanations of their beliefs and activities may well have been lost.

Studying Dying in Old Age

Since Gorer's seminal (1965) text describing a post-war Britain as lacking the ritual support necessary for people to make sense of death, there has been consistent academic interest in what has come to be known as the death taboo thesis. Trends towards secularisation and the confinement of death to medical institutions where it is dealt with by paid specialists meant that for proponents of the taboo thesis, death and dying have become sequestered, cut off from the rest of social life, and avoided and feared in equal measure (Elias 1985; Gorer 1965; Illich 1976). For Aries (1983), the French social historian, the "tame" death of the Middle Ages turned into the "wild" death of the 20th Century.

The "revivalism" of the modern hospice movement, with its strong Christian roots, was intended to stand in opposition to the trend towards the over-medicalisation and the social sequestration of death and dying (Walter 1994). Hospices were to act as spaces where death could be openly acknowledged and discussed. Revivalism precipitated a new emotional openness around death, with people being informed of their prognosis and encouraged to accept that they were, in fact, dying (acceptance being the fifth stage of Kubler-Ross's (1970) popular five-stage psychological model). As Walter notes (1994: 185), revivalism was supposed to take individualism to its logical conclusion by enabling an individual to claim authority over the medical technologies which tended to alienate him or her from his or her own death, and reflexively to plan for death as the summation of the project of self-identity (Giddens 1991). However, the advancement of individualism in the 20th Century also contributed to the revival of calls for a right to a medically hastened death as one way of keeping the narrative of self-identity intact up until death (Seale 1998: 183). The euthanasia or, as it has latterly become known, the right-to-die movement, entailed a different critique of modernist medicine, one which supported an individual's subjective determinations about the value of his or her own life and his or her desire for its end to be hastened if he or she was "suffering unbearably".[1]

Both the death taboo and the revivalism theses have been the subject of much academic debate since the 1960s and indeed still feature in the writings of those continuing to contribute to the death and dying literature (Davies 2005; Green 2008; Holloway 2007; Howarth 2007; Kellehear 2007; Seale 1998). However, as these and other authors note, there is a paucity of sociological or anthropological literature on dying in old age, particularly within the gerontological field (Clark & Seymour 1999: 24; Field 2000: 27; Seymour et al. 2005; Sidell 1993: 154). Seymour and colleagues (2005: ix) observe that this topic appears to have been left to the pursuit of specialist palliative care organisations, which have a wider remit than older adults. It is only recently that research on dying in old age has started to be collated, for example by Gott and Ingleton (2011) in their edited collection.

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[1] This phrase is taken from the most recent attempt to legalise a form of medical assistance to die in England and Wales, the 2006 House of Lords *Assisted Dying for the Terminally Ill* Bill. This Bill took the term "suffering unbearably" from the Dutch *Euthanasia Act*, passed in 2002.

The lack of social scientific literature may be due to a desire to break the naturalised association between old age and death, an association that regards death in old age as ''timely'' or ''natural''. There has also been a rejection of disengagement theory – the theory that older people slowly withdraw from society in preparation for death (Cummings & Henry 1961) – on the grounds that it is deemed to contribute to the devaluation or ghettoisation of older people as expectations of disengagement turned into expectations (and even compulsion) to withdraw from social life (Sidell 1993: 157). As a consequence, researchers have learnt to de-emphasise disengagement and emphasise diversity (Howarth 1998; Lloyd 2004; Williams 1990).

Howarth (1998: 676), for example, is determined to embrace a ''more positive approach to ageing'' by reporting that among her interviewees aged 75+ years, most remained firmly ''attached'' to life and spent little time contemplating their own death. Given increased longevity, people may no longer think of death as imminent at 65, 75 or even 85 years of age. Yet while she tries to make this argument, Howarth also concedes that some interviewees did speak about their readiness for a welcome death and some even spoke of euthanasia as a legitimate end to protracted suffering. It is evident that fears of being criticised for accepting or accentuating the link between old age and death, given the recent ''positive'' ageing discourse, have closed down discussions about dying in old age and resulted in a general reluctance to explore the topic at all. Holloway (2007: 123) makes the same point, stating that while repeated psychological studies have shown that, in general, people are more likely to think about and prepare for their own death the older they get, this is played down in current studies concerned with emphasising quality of life in old age. It is the aim of this article to open up debate about attitudes towards death in old age through an exploration of ways in which a group of active (i.e. in no way ''disengaged'') older people anticipate dying.

In addition to the relative paucity of literature on death and dying in old age, little has been written in the academic sphere about death activism in the UK, and the people who are trying to confront the taboo on death through sustained lobbying of both politicians and the media. Death activism tends to coalesce around what is popularly known as the right-to-die movement. McInerney (2000) argues that this can be categorised as a "new social movement" arising from a sense of injustice and dissatisfaction with the current "system of dying". Briefly, advocates of a right-to-die propose some form of legalised medical assistance to die given a "considered and persistent" request from an individual.[2] Those activists who situate themselves on the other side of the debate refuse to accept that there is either a legal or moral right to be granted medical assistance to die. For some of these activists, the objective to increasee the provision and remit of palliative and hospice care should not be jeopardised by focusing on the demands of a small minority. Access to specialist palliative care, they argue, would likely alleviate the vast majority of patients' requests to be helped to die. However, most who oppose legalisation assume a principled opposition, questioning the morality of one person, whether a doctor or otherwise, knowingly causing or hastening the death of another. The effect of the rhetoric and the media coverage given to both sets of activists in this contentious and emotionally charged debate is that of fostering a new, public discourse around the "good death", which presents a different type of challenge to the taboo on death from that offered by hospice revivalism.

The Founding of FATE: Tactics and Motivations

In November 1999, after disagreements over finances and irreconcilable personality clashes, a few members of EXIT, the Scottish branch of the national Voluntary Euthanasia Society, split off to form a new group, which they called FATE. FATE's founding members determined from the start that they wanted more than a nominal association. They had been dissatisfied with EXIT's lapse into inactivity and they wanted regular meetings and public debates. They were committed to finding a way to share their concerns about their dying. The organisation has three meetings a year and produces a newsletter four times a year. Included in the newsletter are: national and international right-to-die news; the latest book reviews; and articles on new end-of-life research. Since 2002, the group has also been the UK's calling point for people travelling to the

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[2] The wording "considered and persistent" is that used in the 2006 House of Lords *Assisted Dying for the Terminally Ill* Bill.

Dignitas organisation in Switzerland. Dignitas is a not-for-profit organisation based in Zurich, which helps foreign nationals lawfully to obtain a lethal prescription. FATE produces a guide, distributed only to members, which details all the documentation and procedural requirements necessary for applying to die at Dignitas. The Swiss authorities require a lot of identification, including marriage certificates or ''celibacy'' certificates (an Affidavit sworn in front of a public notary that you have never been married) and birth certificates of spouses. People can encounter all sorts of problems sourcing this documentation, so FATE offers advice by phone. On average, the group receives 5–6 calls per week routed through one activist's home telephone (there is a rota set up to answer it). The group also lobbies the Scottish Parliament, responding to various public consultations and making links with Members of the Scottish Parliament, specifically Jeremy Purvis and Margot MacDonald, who both tabled parliamentary bills to legalise a form of assisted dying, in 2007 and 2010, respectively.

FATE also has a strong presence at international right-to-die conferences. Its members strongly support the activities of the World & European Federations of Right-to-Die Societies and value being part of an international movement where they can network closely with other activists. At the 2008 World Federation conference, six FATE delegates attended, whereas there were only three Dignity in Dying representatives present. This shows the importance of such networking opportunities for a small organisation like FATE. FATE had approximately 400 members in 2008. According to Judd's survey in the same year, of the 41% of members who responded, the average age of members was 68 years. Eighty four per cent belonged to social class one, as defined by the National Statistics Socio-economic Classification scheme (Judd & Seale 2011). There are also more women than men involved in the group, which may be a factor of women's longevity – what Arber and Ginn labelled ''the feminisation of later life'' (1991). The composition of FATE, therefore, is similar to that of the Hemlock Society in the US before it disbanded in 2003. The findings of a survey conducted of the latter (Wilson et al. 1998) indicated that it is predominantly older, white, wealthy, highly educated, economically and politically active women who are at the forefront of the right to die movement in the US.

FATE activists are concerned with how older people might experience a "good death". Cross-culturally, the good death is usually considered to be one that can be foreseen, prepared for and controlled, and where the dying person is not alone (Bloch & Parry 1982: 15; Seale & Van der Geest 2004: 884). The desire for control is certainly an important motivator of right-to-die claims. As one FATE board member told me: "control is my big want". Yet, it is important to note that it is not the only motivating factor. Members reported that they wanted to be able to say when they no longer found any *value* in their life due to "suffering unbearably" as a result of illness, disease or, in some cases, the co-morbidities accompanying old age. In fact, "slow dying" seemed to be particularly feared as a result of the reduction in quality of life that was anticipated to accompany it. As one activist told me in an interview:

> At the end of life, you are going to die anyway so why do you have to go through a lot of pain to finally die? The end is the same – you die.

Frogatt (2001) emphasises that it is the process of general deterioration or "slow dying" in old age that is least well understood, yet is significant in nursing homes, for instance. She reported greater uncertainty about the actual timing of death, with many residents lingering for extended periods in what staff designated the "poorly" category. There is great ambiguity and conflict among caregivers over how dying is defined (Sidell & Komaromy 2003: 51–52). The "when" of death is much less easy to foresee than amongst younger people, and this gives rise to anxiety among some older people who would rather plan for their death and die "on time". It is not fear of death that motivates the FATE activists, but rather fear of a protracted dying period in which the fragmenting of social bonds and loss of sociality would precede biological death, entailing a loss of personhood. This phenomenon was explained by one FATE activist I interviewed in the following terms:

> I mean, you're not the person you were, you're a biological but not biographical person.

The concept of "social death" can be traced back to Hertz's (1960[1907]) now classic study of the double burial in Borneo in which he identified that in many parts of the world, death is not considered a ''matter of an instant'' but is rather a long process of separation from the social group. This same concept of ''social death'' has been used to describe the experience of people residing in institutions (Mulkay 1993; Sudnow 1967) as they approach death – hospitals, hospices, nursing homes, residential care homes – as well as people living with dementia (Sweeting & Gilhooly 1997). Lawton, for example, notes that staff in the UK hospice where she was conducting her research described some older patients as having ''already turned their faces to the wall and given up'', implying they had no desire to continue living (2000: 154). This is a form of self-managed disengagement in response to a self-perceived social death. It is to be distinguished from ''other-perceived'' social death whereby *other* people perceive the older dying individual to be ''as good as dead'' and then write them off (Kalish 1968: 254), which may be a deep-seated fear for those people who oppose any change in the law prohibiting assisted dying.

For the FATE activists whom I interviewed and spent time with at meetings and public events, their self-identity was dependent on a sense of agency, which they feared would be compromised by deteriorating bodily and mental capacities. To have the option of travelling to Dignitas, or the campaigned-for option of legalised assistance to die in the UK, would be to have an insurance policy against a self-perceived social death or loss of autonomy. In the US state of Oregon, each year the number of prescriptions written for lethal barbiturates under the *Death With Dignity Act* is more than the number of deaths from making use of those prescriptions. This suggests that, for many, possessing a lethal prescription does not correspond to an immediate intention to use that prescription, but rather offers an ''insurance policy''.

The most high-profile activists viewed it as their mission to reveal the ''truth'' about the miseries of the dying process. One activist, formerly a GP, said:

> The palliative care [philosophy] 'you live until you die' is bilge. A lot of people do live peacefully until they die. But for a lot of people the last few weeks of their lives are very unpleasant and their symptoms dominate them to the extent that they can't really think clearly about anything else. And it's that part that they want to avoid.

Overall, FATE members' determination to fight for their own "timely" death is a way of staving off the fears stemming from the multiple "unknowns" of the dying process. As one of the recurring mottos of the right-to-die movement asserts: it is not death that is feared, but the process of dying.

Differences between FATE and Dignity in Dying

In describing right-to-die societies as a "new" social movement (McInerney 2000: 137), the adjunct "new" might seem misplaced given that historians of the UK movement trace its origin to an essay by Samuel Williams published in 1870 (Kemp 2002: 12). However, the right-to-die movement as a whole has only achieved conspicuous momentum in the last four decades, and its profile bears similarities to other "new" social movements, which have emerged since the 1960s – for example, the civil rights movement; the women's movement; the gay rights movements. Activism turned a corner around this time, shifting its focus from equality in the economic-industrial system to equality in terms of individual rights. Older people's involvement in social movements underwent a similar shift, exemplified by the contrast between the Townsend Movement of the 1930s in America, which had the redistributive aim of securing older people better pensions (Holtzman 1963), and the Gray Panther movement of the 1970s, led by Maggie Kuhn (1991), which was based on an identity politics around old age (Gilleard & Higgs 2009: 282).

According to Snow et al. (2004: 3), social movements arise when people organise into collectivities to give voice to their grievances and concerns about the rights, welfare and well-being of themselves and others by engaging in various types of collective action. Whereas interest groups typically pursue their objectives through institutionalised means, such as lobbying, social movements pursue theirs mainly by non-institutional means such as marches, boycotts, etc. Although FATE members do not organise public demonstrations as such, the nature of their activism certainly puts them outside any institutional support and differentiates them from Dignity in Dying, the much larger, national organisation lobbying for a legal right to a medically hastened death. New social movements are also said to arise “in defense of identity” as individuals struggle to “name” themselves (Johnston et al. 1994: 10). The politics of identity demand that the right not to be discriminated against is culturally recognised and legally upheld. Identity is at stake in the right-to-die debate because it is activists' firmly held belief that their personal identity will be compromised if they die a bad death. This is usually an identity based on a strong belief in autonomy (self-rule or self-actualisation) and in what Isaiah Berlin termed “negative freedom” – the right to non-interference from others (2006[1958]). Activists' social identity as older people is also a factor in their mobilisation. Contrary to Gilleard and Higgs's (2009: 279) view that “age has figured little in the new politics of identity”, I would argue that it is the vision of “slow dying” in old age and the spectre of social death, whether as a result of institutionalisation or general “disengagement”, which results in some older people wanting to found or join right-to-die societies. In other words, the older people who join right-to-die societies do so as a result of both their own personal belief in autonomy and as a result of a political commitment to “face up” to death as an outcome of old age.

Dignity in Dying is the oldest and largest organisation spearheading the campaign for the legalisation of medically hastened death. It was founded in 1935 as the Voluntary Euthanasia Society, but changed its name in 2006 in a deliberate effort to move away from the negative associations of the word “euthanasia”. Since 2000 when the organisation came under new leadership, it has undergone a professionalisation and its agenda has become more mainstream. The aim of those in charge was to transform the organisation into a credible, authoritative and professionally run outfit.[3] In 2001, the organisation supported Dianne Pretty's case,[4] which was referred first to the House of Lords and then to the European Court of Human Rights where it was eventually rejected. This high-profile case represented a turning point both in terms of the organisation's campaign-

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[3] Benjamin, A. 2006. Exit Strategy. *The Guardian*.

[4] Dianne Pretty petitioned the court to allow her husband, Brian, to help her commit suicide with legal immunity. Dianne was living with Motor Neurone Disease and was paralysed from the neck down, making it very difficult to take her own life.

ing strategy and in increasing the public awareness and acceptability of the right-to-die cause. Having gained respectability as a pressure group through association with this case and, more recently, Debbie Purdy's case,[5] which garnered an equally large volume of media coverage, Dignity in Dying is now repositioning itself as an organisation that champions "choice" at the end of life. Choice is high on successive government agendas, and as the Chief Executive told members at its AGM in 2008: "it is much more difficult to be against choice than it is assisted dying". Indeed, the organisations that oppose any form of legalised assistance to die, once previously labelled "pro-life", are now labelled "anti-choice".

In its desire to win mainstream support and become *the* bona fide organisation promoting patient choice at the end-of-life, Dignity in Dying does not dispense any advice to its members about the pragmatics of hastening death. It refuses to give advice about either self-deliverance methods[6] ("rational" suicide) or travelling to Dignitas, which it views as short-term, even irresponsible goals that may jeopardise its hard-won credibility and invite accusations of illegal practice. Indeed, with the change of the leadership in 2000, any board members who favoured more hands-on "exit" methods or were too involved with the work of Dignitas were asked to leave, some of them decamping to FATE. The organisation now campaigns for a very specific form of medically hastened death called "physician-assisted dying", meaning that lethal prescriptions could only be dispensed to people who are "terminally ill", i.e. have only a few months to live. FATE, on the other hand, campaigns for the right to a medically assisted death for all those who request it on the grounds of suffering. Dignity in Dying's new policy, however, does not suit all its

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[5] Debbie Purdy, who has Multiple Sclerosis, wanted a "clarification" of the factors that the Director of Public Prosecution (DPP) would take into account when deciding whether or not to prosecute her husband, Omar Puente, in the event of him helping her travel to Switzerland to end her life. This was the highest-profile legal challenge on this issue since the Pretty case in 2002. Debbie Purdy and Omar Puente won their case at the House of Lords in July 2009 as a result of which the DPP produced an offence-specific policy.

[6] Techniques for taking one's own life when a person has made a "rational" decision to do so due to irreversible illness.

members, as illustrated by the following comment made by a member of the organisation at its 2008 AGM (to a round of applause and "hear hears" from the audience):

> 'Terminal' is not the salient point here. Surely if a person's disease is not terminal, then [assisting them to die] is even more pressing!

Unlike Dignity in Dying, FATE gives advice about self-deliverance methods and travelling to Dignitas. Members are determined to help people who are suffering and who feel they cannot wait for any possible future Act of Parliament (which might also be very restrictive in its scope). FATE, which is a much smaller organisation than Dignity in Dying, does not aspire to become a great political lobbying force that needs to be above reproach. As of 2008, there were still only approximately 400 members, as compared to Dignity in Dying's 100,000 members and "supporters" (those who do not pay annual subscriptions but have in the past consulted the organisation). Such a small, relatively informal group does not have the same levels of accountability or hierarchies of governance as an organisation like Dignity in Dying. Members do not have to maintain a corporate view. Instead, they are a collection of individuals with different personal views. Notwithstanding its recent high profile in the media due, in the main, to its involvement with the activities of Dignitas, FATE remains a grassroots organisation, which focuses on regular networking and information sharing among members. While FATE members do not resist Dignity in Dying's professionalisation and mainstreaming agenda (and indeed they would be the beneficiaries should this agenda ever successfully secure an Act of Parliament), they would not compromise on the more "traditional" goals of the right-to-die movement: receiving help to die on the grounds of suffering and autonomy rather than on the grounds of having a "terminal" diagnosis.

