

AGEING WELL IN THE COMMUNITY: SOCIAL REPRESENTATIONS OF
WELL-BEING PROMOTION IN LATER LIFE



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ABSTRACT

This thesis is a social psychological study on ideas of well-being in later life by older adults, staff members, and volunteers involved in community support. Social representations theory constitutes the theoretical lens through which social constructions of well-being are examined. This project constitutes an ethnography of how groups represent wellness in later life, and how they evaluate receiving and giving support. Three day centres and a scheme of home visits of a voluntary organisation in the United Kingdom were the main sites of this study. Participant observation and 54 in-depth interviews were the main data sources.

The study shows that both clients and practitioners understand wellness in later life as the result of an active, independent, and gainful living. This idea was shared amongst all groups in both settings, indicating the prevalence of a hegemonic view of wellness. This view is present in public understandings and professional discourse on ageing well. Nevertheless, clients and practitioners also challenged this ideology of wellness by representing ageing both as experience of gains (e.g. vitality and autonomy) and limitations (e.g. frailty and social isolation). These views are represented via two binary oppositional themes: activity-passivity and independence-dependence. Moreover, clients and practitioners highlight the importance of health, adaptation, and relationships of support to attain well-being in old age. The concept of canonic themata and the evidence of a complex representational field around the theme of ageing constitute important empirical insights with which to understand the sharedness of well-being amongst all groups. Differences were observed in the way in which clients and practitioners position themselves – the first groups as receivers of help, whereas the second one as providers of care.

Moreover, clients represent themselves as active and independent despite being recipients of support. In negotiating their views of independence, they preserve a positive sense of identity and accept help from others. Cognitive polyphasia also characterises thinking about well-being: physical, psychological, social, and material elements interact to promote wellness.

The study also sheds light on how communities of support make sense of their practices. The concept of representational project offered a rich theoretical insight into how groups represent well-being promotion in the charity. Both clients and practitioners represent well-being promotion as actions to preserve functionality and participation in the community. Therefore, two set of actions were mentioned in both settings: socio-emotive and practical support. Implications for well-being policies and community support were addressed.

PREFACE

This dissertation is the result of my own work and includes nothing which is the outcome of work done in collaboration except as declared in the Preface and specified in the text. It is not substantially the same as any that I have submitted, or, is being concurrently submitted for a degree or diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in the Preface and specified in the text. I further state that no substantial part of my dissertation has already been submitted, or, is being concurrently submitted for any such degree, diploma or other qualification at the University of Cambridge or any other University of similar institution except as declared in the Preface and specified in the text. It does not exceed the prescribed word limit for the relevant Degree Committee.

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CHAPTER ONE: INTRODUCING THE TOPIC

1.1 Introduction

This thesis explores the understandings of wellness in later life held by groups involved in community support for the elderly. It is based on an ethnography of clients, staff members and volunteers of a charitable organisation in the United Kingdom (UK). The perspectives of older adults, staff, and volunteers on the promotion of well-being were the main objects of analysis. This study presents several key empirical findings that contribute to the debate about what it means to age well in Britain today. The research perspective of social representations (Moscovici, 2008) was adopted to analyse people's understandings of well-being, which are generated in the immediate context of community interactions. Firstly, clients, staff members and volunteers share a common view of wellness in later life: well-being is seen as the result of an active, independent and gainful life. Simultaneously, however, older adults' views are complex, and involve considerations of the challenges of living in the community. Concerns over losing independence, becoming passive, and socially isolated are common. In addition to outlining these views on well-being, the thesis highlights the significance of promoting well-being in later life via two set of actions: socioemotional support and instrumental support. These two categories of action address different challenges in old age: loneliness and frailty respectively. The thesis provides evidence for how older adults, staff members and volunteers' perspectives reflect current ideologies of active and successful ageing. Nevertheless, they challenge professional models by demonstrating a contextual and relational perspective of wellness, one which is guided by a project of support in the community.

In this introductory chapter, I will consider the context of the ageing population in the UK and its consequences for public policies on well-being promotion. Current emphases on happiness and community support in the UK will be highlighted. Voluntary organisations and different groups of older adults involved in giving and receiving support will be described as important agents in current policies of well-being promotion. The importance of exploring older adults' understandings of well-being promotion in the community will be made clear. This discussion will point to the main research questions of this study. Following this, I will discuss why the theory of social representations is a fitting psychosocial perspective with which to explore lay perspectives of wellness. Finally, I will introduce the chapters that constitute this thesis.

1.2 Context: ageing society and implications for public policy

Living longer constitutes both a reason for celebration and concern in modern societies, as longer life expectancy challenges social and health care systems (European Union, 2012; Cambridge County Council, 2012). In the UK, approximately 10 million people are 65 years old and over, and this proportion is projected to increase to 19 million by 2050. In addition to this, there are more than 3 million of the *oldest old* in the UK, with this number projected to double in 2030 and reach eight million by 2050 (Cracknell, 2010).¹ The percentage of adults aged 65 and over has increased between 1976 and 2016, from 14.2% of the population to 18%

¹ The term *oldest old* refers to those aged 80 and over who might require specialised services due to physical, psychological and social contingencies (Age-UK, 2013). Although the ageing process involves physiological, psychological and social changes, delimiting age periods is arbitrary, and it might reflect processes of social categorisation and segregation (Nascimento-Schulze, 2011; Stuart-Hamilton, 2011). Nevertheless, research in later life has identified that 'older adults' are not a homogeneous group as an increasing life expectancy raises different health and social care needs (Age-UK, 2013; Christensen et al., 2009).

(See Table 1). This proportion is estimated to grow to approximately a quarter of the population by 2046 (ONS, 2017).²

Table 1

Age distribution of the UK population, 1976 to 2046 (projected)

Year	UK Population	0 to 15 years (%)	16 to 64 years (%)	65 years and over (%)
1976	56.216.121	24.7	61.2	14.2
1986	56.683.835	20.5	64.1	15.4
1996	58.164.374	20.7	63.5	15.9
2006	60.827.067	19.2	64.9	15.9
2016	65.648.054	18.9	63.1	18.0
2026	69.843.515	18.8	60.7	20.5
2036	73.360.907	18.0	58.2	23.9
2046	76.342.235	17.7	57.7	24.7

Source: Office for National Statistics (2017)

This increasing longevity has had an impact on the way in which western societies promote health and social care for the elderly. For instance, two of the main policy responses to ageing populations have taken place in the field of social gerontology. Successful and active ageing policies constitute international and domestic frameworks with a clear focus on healthy ageing in western countries (Foster & Walker, 2015; Matzke, 2011; WHO, 2002). These models emerged in the context of a renewed optimism in later life research and clinical practice (Baltes

² These numbers result mainly from the combination of falling birth rates and steadily rising life expectancy due to increased availability of medical treatments, promotion of healthier lifestyles and prevention of diseases (Byrne & Neville, 2010, Stuart-Hamilton, 2012).

& Baltes, 1990; Erickson, Gildengers, & Butters, 2013). Policymakers and health professionals hoped that this *new gerontology* would enable older adults to be functional and manage their own health (Holstein & Minkler, 2003). These hopes were particularly welcomed in the context of reduced investment in welfare systems across Europe, particularly in the UK, where community care and ageing at home have been advocated as strategies to reduce the costs of care (Sixsmith & Sixsmith, 2008). Therefore, international and local policies of active and successful ageing have been followed by the challenges of redefining ageing according to ideological frameworks of activity, autonomy, and health. These models have defined indicators for policy and practice in later life. A successful old age is seen as achievable via the adoption of behavioural, health, and policy-related actions that aim to optimise later life functioning (Ribeiro, 2015). These professional frameworks of positive ageing have also attempted to create positive images of old age (Featherstone & Hepworth, 1995). Consequently, public and professional discourse on *ageing well* has gained weight as an ideological movement towards a healthy and active later life (Bowling, 1993, 2005; Walker 2002, 2009). In this context, well-being is considered a desired outcome of successful and active ageing policies (Rowe & Kahn, 1987; Kahn, 2002; Walker, 2009; WHO, 2002). This is particularly evident in the Western public sphere where health has been resignified as a generalised state of well-being (Crawford, 1984). Physical status is no longer a primordial indicator of health: subjective, social, and cultural aspects are intertwined to enable individuals and societies age with quality of life (WHO, 2006).

In the context of UK policy, in March of 2013, the House of Lords released *The Select Committee on Public Service and Demographic Change Report* (House of Lords, 2013) on the prospect and implications of the ageing population in the UK. The commission responsible for the report stressed that ‘the Government and our society are woefully underprepared’ to address

the implications of the ageing population (House of Lords, 2013, p. 8). The lack of appropriate integration between health and social care, the increasing number of older adults with dementia, and the lack of adequate support for independent living were some of the main issues raised by the Committee. Thus, the report highlighted the need to adapt services, and it recommended changes in public policies, and health and social care systems. In response, the UK Government released the *Government Response to the House of Lords Select Committee on Public Service and Demographic Change: Ready for Ageing?* (Crown, 2013). The Government addressed the Report's suggestions by emphasising its commitment to empowering older adults to live active and fulfilling lives and involve local communities to address the challenges of ageing. In the course of the proposed changes in social care policy and practice, well-being promotion has been considered an important indicator of quality services (Crown, 2013; DoH, 2014b). Evidence that economic welfare is not linked to people's life satisfaction has challenged policymakers' emphasis on economic models for human well-being (Jordan, 2008). Thus, wellness has become a central value and desired outcome of public policy (Barnes, Taylor, & Ward, 2013). Therefore, in the next section, I will discuss the relevance of this construct for policies which target the ageing population in the UK.

1.3 New emphasis in health and social care policies: well-being in later life

Concomitantly with this renewed interest in ageing, *happiness* has become a major object of interest in local and international policies (Frawley, 2015). In the UK, new measures to appraise progress have moved away from a strict economic ethos such as Gross Domestic Product (Chiripanhura, 2010). This shift has been influenced by escalating evidence that indicates that, in the postwar period, increases of income in the USA and the UK did not

correspond to higher subjective well-being (Frey & Stutzer, 2002; Lane, 2002; Layard, 2011). Furthermore, evidence suggests that choices over consumption, earnings, retirement, rights, and participation in society are not necessarily associated with positive experiences (Frey & Stutzer, 2002; Jordan, 2008). This has prompted researchers and policymakers to move beyond economic progress when assessing public policies (Dolan & White, 2007). In this context, measures of happiness have been considered as indicators of policy progress (Frawley, 2015).

Well-being in old age has also gained attention in public policies in the UK, particularly due to the evidence that subjective states affect health outcomes (DoH, 2014a). For instance, well-being is associated with positive immune functioning and resistance to diseases in later life (Friedman, 2012), longevity (Xu & Roberts, 2010), and physical and mental health (DoH, 2014a; Steptoe, Deaton, & Stone, 2015). Additionally, one aspect that makes the study of well-being particularly relevant is the so-called *paradox of ageing* (Friedman, 2012). Although ageing is often accompanied by cognitive and physical losses, older adults tend to report higher levels of well-being than younger and middle-aged adults (George, 2010; Strawbridge, Wallhagan, & Cohen, 2002).

Considering the growing evidence for the relationship between subjective assessments of life and health, policymakers have sought to explore which aspects are associated with people's wellness. Global assessments of quality of life, and, in particular, social and material well-being have been considered in the Government's attempts to promote well-being (Thomas & Evans, 2010; ONS, 2013). In the context of new statutory policies for health and social care in the UK, well-being promotion is paramount. For instance, in England, the establishment of local Health and Well Being Boards and the renaming of primary mental health provisions as *well-being services* highlight how salient well-being has become in health care (Ward, 2014). In social care, the Care Act 2014 (DoH, 2014b) made well-being promotion the main duty of

local authorities, which suggested that well-being is achieved by actions that promote personal dignity, physical and mental health, and protection against abuse or neglect of vulnerable groups. According to Ward (2014), well-being has become associated with ideas of independence and individual responsibility; and it is intimately related to an active ageing agenda in the UK. This has had implications for health and social care policies for the elderly. For instance, the National Service Framework for Older People (DoH, 2001) has explicitly endorsed active ageing as a way of promoting well-being in later life.³ It proposed a community liaison between health and social support practitioners to meet the complex demands of the ageing population and promote well-being and independence.

Subsequently, the Government's 2010 White Paper set out strategies for a new public health system (DoH, 2010). Local governments and communities acquired a leading role in promoting well-being and health. In this policy context, the voluntary sector became an important partner in the UK's vision of promoting wellness in old age (DoH, 2001, 2005, 2006). Actions to prevent hospitalisation and increased costs in social care for older adults (preventative services) are some of their proposals within this well-being policy (DoH, 2005). This is in line with the Government's direction of sharing the responsibility of care with local communities and wider civil society (DoH, 2010). In this context, promoting well-being for the elderly via community settings has been regarded as a policy response to demographic changes and concerns over increased demands on health and social care (Barnes et al., 2013). Therefore, the leading role of the voluntary sector in promoting well-being through community

³ The National Service Framework was a broad strategy under the Labour Party, which aimed to address the health and social needs of older adults in the UK. It was a ten-year programme, providing standards for services evaluation. The Framework assumed that 'older people wish to remain healthy, active and independent of the need for support from services and from their families' (DoH, 2001, p. 14). Therefore, it strongly emphasised the need to promote health and independence as a way of alleviating public expenditure and the alleged burden on health and social care services.

participation warrants investigation into how their members – volunteers, staff members, and clients – understand their contribution to these policies.