The different perspectives of FATE and Dignity in Dying are exemplified by their views on Dignitas. The Swiss organisation has attracted vast amounts of publicity and media attention on an international scale, and this has helped to keep the assisted dying debate in the public arena as much as any Dignity in Dying campaign of recent years, or even its high-profile legal cases. Yet, Dignity in Dying does not support Dignitas' activities. Ostensibly, the organisation's reasoning is that helping someone travel to Switzerland could be tantamount to "encouraging or assisting a suicide and therefore a criminal offence".[7] However, there is also a sense in which many advocates simply do not like the idea of Dignitas. One House of Lords peer who lobbies strongly in favour of assisted dying legislation in Britain told me in an interview that it was "seedy" and that only "eccentric" people would go there to die. Another right-to-die campaigner who had worked at Dignity in Dying for many years told me that she thought it was "freaky" and dangerous because it was unregulated. FATE activists, on the other hand, do not view Dignitas only as a last resort for desperate people. Instead, they embrace the lay (non-medicalised) model of assistance to die, which Dignitas represents (there is no medical professional present when the lethal dose is taken). FATE actively supports Dignitas, and members believe there would be a role for the organisation even if assisted dying were to be made legal in the UK. As one activist who eventually travelled to Dignitas for help to die told me: "the very last thing I want is to be in the hands of others. I do not want to be dealt with as a medical object". It is this long-term support for different types or models of assistance to die, dependent on individual preference, which differentiates FATE members from Dignity in Dying's paid workers. These differences undoubtedly cause some friction between the two organisations. As Dignity in Dying's Human Rights Officer told me:

> Because FATE assist people more than they should do legally then we can't have anything to do with them, even if we wanted to. And I'm not sure we would want to.

New social movements often fail to demonstrate the same unity that was evident in the "old" social movements, specifically the working-class and party political movements, which were more hierarchical and centralised (Johnston et al. 1994: 9). While Dignity in Dying has a clear "party line" to uphold, FATE, as one activist told me, prides itself on being a "broad church" of ideas with no need for censorship in the expression of those ideas.

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[7] According to Section 2 of the Suicide Act 1961, the wording of which was amended by the Coroners and Justice Act 2009, it is a criminal offence, punishable by up to 14 years in prison, to do an act capable of encouraging or assisting the suicide or attempted suicide of another person.

Pragmatism and the Pursuit of Freedom

It is submitted here that FATE's demographic contributes to its non-conformist approach. While it was observed that the majority of members attending Dignity in Dying's 2007 and 2008 AGMs were older than 65, the organisation's paid staff and Chief Executive represent a much younger demographic (they are in their twenties and thirties). As I stated earlier, FATE's membership has an average age of 68 years and 74% of members are older than 60 (Judd & Seale 2011). The group's key organisers are mostly retired and therefore have fewer concerns about airing "controversial" views that may impact negatively on their careers (especially for people working in the healthcare professions). The fact that they are not getting paid to be active in the movement suggests a different type of commitment, one not associated with careerism. By the age of 68 years, most people will have experienced the death or physical decline of family and friends and will have begun to contemplate their own. As Brogden (2001: 48) notes, suicide rates are higher amongst older people than any other age group, and the suicide attempts of the old have greater lethality, being made with no warning or requests for help. While there is little agreement about the reasons why older people remain at the highest risk of completed suicides (Kellehear 2007: 229), it is possible to deduce that older people are more determined to assert their will.

Some key members of FATE are also less concerned about skirting the fringes or even personally testing the limits of the law on this issue. For example, one member (and key research participant) was arrested and questioned by police for allegedly giving advice on the phone about the techniques of self-deliverance to a caller who subsequently took his own life. That member is 83 years old. It is a very hands-on form of activism, which is a manifestation of deeply held convictions. Gray Panthers founder Maggie Kuhn summarises the commitment of older activists as follows:

> The old, having the benefit of life experience, the time to get things done, and the least to lose by sticking their necks out, [are] in a perfect position to serve as advocates for the larger public good (1991: 38).

The "public good" in which right-to-die activists believe is that of allowing people to die when they want to rather than expending public resources keeping them alive against their will.

My long-term research with FATE led me to conclude that the form that members' activism takes is influenced by their age, in that first and foremost it is guided by pragmatic considerations. Some older members of FATE feel that while they support all political campaigns to change the law on assisted dying, they may not personally have time to wait, if indeed waiting will bring the desired legislative change. This draws them towards matter-of-fact debates about the mechanics of dying and of hastening death, which many outsiders would shrink at. It is not that the moral rightness of their cause is of no interest to activists. Rather, it is that it appears self-evident to them, and therefore the debate, for them at least, can more usefully shift to pragmatics.

FATE's pragmatic mission can be related to Richard Rorty's (1998) pragmatist philosophy. Rather than arguing one's case for a certain course of action from the basis of first principles or from assertions about transcendent human attributes, Rorty (1998: 167) argues that it is better to pose the question "what can we do with ourselves"? He proposes engaging people in effective action which in a simple way makes people's lives better: "niceness champions obedience to moral law" (1998: 182). FATE members' activism reflects this philosophical position. Activists discuss "difficult" cases: deaths that went wrong through bad planning; examples of poor care or poor medical advice; people whose families are proving obstructive. There is little discussion of foundational principles. There is an "ought" that goes without saying, which is that autonomy *ought* to be respected and suffering relieved. It is tacitly assumed that anybody who attends FATE meetings or phones up to ask advice also takes these two principles as given. And from that perceived indisputable point of departure, pragmatics take centre stage.

Activists are interested in seizing the tools and information they have at their disposal to help people achieve the death that they desire. The group has managed to retain an ethic of freedom of both action and expression that Dignity in Dying appears to have lost in its desire to gain mainstream acceptance and to operate very strictly within the law. Whereas Dignity in Dying wants to institutionalise (through legislation) the freedom to die at a time of a person's choosing, the FATE members I got to know are open to adapting to freedom's more contingent character. They want a change in the law, yes, but this would not remove the desire to keep other avenues open – Dignitas, for example – or learning the techniques of self-deliverance. To be free is to be free to adapt to circumstances and the means available. Relying on the state may not always be an option. Their focus on pragmatics rather than procedures, organisational accountability and, for that matter, legality enables them to enlist freedom's contingency. The political philosopher Foucault wrote about the paradox of trying to legislate for freedom:

> Liberty is a *practice* . . . The liberty of man is never assured by the institutions and laws that are intended to guarantee them. This is why almost all of these laws and institutions are quite capable of being turned around. Not because they are ambiguous, but simply because "liberty" is what must be exercised (Foucault 1984: 245).

Part of the desire to resist institutionalising freedom of choice may stem from the fact that many members' motivation for joining the group comes from a determination to resist the societal trend towards institutionalising older people when they become frail due to a shortage of informal care in families (Seale 2005: 381). It is also predominantly older women who live[8] (and die[9]) in care homes, a fact that, along with greater longevity, perhaps explains why right-to-die societies are also dominated by women. For

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[8] According to a 2004 Focus on Gender report published by the UK Office for National Statistics, there were two and half times as many women in residential care and nursing homes compared with men: 269,000 women and 104,000 men. See http://www.unece.org/fileadmin/DAM/stats/gender/publications/UK/Focus_on_Gender.pdf.

[9] A 2010 National End of Life Intelligence Network Report based on figures from the Office for National Statistics states that a lower proportion of males than females aged 75 and older died in nursing homes (males 9.0%; females 14.2%) and old people's homes (6.1% males; 12.8% females), and that the proportion of deaths in nursing homes and old people's homes increased with increasing age (p. 7). See www.endoflifecare-intelligence.org.uk/view.aspx?rid=82

many of the members of FATE whom I interviewed and interacted with, it is the prospect of the loss of personal freedom upon moving to an institution, which motivates them to want to become involved in the right-to-die movement. As one activist said:

> I would never allow myself to go into a home. I'd have to eat everything they ate. And it would be so incredibly boring. Can you imagine? I've seen far too many homes.

Unwanted institutionalisation and dependency has also been postulated by Kellehear (2009) as a reason why older people might choose to die alone. Although "natural" death is often deemed to be the preserve of the old, FATE's older members would rather die an "unnatural" death than be institutionalised, or forced, as they see it, to suffer the "slow dying" resulting from longevity. Whether they are conforming to a stigmatised view of old age (by fearing dependency) or defying it (by choosing death in order to resist the infirmities of old age or institutionalisation), the societal stigma around old age undoubtedly shapes their anticipation of death.

Conclusion

Walter et al. (1995) argued that it is the media that brings death out of private homes and hospital wards and makes death present in public life. Yet, I argue here that it is also the passion and convictions of older right-to-die campaigners that have helped to stimulate a public debate about death in the UK in recent years and present a particular challenge to the taboo on death. FATE's courting of the media through openly publicising the help it has given to people wanting to travel to Dignitas has resulted in many column inches being devoted to the group, quite disproportionate to the size of its membership. The FATE activists who participated in my research were predominantly retired professionals who want a platform from which to articulate their concerns and demands. They want to facilitate people's "good death" experiences, including their own, and are prepared to engage with the practicalities of suicide in order to do this. While it goes without saying that most older people are not affluent, highly-educated activists and, indeed, that many older people may not desire to maintain their autonomy at all costs (as research by Gott et al. (2008) and Kelner

(1995) highlights), it is equally important to record and discuss the experiences of older people who refuse paternalism in all its guises (Kellehear 2009). FATE activists' vision of the ''good death'' is one that is both foreseen and controlled, and where biological and social death converge. The group's main activity is dispensing advice about travelling to Dignitas and, in lieu of this option, methods of self-deliverance. FATE members are more interested in tactics and *action now*, the moral rightness of their cause appearing self-evident to them. The older age of the FATE activists, and the sense they have of their own impending mortality, means that they have less inclination to cogitate and wait for test cases to come to court or a promised groundswell of public opinion, which may or may not deliver a change in the law. It is these factors that differentiate FATE's modus operandi from that of Dignity in Dying and give its members a very specific orientation to freedom in their approach to death.

Acknowledgements

I would like to thank all the participants who contributed to this research. The project was funded by the Economic and Social Research Council (Grant number PTA-031-2005-00228).

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International Journal of Ageing and Later Life, 2012 7(1): 33–52. © The Authors

'He wasn't in that chair': what loneliness means to widowed older people

By Kate Mary Bennett[1] & Christina Victor[2]

Abstract

We have little robust empirical evidence that articulates what being lonely means to older people and even less knowledge about what loneliness means to older widows and widowers; this article addresses that deficit. We undertook a re-analysis of 125 interviews with older people (aged 55–98) that explored their experiences of widowhood. In this article, we focus on those interviews in which participants described themselves as experiencing loneliness by the spontaneous use of terms such as "lonely", "loneliness" or "lonesome". Almost half of the participants (42%) described themselves in that way without *any* prompting from the interviewer. In terms of understanding and describing the meaning of loneliness, 50% explained loneliness in terms of absence of either their spouse, a physical presence in the house or people. One-third (34%) discussed loneliness in relation to time and place: night, weekends and home, and 4% described the emotional impact of loneliness. Fifteen per cent just said they were lonely without elaboration, assuming a common understanding of what loneliness means. Our findings suggest that widowed people's understanding and experience of loneliness resonates

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with the concept of "emotional" loneliness, resulting from the loss of significant social and emotional attachment. This has important implications for the types of interventions that may be appropriate for remediating loneliness in this group.

Keywords: later life, widowhood, loneliness, emotion, time and place.

Introduction

There is extensive quantitative literature in the United Kingdom, Europe, North America and Australasia documenting the prevalence of loneliness and the key risk factors thereof (Dykstra 2009; Fokkema et al. 2012; Victor et al. 2009; Yang & Victor 2011). Sheldon (1948), in his landmark study of old age in Wolverhampton, reported that 7.7% of those aged 60/65 and over were often or always lonely, compared with 13% of widowed participants, and that 78% of those who described themselves as lonely were widowed. Contemporary research has confirmed the statistical association between loneliness and widowhood in old age. Victor et al. (2005a), for example, report that in Britain loneliness amongst widowed individuals aged 65 and above was 20% compared with 1% among married, 7% among divorced and 9% among separated individuals. This is typical of the excess levels of loneliness found amongst widowed people across a diverse range of countries and is not a consequence of confounds, such as age and gender (e.g. Dykstra & Fokkema 2007 for the Netherlands, Kaasa 1998 for Norway, Steed et al. 2007 for Australia, Theeke 2009 for the United States of America and Wang et al. 2011 for China).

Two key conceptualisations of loneliness, cognitive deficit and loss, underpin the quantitative measurement of loneliness. The cognitive deficit perspective proposes that loneliness is a deficit between actual and desired quantity and/or quality of social engagement (Peplau et al. 1982). Within this framework, the Theory of Mental Incongruity (Dykstra & de Jong Gierveld 1994) suggests that loneliness is formed by a mismatch in the interrelationship of cognition, experience and expectations of social relationships (see also van Baarsen 2002). The loss perspective focuses on the absence of specific attachments and differentiates emotional loneliness (the loss of a key attachment figure such as a spouse) from social loneliness (a reduced social network) (see Weiss 1973). In his extended Bowlby theory, Weiss (2007) argues that whether or not a relationship is functionally substitutable is a key feature of the distress that manifests itself as loneliness. Both of these perspectives have relevance to the widowed population who experience reductions in their social networks (Bennett et al. 2005a; Utz et al. 2002) and the loss of a primary attachment relationship that is both functionally highly specific and ''non-substitutable'' (Weiss 1973).

What do studies of widowhood in old age have to say about loneliness? Loneliness has been reported as a feature of widowhood from the earliest studies (Atchley 1975; Bowling & Cartwright 1982; Lopata 1980; Parkes 1972). Lund et al. (1993) reported that it was the greatest difficulty faced by older widowed people. A number of recent studies have examined whether loneliness among widowed people can be explained more effectively by the loss perspective or by the Theory of Mental Incongruity (van Baarsen 2002). There is evidence both for the Theory of Mental Incongruity (Dykstra 1995) and for social loneliness (Utz et al. 2002). Dykstra & De Jong Gierveld (2004) found evidence for both emotional and social loneliness, when marital history was considered alongside gender. Being socially embedded provided protection from emotional loneliness for women but not men, for whom the marital bond was more important both socially and emotionally. Van Baarsen (1999) tested hypotheses from both Mental Incongruity Theory and emotional/social loneliness. She found that whilst there was much support for emotional loneliness, there was only some support for the theory of mental incongruity. What was most interesting was that social support, whilst not providing protection from loneliness in the short term, did so in the long term. Thus, it is important to consider the temporal dimension in widowhood and loneliness research as well as age, gender and factors linked to the quality of the marital relationship. To date, the strongest quantitative evidence supports an emotional loneliness explanation with loneliness caused by the loss of the spousal attachment figure (Stroebe et al. 1996).

As the evidence we have presented so far has shown, the focus in most studies of loneliness has been on enumerating the extent of the ''problem'' of loneliness and establishing the characteristics of those groups most at risk of experiencing this condition with the implicit objective of being able to "screen" potential risk groups and develop remedial interventions. There has been much less emphasis on engaging with the qualitative elements of older people's understanding and experiences of loneliness (see Victor et al. 2009), although the study by Pettigrew (2007) is a notable exception (see Gladstone 1995; Graneheim & Lundman 2010; Hauge & Kirkevold 2010).

The majority of articles on loneliness focus on the precursors to loneliness, the consequences or the correlates of loneliness, with little research examining what it feels like to be lonely (Boyle 2010) and more specifically a widowed person. Qualitative studies of widowhood touch, in passing, on loneliness experiences (Czerenda 2010; Davidson 2001, 2002). Davidson (2001, 2002), for example, reported that for some widowers, motivation for re-partnering was their feelings of loneliness. In the most detailed research, Chambers (2005), in her widows' narratives, identified "loneliness and despair" as one theme. These widows mainly reported feelings of isolation and lack of support from family, with occasional references to the absence of the husband. However, although loneliness was identified as a theme, there is only one quote that directly mentions loneliness. Thus, there are few studies which examine in detail what loneliness means to older widowed people and nothing that examines their spontaneous utterances about loneliness and the situations in which they find themselves to be lonely. This article addresses these deficits in our knowledge base by presenting the re-analysis of two existing qualitative and quantitative studies examining the experience of widowhood amongst older people in England. Our aims in undertaking this analysis were to examine: (1) if participants raised the issue of loneliness unprompted – did it emerge as a spontaneous theme? and (2) how was loneliness following bereavement conceptualised and understood by participants?

Method

The data that formed the basis of this study were derived from two independent studies of older widowed men and women conducted in England. Study 1 was a qualitative study that was designed to explore the experiences of older widowed men and women with an emphasis on understanding the emotional and participatory changes that occurred following spousal bereavement, with data collected in the East Midlands (labelled Mr./Mrs. + letter) (see Bennett & Vidal-Hall 2000). Study 2 focused on gender differences in affect and participation and was a mixed methods study using both in-depth interviews and questionnaire methods, with data collected in Merseyside (labelled Man/Woman + number) (see e.g. Bennett et al. 2005a, b). These two studies combined included 125 widowed men and women aged between 55 and 98 years, who had been widowed between 3 months and 60 years. Table 1 describes our sample. Table 2 shows that there were no statistically significant differences in terms of age, length of time they had been married or duration of widowhood between the lonely and non-lonely groups. There were no differences either between the East Midlands and Merseyside samples.