As discussed above, measures of subjective well-being have been used to monitor progress, inform policy design, and evaluate policy outcomes in the UK (Dolan, Layard, & Metcalfe, 2011). Nevertheless, definitions of well-being and its correlates (happiness, life satisfaction, flourishing) vary in both scientific and policy-oriented literature (Cromby, 2011). Research scholars often agree that well-being involves positive psychological functioning in different stages of life (Friedman, 2012). However, less agreement is found on what aspects of human experience and psychology should be measured in exploring well-being. Three different approaches have been proposed to assess wellness which are particularly relevant to gerontology: life evaluation, hedonic well-being, and eudaimonic well-being (Steptoe, Deaton, & Stone, 2015). The life evaluation approach involves individuals' views and satisfaction with different aspects of their life (Steptoe et al., 2015). Initial research in social gerontology posited life satisfaction as an operational concept to explore successful ageing (Havighurst, 1961; Neugarten et al., 1961; Palmore, 1979, Ryff, 1989a).⁴ Life satisfaction is regarded as distinct from health assessment (Lawton, 1975), associated with physical activity and social participation (Palmore, 1979), as well as functionality (Bowling, Farquhar, & Browne, 1991).

A second perspective on exploring wellness is hedonic well-being, which refers to the appraisal of 'everyday feelings or mood such as experienced happiness (the mood, not the evaluation of life), sadness, anger, and stress' (Steptoe et al., 2014, p. 641). It is mainly concerned with the experiences of positive and negative affect (Ryan and Deci, 2001). Hedonic components of wellness are often assessed by asking individuals to rate their experience of

⁴ Reviews of studies have suggested that life satisfaction does not decrease with age, which points to the role of adaptation in making older adults content to their lives (Diener, Suh, Lucas, & Smith, 1999; Ryff, Singer, & Dienberg Love, 2004).

emotional states such as happiness, sadness, and fear (Steptoe et al., 2015). Respondents are often required to rate their immediate life experiences and how they feel at different times during the day⁵ (Kahneman, 2004).

Research on hedonic well-being in later life has pointed to unique ways of coping with life stressors in later life (Dockeray et al., 2010; Steptoe et al., 2015). Nevertheless, hedonic well-being measures are not enough to capture different indicators of wellness (Steptoe et al., 2015). In this context, eudaimonic well-being has been suggested as a broader framework for human flourishing (Ryff & Singer, 2008). It goes beyond the affective and emotional appraisal of experiences as promoted in hedonic perspectives (Steptoe, Deaton, & Stone, 2014). From this perspective, well-being is the pursuit of meaningful experiences, personal growth, and self-realisation (Ryff, 1989b). This measure has been used to assess different components of wellness which are relevant for older people, such as adaptation, environmental control, and meaningful relationships (Ryff & Keyes, 1995; Springer, Pudrovskaya, & Hauser, 2011).

Taken together, these three perspectives point to different understandings of subjective well-being. This conceptual plurality is deemed a limiting factor for policymakers and researchers to ascertain the unique elements of wellness and what to expect as policy strategies/outcomes (Barnes et al., 2013). This is particularly evident in research and policy papers that point to overlaps between the concept of well-being and quality of life (Barnes et al., 2013; Bowling & Stenner, 2011) successful ageing (Fisher, 1992; Ryff, 1989a), and active ageing (DoH, 2001; WHO, 2002). For instance, research on older adults' views of what brings wellness to their life shows different factors (e.g. participation in community activities, active lifestyle

⁵ In one of the hedonic well-being measures, ecological momentary assessments (EMA), participants are asked to rate their mood by assessing immediate experiences (Dockeray et al., 2010). In this approach, researchers seek to minimise the influence of life evaluation in people's responses, maximise the exploration of immediate mood states, and provide insight into people's daily experiences (Kahneman et al., 2004; Shifman et al., 2008).

and health), which are also conceptualised in the models of successful and active ageing (Barnes et al., 2013). Furthermore, older adults' perspectives may present aspects not thoroughly covered in professional models such as the value of networks of support, relationships, and individuals' perceptions of their place in society (Ward, Barnes, & Gahagan, 2012). This points to the need to consider understandings of well-being contextually.

1.4 The importance of contextual perspectives on well-being⁶

Despite the recognisable value of measuring populational well-being, less is known about what older adults think about it. Participatory research with older adults has challenged previous individualised conceptions of well-being and called for a more contextual approach to research wellness in later life (Barnes et al., 2013; Ward, 2015). This concern has also been shared by economists, psychologists, and sociologists in research which asks individuals directly about their assessment of wellness (Frey & Stutzer, 2002). Nonetheless, as highlighted by Barnes et al. (2013), 'the conceptual difficulty in distinguishing well-being from other ways of characterizing older people's assessments of their lives remains' (p. 476). Thus, there is a need to understand the way that older adults themselves understand wellness in old age, rather than just working with psychological (or other) theories and definitions. This approach has the potential to explore the circumstances in which individuals experience well-being and the meanings associated with them (Barnes et al., 2013). According to Ryff (1989a), societal norms and cultural constructions mediate individuals' appraisals of wellness in later life. Thus, examining older adults' understandings of psychological well-being and the standards from

⁶ The term on contextual perspectives was borrowed from Arcidiacono and Di Martino's (2016) article, 'A critical analysis of happiness and well-being. Where we stand now, where we need to go.' In this chapter, the term *contextual* refers to the views of wellness held by recipients and providers of support.

which they assess their positive experiences is necessary to further understanding of ageing well (Fisher, 1992).

Similarly, voluntary organisations are also included in governmental and local plans for promoting (mental) health in the community (DoH, 2001; Cambridge County Council, 2012). Informal and voluntary provision of support (charities, family caregivers) are considered crucial parts in the management of psycho-social dimensions of ageing in the community (Cummings & Kropf, 2009; Mossabir, Morris, Kennedy, Blickem, & Rogers, 2015; Singh, Hussain, Khan, Irwin, & Foskey, 2014). In the UK's current policies of promoting well-being in old age, the voluntary sector has been considered as an important partner (DoH, 2001, 2005, 2006). Actions to prevent hospitalisation and increased costs in social care for older adults (preventative services) are some of their proposals within this well-being public health agenda (DoH, 2005). Nonetheless, there has been a scarcity of research that addresses the extent to which people working in voluntary organisations understand their role in promoting well-being to older adults in the community.

Furthermore, older volunteers are considered vital actors in the voluntary sector. Historically, volunteering has been considered a main role available to retired older adults (Morrow-Howell, 2010). Underlying this involvement is the assumption that older adults will remain healthy and use less social and health care services (Ward, 2014). Research has indeed indicated that there is a positive relationship between volunteering and improved health and well-being (Hank & Erlinghagen, 2010; Morrow-Howell, 2010), less risk of depression (Thoits & Hewitt, 2001), and increased functional ability in later life (Lum & Lightfoot, 2005). Furthermore, volunteering has been shown to prompt older adults to become more active members of their communities and participate in community development (Narushima, 2005).

This is particularly welcome in the context of the UK where volunteering is promoted within the discourse of social inclusion and positive ageing (Warburton, 2015).

Personal experiences and idiosyncratic motivations also influence older adults' involvement with volunteering. In a review of studies, Warburton (2015) mentioned four main motivations: the opportunity to help others, the possibility of maintaining social networks, the perception that volunteering is commendable, and personal satisfaction. Reciprocity is another relevant outcome and/ or motivation for volunteering in later life (Townsend, Godfrey, & Denby, 2006). Research conducted by Breheny and Stephens (2009) has shown that older adults often understand reciprocity as a way of solving the contradictory moral imperatives of independence and connectedness. Thus, reciprocity – being understood as giving and receiving support with daily issues – may preserve older adults' perceptions of themselves as active and autonomous agents, while allowing dependence via meaningful relationships. Findings also point to the role of reciprocity in giving a sense of well-being for older adults (Ward, Barnes, & Gahagan, 2012) and constructing a notion of successful ageing based on the preserving capacities of contributing to people's lives and remaining active citizens (Townsend, Godfrey, & Denby, 2006). Research is yet to explore how reciprocity is established amongst older adults performing different roles of support (e.g. providers as opposed to receivers of support).

Research into older adults and volunteers' experiences of wellness and service provision would highlight significant aspects involved in the relationship between mental health and everyday life (Lamb et al., 2011). With reference to work involving mental health service users (Foster, 2007), psychiatrists, psychologists, psychiatric nurses, and social workers (Morant, 2006), and wider communities (Jodelet, 1991; Zani, 1995), it seems clear that different social groups express different ideas about what constitutes mental illness/health and interact to promote practices according to these beliefs. In the new context of promotion of positive mental

health, older adults and the voluntary sector are also interacting to make sense of these new concepts and practices.⁷ Thus, they constitute relevant groups for investigating new forms of community-based care as well as for evaluating services and practices (Cummings and Kropf, 2009; McCree & Banerjee, 2011).

In this study, I will endeavour to examine individuals' views of wellness by taking into consideration the major policies of successful and active ageing given their widespread influence in public and professional discourse.⁸ Therefore, I will examine the views of clients (older adults), staff members, and volunteers involved in a voluntary organisation with a focus on support to the elderly.

1.5 Research questions

Considering these issues, the following research questions guided the study of perspectives of well-being in later life:

- 1) What are older people's understandings of *well-being* in later life?
- 2) How is *well-being* understood by those working in the voluntary sector?

⁷ Although literature has focused mainly on the prevention and management of mental illness in this study I focus on lay understandings of positive mental health, which has been defined as the prevention of psychosocial problems, social support and psychological well-being in the community (Rogers & Pilgrim, 2001; Seligman, 2008).

⁸ In this study, I will explore the terms 'well-being', 'successful ageing', and 'active ageing' interchangeably. Research has pointed to a theoretical overlap between these concepts (Bowling, 2009). As will be further considered in Chapter Two, older adults' views of wellness and health are often multidimensional and involve elements present in all three constructs.

- 3) How is the relationship between well-being and community support understood by older adults, staff members and volunteers involved in community support?

In addressing these research questions, beliefs about ageing and mental health must be investigated by social psychological research. Thus, I draw upon the theory of social representations to understand how people working in a voluntary organisation, including older adults, staff members, and volunteers make sense of promotion of mental health care for the elderly.

1.6 Theoretical framework: the theory of social representations

Social psychology can assist gerontology by providing a deeper analysis of how understandings of ageing are socially constructed and lived at individual and community levels (Provencher, Keating, Warburton, & Roos, 2014). Additionally, some movements in health psychology have moved from a biomedical and individualistic ethos to a community-based approach (Campbell & Jovchelovitch, 2000; Israel, Schulz, Parker, & Becker, 1998; Stephens, 2007). This shift involved the search to understand conceptions of health and illness in the context of group interaction. This trend also reflects societal shifts towards community-based care in health and, more particularly, mental health promotion (Roger & Pilgrim, 2014). In this way, health and wellness in later life are seen within a network of individual, cultural, institutional and societal influences (Flick, 1998). Thus, the study of well-being in later life necessarily involves the analysis of the social constructions of indicators of wellness and how these views are negotiated and enacted in the public sphere. Considering these issues, this study will adopt the theory of social representations in order to analyse understandings of well-being in specific social contexts. This research perspective offers key insights into the relationship

between meaning-making and social contexts (Flick & Foster, 2008). This perspective does not consider common sense as an inferior form of knowledge (Foster, 2003). Instead, it considers the different voices that interact to make sense of well-being in later life – in their own terms or context. (Flick & Foster, 2008; Howarth, Foster & Dorrer, 2004).

Historically, the theory of social representations has been used in studies of the societal comprehension of health and illness (Herzlich, 1973; Flick, 2000). It takes a socio-psychological perspective to investigate how different social groups interact to make sense of unfamiliar and relevant phenomena in their everyday lives (Moscovici & Duveen, 2000). Moscovici (1973) defines social representations as systems of beliefs with two main functions: firstly, to allow a common ground for understanding reality which enables individuals and groups to guide themselves in relation to diverse social phenomena, and secondly, to provide consensual codes for communication and interaction in the social reality.

Social representations constitute ‘forms of symbolic mediation firmly rooted in the public sphere’ (Jovchelovitch, 1996, p. 122). According to Moscovici (1988), these forms of symbolic mediation are shared in three different ways, depending on the relations between groups and individuals within society. Firstly, certain representations are pervasive and shared across different groups. These *hegemonic representations* are originated beyond the immediate context of meaning-making of specific social groups (Villas Bôas, 2010). Thus, hegemonic representations are coercive and ‘embedded in culture and history and thus have a tendency towards stability’ (Marková, 2000, p. 455). For instance, according to Howarth (2006) topics such as race and gender can be considered as hegemonic representations for being dominant systems of beliefs across diverse social contexts (Augoutinos, Tuffin & Rapley, 1999; Duveen, 1993). Secondly, representations become *emancipated* to the extent in which social groups assimilate and transform their meanings according to the specific contexts of practice. For

example, social representations of mental illness vary according to the political and pragmatic context of groups such as services users (Foster, 2007) and mental health professionals (Morant, 2006). Thirdly, representations become *polemical* as they are the result of social struggle and resistance. These representations are not shared by all segments of society and ‘are often expressed in terms of a dialogue with an imaginary interlocutor [e.g. powerful social groups]’ (Moscovici, 1988, p. 222).

Representations become salient in times of conflict and change and are dynamic features of modern life (Farr, 1995; Moscovici, 1988). Diverse groups and communities draw upon historically embedded knowledge to make sense of relevant issues (Samutt, Andreouli, Gaskell, & Valsiner, 2015). Relevant phenomena such as biotechnology (Durant, Bauer, Gaskell, 1998), mental illness (Jodelet, 1991), AIDS (Joffe, 1995, 1996a, 1997), and identities in the context of migration (Andreouli & Howarth, 2012) constitute some of the main issues threatening stability in modern societies. These issues constitute some of the conditions for individuals and social groups to engage in the process of making unfamiliar (and threatening) objects familiar to themselves (Moscovici & Duveen, 2000). Similarly, the unprecedented transformation in demography in the UK has brought ageing to the fore in the public arena. In this context, of tension and redefinition of ageing, social representations play a crucial role in enabling groups to make sense of new ideas of ageing and understand their complex experiences in the community.