Participants were all resident in the community, living in their own homes or in sheltered accommodations. They were recruited via a diverse

Table 1. Demographic information distinguishing between sub-groups of lonely and those not spontaneously reporting loneliness

			Age	Years widowed	Years married
Lonely	Men	Mean	79.76	6.63	44.67
		Std. Dev	7.29	6.17	12.36
		Range	72–98	0.5–16	15–64
	Women	Mean	71.27	9.91	33.97
		Std. Dev	7.97	7.78	12.53
		Range	57–90	1–32	12–54
	Total	Mean	75.51	8.27	39.32
		Std. Dev	8.71	7.26	13.43
		Range	57–98	0.5–32	12–64
Non-lonely	Men	Mean	75.32	8.24	40.61
		Std. Dev	8.35	5.9	13.4
		Range	55–90	0.25–25	5–64
	Women	Mean	73.63	13.29	36.85
		Std. Dev	8.14	11.55	12.43
		Range	58–95	1–26 plus an outlier at 60	2–63
	Total	Mean	74.47	10.76	38.73
		Std. Dev	8.23	9.22	13.01
		Range	55–95	0.25–26	2–64

Table 2. *T*-test to show non-significant differences between sub-groups of lonely and those not spontaneously reporting loneliness

	t	df	Sig. p
Age	-0.166	103.827	0.869
Length of time married	0.163	103.479	0.871
Length of time widowed	1.335	116.818	0.184
Place (East Midlands versus Merseyside)	0.174	106.376	0.862

range of formal and informal groups run for or by older people, including organisations run for and by widows, trade unions, organisations supporting older adults and social service departments (see Bennett et al. 2005a for a discussion of selection issues). Interviews were non-prescriptive and semi-structured in nature, as the aims of the original studies were to learn from the widowed people what was important to them using the approach of ''We are the novices and you have the experience.'' We asked about life before widowhood, around the time of bereavement, one year after, and at the time of interview. We wanted to know what respondents did and how they felt at these different times, so we used prompts such as ''what did you do?'' and ''what did you feel?'' (see Bennett & Vidal-Hall 2000). All respondents gave informed consent and the research teams tape-recorded the interviews, conducted at the respondents' homes, ranging from three-quarters of an hour to an hour-and-a-half. Interviews were transcribed verbatim. Ethical approval was obtained from appropriate local ethics committees.

Analysis

Stage 1. This method was the same for both studies. As the interviews were completed, they were transcribed and analysed using a grounded theory approach (Bennett & Vidal-Hall 2000; Charmaz 1995; Smith 1995). More specifically, the interviews were read line-by-line to gain a holistic overview and then re-read and coded. This process was reflexive, and as new codes and themes emerged, the interviews were recoded. Although the two studies were independent, the content of the interviews had many similarities and over 300 codes emerged from the analysis of the 125 interviews. The codes were diverse, including talking to the dead spouse, death narrative, grief and keeping busy. Another notable code was lonely. This was generated when participants spontaneously used the words "lonely", "loneliness" or "lonesome" but not simply the word "alone". Fifty-three of the 125 interviews (42%) were coded as lonely. Analysis of the code "alone" is presented elsewhere – in that work, women (but not men) who talked about being "alone" were more likely to be coping well (Bennett et al. 2005a). Thus, we believe that being alone has different meanings from being lonely or lonesome. All interviews were coded blind by other members of the original research team so that reliability across interviews could be assessed – agreement was found to be 80%.

Stage 2. Fifty-three interviews, where loneliness was spoken of spontaneously, were analysed in detail with the focus on those passages where participants spoke explicitly of being lonely, lonesome or of loneliness. These passages were coded in a similar manner to stage one, that is, independently by members of the current research team.

Three key themes emerged from this reanalysis: notions of absence, the spatial/temporal aspects of loneliness and unelaborated loneliness. The first two of these themes were further analysed to understand in detail the experience of loneliness. Explanations from an individual were not confined to one theme.

Results

Overall, 42% of the participants interviewed in these studies *spontaneously* talked about loneliness: there was no prompting or mention of the topic in the interview guides. Thus, our remaining analysis focuses on this subsample of 53 interviews. We now present the results of the three key themes.

Absence

Absence was a central theme within our participants' narratives of loneliness. In 26 interviews, participants discussed their loneliness focusing on the absence of the spouse, in particular, or the absence of people in general (50% of those participants who reported being lonely).

Of these participants, more than half (61%, $n = 16$) described their loneliness as the absence of their spouse and this broad theme encapsulates four important components: the absence of the spouse, the "irreplaceable" nature of their spouse, the permanence of the loss and the spatial elements of this loss. This notion of loneliness clearly resonates with the ideas of Weiss (1973) about the loss of a "key" attachment figure who is "non-substitutable" being central to the experience of loneliness. Our participants report that they are surrounded by family and friends, live active social lives and do not describe themselves as "outsiders", nor would their communities describe them as lonely. We can see the four dimensions of this theme illustrated as follows:

- Loss of their spouse:

> I felt the absence. (Mr. Q)
> . . . . Only to have her back. (Man 13)

- The specificity of the loss – the absence of the specific person who was their spouse and not simply the absence of someone who could be a spouse:

> Because for me, nobody would ever fill Andrew's shoes. (Mrs. A)

- The permanence of the loss: it is not only the absence that leads to loneliness – it is the permanent absence. Mr. H's wife had been in and out of hospital, sometimes absent for a few months. He had not been lonely then (or at least not in the same way). However, now he knows she is not coming home:

> Suddenly alone . . . previously when I'd been on my own she was goin' to come back in a couple of months but I knew now she wouldn't. (Mr. H)

Although Mr. H uses the term "alone" in this quote (and we have more to say about the use of that word later), rather than the term "lonely", which he does elsewhere, we have chosen this quote because it demonstrates so well the permanence of his situation.

- The spatial elements of the loss of a spouse. Loneliness was associated not simply with the absence of their spouse, or the permanence of this loss but also with their absence from a particular place in the house/home. Often this was absence from a chair,

> He wasn't in that chair. (Woman 29)
> I never sat on my own as my husband was always there. (Woman 9)
> I was always sat in that chair there and whenever I looked up from here she was there. But when she'd gone she was not. (Man 8)

In 10 interviews (39% of those talking about absences), participants talked more generally about the loneliness associated with the absence of people. This resonates more closely with Weiss's (2007) notion of absence of community (friends, kin, etc.) and, perhaps, has more in common with what we would expect when someone describes him or herself as lonely. At the same time, this also reflects the view of Utz et al. (2002) that social networks do shrink, illustrated by comments highlighting that:

> Nobody comes in this house. (Man 28)
> I didn't see neighbors. (Woman 17)
> You haven't got anybody to talk to. (Woman 7)

There is also the pernicious effect that this lack of social interaction can have as illustrated by Mr. D who feels that he no longer can talk to others, and as a result people stop wanting to talk to him – a vicious circle:

> I've lost the art of conversation, people don't have much to do with me.

And the fear that:

> They wouldn't know if I was dead. (Man 12)

Time and Place

The second key theme, that links with the ideas about absence as an explanation and cause of loneliness, relates to the socio-temporal dimension of loneliness. This theme was present in 18 of the interviews (34% of those reporting to be lonely) and relates to the seasonal and weekly patterns of life rather than time since bereavement. Mrs. M drew attention to the importance of time in the genesis of loneliness when she commented:

> Sometimes I . . . from when the sun comes in to the next week, I never sort of see anybody apart from when I go out to see people. Nobody goes, ladies won't come out at night, you know.

Night-time was problematic. In many households, couples would have spent the evenings together, or at least have been in the house together, for most of their married lives, whether working or retired. Now our participants were alone in the house and we can see this illustrated in these comments from both men and women:

> I'm lonely of a night. (Man 16)
> Night-time the worst time. (Woman 31)
> Of a night you're lonely. (Woman 12)

For many women, evenings highlighted their loneliness, making them feel trapped in their own homes. During the day, they could escape the emptiness of their houses but at night there was no escape, unless people visited and as we have seen this was a rare occurrence:

> I shut myself in at night and that's it . . . it begins to worry you. (Mrs. M)
> It's when darkness . . . that you're lonely. (Mrs. C)

This contrasts with most male participants who also spoke of being ''trapped'' within their homes but it was not linked to a specific time of day; in particular, two men (Man 28 and Man 42), used the expression:

> Only got these four walls.

The temporal patterns of loneliness are not simply diurnal but are overlaid by weekly patterns, with weekends seen as a lonely time as these were the days that others spent with family. Interestingly, this observation was confined to the women in our sample as the comments from Mrs. M and Woman 44, respectively, illustrate:

> Such a lonely life .... Saturdays and Sundays are a bit dead for me ....
> So long [Sunday] and so lonely.

In addition, again only our female participants observed that the weekend was also seen as a time when other people were seen in couples ($n = 4$) and this emphasised how lonely the women were without their husbands. As Woman 20 says:

> I find the weekends very lonely because people are always in couples at the weekends.

Unelaborated Loneliness

Fifteen per cent of these participants ($n = 8$) described themselves as being lonely but offered no further elaboration. These participants seem to assume that the interviewer understood what they meant by being lonely and that it needed no additional explanation. Perhaps, they felt that the experience and the underpinning meanings were self-evident. A further 4% simply described the emotional experience of loneliness ($n = 8$):

> The worse thing to endure in life is to be lonely. (Man 43)
> I've never been so lonely in my life ..., it broke my heart .... So you do get a depth of loneliness. (Mrs. I)

Discussion

Significant loneliness is consistently reported by 8–10% of the population aged 65 and above across Britain, Western/Northern Europe, North America and Australasia, with the widowed consistently identified as being at increased risk of experiencing loneliness across a range of studies and countries (Dykstra 2009; Yang & Victor 2011). Rates of reported loneliness are approximately double for the widowed compared with the general population of elders and several orders of magnitude higher than those who are married. Although there are a number of studies that have examined the statistical association between widowhood and loneliness, there are comparatively few studies that have focused on this relationship from a qualitative perspective. Do older widowed people talk about loneliness? How do they conceptualise and understand loneliness and can these understandings help us shape potential interventions to alleviate loneliness both for the widowed and others?

Almost half (42%) of our 125 participants spoke freely and openly about the experience of loneliness without any prompting. Whilst this is a specific population, it suggests that, as Victor et al. (2005b) report, older people are willing to talk about loneliness and that there is scope for more qualitative studies examining this aspect of old age in-depth. We might speculate that, for older people and, more specifically, older widows, the high prevalence of bereavement reduces the ''stigma'' of loneliness that may be more evident at earlier phases of the life-cycle. How do older widows understand loneliness? We can identify three elements of our participants' understandings of loneliness: (1) an intuitive understanding that needed no explanation or which was so profound that participants could not articulate it with precision as illustrated thus ''You felt as though there were something missing but you didn't know what was missing'' (Woman 11); (2), notions of absence; and (3) the importance of time (and place).

It is not surprising that respondents frequently discussed their loneliness in terms of absence, since the popular view of loneliness focuses upon the lack of social contacts (rarely considering that the quality of social contacts might also be important). Indeed, dictionary definitions of loneliness focus on being alone and in solitude rather than either the quality of social relationships or the relationship with a specific ''key'' person. Our respondents were very precise in defining the absence that underpinned their loneliness and it did not, for example, often concern social isolation. Instead, it was identified as the absence of a spouse or indeed the absence of a spouse from a particular location within the home or domestic environment. This focus upon the loss of a key ''attachment'' relationship supports the ideas of Weiss (1973), but our respondents linking the absence of an individual with their absence from a specific location, develops these ideas further. Loneliness is clearly located within both a spatial and temporal context that encompasses the daily and weekly rhythm of life. For our respondents, night-time is clearly a time of vulnerability at which they are most likely to experience loneliness. This resonates with survey results of Victor et al. (2005a), where 64% of those who reported loneliness experienced it at specific times, with almost half (46%) reporting they felt most lonely during the evenings. Loneliness at weekends was only described by women in this study but this again validates the survey findings of Victor et al. (2009) who reported that 75% of women and 52% of men reported that loneliness was linked to the weekends. We may explain the gender differential in terms of the link between loneliness and weekends by reference to the work of Bennett et al. (2003) who observed that widowers are more likely to be taken care of by their families at weekends. For example, they are more likely to be invited for a meal on a Sunday by offspring or other relatives than are widows who are perceived as more “domestically competent”. This may reflect attitudes about the perceived relative abilities (or otherwise) of widowed men and women to care for themselves. Our results show, for the first time, that these social relationships are played out within the context of time, space and place. Our participants’ comments demonstrated how these are explicitly and inextricably linked. We did examine our data to see if there was evidence of patterns of loneliness that were related to time-since-bereavement. However, there was no clear evidence suggesting time-since-bereavement was an important factor in the discussions of loneliness.

Our finding about the different types of loss/absence that underpin loneliness – the death of a spouse and/or the denuding of the social network and the temporal nature of the loneliness (and the variability between men and women) – have implications for both the development and delivery of interventions to alleviate loneliness in general and after bereavement. Some interventions can compensate for some losses that arise from bereavement by providing opportunities for social participation. Interventions could be timed to respond to the time/days of week when feelings of loneliness are most extreme but this suggests the need for flexibility in service delivery timetables that are challenging for statutory service providers. The data also suggest that interventions may need to be scheduled differently for men and women. However, voluntary and “self-help” organisations may be more appropriate and perceptive in developing services/interventions that may mesh more sensitively with expressed needs of widows. For example, services like the Widow-to-Widow’s programme in the United States are more likely to understand the importance of the timing of interventions (Silverman 1986). Many groups for widows meet on a Sunday, as indeed do the widows from the East Midlands in this study. Thus, ‘‘night-time’’ and/or weekend telephone befriending services may be more appreciated than day-time services. However, the majority of our participants report that it is the loss or absence of the spouse that it is the root cause of loneliness and this is more difficult to alleviate and to design interventions for. Some widowed people do put in place strategies to reduce those feelings of absence. For example, widowed women report rearranging the bedroom or the living room and changing the position of ‘‘that chair’’. Others avoid coming home at particular times or go out to avoid reminders of their lost attachment. As with the Widow-to-Widow’s programme or the East Midlands’s widowed groups, this type of advice might be more readily received from other men and women in the ‘‘same boat’’, rather than from more formal agencies.

Loneliness Versus Alone

Statistically, loneliness is associated with a range of negative health and quality of life outcomes (see Luanaigh & Lawlor 2008). We can see these negative consequences articulated by our participants who observed that ‘‘loneliness is a terrible thing’’ (Man 37) and that the experience of loneliness could explain ‘‘. . . why people do silly things to themselves when they’re lonely’’ (Woman 8). Conceptually, it is important to distinguish between being lonely and being alone. Woman 11 points out the distinction between choosing to be alone and the loneliness which is imposed by the loss of a spouse thus ‘‘Loneliness forced upon you – I am lonely. I am also alone but that’s totally different.’’ Indeed being alone and adjusted to this way of life can have positive psychological benefits as Bennett et al. (2005a) found: older widowed women who reported being comfortable alone were more likely to be coping than women who did not, or men in general.

Conclusion

Our data demonstrate that older people are willing and able to talk about loneliness. In our case, participants spontaneously raised this topic. Hence, we feel confident that we can address this issue in-depth within the context of qualitative interviews focusing on social engagement and participation in later life as the work of Victor et al. (2009) also suggests. The study also demonstrates that widowed people are not ashamed, embarrassed or upset about talking of loneliness. To them, and this is illustrated by those who do not elaborate on what it means, loneliness is a common and indeed potentially normative aspect of widowhood. Thus, it seems reasonable for studies to be more direct in discussing loneliness with older people or, indeed, other age groups. It is after all no more sensitive than asking widowed people about their bereavement.

This study provides evidence to support both the cognitive deficit and loss conceptualisations of loneliness illustrating the complex and dynamic nature of loneliness. Widowed people who talk about being lonely are making (implicit) comparisons between what social contact they would like, often with their spouse, and what they actually have, and this is often in the context of the presence of more general social contacts. This is true also of the temporal context of their loneliness, for example, wishing for company at night or on Sunday. At the same time this evidence also supports the deficit approaches – but is more specific than the theory might imply. Our widowed people report, in general but not always, a specific deficit – the loss of a spouse – the location of that within a specific space and/or a specific temporal context, such as night-time or weekends. Rather than seeing these models as in competition our data suggest that they complement each other but that we also need to build on ideas about space and time when developing our theoretical understanding of loneliness and generating interventions. A model of widowhood and loneliness should recognise that widowed people (a) may experience reductions in actual social contacts; (b) may experience incongruence between actual and desired quality and quantity of social contact; (c) may experience losses in the relationships of community; and (d) almost always experience the loss of a single and significant attachment figure. And whilst they may experience all or few of them, they are not static experiences, they are dynamic and any model needs to recognise that these experiences are influenced by time and place. Thus, we would argue that there is a rich research agenda to be pursued in developing our understanding of loneliness and the focus on widowhood enables us to identify key issues that are, perhaps, more obscure in studies of the general population. Our study, based upon the re-analysis of existing interview data, provides new insights into the issue of loneliness in general and loneliness and widowhood more specifically. Older widowed people *do* spontaneously talk about what loneliness means to them and how they experience it.

Acknowledgements

Thanks are due to the men and women who participated in this study and to the people who assisted with data collection. Thanks are also due to Georgina Hughes, Philip Smith and Steph Vidal-Hall. KMB would like to thank the Department of Human Communication, De Montfort University for support. This research study was also supported by the Economic and Social Research Council (Award No. L480254034) and was part of the Growing Older Programme of 24 projects studying the quality of life of older people. However, the findings reported here are entirely the responsibility of the researchers. The studies received ethical approval from appropriate local ethics committees.

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International Journal of Ageing and Later Life, 2012 7(1): 53–78. © The Authors

Rhetoric and reality of daily life in English care homes: the role of organised activities

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Abstract

In divergent ways, both government policy and care home practices influence the everyday life of older people living in English care homes. The rhetoric of choice for care home residents may be in conflict with the reality of government policy-driven service delivery. The aim of the article is to examine the role of organised activities in facilitating choice and active ageing among care home residents. Findings from a study of ten care homes in South East England exemplify the conflict between government policy rhetoric and the reality of care home life. The indication is that the formality of the "activities of daily living" support procedures restricts residents' involvement in the organised social activities. Within the general provision of services, the organised "social activities" offered failed to meet the interest, cognitive and physical abilities of residents. The reality

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of "choice" is therefore questionable. Policy needs to support a transformation in the delivery of care to ensure it addresses the actual needs and expectations of older people experiencing care home life.