1.7 Reasons for theory of social representations: analytical insights into the study of ageing

Social Representations Theory (SRT) may help to understand the social psychology of health and illness in three ways. Firstly, this theory acknowledges the interaction between

different groups in the process of constructing ideas about socially relevant issues (Howarth et al., 2004). This is particularly relevant in research on marginalised groups whose beliefs are regarded as inferior. For instance, Foster's (2007) research on mental health has shown that users of mental health services challenged professionals' definitions of mental illness, and did not accept them as part of their social identities. Professionals' discourses about older adults often depict them as a *continuing care group* (Roger & Pilgrim, 2001). Therefore, their views might not be fully considered when accessing models of well-being promotion. Despite significant changes in policies regarding ageing, older adults have scarcely been consulted when policymakers design interventions that aim to promote well-being (Bowling, 2006). Older adults' views have been considered important when implementing health and social policies, and might constitute a powerful resource with which to evaluate the appropriateness of social and health interventions (Lamb et al., 2011; Lauri, 2009). There is also evidence of more public involvement when social policies and interventions are perceived as relevant by the general population (Jopp et al., 2015).

Secondly, a social representations theory approach to health would explore how different groups make sense of this phenomenon and examine the social functions of these beliefs such as collective identities and health-related behaviours (Bauer & Gaskell, 1999, 2008). As will be further discussed in Chapter Two, social gerontology has focused on individuals' views of ageing well, and not considered the influence of different social groups and social contexts in forming such understandings. Thus, a research into collaborative meaning-making may elucidate the relationship between ideologies of health and social care and social context. Furthermore, there is a need to examine how understandings of wellness have an impact on the way in which older adults structure their lives and organise their identities. Social Representations Theory has focused on analysing how social understandings

mediate the construction of self-orientations and behaviours (Breakwell, 1993, 2017; Duveen, 2001). This is particularly relevant given the cultural imperative of an active lifestyle according to the policy frameworks of active and successful ageing.

Thirdly, SRT may help stakeholders to understand the role of communities in health support. Whereas social gerontology has largely conceptualised community as a place-based sphere, SRT may offer insights into the contextual, meaningful, and practical aspects of ageing in the community (Provencher et al., 2014). Definitions of community are complex and contested (Howarth, 2001). Different socio-demographic arrangements (e.g. intense urban mobility, social isolation), migration, and globalisation challenge traditional definitions of communities as defined solely by geographical areas (Jovchelovitch, 2007). A social psychological analysis of communities ought to consider the common identities, practices and projects with which groups engage, geographically and symbolically (Howarth, Cornish, & Gillespie, 2015). Moreover, the increasing evidence of the role of communities in mediating health-related practices (Campbell & Jovchelovitch, 2000; Howarth, Foster, & Dorrer, 2004) and promoting well-being (Thoits, 2011) have fostered renewed interest in studying communal experiences. Empirical studies of the relationship between social support and well-being have shown underlying mechanisms that influence people's sense of wellness. Thoits (1985) proposes three ways through which social ties and support influence well-being: by providing particular identities, promoting a sense of control over one's health, and as sources of self-evaluation. In this context, a relevant approach to comprehending community dynamics will explore how 'communities think, how they come to define themselves as a community, how the local knowledge of communities is produced and it fares and relates to other regimes of knowledge' (Jovchelovitch, 2007, p. 73).

In this study, I adopted Campbell and Jovchelovitch's (2000) definition of community participation to allow me to explore social constructions of well-being in communities within a network of practices, material and institutional surroundings and personal agency (Hacking, 1999). In this way, community refers to,

... a group of people who 1) share an **identity** which the community is able to articulate; 2) share a set of **social representations** which organises the worldviews of community members and guides their interpretation of reality and their everyday practices; 3) share the conditions and constraints of access to **power**, both in terms of material resources and symbolic recognition. Participation, as the enactment of these dimensions, is the process whereby community is actualised, negotiated and eventually transformed. (Campbell & Jovchelovitch, 2000, p. 264, bold in original).

Social representations are manifested not only in ideas or definitions, but also involve practices and social actions at both conscious (Gervais & Jovchelovitch, 1998) and non-conscious levels (Jodelet, 1991, Joffe, 1996b). According to Stephens (2007), social representations are more than discursive practices. Beliefs inform practices and form the basis for action, which he defined as 'embodied practice' (p.105). Thus, the theory of social representations may offer important insights into 'the relations between cognition and behaviour at the individual and collective levels [...] understanding actions that take place in various settings' (Dallaire et al., 2009, p. 146). This is particularly relevant to exploring how older adults, in different contexts, make sense of ageing well through action. In line with these theoretical assumptions, the research is necessary to examine how meanings of well-being are translated into practice.

Next, I will present an overview of the main chapters and the main aspects related to investigating well-being in the community.

1.8 Introduction to chapters

This thesis seeks to address both the theoretical and empirical gaps in the literature on how groups involved in community support understand well-being in later life. I will argue that understandings of health and wellness are embedded in the ‘network of ideas, metaphors and images’ associated with age, the body, and health (Camargo & Wachelke 2010; Moscovici, 1998, p. 243). Therefore, in Chapter Two, I will examine how ideologies of positive ageing have shaped public and professional discourse about ageing well. Instead of a unifying view of ageing based on positive features, public discourse on ageing reveals an ambivalent and hegemonic representation: ageing is represented as both a period of decline and vitality. These views will be contrasted with older adults’ perceptions of ageing well. Despite empirical and theoretical contributions to the understanding of positive functioning in later life, older adults’ perspectives on positive ageing are often absent. I will contend that their perceptions constitute relevant points of reference to assess not only the adequacy of professional and public discourse on positive ageing but also to challenge some of their unrealistic proposals. In this context, a social psychological analysis, via the theory of social representations, will be proposed as a more comprehensive theoretical framework with which to understand social constructions of well-being promotion in community settings.

In Chapter Three, I will describe the methods I adopted to study how perspectives on wellness are associated with support in later life. I will highlight how ethnography constitutes a relevant methodology with which to capture contextual meanings of wellness in natural

settings. Within this research design, the methods of participant observation and in-depth interviews enabled me to capture social meanings of wellness from groups in immediate interaction: staff members, volunteers, and clients. Subsequently, I will discuss the approach I adopted to analyse data and its implication for the quality of the current study.

In Chapter Four, I will discuss clients, staff members, and volunteers' views of well-being in later life. Two main binary oppositions are inferred from participants' complex and multifaceted representations of well-being in later life: *activity-passivity* and *independence-dependence*. The concept of *themata* (Moscovici, 1993) will be adopted to understand how social groups' definitions of wellness are developed within the 'framework of pre-existing thought' about age and health (Moscovici and Vignaux 2000, p.157). These fundamental categories assisted the participants to deal with the complex experiences of ageing, whilst constructing their identities in the context of living in the community. The relationship between identity formation and representations will be explored by analysing the ideas of wellness in later life. Social representations of well-being will be shown to be characterised by complexity and polysemy. It is evidenced by the third major theme, *conceptions of wellness*. In this context, polyphasic thinking (Jovchelovich, 2007; Sammut et al., 2015) characterised participants' views on wellness. Three main aspects were highlighted as important indicators of well-being in later life, namely adaptation, health promotion, and social relationships. These representations were shared amongst all groups interviewed, indicating the presence of a hegemonic representation of wellness.

In Chapter Five, I will discuss how a common project of well-being promotion is developed in this organisation. I draw upon data from observations and interviews to examine their meanings of support. Two actions of support are viewed as relevant to promote well-being amongst (potentially) frail and socially-isolated individuals: instrumental and socio-emotive

support. Similarly, clients and volunteers from the visiting scheme share the same ethos of support. However, the one-to-one situation of support challenges visitors. They recognise complex and evolving needs in their clients' lives which demands actions of support beyond the initial ones upon which they have agreed.

Finally, in Chapter Six, I will summarise the findings of this project, and examine the theoretical and practical implications of clients, staff and volunteers' views of well-being promotion. Results will be considered in relation to their theoretical contribution and their implications for policy and practices of community support in the UK.

CHAPTER 2 – LITERATURE REVIEW

2.1 Introduction

Having introduced the context in which health and social care policies related to ageing have developed, I will now examine different public understandings of ageing, old age, and wellness in later life. Ideologies and culturally-rooted conceptions of ageing will be reviewed as the frameworks through which conceptions of ageing well are developed in the public sphere. I will discuss how the ideology of *positive ageing* in the public discourse has created an ambivalent representation of old age, both as a period of decay and as a struggle for vitality, independence and wellness. Following this, I will address professional responses to greater longevity in the Western world and how these understandings are related to and influence the public views on ageing. The theoretical concepts of successful ageing and active ageing will be explored further in the context of well-being policies in the UK. However, it will be evident that these frameworks often overlook older adults' perspectives and different experiences of health and well-being. Following this, I will discuss how older adults' views on wellness in later life challenge professional and public discourse. Their representations of positive ageing point rather to a plural and multidimensional understanding of well-being in later life. Thus, older adults and community support volunteers (amateur scholars) will be considered as relevant social actors in making sense of the experience(s) of ageing. Finally, I will propose a social-psychological analysis of how these groups make sense of ageing well in the community.

2.2 Public understandings of ageing and health: the emergence of positive ageing in the public sphere

Public understandings of health in old age have an influential role in how older adults construct their identities and make sense of the ageing body (Ylanne, Williams, & Wadleigh, 2009). Public views of ageing are also deemed influential in debates about what constitutes health care and welfare in old age (Featherstone & Hepworth, 1995). Therefore, in this section, I will explore the dominant ideologies that inform current public debates on health in later life. This analysis will lead to the analysis of implications of these ideologies for older adults' health and well-being and the construction of their identity and place in society.

Notions of ageing, old age, and health are at the core of social policies which address health in later life. In Western culture, ageing is seen mostly as a biological process which requires medicalised management (Moody, 1992, as cited in Wainwright & Williams, 2005). Physical limitations and bodily changes (greying hair, failing eyesight, less vitality) are often perceived as features of ageing (Westerhof & Tulle, 2007). In this context, an ideology of *decline with age* permeates the public sphere in the West, particularly in modern narratives of ageing (Gullette, 2003). The medicalisation of ageing, which has developed since the eighteenth century has drawn a closer link between ageing and disease, or the 'inevitable decline' with age (Westerhof & Tulle, 2007, p. 237).

Images of later life as a period of decline and losses have been salient in popular art, music, and literature (Jesuino, 2014). A closer look at how health in old age is portrayed in those mediums may shed light on how salient these popular understandings are in the public sphere (Blaikie, 1999). For instance, Wainwright and Williams (2005) have shown how narratives of ageing as a period of physical decline and lack of meaning permeate the paintings of Joseph Mallord William Turner (1775–1851) and Leos Janáček's opera 'The Makropulos

Case' (1926).⁹ This image of decline with age is pervasive in Western thought as Covey's (1991) study shows. Corvey analysed paintings and literature to describe how older people were perceived from the late medieval period to the nineteenth-century. Decline in age and increasing dependency were common themes. Despite the pervasiveness of negative images, positive stereotypes have also been portrayed in the arts. This is evident in depictions of later life as a period of wisdom, glory, and generativity (Covey, 1999; Jesuino, 2014). Cole (1992) highlights that Western popular understandings of old age have presented it as an ambivalent condition: a period of life full of virtue and self-reliance, and an inescapable journey towards deterioration, frailty, and dependency.

Throughout the late nineteenth and twentieth centuries, academics and policy-makers also influenced public understandings of old age, particularly by constructing it as a problem (Blaikie, 1999). Health professionals and academics inadvertently reinforced age discrimination by segregating older workers from the productive population and conceptualising them as deserving recipients of health and social care (Cole, 1992). In fact, scientific evaluation of social performance and control over health became the dominant discourses of health promotion in old age (Cole, 1992). Consequently, ageing became a threat, a 'disease that destroyed both the body and the mind' in an advanced capitalist society (Cole, 1992; Haber, 2002, p. 10). Health in old age was represented within the framework of biomedicine: the body in later life was found to be pathological in nature, involved in an inevitable and intrinsic process of deterioration and loss (Tulle-Winton, 2000). Consequently,

⁹ Wainwright and Williams (2005) analysed four paintings: 'Dido Building Carthage; or The Rise of the Carthaginian Empire' (1815: BJ 1311, Tate Britain, London), 'The Decline of the Carthaginian Empire' (1817: BJ 135, The National Gallery, London), 'The Bay of Baiae, with Apollo and the Sibyl' (1823: BJ 230, Tate Britain, London), and 'The Fighting 'Temeraire' Tugged to her Last Berth to be Broken Up' (1839: BJ 377, The National Gallery, London). The authors claim that the last painting portrays Turner's own age deterioration.

an image of later life as a period of lack of creativity and vitality and less productivity permeated political thinking at the beginning of the twentieth century (Blaikie, 1999).

Ambivalent images of ageing have also been found in Western popular culture. More recently, Kelly et al., (2016) explored images of age and ageing identity in popular music texts. Discourse analysis of 76 widespread lyrics available in English language texts revealed both positive and negative representations of ageing, with negative views predominating. Western music depicted ageing as a period of contentment, esteem, and active engagement with life. Nevertheless, two overarching themes pointed to the negative representations of ageing. Firstly, older adults were viewed as *pitiful and petulant pensioners*, referring to the way in which society represents age and ageing as a burden. The second theme, *frail and flagging old folks*, depicted the images of unwelcomed changes associated with age: physical deterioration and social death. Robinson et al. (2007) examined the portrayal of older adults in Disney animated films, given their pervasive influence in Western popular culture (Dundes, 2001). They found that since the 1970s, there had been a rise in the number of older adults per movie, with greater representativeness during the 2000s (3.8 older characters per movie). A content analysis of these films showed that the majority (58%) of older characters were depicted as positive figures. Nevertheless, still a large percentage (42%) of older characters held negative stereotypes (e.g. angry/ grumpy/ stern individuals). These findings parallel research on images of older adults in advertising campaigns (Ylanne, 2017), TV programmes (Robinson & Anderson, 2006), and paintings (Wainwright & Williams, 2005). In these studies, ageing is portrayed in ambiguous ways: frailty and vulnerability are complemented by ideals of an active and fulfilled later life.