Keywords: activities of daily living, organised social activities, daily life, choice, care homes, policies, rhetoric and reality.

Introduction

Both government policy and care home staff practices influence the everyday life of older people living in English care homes, but these present divergent pictures. The rhetoric of "choice", "autonomy" and "dignity" for older people may be in conflict with the reality of policy-driven service delivery in care homes. Rhetoric places the older person in the centre, yet in reality service providers aim to meet formulaic criteria set by governing/regulating bodies and commissioning purchasers.

Whilst the move into a care home is ultimately determined by an individual's health and social care needs, there is a growing awareness that there is more to care home life than providing assistance in personal care, ensuring medication is taken and nutrition is provided. Current government policy rhetoric in the United Kingdom (UK) is focused on facilitating empowered personalised care that is negotiated between resident and care staff (Morton & Morgan 2009) and tailored to an individual's person-centred needs (Innes et al. 2006). The aim of this article is to examine the role of organised activities in facilitating choice and active ageing among care home residents, and in so doing address the relationship between policy rhetoric and reality in practice.

The study was undertaken in ten care homes in South East England. Evaluating the mundane, taken for granted, routine of daily life experienced by older people living in a care home provides insight into how physical and psychosocial aspects of residents needs are catered for.

Background

For the oldest old living in care homes a considerable step towards disengagement from society can be seen to have taken place; active ageing appears to take low priority and social capital diminishes. It is the need for support in the undertaking of formally identified "Activities of Daily Living" (ADLs) that has instigated the transformation in an older person's existence, resulting in their move into a care home. Ultimately, meeting care needs appear to become key determinants of care home residents' quality of life.

Resident's everyday life is determined by the need to adapt to community living (Eyers 2007), and detachment from both their previous living environment and social context becomes unavoidable. This reformed lifestyle within care homes is strongly regulated by UK government policy aiming to ensure basic outcomes are achieved (Care Quality Commission 2009; DH 2003) and influenced by a workforce aiming to provide care and support ADLs to the best of their ability (Eyers & Bryan 2006). Within this revised lifestyle and new environment, the aim should be to maximise an individual's well-being and enable re-engagement in leisure activities previously enjoyed. In turn this should result in an overall improvement in the daily life experiences of older people living in care homes. The following section considers active ageing and the life of older people living in the community in contrast to that of care home residents.

Active Daily Life in the Community and Care Homes

Over the last ten years, active ageing as described by the World Health Organisation (Kaleche et al. 2005; WHO 2002) has been seen to be the panacea of old age. It is predicated on older people having the physical and cognitive abilities to actively and safely take part in society. In turn, society is required to accept and facilitate an environment that welcomes and includes older people. Everyday life for many autonomous old people reflects their personal life course (Clarke & Warren 2007) and consists of a blend of activities ranging from sleeping at night to the pursuit of leisure activities and socialising with other people (Arber et al. 2003; Davidson et al. 2003; Gunnarson 2009). A further important factor is that activities have been found to have a positive impact on health (Agahi & Parker 2005), well-being and self-esteem (Litwin & Shiovtz-Ezra 2006).

Whether an older person lives at home or in a care home, the core principles of active ageing remain the same. However, as Johnson et al. (2010) identified in their comparison of present care home life with Peter

Townsend's (1962) classic study: "In both periods there were residents who were undermined by institutional living, and unhappy at the boredom and inaction imposed by the regime of some homes, and the lack of meaningful occupation" (Johnson et al. 2010: 139). Indeed in some instances Johnson and colleagues observed how a decrease in meaningful activities was now taking place because the residents no longer needed to earn money or help with housework, such as laying the table. As pointed out by one of the managers in the study by Johnson and colleagues, health and safety regulations limit such activities. Contrary to government rhetoric relating to autonomy and person-centred care, such findings imply a restriction in everyday activities. Before considering everyday life in care homes it is salient to initially consider how older people living "at home" fill their days and maintain their lifestyle.

Studies undertaken of the Swedish community-dwelling older people, aged over 75 (Gunnarson 2009; Paillard-Borg et al. 2009), identify reading as the main leisure activity closely followed by "making handicrafts". Mental activities (doing crosswords, cultivating political and cultural interests) were found to be very popular as were "productive activities" (gardening, handicrafts). Some of the least frequently undertaken activities among the oldest old included singing and playing bingo. The findings of Paillard-Borg et al. (2009: 809) provide a highly relevant insight into the reality of activities in later life. They list 31 activities, ranging from reading as the most frequent, down to reminiscing as the least frequent, and the findings exemplify how advanced age impacts on participation in leisure activities.

Within care homes, once support with the ADLs has been provided in the limited available time of approximately 29 minutes per resident (Eyers 2007), there is potentially sufficient time in the day for a care home resident to pursue individual activities and interests that present a continuation of their previous lifestyle. Such aspects of everyday life are relevant to empowered personalised care (Morton & Morgan 2009) aiming to encompass choice, autonomy and dignity.

To date there has been little research on the lifestyle or leisure activities of older people living in care homes. If leisure activities are addressed they tend to be camouflaged by the term "rehabilitation" (e.g. Reilly et al. 2006), which in the UK links to National Health Service policies relating to the health of older people (DH 2001).

Activities of Daily Living Within Care Homes

The emphasis in care home research to date has predominantly been a reductionist approach to care giving (Lhussier et al. 2005; Markle-Ried & Browne 2003), where care giving has been reduced to basic care with a focus on supporting ADLs. Within the context of both health and social care assessments, ADLs relate predominantly to personal hygiene, dressing and eating (Katz et al. 1963; Lawton & Brody 1969; Roper et al. 2000). The formal conceptualisation of ADLs has provided the basis of care plans put in place for older people both in hospital and in care homes. The research literature relating to ADLs tends not to focus on leisure activities but only on an older person's ability to competently complete personal care and instrumental tasks to enable daily living (Warner Schaie et al. 2005). The framework of ADLs is geared towards ensuring that the relevant support or action by care staff is taken, so that a resident is washed, dressed, eats meals and is "toileted".

In the completion of these ADL tasks there is a constant conflict between "clock time" and "process time" (Eyers 2007). Whilst a member of staff might have five minutes to assist a resident with their breakfast, it might well take ten minutes for that person to eat their toast and drink a cup of tea. In addition, it might unexpectedly be necessary to wash the residents' face again and change their clothes. In this instance, care staff are likely to change the clothes without questioning which clothes the resident might like to wear (Eyers 2007).

In reality, care staff have little time to accommodate choice, autonomy or individuality; they have a job to do and according to both Lee-Treweek (1997) and Ungerson (2000), a "product to produce". Supporting and undertaking ADLs are vital to the daily well-being of care home residents and central to the work undertaken by care staff. Indeed, the inability of an older person to undertake these tasks independently is closely linked to the reason they now live in a care home. However, given the available direct contact time between staff and residents to support the

ADLs, facilitating the complex care needs of a group of residents may well conflict with preferred ‘‘social activities’’ of an individual resident.

Policy Frameworks Regarding Daily Care Home Life

Research has shown that leisure and social activities have a strong relationship with well-being in later life (Havighurst & Albrecht 1953; Rowe & Kahn 1997). It is therefore important to evaluate the 24-hour day experienced in care homes and to consider the interconnection between staff undertaking ADLs and residents' opportunities to engage in ‘‘social activities’’. At the time of data collection for this article (2007–2008) the UK National Minimum Standards for Care Homes for Older People (DH 2003) regulated the registration of service providers in the care home sector. This policy document is relevant to service regulators, care home providers and service users, and indicates the expected *minimal standard* of achievements required in order to obtain and maintain registration to operate the care home. The overall aims of the Standards acknowledge the ‘‘... unique and complex needs of individuals ...’’ and aim to ‘‘... deliver an individually tailored and comprehensive service ...’’ (DH 2003: vii).

Within Chapter 3 of the document, daily life and social activities are outlined under Standards 12–15. Here choice, variety, opportunity and flexibilities are specified as key characteristics expected of the care home service provided. Highlighted text in the document states: ‘‘Service users are helped to exercise choice and control over their lives’’ (DH 2003: 15). The aims of the Standards and especially the text in Chapter 3 indicate that policy makers are very much aware of the importance of daily life activities. The successful completion of instrumental ADLs such as washing and dressing in the morning prepares an older person for the rest of the day and is an important step towards residents being able to actively participate in care home life.

At the time of data collection, health and social care policies in England were under review and at government policy level, the ‘‘Berlin Wall’’ (Glendenning et al. 2002) between health and social care services was being prepared for deconstruction. Wide ranging discussions were taking place and a White Paper titled ‘‘Our health, our care, our say:

A new direction for community services" (DH 2006) was published. The document "Putting People First: A shared vision and commitment to the transformation of Adult Social Care" exemplified how the National Health Service and policies on Adult Social Care should work together (DH 2007). An explicit theme was personalised care to ensure the best possible quality of life through "enablement and high quality personally tailored services... maximum choice, control and power ..." (DH 2007: 2). Within English government policy documents and information brochures, promoting dignity was a key concept, irrespective of age. It was, however, also discreetly stated that "the right to self-determination will be at the heart of a reform system only constrained by the realities of finite resources and levels of protection which would be finite but not risk averse" (DH 2007: 2). Thus, indicating an acknowledgement that there may be a conflict between rhetoric and reality.

Since completion of our data collection, the regulation of care home services has transferred from the UK Commission for Social Care Inspection (CSCI) to the Care Quality Commission (CQC) established in April 2009. All care homes in England are now required to register with the governing body that regulates the provision of care home services. The role of the CQC ranges from regulating the architecture of the building, to the quantity and quality of staff, and to the everyday activities provided for residents. A review of the guidelines has been undertaken, and under current policy (November 2011) respecting and involving people who are being provided with a service is identified as an important outcome and can be linked to everyday activities (CQC 2009).

Within a case study used by CQC as an example of bad practice, reference is made to the inability of people with learning disabilities living in a care home to attend a pub quiz because it takes place at a time when a change of staff takes place (CQC 2009: 41). A further CQC example of bad practice relates to the independence of older people living in a care home. It describes how residents were required to use a wheelchair, although they were able to walk with the assistance of a walking frame, because it saved staff time and prevented falls (CQC 2009: 40). These examples of everyday life in care homes, used to exemplify recognised bad practice and assessment outcomes, were seen, respectively, to be of major and moderate concern. As such they indicate the policy interpretation of personalised care. These more measurable aspects of care contrast with the less tangible characteristics of personalised care, which focus on the ability of care staff to have patience, be compassionate, sensitive and be able to empathise with a care recipient whilst supporting them to perform ADLs.

Research Design

The aim of this study was to better understand everyday life in care homes by focusing on the role of organised leisure activities, and how these are influenced by the staff practices to accomplish ADLs for residents. In ten purposively selected care homes for older people situated in South East England, quantitative and qualitative data were collected from 145 male and female residents, aged 60–100 years. In order to ensure a high number of participants were able to give informed consent, only care homes registered for 35+ residents were selected. The ownership of the homes covered local authorities, the voluntary sector, large corporate organisations and small businesses (see Table 1). The intention was to capture the breadth of service providers encountered in the UK where in the norm care homes are independent of the National Health Service. Ownership encompasses municipal Social Services, the voluntary sector, small family businesses and large corporate organisations. For many years, the majority of care homes operated in buildings that were formally large family homes or mansions that were converted into care homes with extensions added. At the time of data collection, a phase of transition was taking place, as many of the converted buildings no longer met the minimum building

Table 1. Characteristics of ten studied care homes

Selection criteria	1	2	3	4	5	6	7	8	9	10
No. of beds	60	44	38	38	72	43	58	74	82	47
Vol. sector owner	✓									
Local authority owner		✓[a]	✓[a]	✓[a]						
Corporate owner					✓[b]	✓[b]	✓[b]	✓	✓	
Small business										✓
Purpose build	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Conversion								✓	✓	✓

[a,b] Same ownership.

standards set out in the National Minimum Standards for Care Homes for Older People (DH 2003). Geographically the homes were situated in suburban and rural areas and aimed to cover a spread of socio-economic groups. All the participating facilities met the required National Minimum Standards for Care Homes for Older People (DH 2003) and consequently were considered to fulfil the statutory criteria set by policy makers.

Prior to conducting the research, information about the study was provided to the home management, all care home staff, residents and their relatives. On the day that the data collection commenced, a presentation was made to residents and staff in each home. Residents who had volunteered and were cognitively able to participate in the study each had a detailed conversation with the researchers before signing the consent form to participate in the study, which included keeping a daily diary log over a period of two weeks denoting their everyday activities. As the majority of participants were not able to personally maintain the diaries, researchers visited daily to record the details of the previous 24 hours. This was done in questionnaire format, which standardised the data collected and facilitated the analysis using SPSS. The aim of the diaries was to gain an insight into resident's everyday life. Each diary also recorded demographic information, and staff provided an assessment of the participants' dependency level based on the amount of time needed to provide care every day (Eyers 2000; 2007). Audio-tape recorded interviews were conducted with all ten care home Managers and with the Activities Organisers in each home. Insight into the support required with ADLs was based on the participating residents' dependency level and continence care needs. Further information regarding the overall ADLs met within each care home was provided by the matron/manager within their interview.

Whilst the diary data was recorded in questionnaire format, the researchers actually conducted conversations with residents to elicit the relevant data. These conversations were held in an informal way and resulted in a range of topics being covered, contributing to the richness of the data.

Daily observational studies were undertaken over a two-week period in each of the care homes. On average, at least two hours were spent in each home at varying times of day, including dawn, dusk and over-night, resulting in a total of 250 hours direct observation. Field notes were maintained in conjunction with the completion of the diaries, which took at least a further two hours per day. The focus was on the activities taking place and the researcher was able to participate in and observe the implementation of the organised activities programme provided in each home. Documentary data in the form of programmes and newsletters relating to the organised activities were also collected. Undertaking the observations and the daily visits to maintain the diaries meant that the key researcher spent a considerable amount of time in each home and was able to assess the validity of the information provided by the participating residents.

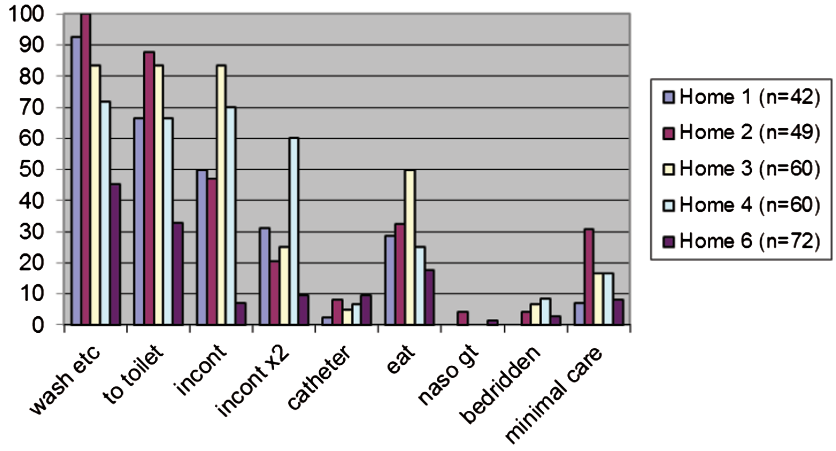
This multi-method approach facilitated ''rigor without rigidity'' (Fielding 2009: 428) for this study with vulnerable older people living in a complex community. Ethical approval for the study was given by the University Ethics Committee and Local Authority Social Research Governance. The names used in this article are pseudonyms to preserve confidentiality.

Characteristics of the Participating Care Home Residents

Diary data was collected from 145 residents who completed all or part of the data sets. There were 105 women and 40 men, covering an age range of 60–100 years, with the strongest representation of both genders in the age group of 85–89 years.

Information about the participant's health care needs was provided by care staff and indicated that 27 did not require physical assistance, whilst 79 received 90–180 minutes of physical care and support per day. Three to five hours of ''hands-on'' care was provided to 30 residents, whilst three participants received over five hours of assistance to meet their health care needs. Data relating to dependency were missing from three participants. As the background data collected about the care homes provided by matron/managers from five care homes indicated, assisting and supporting residents to use the toilet was, alongside assistance in getting washed and dressed, one of the main staff-assisted ADLs of the day (see Figure 1).

Figure 1. Percentage of residents requiring support with ADLs (matron/ manager data from 5 participating care homes)



Wash etc: assistance with washing, getting out of bed, dressing; To toilet: assistance to use the toilet; Incont: dealing with residents who are incontinent of urine and wear a pad or special underwear; Incont x2: dealing with residents who are incontinent of urine and faeces and wear a pad or special underwear; Catheter: residents with a urine catheter inserted in the bladder; Eat: residents who need assistance to eat a meal; Naso gt: nasogatric tube (artificial feeding); Bedridden: residents who do not get out of bed; Minimal care: residents who get washed and dressed independently but for example need supervision to take medication and eat.

The data from the five homes in Figure 1 were typical of all ten care homes. As the following section exemplifies, providing support in the above-described activities determines the rhythm of the day for both residents and care staff. Care staff were constantly aware of their limited time resources (see also Eyers 2007), and residents had plenty of time to undertake leisure activities.

Supporting ADLs: The Rhythm of the Day

The rhythm of care home life is determined by the interaction between residents and staff providing support with ADLs. The morning in a care home starts early and is heralded by the onset of activities related to "continence checks" (approx. 4 a.m.) followed by the clatter of the tea trolley and the early morning "drugs round". The day draws to an end with the serving of the evening meal (supper) usually at 5.30 pm, and by 7 pm most residents are in their individual rooms and often in bed by 8 pm. As identified by Luff et al. (2011), the mean time care home residents spend in bed is 10 hours 50 minutes. For residents needing the assistance of a hoist to be lifted, their personal bed time is determined by the availability of two members of staff to undertake this task. As one participant who needed to be "hoisted" pointed out, she did not really want to go to bed early but she appreciated the fact that due to the lower staffing levels after 8 pm she had no other choice.

Residents were seen to change previous everyday habits and try to "adapt" to the care home as a form of communal living. This is exemplified by a comment made in an interview with one of the matrons who said:

> . . . I notice when I go out to assess people in their own homes they say "I stay up until 11 o'clock and I watch TV in bed". But within a very short period of time, they are going to bed at 9 o'clock. (Joan, Care Home Manager)

This interview extract also indicates how the institution influences the individual and is underpinned by the following field note observation.

> . . . At approximately 7 p.m., when nearly all the other residents were in their rooms, a new resident was offered the choice to stay in the conservatory or to go upstairs to her room. Choice was offered verbally in a form that also made it clear that the member of staff considered it preferable for the new resident to go to her bedroom. Although the new resident vocalised that it was too early to be going to bed, she realised that there was nothing to stay downstairs for, no fellow residents to chat with, no activities, therefore going to her room was the only option and she took it. Her only choice at 7 pm was between being isolated in the conservatory or in her bedroom. The day shift was coming to an end and care staff needed to be seen to have prepared the home for the night staff. All the other residents were in their rooms and, if not already in bed, at least ready to go to bed.

These data extracts exemplify how choice and autonomy are limited within the confines of a care home and life style changes become unavoidable.

Based on data from one home (where care staff worked in 12-hour shifts) it was established that during the day (8 am–8 pm), the ratio of staff (13) to residents (49) meant that within the 12-hour shift period, 2.9 hours contact time was available to support and assist each resident with their ADLs. This leaves the remaining 9.1 hours in the hands of the individual resident or the Activities Organiser or to fill the day with active or passive leisure and recreational activities. The rhythm of the institutional day appears to dominate over a personal daily routine, which has previously been embedded in the life course of the oldest old who are now living in a care home.

Little opportunity appeared to remain for resident choice or individuality, which could theoretically be related to person-centred care or personalised care. The care home day resembled that of the clinical model encountered in a hospital rather than the lifestyle of an older person living in their accustomed personal home environment. The policy rhetoric related to individual choice, autonomy and dignity is confronted by the reality of institutional care home life. In the following section, an overview of the formal organised activities offered in the care homes is provided and their relationship to ADLs is considered.

Activities of Daily Living versus Formally Organised Activities

The nature of this study meant that the participants were amongst the most active in each of the ten care homes. The following analysis of "formally organised activities" provides evidence of a hospitalised lifestyle in care homes that has little resemblance to that of the residents' contemporaries living in the community.

From the two-week diary data relating to activities, which was completed by 125 of the participants, it was found that participation in organised activities was low with 51% of residents not participating in any morning activities and 42% not participating at all in the afternoon across the two-week period (see Table 2). The 2% who did participate in an evening activity reflects participants who attended the one evening activity

Table 2. Diary data indicating the average number of activities attended per week (in percentage)

Time of activity	None (0.5 < 2)	2 or more (total)
Morning	51 (25)	24 ($n = 125$)
Afternoon	42 (35)	23 ($n = 125$)
Evening	98 (2)	0 ($n = 125$)
All organised activities	29 (31)	40 ($n = 125$)

that took place in one home during the two-week data collection period. Overall, 29% of residents did not participate in any organised activities across the two-week study period, and only a minority of residents (40%) participated in two or more activities per week. Since the organised activities usually lasted no more than 1–1½ hours, this indicates that care home residents spent only a tiny amount of their time involved in organised leisure activities.

The field notes and interview data indicated that residents had limited actual interest in the organised activities provided. An indication that this could be related to the timing of activities was observed when morning activities were delayed to 11.00 a.m. This later starting time was observed to result in an increased number of residents participating. This may also be a factor in the slightly higher participation in afternoon activities, as shown in Table 2. Participation in the organised activities for many is dependent on care staff taking them to the relevant room in the home, and observational data suggested that much of the morning is taken up by the completion of formally acknowledged ADLs. The timing of organised activities was not always suited to care staff's ability to prepare residents in time to attend. At this point, the completion of ADLs, representing the identified care needs that initiated the move into a care home, conflicts with ''social activities'' described within the National Minimal Standards for Care Homes (DH 2003). As previously stated, Standards 12–15 do place an emphasis on leisure activities and structured provision of a social activities programme in care homes.

The organised social activities encountered in the ten care homes were primarily related to music, arts and crafts, with occasional outings to local parks or gardens. Despite the range of homes (see Table 1) participating in the study, there was ultimately little difference in content of the organised activities programme in the participating homes. Very few of the observed activities could be categorised as "rehabilitation", which would for example encourage a resident who had suffered a "Stroke" to regain dexterity or joint mobility without receiving dedicated Physiotherapy. On the other hand, the observational data and informal conversations with residents indicated that they perceived many of the arranged activities to be bland, almost childish and often inappropriate. The extract from one of the care homes' activities programme for a typical week (Table 3) shows that music in the form of listening to music, alongside reading the newspaper, exemplifies the passive (non-physical) activities organised within the care homes.

Whilst "baby talk" was not observed in communication between residents and staff, a form of institutional infantilisation in terms of the content of the organised activities was taking place and indicates that a loss of dignity and respect was occurring. In one home, especially when entering the building, you could be excused for thinking you were entering a nursery school building with childlike art and craft work on display. Whilst it could be argued that it is good to see that organised activities are taking place, for some older people and their relatives it must be demeaning to see yourself or your parent publicly being reduced to childlike activities.

By focusing on organised activities relating to music, seen as a fundamental component of human life (Biley 2000), it becomes clear that an activity, which may initially appear suitable to management, Activities Organisers and the care home inspectorate, was not always provided in a format welcomed by older care home residents. Choice and individual interests that would reflect a person-centred or personalised care approach failed to be a component of service delivery. However, the service offered could be "formally" seen to be in keeping with the National Minimal Standards for Care Homes (DH 2003).

The following field note extracts exemplify a conflict between policy rhetoric and actual care provision indicating a lack of knowledge and awareness of residents' previous lifestyles, current interests or abilities. In dialogue with residents who were maintaining a diary with the support of the researcher, the following comments relating to musical activities were

Table 3. Extracts from an activities programme in one typical care home

Monday Hairdresser All day	**11.00 am:** Shoulder Class 20 mins exercise *Ground Floor Lounge*	**2.00 pm:** Annie with Freddie and Ginger (Pat dogs) **3.00 pm:** Tea Rooms and Home Shop *Ground Floor Lounge*
Tuesday Hairdresser All day	**10.30 am:** Coffee and home-made cakes. Bring your newspaper. All welcome *Ground Floor Lounge*	**2.30 pm:** Home Choir with Billy Songster *Ground Floor Lounge*
Wednesday	**10.30 am:** Coffee and home-made cakes. Bring your newspaper. All welcome *Ground Floor Lounge*	**2.30 pm:** Exercise Classes *Ground Floor Lounge*
Thursday	**10.30 am:** Coffee and home-made cakes. Bring your newspaper. All welcome *Ground Floor Lounge*	**2.30 pm:** Beauty Nail Care with Sherry and Relaxing Music *Ground Floor Lounge*
Friday	**10.30 am:** Sherry with Relaxing Music Lounge Ground Floor **11.00 am:** Holy Communion Lounge Ground Floor	**2.30 pm:** Bingo *Ground Floor Lounge*
	Lunch: 12.30 pm	Supper: 5.30 pm

made: "I have no inclination to sing the Lambeth Walk, thank you very much". This was said by Emily who loved classical music and often listened to it in her room and found "the man" who arranged and accompanied the choir offensive, as by her standards he did not play the piano adequately.

Field notes from another home exemplify a situation where residents did express discontent:

> . . . A man, who couldn't sing, was singing *at* the residents. He failed to interact with the people he was entertaining. No eye contact was made and there was a distinct lack of dialogue with the residents. However, some residents were reacting by yelling "shut up" and "get off". Others who had been wheeled in by the staff, sat there motionless.

These extracts from the field notes exemplify that some residents do have strong opinions about the organised activities. Residents were clearly vocalising discontent, but this was not being heard, indicating that choice, variety, opportunity and flexibility had little space within the activities programme.

The interviews with the Activities Organisers indicated that they were oblivious to residents' opinions about the activities, and that they were confident they were providing suitable activities to the best of their ability. Our data emphasise that taking a generalised simplistic approach to providing organised "social activities" is not appropriate and needs to be reconsidered. However, many of our research participants did not want to be seen to make a fuss and appreciated that the existing Activities Programmes were well intended. This implies that the residents were acutely aware of the situation that care staff were confronted with daily and further indicates the adaptation process an old person undertakes after the transition into care home life has taken place. This also reiterates the importance of identifying and acknowledging each resident's interests and abilities as part of a person-centred service delivery that takes both body and soul into consideration.

Accommodating Organised "Social Activities" Into the Routine of the Care Home

During the data collection it was noted that programmed morning activities were more likely to be cancelled than those in the afternoon. The morning was the busiest time of the day, and the main aim of care staff appeared to be to ensure that, in accordance with the care plans, support with ADLs was provided. Activities offered in the afternoon tended to be slightly more popular with the residents, and evening activities only took place once in one home during the two-week study across the ten care homes. Only in the most exclusive of the care homes was it observed that residents independently arranged evening games of "Scrabble". Regular weekend activities were not the norm; however, all the participating homes did host "events" such as a Summer Fayre that took place during data collection in one home and was enjoyed by all who were able to attend and participate. The findings from the daily fieldwork observations indicated that the working hours of Activities Organisers were not in tune with the resident's daily routine and consequently restricted residents' ability to participate if they were not washed and dressed in time to be in the relevant room at the start of an organised activity.

In all care homes, it was noticeable that when the person employed to facilitate "formal activities" was absent, they were not replaced, and formal activities did not occur. In some homes the Activities Organiser was employed on a part-time basis and was not in the care home each weekday. The general lack of activities after 4 pm also indicates the driving role the Activities Organiser has in the "active ageing" experienced in care homes. Formal activities were not always intended to take place daily, and weekends or evenings were rarely taken into consideration as a time when it would be suitable or appropriate to facilitate organised "social activities".

Linking ADLs to "Social Activities"

Whilst there is clearly an issue relating to the appropriateness of the organised social activities, the data indicate that the "gatekeepers" to participation in activities were the care staff. Residents were dependent on care staff availability to wash, dress and assist them to the venue. The field notes also indicated there was a need for staff to remind residents every morning of the arranged activity for the day. Furthermore, care staff perceived that physical dependency was linked to participation, disregarding older people's intellect, interests and abilities.

The uptake of the activities provided was low, and there was an apparent disinterest in the provided programmes. The interview and diary data in conjunction with the field notes showed that overall it was mainly the same group of residents who participated. In many of the homes it appeared to be accepted by staff that many residents would not leave their room. However, many of the research participants who rejected the organised activities did enjoy social interaction as was evident through the conversations with the researchers held on a daily basis during the two-week data collection.

When the Activities Organisers were asked what activities residents seemed to enjoy the most, they identified "outings" to be the most popular. From the dialogue between the researchers and residents, the popularity of trips outside the boundaries of the care home was also obvious. However, as was pointed out by the interviewed Activities Organisers and managers, this required the involvement of care staff, which unavoidably resulted in staffing problems as extra staff would need to be on duty. Cost and the requirement to undertake a risk assessment for each trip outside the home also needed to be taken into consideration. This invariably curtailed the amount of activities outside the care home environment.

Most Activities Organisers claimed to be willing to facilitate individual activities for residents on a one-to-one basis. However, this was actually only observed in one care home. When asked about individual activities the responses indicated that meeting the needs of *all* residents was difficult, underpinned by one interviewee who pointed out that she was "on her own doing her best to meet the requirements of over 35 residents". This comment reflects the conflict that care home staff encounters on a daily basis and underpins the complexity of addressing the gap between government rhetoric and care home reality.

Discussion

The organised activities observed in this care home study reflect those described by Goffman (1961) in his seminal work on institutional life. The "attempts by staff to manage the daily activity of a large number of persons in a restricted space with small expenditure of resources" (Goffman 1961: 50) were also observed in this study. In an institutional environment it is unavoidable that trying to please the majority takes precedence over the rhetoric of choice, and the pursuit of personal interests and respect for individuality are confronted by the reality of resources, formal structures and procedures. The principle objective of a care home is to provide a care service to a group of vulnerable older people, in a large building with communal areas. The policy rhetoric of person-centred care that facilitates choice, autonomy and dignity is put into question.

The indication is that in practice lip service is being paid especially to Standards 12 and 13 of the National Minimal Standards for Care Homes for Older People (DH 2003). In addition, presenting a ‘‘social activities programme’’ forms part of the marketing tools used to promote a care home to potential new customers. It also pacifies relatives, friends and the care home inspectorate. However, establishing their views on the organised activities provided was not part of this study and would call for further investigation.

For an older person living in a care home, mundane life appears to be based on a blend of care assistants’ support with formally identified ADLs and the option to participate in an organised ‘‘activities programme’’ that seldom appears to be appropriate or attractive. The majority of programmes in the sampled homes indicate little knowledge or understanding of older peoples’ actual interests either as individuals or as social groups. There is little opportunity for residents to pursue interests they have developed over their life course, nor is consideration given to how activities might impact on an individual’s health, well-being or self-esteem. Despite all UK government rhetoric focusing on dignity, individuality and choice, the institutional requirements dominate over those of the individual.

The care home day, in conjunction with care home managers and staff, can be deconstructed to identify core elements that must be maintained. If a component such as the timing of meals were to be reconsidered to facilitate flexibility and choice, it could for example result in the construction of a more individualised daily timeframe for residents. Less prescriptive meal times provided in a restaurant style would for example mean that leisure activities could possibly be facilitated in a different, more personalised way, and would potentially facilitate the socialisation of like-minded people.

It is crucial that the importance of the Activities Organiser is acknowledged and formalised by policy makers to ensure skilled services are provided that enhance the lives of older people living in a care home. To ensure a truly holistic service provision that encompasses all the needs of an individual would be an alternative that meets Standards 12–15 (DH 2003) and also extends the role of care staff, by enabling them to facilitate all forms of everyday activities. The formalised ADL tasks related to getting a resident up, washed and dressed in the morning is after all the first and most important step towards enabling a resident to pursue or participate in activities that are important to their quality of life. The second step to then facilitate informal daily activities would be a natural progression. If this was the case, the daily routine experienced by older people living in a care home would be able to resemble more that of their contemporaries living in their own homes than that of a patient in hospital.

Enabling care staff to provide such a holistic service would invariably require relevant training and an increased ratio of staff to residents. Currently, residents have a surplus of time whilst staff has barely enough time to provide support and assistance with acknowledged ADLs. A third solution could be for structures to be put in place that would enable and encourage voluntary organisations to be actively involved in the daily social life in care homes as part of a reconstructed daily routine. The care homes studied during the research were providing the best possible services under the given circumstances, which are determined by how care homes are funded and regulated. Only if policy drives change in care homes will it become the norm that a balance is struck between meeting the needs of both body and soul.

Conclusion

For the oldest old living in care homes, the UK Department of Health (CQC 2009) rhetoric of dignity, choice, variety, opportunity and flexibilities, alongside a focus on the facilitation of person-centred care is far from the reality experienced. The reductionist ADLs of an older person living in a care home become a dominant feature. They relate to factors that can be visually assessed by both professionals and relatives, leaving little space for the less measurable, at times invisible and intangible, aspects that are important to the well-being of every human being's life, irrespective of age. At the simplest level, it is possible to *see* if someone is wearing clean clothes and *smell* that they have not been incontinent and have been washed. To measure or assess the outcome of social interaction or a leisure activity, such as listening to music, is more complex and appears therefore to be overlooked.

In this research the conflict, between care staff supporting ADLs and residents participating in organised ''social activities'' within a care home became evident. We conclude that there is a need to deconstruct the standardised framework in which institutional care is provided and to reconstruct a frame that facilitates and respects individuality. A transformation in the philosophy of care needs to take place to enhance the everyday life encountered in care homes and to enable the oldest old to maintain a lifestyle to which each individual is accustomed and which is adapted to their physical and cognitive abilities. The rhetoric of choice, autonomy and dignity needs to realistically consider the importance of balancing residents' physical care needs with the less tangible aspects of mundane life.

A care home is not a clinical environment; therefore, it is inappropriate to reflect the routine of hospital life. Whilst the need to live in a care home is rooted in frailty or a medical condition resulting in the need for support in accomplishing ADLs, it is also of great importance that the formal activities taking place in care homes reflect the resident's intellect, interests, physical and cognitive abilities. This would bring body and soul in tune and actually result in a service that centres on the individual person. To ameliorate the current situation, future developments in both policy and practice need to give these factors of care home life due consideration.

Acknowledgements

The authors would like to thank the older people who allowed us into their everyday life in a care home and participated in this research. Our gratitude is also expressed to the ten care homes that enabled us to conduct the data collection on their properties. All the homes were providing care to the best of their ability. Points raised in this article aim to support them and help improve the lives of both residents and staff. Last but not least, many thanks to Karen Bryan, Cynthia Wyld, Robert Meadows and Wendy Knibb for their contributions and support in collecting this data during a difficult time for the original research team. The SomnIA research was supported by the New Dynamics of Ageing initiative, a multidisciplinary research programme funded by AHRC, BBSRC, EPSRC, ESRC and MRC (RES-339-25-0009). This is a revised version of a paper presented at the ''Transformation of Care Conference'' in Copenhagen in June 2010.

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International Journal of Ageing and Later Life, 2012 7(1): 79–106. © The Authors

"Otherwise it would be nothing but cruises": exploring the subjective benefits of working beyond 65

By Frances Reynolds*, Alexandra Farrow* & Alison Blank*

Abstract

The age at which statutory and private pensions are being paid is increasing in many countries and hence more people will need to work into their late 60s and beyond. At present, relatively little is known about the meanings of work for people who actively choose to work into their later life. This qualitative study examined the subjective benefits of continuing in a paid job or self-employment beyond the age of 65 in the United Kingdom. Thirty-one participants were interviewed, aged 65–91 years (median age 71), with 11 females and 20 males. Fourteen were working full-time and seventeen part-time. Interview transcripts were subject to thematic analysis. Although financial reward was acknowledged (more so by the female participants and the males who had young second families), there was more elaboration of the role of work in maintaining health and enabling continuing personal development. Work was framed as increasing personal control over later life, lifestyle choices and active participation in wider society, an antithesis to "cruising".