In modern European consumerist societies, youth, beauty and vitality are valued; whereas ageing bodies are represented as ugly, degenerative, and frail (Bond & Cabrero, 2007). This recurrent stereotyping of individuals based on age and the associated discrimination

against older people has been conceptualised as ageism. (Bond & Cabrero, 2007; Butler, 1969). Ideas, stereotypes and images of old age affect older adults in different ways. They offer templates through which modern societies act and feel about the ageing process. These negative characterisations are assumed to influence how older adults' health priorities are defined and addressed (Dallaire et al., 2009). For instance, the belief that old age is synonymous with physical and psychological deterioration is usually translated into *therapeutic nihilism* in health professionals' discourse (Falcão & Carvalho, 2010; Burroughs et al., 2006).¹⁰ Furthermore, research in later life has identified that older adults are not a homogeneous group, as an increasing life expectancy raises different health and social care needs (Age-UK, 2013; Christensen et al., 2009). Thus, the organisation and provision of mental health services for older adults based solely on chronological age may constitute a form of discrimination by failing to consider different psychosocial needs in later life (Royal College of Psychiatrists, 2009).

Research on stereotypes of ageing has shown the pervasive influence of such beliefs on older adults' daily experiences. In a review of studies on positive and negative views of ageing, Levy (2003) has pointed out three characteristics of such beliefs: firstly, they originate in early childhood and become increasingly pervasive across the lifespan (Burke, 1982; Hess, Hinson, & Statham, 2004; Seefeldt et al., 1977); secondly, they may operate on a non-conscious level (Levy, 2009); and thirdly, these beliefs become *self-stereotypes*, creating social expectations and influencing health-seeking behaviours (Levy, Ashman, & Dror, 2000). These dominant views have informed the way in which modern societies relate to the phenomenon of ageing, assigning specific identities and expectations to older adults (Kelly et al., 2016).

¹⁰ In the sociological literature, therapeutic nihilism is defined as the belief that less or nothing can be done for older adults who naturally face physical and cognitive deterioration (Rogers & Pilgram, 2010).

Nevertheless, ideas of ageing as a period of physical deterioration, poor health, and loss are also accompanied by notions of participation, autonomy, consumption, and independence (Westerhof & Tulle, 2007). Social attempts to promote positive images of ageing that challenge negative discourse have permeated public discussion on health in old age (Featherstone & Hepworth, 1995). According to Katz (1999), social gerontologists and communities of elderly people and groups have challenged negative perspectives in gerontology and geriatrics of later life as a period of decline, unproductivity, and illness. In his analysis, movements within social gerontology that challenged ageism and promoted a more optimistic orientation to gerontology, had an impact on public views on ageing (See Butler, 1969). Positive images of ageing were advocated as a way of making sense of old age as a period of ‘activity, independence, resourcefulness, and well-being’ (Katz, 1999, p. 2).

In this context, a shift in public views of ageing and health has been observed in the mass media targeting older adults, particularly in the construction of images of *positive ageing*. In a study conducted by Robinson and Callister (2008) older adults were represented positively (97.5%) in magazines with an older adult readership. This points to the fact that the target audience shapes the display of views about ageing. Featherstone & Hepworth (1995) conducted a longitudinal (1972-93) and exploratory study of *Choice* magazine (formerly *Retirement Choice*) in the UK. They found that public views of ageing expressed in this media have changed over the years, from viewing retirement as a period of disengagement, uselessness and passivity to one of an active and consumerist lifestyle. The adverts included in the publication present images of older adults as active citizens who are also solely responsible for their care.

This shift in public views of ageing points to the emergence of notions of successful ageing in the public discourse, namely ‘images of middle-aged and older adults looking relatively glamorous, healthy, youthful, and [...] “ageless”’ (Ylanne, 2017, p. 372). These

views have also challenged ageist attitudes towards the elderly and promoted *positive ageing* (Featherstone & Hepworth, 1995). This new ideology has been influenced by the scientific management of later life – via the disciplines of gerontology and geriatrics – and a consumerist ethos that focuses on an active lifestyle (Blaikie, 1999; Cole, 1992). Health in later life becomes a synonym for an individualised lifestyle, self-control, and responsibility (Blaikie, 1999). Consequently, in public understandings, activity and participation in social life are regarded as some of the main criteria for *ageing well* (Ylanne, 2017). For instance, Ylanne et al. (2009) explored images, accounts, and ideologies of well-being and health across 140 UK magazines portraying older adults. Adverts still express an underlying assumption of health decline and risk with age. Consequently, the adverts propose that older individuals ought to act to improve their health and well-being. In this context, the ideals of choice, personal responsibility, and consumption in a market of care are the frameworks for health promotion and social care in later life (Lloyd et al., 2013).

A paradox is then created in modern attempts to give meaning to the complexities of ageing: on the one hand, this new imagery attempts to challenge ageist conceptions of ageing, mostly associated with disengagement, passivity, and frailty (Featherstone & Hepworth, 1995). On the other hand, it subscribes to a consumerist and individualistic ethos (Ylanne, 2017). Older adults are regarded as responsible for their care and called upon to employ cultural and technological resources to delay ageing. Thus, ageing well is seen as a process of slowing down biological deterioration (Ylanne et al., 2009). In addition to this, advertisements tend not to include images of the ‘oldest-old’ or experiences of physical limitations with age (See Chapter One, p. 6). The emphasis on a third age group or youth ideals (activity, progress, and vitality) therefore excludes less active and frail individuals who also consider themselves to be ageing well (Ylanne, 2017). Moreover, the association between old age and health deterioration,

underlying some of the adverts, is not corroborated by older adults' views of their experience of ageing. As further explored below, studies on older adults' views of themselves show that they often do not subscribe to public views of ageing associated with deterioration (Kelly, Watson, Pankratova, & Pedzeni, 2016; Rozario & Derienzis, 2009) and often rate themselves as ageing healthily despite their physical problems (Strawbridge, Wallhagen, & Cohen, 2002).

Yet, within this renewed interest in ageing, positive images of ageing are deemed necessary to recreate spaces of political participation, health, and well-being in later life. Thus, positive ageing has been advocated as the main ideology to challenge ageism (Nelson, 2004). Positive images of later life are also influential to people's sense of well-being. Psychosocial resources are deemed necessary to assure quality of life as people age (Craciun, Gellert, & Flick, 2015). One of the main psychological resources evidenced in policy and research is positive views of ageing. Research on age-related identities has shown that positive views of ageing and old age influence cognitive and physical functioning (Hess, Hinson, & Statham, 2004; Levy, 2003), and undermine the impact of memory loss among older adults (Levy & Langer, 1994). Moreover, experimental studies have pointed to the influence of positive views of ageing on walking speed and swing time (Hausdorff, Levy, & Wei, 1999), cardiovascular functioning (Levy, Hausdorff, Hencke, & Wei, 2000), and motor-activity (handwriting) (Levy, 2000) amongst older adults.

This review of studies points to images of old age which are deep-seated in collective memories and representations of ageing as both a process of decay and of glory (Achenbaum, 1995; Jesuino, 2014), passivity and activity (Stenner, McFarquhar, & Bowling, 2011), and obsolescence and usefulness (Haber, 2002). Despite ideological and political moves towards a more positive concept of ageing, negative representations are still pervasive (Dallaire et al., 2009). This lasting imagery in social discourse and practice reflects underlying assumptions

that organise how individuals and social groups make sense of *old age*. According to the theory of social representations, popular understandings and images about ageing are organised around underlying principles called *themata* (Moscovici & Vignaux 2000; Marková 2003; Jesuino 2008). They operate dialogically through fundamental dichotomies, good-evil, light-darkness, body-mind and provide common sense with fundamental categories for organising social cognition (Jesuino, 2014). Research on social representations of ageing has revealed a hegemonic representation characterised by two aspects: gains and losses in cognitive and physical domains (Soares et al., 2014, for a review of studies). Pervasive images of old age characterised by gains (psychological reserves) and losses (decay in the body) are also embedded in the literature (Pike, 2013). Consequently, public views of the elderly are often objectified in two images: the active/fulfilled older adult and the unpleasant/ disabled elder (Hummel, 1998; Quéniart & Charpentier, 2012). These representations are often held together in modern stereotypes of older adults as *doddering but dear* (Jesuino, 2014). In public discourse, new metaphors do not replace old ones, but rather serve to create a complex (and ambivalent) field of meanings around ageing, health, and wellness. Thus, a hegemonic understanding of ageing is developed, guiding societal expectations about ageing with quality of life and corresponding age identities.

Having considered the ambiguous images of old age and health progression with age in popular understandings, I will consider how professionals have addressed the need to promote positive ageing in their practice. According to Featherstone and Hepworth (1995), the increasing interest of social gerontology, geriatrics, psychology, and sociology in positive ageing is also associated with escalating criticism of ageism in the western world. A *new gerontology* was then suggested to enable older adults to be functional, healthy, and participative in society (Holstein & Minkler, 2003). Thus, in the next section, I will discuss how

gerontology, psychology and sociology have transformed ageing into a process of possibilities and gains (Rowe & Kahn, 2015). This new ideology and its implications for conceptualising health and wellness in later life will also be analysed.

2.3 Promoting the ideology of positive ageing in professional thinking: the emergence of *successful ageing* and *active ageing* concepts

With people living longer, increasing concerns with costs in social and health care generated international interest in policy responses which focus on healthy ageing, the prevention of illnesses and disabilities, and community support (Bowling & Dieppe, 2005; Ribeiro, 2015). Furthermore, older generations were expected to be active and fully engaged in modern societies as ways of preventing health deterioration and the associated burden on health and social care services (Martin et al., 2015; Pike, 2013; WHO, 2002). This cultural narrative was further emphasised by the appropriation of findings regarding older adults' cognitive and physical reserves, brain plasticity, and potential for change (Baltes & Baltes, 1990; Erickson, Gildengers, & Butters, 2013; Jeste, Depp, & Vahia, 2010). Consequently, negative views on later life—based on medical failure, passivity, and illness management—gave way to more positive views on ageing and the possibility of controlling it (Blaikie, 1999; Bowling & Dieppe, 2005).

In this context, social gerontology started to pay attention to 'the ways in which health and well-being were maintained [...] as a common feature of normal ageing' (Johnson & Mutchler 2014, p. 94). This new focus on positive ageing not only stressed the possibility of living an active and healthy old age but also challenged ageist concepts of ageing as a period of decline and deterioration (Featherstone & Hepworth, 1995, Rozanova, 2010). This new

perspective aimed to empower older adults through political and civil engagement and promote positive images of ageing (associated with the cultural narrative of activity, independence and well-being) (Katz, 1999). Thus, gerontology entered the public debate about ageing with defined categories about success, vitality, and optimal functioning in later life (Leibing, 2005). Two overlapping concepts have been promoted to foster a positive imagery around old age: successful ageing and active ageing. These frameworks highlight the importance of social engagement and continuing participation in social roles for individuals' well-being (Johnson and Mutcheler, 2014).

The movement of positive ageing in social gerontology has had an impact upon public understandings of ageing and health. As explored above, youth values, the imperative of an active lifestyle, and the ideology of productive ageing have been constantly promoted in the media and public discourse of ageing (Featherstone & Hepworth, 1995; Ylanne et al., 2009). Positive ageing promotes activity, health, and social engagement as normative ideals for individuals (Rozanova et al., 2006). According to McHugh (2003), 'in popular culture, wise lifestyle choices and active engagement in life are touted as pathways to happiness and longevity' (p.165). In this context, the 'idealization of 'a good old age' reflects the dominance in the Western societies of values of independence, youthfulness, effectiveness, and productivity' (Rozanova, 2010, p. 214). Despite the advances in promoting a more positive image of ageing, professional discourse is also embedded in the consumerist ideal of 'third age' (Ylanne, 2017). This intersection between positive ageing and consumerist industries around later life is due to the adoption of a political (and ethical) orientation based on consumption (Katz, 1999). In this context, ideals of success and healthy ageing are necessary for the promotion of a consumerist and more empowered later life. In this context, the concept of

successful ageing gained preponderance in Western public thinking due to its promises of extending health and quality of life with age.¹¹

2.3.1 Success in old age? The framework of successful ageing in gerontological research

An initial professional response to longevity in the developed world was the framework of *successful ageing* (Rowe & Kahn, 1987, 1997). This health-related model entails the recognition of the biological limitations associated with ageing (Martin et al., 2015). However, Rowe and Kahn (1987) differentiated *usual* from *successful* ageing. In so doing, they stressed the heterogeneity of ageing experience in the *normal* population, and surveyed extrinsic factors that may enhance quality of life in the elderly. This model suggested three criteria for ageing well: low probability of disease and disease-related disability, high cognitive and physical functioning, and active engagement with different aspects of life (Rowe & Kahn, 1997). In this way, successful ageing is the combination of health and functionality with active participation in society. This framework stressed the need to control age-extrinsic factors such as diet, physical health, and exercise to promote optimal functioning in later life. Consequently, it fostered a cultural narrative of individual responsibility and active engagement with life as conditions to age well (Bülow & Söderqvist, 2014).

Successful ageing has captured the attention of gerontologists by fostering ‘interest in the biological, behavioural and social factors which determine the attainment of ageing well,’ (Rowe & Kahn, 1997, p. 1089). Thus, it provided policy-makers and health professionals with indicators for public health interventions toward older populations (Ribeiro, 2015). Moreover,

¹¹ The concept of successful has been advocated widely in the United States and Europe (Bülow & Söderqvist, 2014) Therefore, given its influence across Western countries, I examined it in the context of the UK (Fernández-Ballesteros et al., 2010).

Rowe and Kahn's definition of successful ageing contributed to a more positive approach to gerontology: age-related deterioration was not deemed inevitable in later life, but was seen as a result of complex interactions between environment, lifestyles and genetics (Rowe and Kahn, 1987).

Despite its enduring influence in social gerontology, Rowe and Kahn's model has been criticised for downplaying age as the main explanatory factor of wellness (Martin et al., 2015). Recent theoretical developments have drawn attention to how human developmental processes, changes in society, and structural/symbolic aspects are involved in the ageing process (Dannefer, 2012; Rowe & Kahn, 2015). In this context, gerontologists have considered psychosocial aspects as important determinants of success in old age. Psychosocial determinants such as cognitive stimulation, social support, and stress management have been highlighted as relevant criteria to age successfully (Jeste et al., 2010). These theoretical developments led professionals to apply psychology-based frameworks of well-being to examine psychosocial determinants of healthy ageing (Rowe & Kahn, 2015).

2.3.1.1 Psychological-based theories of successful ageing: the role of adaptation and subjective well-being in later life

In this context, Baltes and Baltes (1990) proposed an adaptive model of successful ageing. They defined it as 'an adaptive process involving the components of selection, optimisation and compensation (SOC)' (Baltes & Baltes, 1990, pp. 1-2). This is a social psychological model, in which elements of adaptation to life circumstances, optimisation of resources, and positive aspects of life are necessary for ageing well. Their model of selective optimisation with compensation comprised a framework to understand adaptive behaviour and

compensatory mechanisms to cope with losses and capitalise biological and cognitive reserves in later life. Moreover, its proponents sought to promote a more positive image of old age, one in line with current public views of ageing as a period of vitality, activity, and gainful living (Yllanne, 2017).

Some proponents of the SOC model understand successful ageing as a transitional process, in which the interaction between human development and contextual features of society enables functioning (Featherman, Smith, & Peterson, 1990). The focus is on adaptation rather than outcomes. Researchers explored adaptive ways of compensating for biological and psychological losses with age. For instance, Schaie (1990) suggested that older adults selectively optimise their cognitive functioning in order to respond to biological and cognitive limitations and keep functioning in society. From enhancing cognitive functioning to promoting coping strategies to deal efficaciously with bereavement, the SOC model proposes psychosocial resources to overcome losses and optimise gains in later life (Backman, Mantyla, & Herlitz, 1990; Schaie, 1990; Wortman & Silver, 1990). Subsequently, parallel frameworks included the role of emotion regulation and stress management in dealing with contingencies in later life (Martin et al., 2015). For instance, in socioemotional selectivity theory, the perception of limitations on lifetime leads to increased preference for emotionally-meaningful purposes, mainly positive relationships (Carstensen, Fung, & Charles, 2003; Carstensen, Isaacowitz, & Charles, 1999). These claims were further confirmed by one study which showed that older adults were more satisfied with their current (although fewer) number of friends and network of support than younger adults (Lansford, Sherman, & Antonucci, 1998).

Subjective aspects of human experience were also thought to be part of adaptive processes to age well. Rudinger and Thomae (1990) developed a cognitive model of ageing, in which cognitive representations of life experiences predict life satisfaction more than external

health assessment, income, educational attainment, etc.¹² Similarly, Steverink, Lindenberg and Ormel (1998) integrated the attainment of goals into the selection, optimisation, and compensation model of ageing. More specifically, Villar (2012), proposed that *generativity* constitutes a specific life goal which guides adaptive actions in later life. In this case, generativity would involve actions which seek growth, maturity, and community participation. Although theorists indicated that generativity is a central value in old age (McAdams, Diamond, Aubin, & Mansfield, 1997; Narushima, 2005), another study revealed that middle-aged groups perceive themselves as more generative oriented than older generations (Ryff & Heincke, 1983). This adds to the complexity in finding specific developmental goals for each *life stage*.

Another adaptive framework, the preventive and proactive model of stress management, has been developed to build psychological and contextual resources to manage stressors in later life (Martin et al., 2015). Successful ageing is thus conceptualised as the ability to set goals and engage with proactive actions to reach these aims in order to preserve functionality and a positive identity (Kahana & Kahana, 2003, cited by Kahana, Kahana, & Kercher, 2003). In this way, Kahana, Kahana, and Lee (2014) highlighted the role of proactive behavioural adaptations in compensating for physical, psychological, and social stressors. Such adaptations involve the integration of internal resources (e.g. hopefulness, coping dispositions), external resources (e.g. financial resources, access to technology), and proactive adaptations (e.g. health-seeking behaviours, environmental modifications) to address life stressors (Kahana et al., 2003). The advantage of this academic model in relation to Rowe and Kahn's conceptualisation of successful ageing is the inclusion of frail and vulnerable adults dealing with different life stressors (Kahana, Kelley-Moore, & Kahana, 2012; Kahana & Kahana, 2001; Martin et al., 2015). Such developments, with their adaptive ethos, are compatible with the SOC model for

¹² Health assessment performed by health practitioners.

examining selective behaviours, optimisation of social resources, and corrective adaptations to a functional life (Martin et al., 2015).

Beyond functionality and adaptation other proponents of successful ageing highlighted the importance of older people's assessments of wellness. In social gerontology, Havighurst (1961, 1963) developed a model of successful ageing based on life satisfaction. This life evaluation approach involves individuals' views and satisfaction with different aspects of their life (Steptoe et al., 2015).¹³ In this sense, ageing well meant the ability to be happy and satisfied regardless of a level of participation or disengagement in later life. In the same way, Neugarten, Havighurst, and Tobin (1961) developed a model of assessing successful ageing based on participants' own evaluations of their life. Within the scope of the Kansas City Study of Adult Life, the authors developed one measure of successful ageing that involved the dimensions proposed by Havighurst (1961), the Life Satisfaction Ratings scale (Neugarten et al., 1961), which uses people's own evaluations of these different domains.¹⁴

Nonetheless, Ryff (1989b) argued that over-reliance on life satisfaction may obliterate important social, psychological, and biological aspects that promote optimal development in later life. She contended that life satisfaction can be expressed and examined across the entire life span, which does not bring insight into unique aspects of positive functioning with age. Therefore, cognitive and affective evaluations of life are not enough to capture happiness and self-fulfilment in life (Chandler & Robinson, 2014). To address this issue, Ryff (1982, 1989a, 1989b) proposed a psychological model which explores unique aspects of growth and functioning in later life. Ryff's integrated model of wellness involves six dimensions of optimal

¹³ According to Stowe and Cooney (2015), a subjective approach to adaptation and success avoided the pitfall of subscribing to the behavioural-oriented frameworks of disengagement and activity theories.

¹⁴ Havighurst's operational definition of satisfaction with life involves five features: i) zest versus apathy; ii) resolution and fortitude; iii) goodness of fit between desired and achieved goals; iv) positive self-concept; and v) mood tone.

functioning: self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth (Ryff, 1989a). This is a heuristic model of multiple facets of what constitutes a good life, not only life satisfaction and pleasure (Chandler & Robinson, 2014). Although this model may be used to examine wellness across the entire life span, Ryff (1982, 1989a) proposed a research agenda to identify unique features of psychological well-being with ageing. Such an approach highlights positive functioning and fulfilment of life potentials as the main criteria for defining successful ageing (Ryff, 1989a).

This model of successful ageing was first tested in a representative sample of North Americans aged 25 and over (N=1108) (Ryff & Keyes, 1995). Autonomy and environmental mastery were regarded as the main dimensions of well-being for older individuals. Another comparative study of young and older Americans and South Koreans' appraisals of psychological needs revealed that both groups expressed autonomy and meaningful relationships as important needs (Hahn & Oishi, 2006). Later, Springer, Pudrovskaya, & Hauser (2011) assessed the extent to which Ryff's six dimensions of well-being remained stable or varied across a period of 10 years. They reported that purpose in life and personal growth were the only dimensions that declined with age, which may indicate that significant changes in social roles and limited societal opportunities to personal development are constraints to ageing well (Ryff and Singer, 2008). Furthermore, the value placed on autonomy and environmental mastery points to socio-psychological processes of redefining identities and preserving functionality as people age (Ryff, 2013).

Taken together, the studies above show how psychological components are implicated in older people's assessment of what successful ageing is. Moreover, they point to the role of societal norms and cultural constructions in mediating individuals' appraisals of wellness in later life. In fact, one important outcome of this model is the acknowledgement that definitions

of successful ageing cannot avoid value systems or ideologies (Ryff, 1989a). As Ryff (1989a) puts it, '[...] the criteria of well-being need constant re-evaluation and refinement, as new cohorts of aged individuals bring different standards and ideals by which to evaluate themselves and others' (p. 39). Thus, examining older adults' concepts of psychological well-being and the standards from which they assess their positive experiences are necessary to further understanding of ageing well (Fisher, 1992).

According to Ryff (1989a), 'implicit [lay] theories of successful ageing' (p. 49) may bring researchers closer to the difficulties, potentials and resources available to age with quality of life. Furthermore, professional and lay models have the potential to advance social scientific understandings of ageing well. Nevertheless, Ryff's perspective on successful ageing has been criticised for its lack of inclusion of frail older adults (Miller, 2008). Secondly, the suggestion that successful ageing can be understood mainly as a psychological functioning decontextualises wellness (Frawley, 2015). This may incur the perpetuation of an *ideology of privatisation*, which promotes 'individual solutions to socially created problems' (Bauman, 2008, p. 20). Aspects such as education, health inequalities, race, and gender have gained considerable attention in current academic understandings of successful ageing (see Martinson & Berridge, 2015; Minkler, 1990).

In addition to promoting positive ageing via a focus on functionality, adaptation and subjective well-being, social gerontology has focused on activity as an indicator of health in later life. Paralleling *successful ageing*, the concept of *active ageing* has become preponderant in policymakers' discourse of ageing well, particularly in the UK.

2.3.2 Active ageing as a relevant framework within the politics of well-being

Active ageing is another equivalent concept which has flourished as a policy response to social demands and new expectations for the ageing population (Bowling, 2005). As a policy framework it advocates that ‘human rights will enable the expanding older population to remain healthy (reducing the burden on health and social care system), [and] stay in employment longer (reducing pension costs), whilst also fully participating in community and political processes’ (Stenner, McFarquhar, & Bowling, 2011, p. 467). The World Health Organization (WHO) proposed the concept of active ageing as an international framework for ageing healthily (Kildal & Nilssen, 2013). As a policy framework, it refers to the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age,’ (WHO, 2002, p.12). Its focus on activity refers to enabling older adults to participate in all spheres of life, not simply being able to work. This perspective opposes representations of older adults as passive and dependent, and reinforces autonomy and participation as criteria for ageing well (Foster & Walker, 2015). Thus, it combines socio-economic aspects such as productivity and participation with health-related elements (Walker, 2002).

Active ageing policy also involves complex relationships between social scientific understandings of ageing and political orientations (Stenner et al., 2011). In relation to the former, scientific efforts have been made to explore determinants and processes, to unveil biopsychosocial aspects that contribute to a more active experience in later life (Stenner et al., 2011). The latter refers to how this concept has been adopted in European social policy towards older adults (Walker & Foster, 2013). International policy aims to recreate the meanings of later life, and propose a normative framework of participation and economic productivity (Foster & Walker, 2015). As discussed in Chapter One, active ageing has been promoted within a public

health well-being agenda which aims to reduce costs of care and promote individual and community responsibility for care in the UK (DoH, 2005; Ward, 2015).

Labour and Conservative governments have focus continuously on active ageing, independence, and choice for health and social care (Barnes et al., 2013).¹⁵ These policy aims are considered achievable by supporting individuals to remain active and functional in their own homes (DoH 2006; Ward, 2014). The social values of independence, autonomy and citizenship permeate the cultural orientation of active ageing policies in the UK (Lloyd, 2004). Nevertheless, critics of active ageing in the UK have pointed to how this concept has been translated into a narrative of productivity and social engagement to alleviate social and economic costs (Foster & Walker, 2015; Martinson & Minkler, 2006). Policy focus has been on employment, and not on non-profitable forms of activity (Walker, 2009).

Contrasting this discourse, research has pointed to the benefits of unpaid, meaningful, and low-level activities to people's health (for a review of studies, see Boudiny & Mortelmans, 2011). Research has also shown that participation in everyday activities, such as crosswords and reading, were significant aspects related to ageing well (Clarke & Warren, 2007). This professional framework has also been criticised for its lack of consideration of older adults' perspectives on an active life (Sánchez & Hatton-Yeo, 2012; Soares et al., 2014). Stenner et al., (2011) highlights that academic models may 'diverge from the modes of thought of older people themselves [...]' (p. 469). This aspect warrants the investigation into how older adults understand active ageing in their everyday lives. Research has also demonstrated the relevance of subjective dimensions, such as life satisfaction and subjective well-being, in assessing levels of activity (Bowling, 2008, 2009). In fact, concepts such as subjective well-being, successful

¹⁵ These values are thoroughly described in policy papers such as *Independence, Well-Being and Choice: Our Vision for the Future of Adult Social Care in England* (DoH, 2005), *Our Health Our Care Our Say; a new direction for community services* (DoH, 2006), and the *A Vision for Older Adults Social Care: Capable Communities and Active Citizens* (DoH, 2010).

ageing, active ageing, and happiness have been used interchangeably in different policy-frameworks of ageing well. As discussed below, this is particularly evident in considerations of lay views on positive ageing and raises the need for theoretical flexibility and an exploratory approach to older adults' perspectives on well-being.

Similarly, the academic frameworks of successful ageing and active ageing, coupled with public understandings of ageing well, may overlook the multiplicity of experiences of ageing and how older adults attribute specific meanings to the concepts such as wellness, activity, and success. As discussed in Chapter One, older adults are considered to be a group less empowered to express their needs and determine the course of action in social and health care. However, according to Degnen (2015), the increasing visibility of older adults in the public sphere and their paradoxical stigmatising place in society gave rise to a growing academic interest in later life issues. Consequently, amongst cultural and social gerontologists, there has been a new emphasis on exploring older adults' views on ageing and their lived experiences (for a review, see Degnen, 2015). Ethnographies and case studies have considered older adults' collective and personal memories, perspectives, and coping strategies to deal with complex issues in later life, such living with dementia, socio-economic deprivation, social identities, and community participation (Blaikie, 1999; Degnen, 2012; Gullette, 2003; Reed-Danahay, 2001).