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Keywords: employment, older adults, health, well-being, personal development, qualitative.

Introduction

Older people appear to derive positive well-being from a range of activities, including recreational interests, contributing to others and achieving valued goals (Henricksen & Stephens 2010; Hinterlong et al. 2007). The meanings of continuing paid work or self-employment in later life deserves more research attention, particularly as the default retirement age has been or is being abandoned in many countries, with consequent delays to payment of both statutory and private pensions. These political and economic changes are likely to lead to an increasing number of older people remaining in (or returning to) work. This qualitative study examined the subjective benefits of continuing in a paid job or self-employment beyond the age of 65 in Britain. Data were collected a few months prior to the abolition of the default retirement age in October 2011.

In Britain, individuals are eligible for a state pension if they have made contributions to the National Insurance (NI) scheme over a 30 year period of employment. Until recently, women received state pensions at 60 years and men at 65 years, but currently women's age of entitlement is being raised. By the year 2018, both men and women will become eligible at 65 years. This will rise to 66 years in 2020. According to a recent Pensions Policy Institute (PPI) report, 61% of retired people in the United Kingdom also receive occupational pensions, but this leaves a large minority reliant solely on the state pension, additional state benefits and personal savings (PPI 2011).

Even before the British government abolished the default retirement age, an increasing proportion of people were working beyond statutory pension (SPA). In 2011, there were about 1.4 million such workers (Office for National Statistics; ONS 2012), with higher proportions working in the more affluent South East regions of the country. Self-employment is more common among people working beyond SPA, with 32% in this category, compared with 13% of younger workers. This post-SPA workforce is also more likely to be working part-time (66% compared with 25% of people under SPA). Working patterns are different for men and women, with men in highly skilled jobs (and women in lower skilled jobs) more likely to work beyond SPA. These patterns suggest that men may be motivated more by interest in their work, whereas women may work primarily for income. Women are more vulnerable to poverty in later life (about 52% received less than the full state pension in 2010 through not having paid the required set of NI contributions) and, hence, may need to continue working for financial reasons. As with the wider British population, relatively few older people work in the manufacturing sector (Hotopp 2005). Disney and Hawkes (2003) have argued that the growth of the service sector, with its more flexible hours and less physically demanding work, has helped facilitate the rise in later life working over the past two decades.

Previous research on people's reasons for working beyond SPA is somewhat limited (Kooij et al. 2007). Studies that have examined attitudes to later life working have tended to focus on "older workers" who are in their 50s and *approaching* statutory pension age (SPA) rather than focusing entirely on the views of those who are currently working beyond 65 (e.g. Felstead 2010; Shacklock et al. 2009; Templer et al. 2010). Attitudes to work among people who are approaching retirement age may differ from those who have actively chosen to work beyond this age.

Financial need and work satisfaction (or fulfilment) have been noted in several studies as key motivators for working beyond SPA (Barnes et al. 2004; Smeaton & McKay 2003; Smyer & Pitt-Catsouphes 2007; Templer et al. 2010). Choi (2001) found that the life satisfaction of women working into later life was more dependent on their financial resources and feelings of economic security than the work itself. However, Humphrey and colleagues (2003) reported that participants remaining in work between 65 and 69 years did not give high priority to financial needs. In contrast, Smeaton and colleagues (2009) surveyed older workers about their decisions to continue working or retire at SPA. Perhaps reflecting worsening economic conditions since the earlier studies, the authors found that financial motives predominated in the decision to work beyond SPA. Nonetheless, certain psychological needs were also uncovered. As in previous studies, many people continued to work because they enjoyed the content of their work and using their job-related skills. They also wished to preserve routine and keep busy, make a worthwhile contribution and enjoy social contact. Those who had better education aimed to work for longer, and about 10% of the men surveyed wished to set up their own business after SPA. Nonetheless, the majority who were planning to stay in work wanted to reduce their hours to gain a better lifestyle balance. In this study, the ''push'' factors encouraging older people to leave work at or before SPA included stress at work, long commuting journeys and tiredness.

Phillipson and Smith (2005) noted that people are more likely to work in later life if their partners are working, if they have outstanding mortgage debt and if they enjoy better education and higher status work. McNair (2006) reported similar findings. Komp and colleagues (2010) also found across Europe that people who remained in work from 60 to 70 years of age tended to have more education and more prestigious jobs. As a group, women may have greater financial needs than men (and thereby feel more obliged to work beyond SPA) because they have more limited pension entitlements linked with career breaks, and their greater likelihood of working for large parts of their adult life in part-time and/or lower paid jobs (Phillipson & Smith 2005; Templer et al. 2010).

The decision to work beyond SPA is also shaped by people's attitudes to work, and degree of identification with their working roles (Barnes & Parry 2004; Barnes et al. 2004; Parry & Taylor 2007). It has been suggested that even though women commonly have poorer pension entitlements, older men are more likely to delay retirement through being more attached to their worker identities and through having insufficient time or inclination to acquire alternative satisfying roles and activities during their earlier working lives (Barnes & Parry 2004).

Barnes and colleagues (2004) and Parry and Taylor (2007) reported a qualitative interview study that was unusual in identifying distinctive motivations for working among different groups of people working beyond statutory pension age. Data were gathered from 24 interviewees (21 of whom were over 60, with 17 continuing to work beyond SPA) and additional focus groups. Work was valued for promoting personal and social identity. One distinct sub-group of participants, labelled ''workers'', identified themselves as people who had always worked hard and who enjoyed being active and ''doing''. These older workers did not necessarily gain deep satisfaction from their work roles but some continued to work through fearing that retirement would bring inactivity which risked turning them "into a vegetable" (Barnes et al. 2004: 32). Many from this group also needed extra income to supplement their limited state pension. In contrast, intrinsic motivations for working were typically emphasized by those involved in professional or creative roles. These participants resisted retiring at the SPA because they enjoyed autonomy, creativity and deep satisfaction at work. The third group consisted largely of self-employed entrepreneurs who emphasized that their work offered self-direction and self-sufficiency. Some who owned their own businesses enjoyed continuing (or having even more time) to work with their spouse or partner. The importance of paid work for confirming personal identity and for offering social contact has also been found in other studies of older workers (Aquino et al. 1996; Noonan 2005). However, various discomforts in later life working have also emerged, including experiences of regret about limited personal development, insecurity and age discrimination (Altschuler 2004; Noonan 2005).

In conclusion, previous studies have found that the decision to work beyond statutory pension age is often driven not only by financial concerns, but also a complex array of psychosocial needs. Later life working may help some people to maintain a familiar positive identity, larger social networks and a suitable balance of activities both with and without their partners. However, the potential of work to promote older people's generativity or personal development has been relatively neglected. Given changing economic conditions, recent legislation to delay SPA, and the likelihood that increasing numbers of people will be working into their late 60s and beyond, further enquiry into people's experiences of working beyond 65 is justified. Even though some large-scale surveys are available (e.g. Komp et al. 2010), a qualitative research method is highly suitable for eliciting nuanced accounts of the meanings of work, with potential for uncovering some new issues.

Method

Ethics

Prior to data collection, the project was approved by the ethics committee of the host university. Participants making enquiries about the project received full information, including the interview topic guide, and signed consent forms prior to interview. In line with ethics committee requirements, all data have been anonymised and are held securely. Participants are referred to by pseudonyms.

Design

A qualitative interview study was conducted based on single interviews with people working at or beyond 65 years of age. Participants were eligible to join the study, if they were in full-time or part-time paid employment or self-employment. There were no further criteria.

Recruitment

Participants were recruited through local and national advertising in the United Kingdom. Full information was sent to those who expressed interest in the study.

Sample

The sample comprised 31 people aged 65 or over who volunteered within the required time frame. Participants were aged between 65 and 91 years (11 women, aged 65–76; 20 men, aged 67–91), and all were in paid employment (18) or self-employment (13) at the time of interview, with a median age of 71 years. Fourteen were in full-time work, mostly males (12 males; 2 females) and seventeen worked part-time (9 females and 12 males). Twelve people (7 females; 5 males) had previously worked or were continuing in the public sector (in education and health services), and most of these had opted for part-time hours. Various types of work in the private sector were also described, with individuals engaged in market research, estate agency, company management, tax consultancy, creative writing and horticulture. Most of the sample had persisted with their main careers, either full-time or moving to part-time hours. Two women and five men had changed their lines of work after retiring from their main careers (e.g. developing a mail order business after retiring from a health profession; working with asylum seekers within the judicial system after a career in education).

Procedure

Semi-structured interviews were conducted in person or by telephone, according to participants' preference. All interviews were audio-recorded and transcribed verbatim. Interviews were on average one hour in length, with face-to-face and telephone interviews being similar in duration and richness of data. The key topics were presented to participants (along with the information sheet), with additional questions asked in the interview as needed to help them elaborate their accounts:

1. A brief overview of the participant's past and current work.
2. The perceived benefits of working beyond what many regard as the "expected" age of retirement.

Data analysis

This report is based on a thematic analysis of the data (Braun & Clarke 1996). Independent coding by the researchers, and discussion to elaborate emerging interpretations of the data, helped to establish the credibility and trustworthiness of the findings.

Findings

In the following quotations, intentional shortening is indicated by the usual convention for ellipsis (...). Words that have been added by the authors to clarify the meaning of quotations are indicated by square brackets.

Three main themes emerged, namely that later life working was valued for increasing financial security, that it helped to maintain health and that it offered many opportunities for continuing personal development. Overall, most participants regarded later life as a time for continuing active participation in their wider social networks and perceived their work as supporting this endeavour. Linguistically, these attitudes were conveyed by the recurring strategy of comparing the self more favourably to others who had decided to retire and by using negative descriptors such as "lazy", "cruising" or "dull" to depict a retired lifestyle characterized by lack of direction and personal effort. These issues will be commented on during the presentation of themes below (Table 1).

1. *Financial security*

As in previous studies, and unsurprisingly, working beyond 65 was valued by some for increasing income. However, just over half of the participants did not refer explicitly to this issue. Two principal reasons were put forward for needing to supplement pensions, namely to support a more varied, satisfying lifestyle and to support other family members.

a. Maintaining a satisfying lifestyle. Some of the female participants described how they would struggle to survive on a basic state pension and, therefore, felt obliged to continue in work. They had contributed little or nothing to occupational pension schemes through having had disjointed work histories or poorly paid jobs for much of their working lives. Aileen (aged 67 years and working in a telephone call centre) summed up her reasons for working as ''lack of a pension mainly''. Even so, income was rarely an end in itself. Rather, the income earned through working enabled participants to participate in more activities than would be possible on a basic state pension. Aileen went on to explain:

Table 1. Interview themes: subjective benefits of working beyond 65

1. *Financial security*
    a. Maintaining a satisfying lifestyle
    b. On-going support of dependents
2. *Active control over health*
    a. Keeping physically active
    b. Mental alertness and vitality
    c. Work obligations and routines help resist ''giving in'' to illness, laziness and low mood
    d. Work as a distraction from pain and other health problems
3. *Later life as a time for continuing personal development*
    a. Learning and change
    b. Challenge and achievement
    c. Social connectedness and affirmation
    d. Resistance to ageist stereotypes
    e. Preserving personal and professional identity

> The job allows me to do the sort of things I enjoy doing [like] travelling to meet my family.

Having a higher income than afforded by a basic retirement pension was perceived as enabling a more varied lifestyle, which in turn was thought to promote emotional and physical health:

> Well, I think it [work] just keeps your mind active and, uh, well a lot of it's the money that it gives you ... I mean I like to swim and I like to play bowls and I like to play tennis ... We're going to Egypt, and I'm going to Holland next week ... The work pays for you to do all these things. Although you get a pension, it's not a brilliant pension at the minute.
> (Sarah, 68, "bank" nurse)

A few were using some of their increased income to fulfil long-held plans:

> If I had the money [when younger], I'd have learned to fly, but then I'm now too old and I've got a pacemaker, so that's not going to happen, but I have to confess, I bought a flight simulator a month ago, a computer programme!
> (James, 79, set up a successful mail order business after retiring from his main career as a social worker)

b. On-going support of dependents. Several participants needed additional income not only for maintaining their personal lifestyles but also for supporting others within their families. Four male participants were supporting dependent children, through having second families with much younger wives:

> Having a 12½ year old daughter, I'm compelled to do quite a lot of things, which I would not necessarily do, to support her, but I find very rewarding.
> (James, 79, also quoted in the previous section).

Some of the other participants (both male and female) also referred to their need or wish to support adult children who were in financial difficulties, for example, through being unwell or recently divorced.

> And the money is handy because we have a daughter living in America who's a ... transplant patient. And, um, her health is indeterminate. You know she's reasonably well, but we're able to help her financially because I work ... Earlier in the year,

> she had pneumonia and she had to get some inhalers and they weren't covered by the medical insurance, so we had to pay for the inhalers.
> (Marilyn, 69, nursery school administrator)

Although a sizeable minority included a financial motive among their varied reasons for continuing to work, several participants rejected this motive entirely:

> I like being away from the house (pause) I do like a mixture of people . . . It sounds as though we're incredibly rich but we don't need the money. I have the mortgage paid and my husband gets a reasonable pension, so it's not about the money.
> (Jennifer, 65, market research interviewer)

2. *Active control over health*

a. Keeping physically active. Physically, most of the participants regarded themselves as in at least reasonably good health and, therefore, capable of work. Many links were made between keeping physically active through work and other activities, and staying fit:

> I'm not slowing down at all, in fact, to the contrary because I had about five or six years when I had a health problem and in fact, I thought I'd have to give up [work] because of that, but I managed to get through it and it was treated. So since I've really recovered from that, I feel a new lease of life, so I feel better in myself than eight years ago.
> (Marta, 71, executive coach)

Almost all participants regarded their continuing work as promoting or maintaining their physical, as well as mental, health.

> I don't feel inside, old. And I think that that is encouraged by continuing to work. And it's probably the biggest . . . one of the biggest contributory factor to what follows from that, which is basically, reasonably good health.
> (James, 79, mail order business owner)

Many participants defended their arguments about the health benefits that they attributed to working by contrasting their own good health with that of others whose retirement was shortly followed by illness:

> I always feel sorry for people who retire at the age of whatever it might be, say 55, and they only last for a few weeks or a year or so and then they're dead ... and that can happen either because they've become vegetables and sort of not got up from their chair to turn the TV off or on ... or it can be because of the nature of the job they did.
> (Adrian, 72, part-time estate agent)

b. Mental alertness and vitality. Complex transactions were portrayed between physical and cognitive health. Most participants thought that their work benefited their overall health through encouraging mental engagement and preserving vitality:

> I think one could quickly stagnate really, just not becoming involved ... it allows me to still explore quite new and exciting concepts and ways of working and in that way, I think it does keep me very alert ... When you have to do things, you're timetabled to do them and there's a sense of vitality almost, it's difficult to explain precisely, but I think that vitality, that awareness of things increases.
> (Beatrice, 70, art therapist)

Some spoke of feeling refreshed, rejuvenated or younger since they had returned to work after retiring from their main careers:

> The whole attitude that someone of my age, or my wife's age, has to working and to living, is [that it is] part of the rejuvenation process. For Saturdays [taking people on property viewings for an estate agency], I think, oh you know, I've got to be sort of bright and sharp ... and unconsciously that may sort of be an aid to maintaining good health.
> (Adrian, 72, part-time estate agent)

Some who worked in part-time consultancy roles experienced periods of stagnation when not called upon to work, again confirming the sense of vitality that they drew from their valued occupation:

> If I have long periods of inactivity, if we don't have much work on ... I do miss the buzz ... I'm saying that it [work] has kept me healthy.
> (Laura, 73, self-employed in-service course instructor)

c. Work obligations and routines help resist "giving in" to illness, laziness and low mood. Work was valued for preserving vitality and health partly through maintaining the person's engagement in healthful routines. Accounts implied a strong belief in exercising personal control over health.

> I think if I didn't do it [work], I would just sag, I would let it [health] get worse.
> (Jeffrey, 88, freelance writer, living with long-term illness).

Many described making efforts not to "give in" to the threat of physical or mental deterioration and perceived their work obligations as helping them to resist illness:

> If you're, say, doing a viewing of a house [in estate agency], you're doing a presentation, and you can't stop half way through and think . . . oh I've got a headache or I've got this, I've got that. You drive things like that away.
> (Adrian, 72, part-time estate agent)

There was a commonly expressed fear that giving up work would lead to both mental and physical "laziness", through disconnection from the stimulating experiences that maintained cognitive functioning. Again, it was a common linguistic strategy for participants to draw a contrast between their own engaged and busy lives and the lives of others who had retired:

> Some of these guys [I knew] in the larger companies, they had this statutory retirement age of 65 or whatever, and the first six months, they're euphoric. And then after six months, irrespective of whatever hobbies they had, which they enjoyed anyway while they were at work, they became a bit . . . not down but there wasn't a focus of getting up every morning. And that, I don't want. I'm up at five every morning. I check the [computer] screen, shower, I go to an office . . . the last thing at night, probably go to bed at eleven, just check things [e-mails], do a bit of reading, that's it, that's basically the working day to be honest.
> (Derek, 68, ship-broker)

d. Work as a distraction from pain and other health problems. The minority who described themselves as having health problems generally considered that they had adapted their working patterns to suit their decreased energy and functional levels. Several of this group valued their work as it distracted them from pain or other limitations.