Local meanings and subjective experiences of ageing are gaining prominence over stereotypical and homogenizing views of old age (Gullette, 2015). Therefore, in the next section, I will discuss older adults' views on *ageing well* amongst lay perspectives. The criteria older adults use to assess their experiences and the meanings associated with them will be discussed as important social psychological tools with which to explore wellness.

2.4 Older adults' assessments of positive ageing or *ageing well*

One important outcome from psychology, sociology, and social gerontology research is the recognition of lay perspectives on what is known as *ageing well* (Bowling, 2006, 2008; Fernández-Ballesteros et al., 2008). For instance, literature has shown a disparity between biomedical models of assessing successful ageing and self-rated subjective measurements (Martinson & Berridge, 2015). Such a discrepancy has led researchers to explore additional criteria to ascribe quality to later life (Pruchno, Wilson-Genderson, & Cartwright, 2010). This has been translated into mixed-methods research into different, but complementary features of people's definitions of ageing well. In research on successful ageing, quantitative, and qualitative designs of enquiry have been adopted to explore the multidimensionality, complexity, and specificity of criteria for ageing healthily (Cosco, Matthew Prina, Perales, Stephan, & Brayne, 2014). Such a research agenda has sought to uncover the *missing voices* in social gerontology—namely older people's understandings of positive ageing and the impact of physical, psychological, and cultural changes on their sense of well-being (Martinson & Berridge, 2015; Ward, 2014).

In this context, self-ratings have been used to compare older adults' experiences of ageing with professional criteria. For example, Strawbridge et al. (2002) showed that 50.3% of the 867 Alameda County Study participants (aged 65-99 years) rated themselves as ageing successfully. In contrast, only 18% were regarded by professionals as ageing successfully according to Rower and Kahn's (1997) criteria. Similarly, another survey with older adults over age 60 in the US revealed that this group assessed themselves as ageing successfully despite experiencing illnesses and disabilities (Montross et al., 2006). These findings challenge the anti-ageing ideologies, which are common in popular understandings, by acknowledging frailty and

limitations even in individuals who consider themselves successful agers. Further evidence shows that self-ratings and professional ratings differ significantly (Cernin, Lysack, & Lichtenberg, 2011; Phelan, Anderson, LaCroix, & Larson, 2004). Taken together, research has indicated that older adults' assessments of successful ageing present broader indicators than clinical and functional models of positive ageing.

Concerns about subjective assessments of successful ageing across the life span led Tate, Leedine, and Cuddy (2003) to ask the members of the 1996 Manitoba Follow-up Study two main questions: *a) What is your definition of successful ageing?* and *b) Would you say you have aged successfully?*¹⁶ Approximately 83.8% of the sample of 1,821 older male adults (at a mean age of 78 years) responded that they had aged successfully. However, the probability of positive evaluations decreased with age, physical limitations, self-rated health, and life satisfaction. Tate, Swift, and Bayomi (2013) explored whether male older adults' definitions of successful ageing had changed over the course of 11 years after the first study. The percentage of participants who rated their health as excellent declined considerably. Concomitantly, self-rated life satisfaction declined with age. These results indicate a relationship between subjective states and health-related issues in ageing.

All in all, these findings point to the need to explore notions of successful ageing, active ageing, and well-being comprehensively (Phelan, Anderson, LaCroix, & Larson, 2004). Moreover, they warrant research on the different 'criteria used by older persons to assess their own successful ageing' (Strawbridge et al., 2002, p. 727). Nevertheless, self-ratings measures are not enough to capture the complex and socially constructed nature of conceptions of wellness (Ryff, 1989). As pointed out by Bowling (2006), most of these studies do not explore

¹⁶ The Manitoba Follow-Up Study surveyed a group of 3,983 World War II Royal Canadian Air Force male aircrew recruits since July 1, 1948. This longitudinal study aimed to identify preventative factors of cardiovascular disease across the life span of young adults (Mathewson, Manfreda, Tate, & Cuddy, 1987; Tate et al., 2003).

older adults' conceptions, but ask them to rate professional definitions of successful ageing (Phelan et al., 2004). This empirical choice may overlook contextual meanings associated with ageing satisfactorily, particularly in local communities where different groups interact to promote health and social care. Therefore, research in social gerontology and psychology has turned its focus to biographies and shared views of ageing well. Biographical and in-depth studies of ageing may address the lack of knowledge of the cultural, structural, and meaning-making processes (Holstein & Minkler, 2003). These dimensions may assist researchers in uncovering the ways in which older adults make sense of well-being in their lives and assist policy makers in promoting contextually relevant social and health care (Clarke & Warren 2007).

2.5 In-depth studies of older adults' understandings of ageing well

The first attempts to access older adults' views of ageing well in the UK were observed in a series of surveys guided by Abrams at the end of the 1970s (undated, cited in Bowling, 1993). He asked older adults who were supported by a voluntary organisation what would make them satisfied and pleased in their lives.¹⁷¹⁸ Participants regarded 'having good neighbours', 'good health,' and 'a happy marriage and family' as the three most important features of satisfaction in later life (Bowling, 1993, pp. 450-451). In this way, psychosocial aspects were added to health concerns as important aspects of ageing well, although at that time this construct was seen as unidimensional.

¹⁷ The same organisation supported this study.

¹⁸ Abrams explored life satisfaction by asking participants to give only one answer to the question *What would you say makes life really pleasant and satisfying for people of your age?*

In the same way, Fisher (1992) conducted a pilot study with 19 older adults aged 62-85 years (average age of 75) at a senior activity centre in Missouri. Older adults defined life satisfaction in relation to positive past experiences and contentment with life. Coping strategies and adaptation were the main strategies with which to age well. That study provided empirical evidence of Ryff's (1989b) model of eudaimonic well-being, particularly for suggesting the association of positive past experiences with present (and future) life outcomes as coping strategies to age well. This form of integration constitutes not only an important index of mental health, but also a way of coping with significant changes in later life (Bowling, 2006; Quéniart & Charpentier, 2012). This similar pattern was found in Fisher and Specht's (1999) study of conceptions of successful ageing and creative work amongst thirty-six contributors (aged 60-93) to a senior art exhibition. Ideas of successful ageing involved having a coping orientation towards life which reflected early-life strategies of adaptation and future projects.

Ryff (1989c) sampled the views of 102 older community dwellers (average age of 73.5 years) on well-being and quality of life.¹⁹ Older adults challenged individualistic and hedonic perspectives of well-being by highlighting the importance of adaptation and relationships as indicators of wellness. Similarly, Fisher (1995) examined lay views of successful ageing and associated factors among older employees aged between 61 and 95 years. Their meanings of successful ageing mirrored Ryff's (1989a) dimensions of autonomy, purpose in life, meaningful relationships, and personal growth. Correspondingly, Knight & Ricciardelli (2003) investigated older adults' perspectives of successful ageing among Australians aged 71-101, and compared these views with the main concepts present in social gerontology. Participants' criteria for successful ageing involved personal growth, happiness, close relationships, independence and

¹⁹ 'Community dwellers' refers to participants who are socially active in their city. In this study, they were recruited through civic, social and neighborhood organisations (Ryff, 1989c).

appreciation of life. Again, happiness, and meaningful relationships appeared as indicators of *success* and wellness for older adults.

Ryff's taxonomic model was also used to explore the subjective experience of well-being amongst residents of two retirement villages in the south east of England (Chandler & Robinson, 2014). Researchers explored participants' narratives of their experiences as residents, and how these experiences affected their sense of well-being. Residents expressed ambivalent appraisals of how the retirement village affected their well-being. On the one hand, well-being was ascribed to experiences of safety and support within the villages, making new friends, a sense of autonomy, personal growth, and environmental mastery. On the other hand, a sense of exclusion from society, reminders of mortality and morbidity, and difficulties adjusting to a different social environment challenged residents' sense of well-being. These studies point to the complexities of the experiences of ageing in different settings as well as to the importance of considering negative experiences in people's conceptualisations of ageing well.

According to Tate, Swift, and Bayomi (2013), two main perspectives are salient in older adults' understanding of ageing: firstly, a biomedical model which focuses on physical health and cognitive functioning (Rowe & Kahn, 1987), and secondly, psychosocial perspectives which value life satisfaction, social functioning, and adaptive psychological components (Baltes & Baltes, 1990). Taken together, those features reflect a broader and complex definition of ageing by older adults. With regard to biomedical/functional models of ageing, Canadian older adults (average age of 78 years), enrolled in the Manitoba Follow-up Study reported that health and the absence of disease were the main components of ageing successfully. Significantly, they also regarded physical and cognitive activity as relevant dimensions (Tate et al., 2003). In the same way, physical and mental health determinants were the most repeatedly

reported features of successful ageing amongst another sample of American and German older adults (Jopp et al., 2015). In her study of British community-dwellers aged 50 and over, Bowling (2006) also compared lay views with theory-driven concepts of successful ageing. Respondents' answers to the question *What do you think are the things associated with successful ageing?* showed a broad understanding of ageing well. Two-thirds of participants defined successful ageing as physical health and functioning, corroborating the clinical models of ageing (Rowe & Kahn, 1997). Nevertheless, half of the respondents defined it as a psychological dimension to life (e.g. having an active mind, life satisfaction). Others defined successful ageing as a function of social relationships and social support. Despite the pervasiveness of a biomedical ethos in older adults' conceptions of well-being, findings are complex and concepts are deemed multidimensional (Bowling, 2006). In the same Manitoba Follow-up Study described above, along with health and functionality, subjective dimensions of happiness and life satisfaction and positive outlook were the main criteria for ageing with quality (Tate et al., 2003). In the 11-year follow-up study (Tate et al., 2013), coping abilities and adjustment to life were the main themes evoked by older participants to engage with life positively.

In contrast to the concepts of successful ageing (Bowling, 2006, 2007), and quality of life (Bowling, 2005), there is a paucity of studies regarding how older adults, particularly in Britain, make sense of the concept of *active ageing* (Bowling, 2008). This is the case despite governmental attempts to conform to international policies of active ageing in the UK as discussed above (Ward, 2014). To address this gap, Bowling (2008) interviewed a group of 336 people aged over 70, who were enrolled in the British Omnibus Survey. Older adults defined active ageing mainly in terms of keeping health and functionality, leisure and social activities, and psychological well-being. In Portugal, Paúl, Ribeiro, & Teixeira (2012), interviewed 1322

older adults aged 55-101 years old living in the community. They used an extensive protocol to investigate different determinants of active ageing according to the WHO's definition—behaviours, social environment, health and social services, physical and social environment, and economic determinants. Researchers reported the relevance of psychosocial aspects (e.g. happiness, positive outlook) in people's understandings of active ageing.

Current theoretical frameworks of active ageing include productivity, dignity, empowerment, and social support (European Union, 2012; Foster & Walker, 2015; WHO, 2002). Such aspects were absent in the first survey with British older adults (Bowling, 2008). Bowling (2009) also explored differences between the concepts of active ageing, successful ageing, and quality of life (QoL) amongst ethnically diverse and more ethnically homogeneous groups of older adults in Britain. Both groups defined these concepts in terms of health, functionality, participation in society, and psychological functioning. However, the ethnic minority group was less likely to perceive health and fitness as relevant domains of active ageing. In addition, both groups did not mention productivity and economic gain as important factors to age well, contrasting with international policy frameworks.

Overall, the studies above revealed a conceptual overlap between the concepts of active ageing, successful ageing, and quality of life. Bowling (2008) also compared older adults' perspectives of active ageing with older people's definitions of successful ageing and quality of life from related representative studies (Bowling, 2006; Bowling, 2005; Bowling & Gabriel, 2007). *Health* and *functionality* were the main themes in conceptions of active and successful ageing, whereas, *social roles* and *activities* are present in older adults' views of QoL and active ageing. Significantly, their definitions of active, successful ageing and QoL share similarities. Similar overlap was found by Fisher (1992) and Tate et al. (2013).

As discussed above, approaches to exploring concepts such as successful ageing, active ageing and well-being based solely on professional models and surveys may fail to identify contextual meanings of successful/healthy/active ageing. Two main limitations stem from this: firstly, researchers' definitions of happiness may not be shared by the participants in their studies; secondly, researchers' choices of factors which allegedly promote happiness may not be grounded in participants' views of such aspects. In this context, as 'happiness becomes professionalised and medicalised', lay practices and ways of being are devalued (Frawley, 2015, p. 69). Thus, overreliance on existing theoretical models of well-being and positive ageing hinders researchers from grasping the context-specific and culturally-shaped experiences of older adults (Chung & Park, 2008; Falb & Pargament, 2014; Iwamasa & Iwasaki, 2011; Laditka et al., 2009; Lewis, 2011; Martinson & Berridge, 2015; Sugarman, 2007; Torres, 2001, 2003).

Furthermore, although the studies mentioned above have pointed out different components associated with ageing well, there is a dearth of research on meanings associated with those dimensions. Exceptionally, Stenner et al., (2011) explored subjective views on activity in later life amongst British people aged 72 years and over. Ageing was perceived in terms of the duality of activity-passivity, which parallels popular understandings of ageing as a period of both vitality and decline (Covey, 1991; Jesuino, 2014; Kelly et al., 2016). In their views, *becoming passive* entails *being old*. On the other hand, *being active* or *keeping oneself active* is expressed in terms autonomy, power to act, and independence. These aspects are considered resources for individuals to avoid *feeling old* or, as expressed in the media and public discourse, to delay the ageing process (Ylanne et al., 2009). Similarly, a survey of older women's social representations of ageing in Brazil has shown a dichotomous view of ageing:

physical limitations and subjective views on ageing (based on vitality and an active lifestyle) are two contrasting components of their ageing experience (Teixeira, Settembre, & Leal, 2007).

In both studies discussed above, people's views of ageing were influenced by the active and successful ageing models. These hegemonic representations of positive ageing originate in more powerful groups and 'prevail implicitly in all [the] symbolic or affective practices' of lay people in general and older adults in particular (Moscovici, 1988, p. 221). For instance, Fernández-Ballesteros et al. (2010) surveyed the conceptions of successful ageing amongst older adults aged 65 and over (average age of 68) in Latin American and European countries. Contrary to evidence of context-specific views of ageing well, older adults on both continents shared similar views on successful ageing. According to Fernández-Ballesteros et al. (2010), this indicates the large influence and assimilation of research on successful ageing and international models of active ageing (Sánchez & Hatton-Yeo, 2012; WHO, 2002). Nevertheless, the authors did not question participants directly on their views of ageing well; instead, older adults were asked to answer a 20-item questionnaire (Matsubayashi et al., 2006; Phelan et al., 2004) with pre-defined dimensions of successful ageing. This may have had limitations in terms of capturing contextual meanings of words and definitions, and imposed professionals' views on respondents.

Meanings and ideologies of positive ageing and the lived experiences of older adults may, therefore, constitute relevant resources to assess the extent to which public understandings and professional discourse are assimilated and challenged amongst older people. Research on social representations has shown that older adults do not necessarily adopt professionals' definitions. Instead, they creatively assimilate them within own their value systems, social identities, and projects of life (Murray et al., 2003). In this context, adopting the theory of social representations, Murray, Pullman, and Rodgers (2003) used narrative interviews to capture how

Canadian baby-boomers (45-55 years old) incorporated health system changes into their personal and social life stories. Health and illness were seen as dimensions which depend on lifestyle (health as lifestyle). Participants assimilated public health messages into their narratives, sharing a moral obligation to be healthy (Flick, 2000).²⁰ Sotgiu, Galati, Manzano, and Rognoni (2011) compared older Cuban and Italians' subjective views of components of happiness. Health was also considered the most important component of well-being from both groups.

In the context of how older individuals conceive of new ideologies of ageing, research from three different geo-political contexts, Italy, Germany, and Brazil, has shown more positive views of ageing, mainly associated with wisdom and life experience (Nagel, Contarello, & Wachelke, 2011). Another study with older adults in three different cities in Chile has demonstrated the heterogeneity of social representations of ageing, mostly expressed in the form of gains (e.g. acquired experience, grandparenting) and losses (e.g. loss of social status, social isolation) as people age (Moreno, Sánchez, Huerta, Albala, & Márquez, 2016). Furthermore, Soares et al. (2014) explored older adults' views of ageing well amongst older Portuguese citizens (average age of 79 years old). Participants' representations of ageing showed a binary content: potentials and constraints with ageing. They also found that older adults' views of positive ageing not only reproduced the active and successful ageing frameworks, but also involved broader elements of their daily life experiences, such as gains in family relationships, networks of social support, and acquired knowledge. Corroborating this, a social representations study of definitions of successful ageing across 26 countries has shown a pervasive representation of ageing which is characterised by biological decline and

²⁰ These findings revealed another character of social thinking, namely expressing a moral order, a collective identity with obligations and duties (Marková 2013; Smith, 2003).

functionality but increase in knowledge, wisdom, and social status (Löckenhoff, Terracciano, Mccrae, & Alcalay, 2009).

In sum, these studies point to the need to understand socially-constructed meanings about ageing well. However, there is a paucity of research on how different groups interact daily to share, reproduce, and challenge positive and negative representations of ageing. Research has focused mainly on older adults, not considering the impact of other groups in defining ageing and interacting with the elderly. Teixeira, Nascimento-Schulze, and Camargo (2002) examined social representations of old age among healthy and unhealthy older adults, health practitioners, and caregivers in Brazil.²¹ Older adults conceived of ageing healthily as pursuing a healthy mind and being autonomous. In the same context, health professionals anchored healthy ageing in a representation of active life, which corroborated models of active ageing (WHO, 2002). Autonomy and healthy lifestyle were the main representations shared by caregivers. They anchored their views of healthy ageing in their daily experiences of care and a more comprehensive concept of health: health as a lifestyle (Flick et al., 2003).

Social care in later life involves the interaction of different stakeholders with different power relations (Campbell & Jovchelovitch, 2000). As explored above, older volunteers may add to the complexity of understanding ageing well in community settings. Volunteers and staff members involved in community support constitute important agents in the translation of professional and public views of healthy ageing into the daily practices of support. In this case, social position might be an important sphere to consider when examining the lay definitions of ageing well (Howarth, 2002a). In the context of active ageing policies, volunteering has been considered as a relevant way of promoting participation amongst older adults. A theoretical

²¹ Researchers based their selection criteria on the way in which health users felt about themselves; for instance, they recruited individuals who reported that they were feeling ill.

framework that would include such aspects is paramount. Therefore, next, I will present the contribution of social psychology to understanding psychological well-being in later life.

2.6 Summary and research implications: building a social psychology of ageing and health

This review of studies points to important features of exploring wellness in later life. Despite theoretical and measurement boundaries, current conceptions of successful ageing, active ageing, and healthy ageing share similar meanings. Therefore, exploring psychological well-being in old age necessarily involves associated meanings such as *ageing well*, *successful ageing*, and *wellness*. As discussed above, this polysemy of concepts is associated with socio-historical understandings of ageing and *the good life*. Therefore, in this study, I will examine multi-faceted and contextual meanings of psychological well-being in later life.

Health and illness are not simply individual aspects of human experience, but subjective, community-level, representational, and institutional features are all also implicated in the social construction of these phenomena (Flick 1998).²² Challenging the dominant construction of old age as a problematic stage of life, social gerontology has acknowledged the need to consider the multiplicity of ways in which older people conceive of ageing. In this context, ‘the subjectivity of older people, the width and depth of their lives, [are placed] at the forefront of analysis’ (Twigg & Martin, 2017, p. 2). Thus, I adopted the theory of social representations to explore ‘both [the] context and process’ through which understandings of ageing, health, and wellness, and their manifestation in practices, are developed (Murray & Chamberlain, 1999, p.

²² Representational feature refers to individual and collective actions of meaning-making. It parallels the concept of collective intentionality (Searle, 1995), which refers to the way in which groups represent objects through social interaction. Collective intentionality is one of the main focuses of the theory of social representations (Moscovici, 2008).

6). The processes of meaning-making, discourse, and symbolic practices are relevant to a social psychology of health (Berger & Luckman, 1966; Flick, 1998).

From this literature review, older adults actively construct meanings of old age, ‘drawing on socially shared stocks of knowledge’ about ageing, health, and the body (Foster, 2007, p. 7). Moreover, as discussed above, popular images of ageing mediate the construction of social expectations, identities, and health-related behaviours amongst the elderly. Thus, a social psychology of health will also be able to address the question of how older adults negotiate cultural narratives of well-being, successful ageing, and active ageing in their views of themselves. According to Bauer and Gaskell (1999) and Foster (2011), the analytical focus of social representations research is not on the objects of representations (mental health, ageing, the human body), but on the representations and their purposes for different groups. In this way, constructed meanings of ageing and *well-being in later life* and their functions in relation to different groups—identity formation and health-related practices—constituted the main analytical focus of this study (Howarth et al., 2004). Within this analytical approach, lay understandings are regarded as resourceful ways of making sense of the world rather than an inferior form of knowledge (Flick and Foster, 2008; Foster, 2003a, Moscovici 1973). Therefore, common sense ought to be studied in its own context of elaboration and practice (Bauer & Gaskell, 1999; Flick & Foster, 2008).

Nonetheless, collective meanings, institutional practice, and normative frameworks often remain unquestioned, and representations that maintain social inequalities may not be reflected upon or even challenged in health and social care settings (Howarth, Foster & Dorrer, 2004). Therefore, there is a need to consider methods of research that examine views and perceptions of health not only through discourse, but also through the observation of institutional practices and routines. For instance, in her classic ethnographic study of social

representations of madness in a French community, Jodelet (1991) described how families dealt with psychiatric hospital patients who were placed among them. Practices of separation and concerns with hygiene pointed to a non-spoken representation of ‘transmissibility of insanity’ (Jodelet, 1991, p. 243). Joffe (1996a, 2003) stressed how emotions—operating at a non-conscious level—influenced groups’ ideas of AIDS and the infection. In the context of health research, Gervais and Jovchelovitch (1998) demonstrated how social practice—particularly food preparation and social relations—expressed ideas of health and illness within a Chinese community. Therefore, I sought to explore not only the linguistic features of ideas of well-being, but also the non-conversational, behavioural, and institutional aspects associated with them (Flick, Foster & Caillaud, 2015).

This review of studies also points to the need to examine psychological well-being beyond individualistic and academic models (Frawley, 2015). In this context, the community is considered the *main stage* in which *social actors* enact and negotiate beliefs, practices, and well-being promotion. Furthermore, community relationships are deemed important due to the mutual social influence and power relations operating in health and social care spaces (Campbell & Jovchelovitch, 2000; Provencher et al., 2014). Nevertheless, there is a lack of research on how different agents make sense of well-being in later life. In this context, older adults, staff members, and volunteers involved in the voluntary sector are relevant groups promoting positive ageing. This is particularly pertinent in the structural background of community care policy in the UK as discussed in Chapter One (Barnes, 1997). Therefore, this project seeks to address this empirical gap in community care.

Finally, critical gerontology points to the need to consider people’s biographies and their own in-depth understandings of positive ageing (Biggs, 2001; Holstein & Minkler, 2003). Such an analysis will assist researchers and policy makers in uncovering symbolic, cultural,

structural, and economic aspects that mediate the experience of ageing in the community. Given the fact that these aspects are embedded in contextual practices, a more naturalistic research design is paramount. Therefore, a more collaborative model is necessary to examine representations within a set of health practices and support (Howarth et al., 2004). This collaborative approach to social psychology involves taking different perspectives into account when examining an important social issue (Wagner, Duveen, Verma, & Themel, 2000). In the next chapter, I will examine the rationale for the selected methods and research procedures adopted to explore the social representations of wellness. Given the complexity of this theme and the diversity of groups involved in this study, I will also discuss the rationale for choosing the participants. Ethical issues and my own reflexive position on this project will also be considered when discussing the methodology used.

CHAPTER 3: METHODS

3.1 Introduction

In this chapter, I will describe the study design I adopted to examine meanings of well-being in later life. I will argue that a qualitative and interpretative methodology is well-suited to understanding meanings of ageing well (Flick & Foster, 2008; Willig & Stainton-Rogers, 2008). In this context, ethnography will be described as a relevant methodology to explore meaning-making in community settings. I will characterise the two main settings where the fieldwork took place (namely, daycentres and the visiting scheme). I will then describe the main groups of participants who took part in interviews. Methods and selection of participants will be justified in relation to my main research purposes. Additionally, I will consider important ethical considerations regarding my position in the field and research with vulnerable groups (e.g. older adults with dementia). Following this, the main procedures for gathering and analysing this data will be discussed, maintaining a reflexive attitude towards my experiences of negotiating access and entering the field. Finally, I will present the main quality indicators used to assess this research project.

3.2 Context of research: Age UK Cambridge

Given the importance of studying understandings of well-being and their associated practices in community settings, I contacted one of the largest charities in the UK that promotes social care for older people—Age UK. This charity is comprised of approximately 170 local organisations in the UK and others worldwide. Age-UK aims to promote well-being in later life and support the elderly to live independently in the community.

Age UK promotes a wide range of programmes and activities to people aged 50 years and over, including home visiting schemes to prevent isolation and loneliness, advocacy services, information on health and social care, national and local government campaigns to quality care, and day centres. Its aims correlate with governmental plans of (mental) health promotion to older adults in the community (Cambridge County Council, 2012; DoH, 2001). In Cambridgeshire, Age UK delivers community services, social support, and liaises with health and social care services to promote independent living (Cambridge County Council, 2012). I sought collaboration with different stakeholders (namely, older adults, staff members and volunteers) within this charity to design a study that would involve relevant groups committed to understand and promote well-being.

3.3 Study design: ethnography in social psychology

The fieldwork consisted of an ethnography of a voluntary organisation which supports older adults to live independently, healthy, and well in the community. This case-oriented approach focused on people's views on *well-being in later life* or *ageing well* and support mechanisms. Ethnography may be defined as 'the study of people in naturally occurring settings or 'fields' by means of methods which capture their social meanings and ordinary practices' (Brewer, 2000, p.10). This research methodology is grounded in the interpretative tradition of *Verstehen* (Abel, 1948), in which meanings are attributed to practices and conversations (Kelle, 2000). As discussed in Chapters One and Two, the voluntary sector has been placed as a strategic partner in public policies which promote well-being, active ageing, and independence in later life (DoH, 2001, 2005, 2006). There is a need to understand how people involved in community support—either as a giver or a receiver of help—construct meanings about well-

being promotion in later life.²³ Two questions stem from this: 1) how these groups incorporated the policy frameworks of well-being, active, and successful ageing in their meanings of support and well-being promotion; and 2) what does it mean to be well through community support (either by giving or receiving support). Thus, I adopted ethnography to explore meanings of well-being and practices in the daily interactions of groups involved in community support (Foster, 2015; Hammersley & Atkinson, 2007).

According to Flick and Foster (2008), ethnography more suited to explore how social representations are developed, accepted, or resisted not only in conversations, but also in institutional practices.²⁴ Both ethnographic research and social representations theory assume that social reality ‘revolves around collective systems of meaning, and that it is through the interrogation of the beliefs and practices of a community that these systems can be analysed.’ (Duveen & Lloyd, 1993, p. 96). More importantly, in this project, the use of ethnography enabled me to develop a deeper understanding of ‘communities of practice,’ and to provide a thick description of meanings of well-being promotion (Geertz, 1973, Howarth, Cornish, & Gillespie, 2015, p. 190).

3.4 Negotiating access to the field using a collaborative approach

Throughout the project, I adopted a more collaborative approach to research which involved taking perspectives of different stakeholders into account when investigating well-being promotion (Barnes et al., 2013; see also Dewing, 2007; Langan & Morton, 2009). This

²³In this study, I adopted a weak version of social constructionism, in which everyday knowledge develops creatively in relation to social and physical reality (Burningham & Cooper, 1999). This form of constructionism acknowledges the presence of an object of representation, the referent in relation to which representations are elaborated, contested and internalised (Bauer & Gaskell, 1999; see also Nellaus, 1998).