> I had this, couple of years ago, a very nasty operation. I had my right leg removed. That pinned me down very badly. I am in a wheelchair all the time, but I'm still going

> on, I'm just finishing a novel. Funny enough, in hospital, I corrected the proofs of X [a novel], which came out last year . . . They [nurses] were very sweet, they brought me coffee and things, it kept me going and the book came out. It may not sound a lot nowadays, I'm not making very much [money] at all, but it keeps me going. I don't just sit here thinking what a miserable time I'm having.
> (Jeffrey, 88, freelance writer)

The enjoyment, deep focusing or flow associated with work encouraged some to continue working despite their health problems, rather than accept retirement:

> You know, because of my physical problems or health problems [prostate cancer], I think if I had not been working I would have worried about them much more. Of course working distracts you, because you have far more important things to do than be worrying about your twinges and the rest of it.
> (Joseph, 78, self-employed recruitment consultant)

3. *Later life as a time for continuing personal development*

Most of the participants regarded their later life as a time for continuing change and personal development. Some had chosen to work part-time in order to have more opportunities to engage in new experiences such as travel and volunteering. But work was also seen as offering opportunities to develop skills and experience new challenges.

a. Learning and change. Continuing in work beyond 65 was perceived as promoting subjective well-being through offering a range of opportunities to learn, develop and to keep updated:

> I have to say I watch them (other older business people) very closely because I look and I think "Well, I wouldn't have done that, you're doing that because you're old" . . . People say "Well in my day, how we used to do it . . ." You've got to beware of that, it's a different world now that we're in. [If people say], "It wouldn't be done like this when I first joined" or "Now, I've been here so many years and I can remember . . ." Not interested! We haven't got time, we're moving on!
> (Jack, 67, Director of Communications, manufacturing company)

Most of the participants (most typically working in the business, creative and health sectors) presented themselves as having a strong need for continuing problem-solving, new activities and personal development in their lives. Some were motivated to keep up with rapidly changing evidence and technology, in order to remain stimulated and to see themselves as active players in both the work context and wider society.

> The work is constantly stimulating, the internet world is a changing world. Yesterday, we spent all day in Earls Court [conference centre] looking at various things in the internet marketing side and . . . there's a sort of circular stimulating . . . you do some more and then you want to do even more.
> (James, 79, self-employed mail order business).

Many participants described having a strong need for personal development in their earlier working lives, a need that prompted them to devise a post-retirement age "career", either by setting up a new business venture, or by constructing a "portfolio" of interesting part-time jobs.

> If I didn't do this [job], I've got two or three other good business ideas, which would be equally interesting, though I see no point in retiring. I expect to have an interesting life where I can laugh a lot and think a lot and where my experience can be useful to people, where their experience can be useful to me.
> (Adam, 75, business consultant)

In undertaking these new initiatives, being older was generally considered an advantage. Without mortgages to pay, and with the helpful "fall-back" of a State (and in some cases an occupational pension), several participants (mostly women) described taking on more training, and/or riskier projects that might not pay well, but that promised fulfilment in their work and personal growth.

b. Challenge and achievement. Work's challenges, achievements and excitements motivated the majority of the participants to continue, increasing subjective well-being:

> It's still as exhilarating to get involved in dealings, quite frankly, so yeah, that's about it [the main reason for continuing in work].
> (Derek, 68, ship broker)

Challenges were enjoyed for their own sake and for challenging (in self and others) any negative expectations of later life:

> I enjoy challenges, with the computer for example, because like most people of my age I came to computers late in life. And I still enjoy being able to, ooh, I can remember how to fix the heading on my Excel table that I've just set up to monitor the incoming voucher payments . . . . I think it gives me a purpose . . . . Plus I like using the skills I've acquired. And I like feeling youthful and I like the contact I have with the parents.
> (Marilyn, 69, nursery school administrator)

Several described taking on new work roles in recent years which offered a level of challenge that they now felt better prepared for, through their increased age and experience:

> I do a session with very challenging boys at a residential unit for teenage boys and that has also made me very aware of ways of working that perhaps I hadn't thought of before and it's quite a new area for me, but one that I'm finding very rewarding.
> (Beatrice, 70, art therapist)

Despite their need for challenge, it should be noted that about half had taken up part-time work (or self-employment) in their 60s and described thereby gaining a more satisfying balance between challenge and relaxation in their lives.

c. Social connectedness and affirmation. There was a recurring emphasis on the ways in which work confirmed the person's sense of social value, maintaining self-esteem and (among those who worked with colleagues) offering a respected place within the team:

> You need to feel properly engaged and valuable.
> (Adam, 75, business consultant)

> There are people there [at work] who regard me as an integral part of the team . . . My boss always said that I was, you know, a valuable person . . . She didn't ask my age. Because it didn't matter.
> (Adrian, 72, part-time estate agent)

Nearly every participant had social reasons for working, including many who were delighted in being more appreciated and less taken-for-granted by colleagues since moving to new work roles after retirement from their main careers. Some were surprised at the level of respect received from colleagues and/or clients, which they connected with their considerable work experience and commitment to their roles:

> I can get dragged in [by other vets in the practice] to look at X-rays time and again because when you've been looking at X-rays for 40 years, you see things that, no matter how highly qualified a youngster is, they just haven't been doing it that long. And I must admit, that is one of the rewarding parts of it, is somebody saying "Oh, could you have a look at this, Graham?"
> (Graham, 68, locum vet)

Participants who essentially worked alone (usually in self-employed or freelance roles) also referred to the pleasure of gaining social contact and status from their work roles:

> I don't make very much [money] now, but people still know me and improbably I was invited to a Convention ... in X [town] because I had written [this novel] ... and people are still in touch and that's a nice thing.
> (Jeffrey, 88, freelance novelist)

Participants who lived alone also appreciated the social value of working:

> It's nice to be acknowledged, isn't it, in the street? People know you, for whatever reason ... I would hate ... to sit back in my little flat just drinking gin or beer and not mixing with anybody, that's certainly a total disaster.
> (Christopher, 70, part-time hospital worker; former engineer)

d. Resistance to ageist stereotypes. Some participants explicitly framed work as challenging the ageist stereotypes which they thought were prevalent in the wider culture. Beatrice, for example, had been obliged by the health authority to leave her full-time post at the default retirement age, and felt insulted by her colleagues' reactions:

> People kept saying "Oh, are you going on cruises?" and all this sort of thing and if I met ex-colleagues, they'd raise their voices as if I might have instantly kind of developed general deafness or something (laughs) ... I found all that quite irritating.
> (Beatrice, 70, art therapist)

Doug (73) had taken up new part-time work as a family mediator within the court system after retiring from his main career. He was aware of ageist stereotypes:

> People assume that if you retire you've kind of lost all of that [knowledge] or somehow . . . didn't ever have those skills. I think some people feel like that.

For several participants, the prospect of spending their days in leisure activities such as golf and taking holiday cruises appeared to threaten their sense of self as an actively engaged, self-directed person:

> I enjoy my work and I play at it in a serious sense, work is serious play for me, I think I'm very lucky in the sense that I've built my life around work . . . there seems to be a view that the way to enjoy the rest of your life is to retire and stop working. I don't think I subscribe to that. I know people who spend their life on the golf course that, on the whole, are pretty dull, they are pretty dull.
> (Adam, 75, manager)

e. Preserving personal and professional identity. Most of the participants described needing to work to confirm their personal or professional identities:

> I think it [work] does give me a feeling of who I am.
> (Marilyn, 69, nursery school administrator)

Some who had moved on from their original jobs nonetheless conveyed that their new roles provided them with a sense of personal and professional continuity. Graham, for example, was rather self-deprecating about his veterinary career and yet also conveyed some pride in what he was achieving in his current locum position:

> I suppose in a way it's a bit sad but I think, to some extent, I'm defined by what I do. When I had the [veterinary] practice, which I sold, I was the town vet . . . whereas now, I'm just a Joe standing behind a table [as a locum] but older people tend to say "Oh, is he there today?" because they like an older person. Which is quite interesting.
> (Graham, 68, locum vet)

For many, particularly the male participants, work was much preferred to leisure pursuits that had never offered a positive source of identity:

> I enjoy it [work], I suppose that's it, also I'm not interested in golf or those sorts of activities really, I've never been sporty.
> (James, 79, self-employed mail order business)

Participants were asked during the interview if they had any plans to retire, to further elucidate the meanings of work. Few perceived any obstacles to continuing in their roles, unless ill-health (of self or partner) intervened.

> I just think if you keep your mind active and you're doing something that you think is worthwhile and fair, then I don't see you should see an end really, I think you just should go on whilst you're still capable.
> (Linda, 76, former teacher, now represents asylum seekers within the legal system, part-time)

The oldest participant (Bob, 91, part-time tax accountant) was on the brink of retiring only because his wife was seriously ill.

Some participants even revealed plans for new work-related activities should they retire from their current jobs, again confirming the powerful identity functions of later life working:

> I think I probably would embark upon a course of study, teaching, if I weren't working, because I have done lots of different study and I still do because I'm a professional coach and I have to do continuous personal development. So I'm always doing things, I'm going on a course in a few weeks' time . . . I think I would go into something more academic if I weren't working.
> (Marta, 71, executive coach)

Almost all participants summarized their experience of later life working as preserving their identities or sense of self. Interestingly, four participants explicitly rejected the notion of ''cruising'' as a suitable retirement occupation, with its associations of passivity and over-indulgence:

> I'm sure cruises are very nice, I haven't got anything against them, but it was the thought . . . retired? You're into cruises and nothing meaningful in life . . . I've enjoyed life outside being an art therapist, but nevertheless, whether you like it or not, it's

> become an integral part of your identity and there's a sense of mourning when one day you're there and the next day you're not.
> (Beatrice, 70, art therapist)

Nonetheless, it is to be noted that just over half of the participants were working *part-time*. It appeared therefore that identity was maintained through exercising *choice* over the balance of lifestyle activities and preserving what they regarded as *sufficient* connection with their careers.

Discussion

The participants in this study almost all portrayed themselves as a highly engaged, experienced workforce, largely unencumbered by the frailties that can result from the ageing process. In this respect, they resembled post-SPA workers in previous studies whose good health is presented as *enabling* them to continue in the workplace (Barnes et al. 2004; Ozawa & Lum 2005). Previous studies of people's motives for continuing in work up to and beyond the default retirement age have tended to focus on financial gain, work fulfilment, social contact and life satisfaction (Barnes et al. 2004; Feldman & Kim 2000; Smeaton & McKay 2003; Smyer & Pitt-Catsouphes 2007; Warr et al. 2004). On the whole, these previous studies have portrayed good physical health primarily as a prerequisite for working beyond SPA not as a subjective benefit of continued employment. Positive health consequences of post-SPA working were noted by Barnes and colleagues (2004) but by very few participants. Some reviews and empirical studies of older people's reasons for working into their mid-60s and beyond have not uncovered any themes relating to health benefits (e.g. Feldman & Kim 2000; Kooij et al. 2008; Templer et al. 2010). Yet this particular theme was prominent in the current study and is worthy of further exploration.

The routines and regular obligations of work were experienced as helping participants to preserve their current health status, experience more vitality, and in some cases, to recover from illness and to resist further deterioration. These subjective views resonate with research findings which link personal control beliefs to the maintenance of health in later life. For example, older people who have strong beliefs that they can influence their own health show less cognitive decline over time (Caplan & Schooler 2003), and seem to use more active health promotion strategies (Lachman 2006).

Previous studies have presented personally valued goals and projects as contributing to well-being in later life through enabling personal development, cognitive stimulation and social engagement, although they have mostly focused on *recreational* pursuits (Henricksen & Stephens 2010; Howie 2007; Lampinen et al. 2006; Reynolds 2010). This study found that paid work and self-employment may have similar meanings for people who choose to continue working into their 70s and beyond. The qualitative accounts revealed that work post-SPA held a rich array of meanings, and that participants were motivated not only by financial benefits, but also their needs for personal development, identity, stimulation, challenge, and a sense of belonging within a wider social network. The majority of the participants in this current project were explicit about the intrinsic well-being derived from maintaining their involvement in learning and taking on new challenges right into their seventh and eighth decade of life. These benefits are well described by the concept of flourishing. Keyes and Haidt (2003: 6) describe flourishing individuals as ‘‘truly living rather than merely existing’’ and as being filled with ‘‘emotional vitality’’, and these phrases very much reflect participants’ accounts.

Participants also appeared to manifest many of the characteristics of ‘‘successful’’, ‘‘active’’ or ‘‘positive’’ ageing. These overlapping, multi-dimensional constructs encompass not only the experience of good physical health in later life but a state of life satisfaction derived from engagement in meaningful roles, personal development and affirmative social relationships (Hill 2006). The findings demonstrate that older people may be actively engaged in transforming the meanings of later life and what may have previously been regarded as normative leisure-focused lifestyles for this life stage (Westerhof & Tulle 2007). Whilst there were proportionately a few more females who described themselves as working primarily for financial reasons (as expected from previous research), accounts were not otherwise strongly gendered (in some contrast with the findings of Barnes & Parry 2004). The one exception was that a few of the male participants were living a lifestyle perhaps more ‘‘typical’’ of mid-life fathers, with young families for whom they were financially responsible. Most of the men and women who were interviewed framed their later years as a period of opportunity rather than decline, and a time to apply and further develop their work-related expertise rather than withdraw wholly into leisure and family activities. Only poor health (of self or partner) was seen as a significant future threat to continuing in work.

Critical evaluation

No simple generalizations are possible from qualitative studies, not least because participants are inevitably self-selected. By virtue of their interest in being interviewed, volunteer participants tend to be reflective and better educated. As in previous research (Barnes et al. 2004; Smeaton & McKay 2003), very few reported manual employment, and no-one reported working in harsh conditions, so the experiences of people who continue to work post-SPA in physically challenging jobs through absolute financial necessity rather than through choice are largely absent from the data. Participants, especially the men, tended to have had professional and managerial careers, and potentially had considerable choice over both the nature and hours of their work post-65. Nonetheless, the sample should not be regarded as an "elite" group of post SPA workers as it was broadly reflective of wider national figures, especially in relation to post-SPA men who are more likely to be found in high-skills jobs, management and self-employment (ONS 2012).

Whilst the study identified a number of subjective benefits associated with continuing to work into later life, no objective benefits can be established (e.g. concerning physical or cognitive health). No comparison was made with retired people of similar age who may derive similar levels of well-being from engaging in leisure or volunteering activities (Warr et al. 2004) or from experiencing high levels of choice over other aspects of their lives (Herzog et al. 1991). Nevertheless, the participants' beliefs in the many health and subjective benefits of continuing to work beyond 65 clearly deserve further enquiry. Caution is needed, though, as such benefits will not necessarily be experienced in the future by older people who are *obliged* to work for longer through government decisions to increase SPA, rather than through their own choice.

Positively, the sample was larger, and older, than those recruited in most previous UK qualitative interview studies of people working beyond statutory pension age (e.g. studies by Barnes et al. 2004 and Parry & Taylor 2007 were based on 17 people working past SPA). It has been valuable, in particular, for illuminating the complex array of reasons why people choose to work into their 70s and beyond. Saturation in the themes offered credibility to the findings.

Conclusions

This qualitative study was based on the accounts of 31 men and women working in the UK context beyond 65, with a median sample age of 71 years. Just over half were working part-time; a small minority worked in manual or semi-skilled occupations, and therefore the group was reasonably reflective of the patterns seen in the wider population of people working post-SPA in the United Kingdom (ONS 2012). Thirteen were self-employed and this also tallies broadly with the one third of this age group who are self-employed according to recent British figures (ONS 2012). Most (77%) were continuing with their main careers (full-time or part-time), rather than entering bridging or low status roles, and this also matches broader population trends (66% of people working beyond 65 in the United Kingdom have remained with their employers according to ONS 2012). The male sample had a high proportion of professionals in highly skilled jobs, but this is characteristic of the wider pattern noted among men working beyond SPA (ONS 2012).

Nearly half the sample appreciated the additional income gained by working, but this was never portrayed as the sole reason for continuing to work. Those who did emphasise the financial benefits of working desired additional income to pay for favoured leisure occupations, to assist adult children (or, in a few cases, to support young children in their second families) or to support their voluntary work (e.g. travel abroad). The sample included very few people who were working primarily to provide for fundamental everyday needs.

In this sample, the decision to continue in work beyond 65 reflected a complex array of reasons. Most of the men and women found enjoyment and satisfaction in the work itself, and believed that their work increased or maintained their health and well-being. These reported health-related benefits of later life working have been largely neglected in previous studies. Several used their late 60s and beyond to set up businesses, or to develop part-time in roles that brought particular satisfaction, or challenges. One implication is that older people might gain a more satisfactory, as well as more affluent, lifestyle by planning for a similar balance of occupations post-SPA. Coupled with published evidence showing that engagement in committed activities such as volunteering and active leisure predicts greater longevity and cognitive health (e.g. Harris & Thoresen 2005; Luoh & Herzog 2002; Newson & Kemps 2005; Scarmeas & Stern 2003), a need for further longitudinal research into the health benefits of later-life working is indicated.

The majority of participants were self-employed (full- or part-time) or working for employers part-time. Both of these patterns of working offer a high degree of control over everyday life and perhaps even align work with some of the characteristics of "serious leisure". According to Stebbins (1982: 257), serious leisure involves a high degree of personal effort and special knowledge. It is not simply enjoyable but offers "self-actualization, self-enrichment, re-creation or renewal of self, feelings of accomplishment, enhancement of self-image, self-expression, social interaction and belongingness ...". Interestingly, one participant made this link himself. But caution is needed before regarding post-SPA paid work in this way. Some of the participants were explicit that their subjective well-being was enhanced through having an improved work-leisure *balance* (and choice over lifestyle) rather than work *per se*. With the UK government's planned delays to SPA, fewer older people will enjoy the option of working part-time whilst simultaneously drawing a state pension (protecting their income). Furthermore, older people are currently finding that opportunities to engage in stimulating, social non-work activities (particularly through informal adult education) are being restricted in the United Kingdom through redirections of central funds to younger people's training (McNair 2009). Thus the positive choices and health-promoting lifestyle patterns enjoyed by this sample of people aged 65 and over will not be so readily available in future years.

Follow-up studies are needed to explore how the accumulating adversities of old age (such as health problems, care-giving and bereavement) are addressed by people who have extended their working careers into their late 60s and beyond, and whether they have more or less resilience to cope with such changes. It has been argued (at least in a leisure context) that older people may feel under pressure to adopt an ‘‘active ageing’’ lifestyle (Marhankova 2011) and questions arise in the current study as to whether eventual retirement (imposed perhaps by ill-health or caring responsibilities) might pose particular psychosocial challenges to older people who are committed to regarding later life as an opportunity for work and continuing development. Furthermore, a recent study of employers in four European countries found that only UK employers positively valued their older workers (Van Dalen et al. 2009). Whether the United Kingdom offers distinctive levels of support for older people to stay in employment or self-employment also needs further research, as contextual influences within the workplace were not explored.

This study located a group of highly motivated people for whom full retirement carried unwelcome connotations of passivity, decline, laziness and ‘‘cruising’’:

> I think people have to feel valuable, otherwise they just spend their time playing golf and I really don’t think it would be satisfying . . . really, life is very short and you’ve really got to do something with it.
> (Adam, 75, business consultant)

Acknowledgement

This study was completed as part of a project funded by the Institution of Occupational Safety and Health (UK).

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International Journal of Ageing and Later Life, 2012 7(1): I–III. © The Author

Dale Dannefer & Chris Phillipson (eds.) (2010). *The SAGE Handbook of Social Gerontology.* Los Angeles, London, New Delhi, Singapore, Washington DC: SAGE Publications, 712 pp. ISBN 978 1 4129 3464 0 (hardcover)

Reviewed by Peter Öberg[*]

The SAGE Handbook of Social Gerontology with 50 chapters on 712 pages is a comprehensive handbook covering a vast range of different topics in social gerontology. The chapters are generally well-written by internationally recognised experts representing multidisciplinary approaches to social gerontology. One of the editors is North American, the other European.

The book is divided into five sections. The first section, *Fundamental and Disciplinary Perspectives on Ageing,* gives an introduction to the book by eight chapters on topics such as: the life course, global history, economics, demography, epidemiology, disability and environmental perspectives – i.e. perspectives from central core disciplines in social gerontology.

The second section, *Ageing and Social Structure,* covers topics such as inequality, gender, ethnic and sexual minorities, religion, family, networks and intergenerational relations. The third section, *Ageing and Individual Change,* is comprised of chapters on identity, cognition, stress, agency and structure, wisdom, loneliness, health, dementia, the body and time.

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The fourth section, *Ageing, Culture, and Development*, covers the topics of – and comparative perspectives on – migration, global and population ageing, grandparents, health and anti-ageing medicine. The fifth and last section, *Ageing and Social Policy*, contains chapters on social policy from different contexts (European, North American, Australian) relating to topics such as work and retirement, long term care, technology and urban ageing, imprisonment in later life, politics, ethics and end of life issues.

The scope of the handbook is consistent, both in terms of its focus on social gerontology and sociological aspects on ageing, and when it comes to its global and comparative approach. While there always is a risk in social gerontology that empirical issues are too local and context bound to be relevant for readers from other places, the global perspective and the focus on theory in this volume make it valuable for readers from different parts of the world.

The chapters give good, well-written introductions and overviews of the field considered. The empirical parts in many chapters cover an impressive view of selected countries. For instance, in chapter 17, "The Significance of Grandparents to Grandchildren: An International Perspective", empirical material is used from the European Union, USA, Africa, Russia and China, among others. Some of the chapters however seem more local than global, e.g. chapter 11 on "Ageing and Health among Hispanics/Latinos in the Americas" – although there is an intention to generalize the issue concerning selective migration and health outcomes. A reader with special interests could always find some issues that have not been included, but still the 50 chapters correspond to what can be expected from a handbook in social gerontology.

The book is also well structured, although the difference between section two on social structure and section three on individual change seems to blur for some chapters. Chapter 18 on "Friendship and Ageing" is e.g. placed under section two on social structure, while the micro-macro theorizing in chapter 22 "Agency and Social Structure in Aging and Life-Course Research" is placed in section three on individual change.

One merit of the handbook is the generally strong emphasis on theories and theoretical perspectives, as can be found for instance in the historization and generational discussion on LGBT ageing in chapter 17. The book also includes chapters on rather "new" issues in social gerontology, such as chapter 45 ''Later Life and Imprisonment''. The last chapters in the handbook are pointing at future directions and need of research, such as ''Growing Old in the Century of the City'' and ''Technology and Older People''.

In conclusion, this is an important contribution to the literature in social gerontology, covering a broad range of issues of high relevance which should be interesting internationally for both students and researchers in the field. It is easy to support one of the advertising statements about the publication, namely that this handbook should be in the library of every social gerontologist (or, one could add, at least the library of every social gerontology department – considering the price of the volume).

International Journal of Ageing and Later Life, 2012 7(1): 5–8. © The Author

Aagje Swinnen and John A. Stotesbury (eds.) (2012). *Aging, Performance and Stardom: Doing Age on the Stage of Consumerist Culture*. Berlin: LIT Verlag, 208 pp. ISBN 978 3 6439 0176 7 (paperback)

Reviewed by Karin Lövgren[*]

This second volume in the series *Aging studies in Europe* deals with performances in film, television and theatre. The chapters analyse cultural productions ranging from the film *The Mother* (2003) to the televised hidden camera show *Benidorm Bastards* (2010). The former is a much talked about movie, in which May, in her sixties, comes to London after her husband's death and begins a love and sexual relationship with a younger man, her daughter's boyfriend. From a psychoanalytic framework Ann Kaplan analyses how the reception and criticism of the movie dealt with the age differences in the relationship as well as with gendered role expectations of women, especially mothers. *Benidorm Bastards* is a format exported to several European countries. In the show, pensioners are cast in different situations which are meant to be provoking for the unwitting bystanders, mostly young people. In her introduction to the book Aagje Swinnen discusses different interpretations of the show. In other chapters adverts are examined, discussing representations of age and ageing in a commercial culture.

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The aim of the anthology is to decipher how age and ageing is done; here performing age, as in doing age, intersects with performances on stage. Theoretically this is inspired by Judith Butler, understanding the concept of gender as being repeatedly *performed* and learned, rather than something one is – or has. In the same way Ann Basting and Margaret Gullette look on age as an equally performed and learned identity: texts by them are theoretical inspirations for the anthology. A common denominator in several chapters is celebrity culture, exploring the tension between a star's persona and the different roles she is playing. Several of the chapters explore how a youth-fixated commercial film industry deals with ageing stars. In some chapters there are comparisons between for instance the casting of women and men – and these I find add to the strength of arguments in the book. Gender-bending – and age-bending – helps develop a clearer understanding of contemporary conceptions and cultural constructions of ageing.

The book is divided into three sections. The first focuses on performances such as Helen Mirren as Queen Elizabeth II in the movie *The Queen* (2006). By combining her star persona as glamorous and modern in the role as an ageing queen, tensions between modernity and tradition are handled. The queen is portrayed also as a private person, a fragile grandmother who – in the turmoil after the death of the younger celebrity Princess Diana, Queen of hearts – manages to reconcile the wounded royal family with the indignant feelings of the public, in the narrative thus partaking in the recuperation of the monarchy.

Performance is also at the centre of Cristel Stalpert's interesting and moving chapter, which analyses different stage versions of Stravinskijs' *The Rite of Spring*, focusing on how casting of dancers in terms of gender and age impacts on the meaning of the ballet.

The second section focuses on ageing stars. In one chapter Estella Ticknell shows the interconnections between Goldie Hawn's persona, her different roles in movies and the symbiotic relationship between popular press and the movie industry. Goldie Hawn – in several roles and as persona – comes across as youthful, girlish, funny, naïve, but also as a dumb blonde. "Hawn's sexual star persona is, then, closely associated with the post-pill, non-maternal, recreationally available female body, even in self-parodic form" (p. 101). Hawn has managed to keep her career going as the ditzy blonde; the chapter pursues and problematizes how this image is managed in relation to ageing, showing that maturity must be denied in popular culture. Ticknell demonstrates how not just Hollywood but Western culture in general struggles with a limited conception of femininity, equalling beauty and sexuality with youth.

In a chapter on Sharon Stone's career, Rebecca Feasey discusses the actress's roles and her star image as a sexual femme fatale. When in the sequel to the box office success *Basic Instinct* Stone, then in her late forties, repeats this persona she is criticized and ridiculed. Feasey, referring to Ginn and Arber, claims that fear and derision of the ageing female has little to do with age in terms of lifestyle, behaviour or cultural norms, and more to do with visible signs of chronological ageing (p. 117). In popular press the failure of the movie sequel seems to have been ascribed to Stone due to her age, but was it because of her actual appearance? As far as Stone goes, it seems debatable if there were visible signs of ageing. The mere fact of her chronological age got attention, aptly illustrating that age also is a number.

The third section of the book contains three chapters, with the common theme stated to be ageing in a consumerist culture. There is for instance a chapter by Apostolos Poulios using conversation analysis on televised talk shows, where a number of Greek actors are expected to relate to their chronological age – some do this by denying it, and others by referring to acquired wisdom and experience. Stating correct birth date seemed to indicate authenticity but also courage, thus confirming that high age is a liability in this line of work.

In another chapter, Swinnen examines photographs by Erwin Olaf – both a series of commercial shots advertising a jeans brand and a series of art photographs. In both series the photographer uses an older main character in a role commonly visually represented by a young, sexualised woman. Symbols and tropes are playfully used, making conceptions of ageing apparent to the viewer.

The book is enlightening, educating and entertaining, ranging from close readings of celebrities' careers, using movies and popular press as empirical material, to visual analyses of adverts and art photographs. The tension between youth, popular culture and especially female ageing is explored. The strength of the anthology is the close reading with examples that illustrate how age is culturally given meaning in contemporary society. The chapters are well written, well argued, using interesting examples and references that help shed light on social meaning making of ageing.

The book is quite dense, both because it consists of chapters with different theoretical frameworks – ranging from psychoanalysis to film theory – and because of the large range of movies that are closely read in several chapters. But the impression of density is also due to the font size in relation to number of characters per line that gives it a compact, albeit academic impression. This is, in my opinion, a beauty flaw: more space in the layout would have been more reader friendly – and perhaps helped this book to reach even more readers in addition to the already committed and interested audience. I would recommend this readable book to those interested in film studies, celebrity studies, cultural studies, age studies and critical gerontology.

International Journal of Ageing and Later Life, 2012 7(1): IX–XII. © The Author

Jordan I. Kosberg (ed.) (2007). *Abuse of Older Men*. New York: Haworth Press, 202 pp. ISBN 978 0 7890 3541 7 (paperback)

REVIEWED by M. GABRIELLA MELCHIORRE*

The book *Abuse of Older Men* represents a real turnaround in our usual understanding of elder abuse. Findings from various research studies and the majority of literature from all countries highlight that older women, generally and historically, are more likely to be presented as victims of maltreatment, whereas older men are more likely to be presented as abusers. In such a context, a notion of domestic violence in terms of a powerful male perpetrator in his societal and family network clearly emerges. At the same time, social and cultural norms still remain as strong barriers, hindering the recognition of male victims of abuse because of the usual socially constructed consideration of gender, where by nature women are considered pacific and men violent.

Nevertheless, recent surveys show that both genders experience elder abuse though it may differ in terms of the types of violence experienced. In this respect, the book *Abuse of Older Men*, entirely dedicated to this specific theme with a multidisciplinary approach and interestingly achieved by collecting scientific contributions from different backgrounds – criminology, psychology, health and social care – represents a crucial and positive expansion of elder abuse literature. The ten chapters included in this anthology indeed highlight abuse as a health and social problem,

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reviewing different typologies of mistreatment and showing that violence towards men is often greatly under-investigated and under-theorized.

The book covers a broad range of topics. The two initial chapters are of great importance because they highlight that some crucial types of mistreatment, such as intimate partner violence (Reeves et al.) and sexual abuse (Teaster et al.) cross both genders, thus offering new cultural and societal interpretations of these dramatic types of violence. The authors of the other chapters are from ancillary professions, drawing for instance upon data on experiences of family doctors (Yaffe et al.) identified through a systematic English language literature review. General practitioners in particular, because of their frequent contacts with older citizens, may have the concrete possibility of tackling episodes of elder abuse and of reporting cases to Adult Protective Services. Nevertheless, these community resources are often under-used by older men who are victims of abuse (Blundo & Bullington). The social construction of manhood and cultural male stoicism are indeed crucial factors for understanding the reasons that prevent older men who are abused from seeking assistance, even though they also need support and protection. Other contributions highlight older men as subjects needing specific treatments from clinicians, and recommendations for helping male victims through structured and dedicated clinical services are made (Kaye et al.). Moreover, the existence of ''gendered policies and practices that increase older men's risk of elder mistreatment'' (Thompson et al.) is underscored to analyse the abuse of male seniors as a societal problem and not only as an individual or family question. Another interesting chapter (Stratton & Moore) focuses on the effects of past, poor and ''fractured'' relationships between older males and their family members as potential driving forces towards episodes of mistreatment, with the consequence of an increased risk for abandonment and neglect of elderly men. Finally, some articles and media accounts from 1986 to 2007 also report cases of older men who are victims of economic exploitation, apart from the violence from family and institutional carers (McNeely & Cook).

Worthy of note is the contribution from Jacki Pritchard, the only one from the United Kingdom (whereas the remaining nine are based on evidence from the United States), who presents results from a further development of an earlier study which originally focused on older women victims of violence. During the project, some older men approached the researchers to report their experiences of being mistreated in childhood and adulthood, and this circumstance convinced the scientists to extend the study to include male victims, who surprisingly were willing to talk about this important and sensitive issue.

Conversely, an oddity of the volume concerns a chapter on osteoporosis (Haas & Moore), a pathology of the musculoskeletal system presented as one of the main factors of mortality and morbidity in the United States. It is analyzed here as a silent, invisible, and "neglected disease of elderly men", whereas usually osteoporosis is studied and perceived as a specific female problem. Although this part shows the important issue of neglect in the health care field, it seems to be less correlated with the main and wider topic of the volume.

Besides its multiple strengths, the book also presents some shortcomings because of the various definitions and descriptions of elder abuse and neglect used by different authors (e.g. a general definition of violence is drawn from the HCR-20 items checklist in Reeves et al.; Stratton & Moore adopted the main forms of abuse as they are described by the National Center on Elder Abuse). Moreover, categories of abuse are often just listed but only seldom specified in their characteristics, and different ages for identifying the elderly are considered (e.g. 60 years and older in Blundo & Bullington; from 65 years onwards in Pritchard). Despite the awareness that both definitions of old age and mistreatment vary across cultures and among researchers, thus making it complex to reach a uniform and shared understanding of elder abuse, the inclusion of some specifications in the introduction of the book concerning these objective difficulties could have been explanatory and of great help in approaching the issue. Finally, to integrate the various perspectives, it would have been useful to include a final chapter with a global look to the future, crossing all the contributions of the book, and including (as separately made in some chapters only) recommendations for further studies and interventions.

Despite the aforementioned few limitations, the contents of the book provide researchers, educators, practitioners and students with crucial information useful for social work, nursing and Adult Protective Services dealing with episodes of violence against elderly men. As can be read on the back cover of the book, it can help to "learn the causes of – and consequences from – elder abuse of men'', also by indicating new gendered directions and a wider perspective to the common understanding of elder abuse, thereby raising awareness about violence against older men. The book, which also has been co-published as a special edition of the *Journal of Elder Abuse and Neglect* (2007, 19 (1/2)), clearly highlights that men are subject to elder abuse just like women, but it also clearly acknowledges that older abused men may need different health and social interventions. It thus represents an important starting point for further and more specific studies on the issue, and the effort of Kosberg, in considering and highlighting it, shows a great sensitivity of this author in perceiving the social world around him, which in a global context is difficult to understand without assuming a gender perspective.

International Journal of Ageing and Later Life, 2012 7(1): XIII–XIV. © The Author

Dirk Hofäcker (2010). *Older Workers in a Globalizing World*. Cheltenham: Edward Elgar, 336 pp. ISBN 978 1 84844 817 9 (hardback)

*REVIEWED by JILL MANTHORPE**

It is a complication of gerontology that while the ageing of the population is well known, trends in retirement are uneven and often unpredictable. In this comparison of retirement across Western developed or industrialised countries, Dirk Hofäcker presents the findings of his scholarly dissertation. The research was supported through the Volkswagen Foundation's Globalife project, and the title neatly sums up the interaction of globalisation and its contextual influences on the people in work and after retirement.

Hofäcker's thesis is that most research has concentrated on the transition from work to retirement, which may of course say much about the anxieties of researchers themselves. This is a narrow but clear furrow to plough because most people think about their own position long before the event of actual retirement and in the context of other pressures and options. Hofäcker describes such deliberations as multi-dimensional. Similarly, he argues that research on the trend to early retirement has become rather over-generalised, with vague references often being made to the economy or social trends.

This book is structured into three main parts: (1) an overview of globalisation and work in later life; (2) a macro-perspective of late careers; and (3) a micro-perspective using four countries' experiences

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(Denmark, the UK, The Netherlands and Italy). The four-country comparison enables extensive similarities to be drawn, such as the presence of labour mobility or the ability of older workers to move between employment rather than simply to cease work altogether. This close focus also reveals great differences between the countries that illustrate certain trends. These relate, not surprisingly, to social and economic influences, which can, of course, cover almost everything. The author highlights that countries that have been quick or relaxed about shedding labour may need to work harder at increasing options and opportunities for older workers since they may be taking on feelings of exclusion. Indeed he suggests that governments will need to change the perspectives of people in mid-life to have a chance of altering aspirations for early exit from employment.

Linked to this is the author's recommendation that education and training must be re-engineered to address older workers' and employers' needs to ensure a fit between older workers and employment. In his view both education and training operate within a mindset that they are preparing young people for the world of work.

There are numerous points to ponder in this book but it is not for the faint-hearted. In my view the book could have benefitted from "key points" and summary sections throughout. But, unlike many texts of such detail, it is well written and presents a wealth of data clearly. The text may be a useful resource for scholars seeking to go beyond generalisations about early retirement whether they be gerontologists, economists with interests in pension policies, or social historians who wish to investigate the perplexities of ageing societies at a time when retirement curiously seemed to be occurring earlier.

IJAL

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eISSN 1652-8670