²⁴Berger and Luckmann (1966) and Smith (2010) emphasise that society pursues an objective facticity which is expressed by institutional practices. These constructions express subjective meanings and social representations (Jovchelovitch, 1996).

collaborative approach involved an ongoing negotiation of access to different groups in order to inform them of my research actions. Moreover, the ethnographic design enabled me to explore older adults' ideas of health and social support in a collaborative and spontaneous manner, particularly through interviewing them about their conceptions of well-being promotion. I interacted regularly with them, adapting my questions, and identifying different venues for research within that organisation.

In December 2012, I met with the senior operations manager of Age UK to discuss my ideas and potential collaboration. In our first meeting, I discussed the importance of evidence-based practice for supporting the elderly in the community, and how voluntary organisations are included in governmental policies to promote mental health in later life.²⁵ Furthermore, I stressed the importance of their views on what can promote well-being and how they influence institutional practices. The administrative board was interested in new ways of delivering services to support the elderly in the community, decreasing hospital admission, and acquiring evidence-based knowledge on their actions of support. Although this fieldwork would explore some of these concerns, I made clear from the beginning the need to focus on their understandings of well-being promotion in later life. Subsequently, in negotiation with the administrative board, three potential areas of research were identified: daily practices in daycentres, social support by different groups involved with the day centres, and home visits. Beyond this, we discussed an initial timeline for conducting research and how to obtain access to different groups directly involved with well-being promotion (volunteers/staff, older adults and family caregivers) in relevant settings (daycentres and home visits). In this study, I selected social groups that were directly involved in providing and receiving psychosocial support via

²⁵ In the first meetings, a member of the administrative board constantly suggested that I changed the term *mental health* in later life to *mental well-being* or simply *well-being*. They were concerned with potential problems arising from discussing openly mental health issues among their clients. This experience revealed how mental health is a contentious subject within public understandings (Foster, 2003b).

the voluntary organisation:

- a) *Clients of day centres*. This group constitutes the recipients of support.
- b) *Staff members working in day centres*. Staff members constitute an *intermediate professional group*, positioned between expert and lay systems of knowledge (Morant, 2006). They also play an important role in translating organisational policies of well-being into practices of support.
- c) *Volunteers involved in the day centres*. Volunteers are important stakeholders within well-being public health policies in the UK (DoH, 2001, 2005). Their participation in promoting well-being and active ageing warrants the investigation of how this group understand well-being through giving support.
- d) *Volunteers involved in the visiting scheme*. The inclusion of this group enabled me to explore ideas of well-being beyond the institutional boundaries of day centres. The relationship between well-being and practices of support was assessed in the immediate and relational context of visits as opposed to the more structured setting of day centres.
- e) *Clients involved in the visiting scheme*. Clients who receive support via the visiting scheme. Their views on what brings well-being to their lives in the context of more social isolation and frailty.

In agreement with staff coordinators, three main fieldwork sites were selected. These locations reflect relatively different social milieus, ranging from a rural to a more urbanised context. The visiting scheme was also included as a relevant setting to explore social representations of wellness; its focus on one-to-one support and socially isolated individuals

enabled me to explore how ideas of well-being were developed in a less structural and communal service. Research has shown that different socio-cultural contexts (Flick et al., 2003; Wachelke & Contarello, 2010), socio-demographics and group identification (Costa et al., 2015; Moreno, Sánchez, Huerta, Albala, & Márquez, 2016; Moscovici, 1973, 2008) and pragmatic contexts of practice (Foster, 2003b, 2007; Morant, 2006) shape the development and maintenance of social representations of health, ageing, and mental health. Therefore, I hypothesised that views on well-being promotion would be mediated by these specific contexts. Thus, I sought to map how social representations were developed and enacted in different public spheres (day centres and the private settings of the visiting scheme) (Jovchelovitch & Priego-Hernández, 2015). In the next section, I describe some of the main characteristics of each day centre and the visiting scheme.

3.5 Locus of research

*Field Maple Day Centre*²⁶ is situated in an urbanised area of Cambridgeshire. The voluntary organisation owns the building, which serves numerous purposes (community meetings, association meetings, charity office, and day centre). The building is comprised of a large common area, offices, meeting rooms, a garden area, a dining area and a kitchen. The day centre is open on Mondays, Tuesdays, and Thursdays, with activities starting at 10am and finishing at 2:30pm. Approximately 16-18 older adults attend this day centre. They are referred by health and social care professionals, the local community mental health team, and family members who seek to promote social support for their loved ones. Most of the clients are 65 years old and over, and live in their own homes or sheltered accommodation. The majority of

²⁶ I have adopted pseudonyms to refer to day centres and participants' identities throughout the text.

clients reach the day centre using transport provided by the county council or the voluntary organisation. Some are in early or moderate stages of Alzheimer's or another dementia whilst others present certain levels of physical limitations (having to walk with the aid of walking frames, or using hearing aids).²⁷ According to staff members, clients must be able to care for themselves, be mobile and not exhibit severe cognitive impairment in order to attend the day centre.

All daily activities are coordinated by two staff members and seven volunteers.²⁸ They usually provide hot drinks and a hot meal per day. Activities involve games, quizzes, bingo, speakers on different topics, and occasional outings. They also provide advice on later life issues, liaise with social and health services and families to support their clients. Their focus is on *preventative services*; particularly, actions that aim at reducing the risk of hospitalisation, social isolation and mental and physical health issues.²⁹

Aspen Day Centre is located in a relatively smaller town in Cambridgeshire. Activities take place in a small building situated in a local primary school, which accommodate a slightly smaller number of clients—about 14 adults aged 65 and over. It opens two days a week and has almost the same clientele each day. The centre is a large room, which includes a meeting and dining space. Clients are mostly referred by social services, general practitioners and family members. The local community mental health team for adults also plays an important role in referring clients with a diagnosis of dementia or other cognitive impairments. They liaise with the day centre to promote respite to family carers and social support and stimulation to clients with mild or moderate symptoms of dementia. Transport is provided by the day centre mainly

²⁷ Terms like 'early', 'mild', 'moderate', and 'severe' stages of Alzheimer's or other cognitive impairments reflect expert and clinical taxonomy of these conditions (Kane & Terry, 2015). Here, I relied on staff's expertise to identify older adults with different cognitive conditions at the day centres.

²⁸ A few family members also interact with staff and volunteers to support clients in all day centres. On some occasions, they run the activities.

²⁹ These aims were shared across all day centres.

in collaboration with the county council. Two members of staff and three volunteers coordinate all activities during the day. Similar to Field Maple Day Centre, most of the clients live in their own homes or sheltered accommodation, and only one of them lives in a care home. They demonstrate relatively good health and mobility, but a few were diagnosed as suffering from mild or moderate symptoms of Alzheimer's or other cognitive impairments. Most clients need walking frames to move around the site. Activities involve quizzes, bingo, speakers, and outings. The routine is similar to Field Maple Day Centre; with both day centres managed by the same day centre coordinator.

Tulip Tree Day Centre is situated in a rural area of Cambridgeshire. The day centre is located in a community centre, where it shares space with other community organisations and age groups. They organise a series of activities aimed at promoting independence, creativity and a sense of well-being: quizzes, craft activities (painting, craft activities, cookery, etc.), gardening, group discussions, chair-based exercises, and musical events. The day centre is open from Wednesday to Friday, and it operates from a small meeting room in the community centre, with tables for crafting and games, and seating for the group to socialise. The area also contains a small kitchen, where hot drinks are prepared, and a garden with raised beds and seating. A group of approximately 12 clients attend the day centre each day, who are referred by health and social care teams, relatives, and themselves. They are all in relatively good health, although some are in early stages of dementia, or present mobility problems (as observed in both Field Maple and Aspen Day Centre). A group of two staff members and four volunteers help to coordinate all activities and support the clients.

The visiting scheme offers a service for more isolated and frail older adults. Support is offered in the form of weekly visits from a trained volunteer.³⁰ The service is comprised of two types of support: firstly, *face-to-face befriending*, where a volunteer visits an individual in their house; and, secondly, *telephone befriending*, where a volunteer gives support on the phone to a socially isolated older adult. Volunteers are overseen by a supervisor who puts them in contact with each client and is the first port of call if any issue arises.

3.6 Entering the field

Before starting the fieldwork in the day centres and the visiting scheme, I was invited to attend community events on relevant issues in later life (e.g. security, information on preventative services, and entertainment). I also took part in a consultation meeting organised by the local providers. In this gathering, older adults, representatives from the local health services and county council discussed how best to optimise service delivery.³¹ Attending this and subsequent meetings constituted relevant steps to introduce me to the organisation, liaise with day centre staff members and volunteers, and know more about the context of preventative care in the community. Consequently, I familiarised myself with the charity's social organisation, follow their interactions with local communities, and have contact with the *local language* used in these meetings (Becker and Geer, 1957). This experience was essential not only for establishing trust, but also for planning the practicalities of the research project, identifying potential groups and design the study.

³⁰ Information on this service and guidelines are offered to the public in the voluntary organisation's website at <http://www.ageuk.org.uk/cambridgeshireandpeterborough/our-services/our-services/visiting-scheme/>.

³¹ Health commissioners and city council representatives asked an audience of 20 invited older people what they would like local commissioners to purchase as services to support older adults, enhance their well-being and improve resilience in the community. Two speakers set the scene for the older people, so they could understand and follow the process the commissioning organisations have to go through in order to provide such services. This meeting focused on preventative services.

3.7 Methods

In this project, I opted for methods of inquiry that facilitated my access to unexplored and difficult-to-reach settings, and built rapport and trust (Flick, Foster & Caillaud, 2015; Lamb et al., 2011). In this context, participant observation and open-ended interviews were the main methods of accessing social representations of well-being promotion in community settings.

3.7.1 Participant observation in natural settings

Participant observation involves non-systematic observations and questioning in a natural setting where I get involved to acquire a clearer picture of meanings of well-being (Banister et al., 1994). Given the research questions of this study, participant observation served two purposes: firstly, it enabled me to familiarise myself with the research setting; and, secondly, it helped me to explore relevant issues to be inquired in the interviews. During the fieldwork, I volunteered to work in day centres, serving hot drinks, helping older adults to move around the day centres, setting up tables for meals, and assisting staff members in conducting group activities. I spent six to eight weeks in each setting and familiarised myself with staff, volunteers and clients as well as the daily routine of day centres. In this time, I had informal conversations with these groups, observed their interactions and invited some of them to in-depth interviews which explored meanings associated with their practices. My active role at the day centre as well as my reflexive attitude towards it allowed me to gain a richer comprehension of my participants and myself (Hertz, 1997). This approach allowed me to build relationships of trust with members of daycentres and facilitated an appropriate rapport for subsequent interviews (Banister, Burman, Parker, Taylor, & Tindall, 1994).

Following Glaser and Strauss (1967) and Banister's et al., (1994) recommendations, my analytical notes delimited my research focus as well as the selection of appropriate methods. A total of 49 Word document files containing fieldnotes covered some of my encounters with staff members, volunteers, and clients in the day centres (see Appendix 1 for samples of fieldnotes). These fieldnotes helped me to explore the local meanings of *well-being promotion* and to develop more suitable methodological ways of addressing my research questions (Flick, 2007; Hammersley and Atkinson, 2007). From descriptive, reflexive and analytical notes, I developed a series of in-depth interviews guides covering relevant topics on well-being promotion in community settings (see the following section).

3.7.2 Exploring meaning-making: semi-structured interviews

The focus on representations of well-being in daily life demands the use of 'methods that are sensitive to personal and subjective experiences' (Naaldenberg, Vaandrager, Koelen, & Leeuwis, 2011, p. 715). Thus, interviews were conducted to capture meanings of daily experiences of support.

In this study, participants were asked to talk freely about themes associated with my research questions and observations (Naaldenberg et al., 2011).³² In this case, individual interviews helped the informants to speak without constraints that might be associated with a larger group, reassuring them of confidentiality while preserving an informal atmosphere for research. Two topic guides were constructed to orientate the interviews with clients, staff members and volunteers of the day centres and the visiting scheme (see Appendix 2). Each

³² The fact that English is not my first language, and that I was perceived as an international student—in a more learning role—facilitated rapport during the interviews. These features may also have undermined the power play inherent in the relationship between interviewer and interviewee, and allowed participants to talk confidently about their meanings and experiences in later life (Howarth, 2002b).

topic guide covered contextual information—access to social and health care, social support and network of care, marital status, age, sex, length of time in contact with services, and living arrangements—according to each group of participants. Questions involved five themes associated with well-being promotion in the day centres and the visiting scheme. These themes were drawn from the review of studies on ageing well, and my fieldnotes:

1. *Understandings of psychological well-being in later life*: definitions of well-being, contextual features of well-being (social support, social network), the role of independence and mobility, and the potential impact of later life experiences on well-being.
2. *Changes in later life*: meanings of main cognitive and physical changes in the life course, and their influence on well-being.
3. *Mental health in later life*: mental health promotion in the community. Concerns associated with dementia, depression, social isolation and loneliness.
4. *Role of the family*.: family's participation in supporting the elderly and impact on well-being in later life.
5. *Institutional support in later life*: view on the role of the day centre and the visiting scheme in promoting well-being in later life. Questions involved the rationale of activities, meanings associated with participating in day centres, and clients and volunteers' views on the visiting scheme.

I asked participants to talk openly about the five topics in the interview guides. Questions were prompts to facilitate conversation, and other questions were added according

to the immediate context of the interview.³³ Given the spontaneous and ongoing character of the research design, I was flexible in choosing the order of the questions. For instance, for the group of volunteers, I started the interviews by asking them about their experience of giving support before questioning them directly about their views on well-being in old age. This approach enabled me to consider participants' views on well-being in different contexts.

Interviews with clients were conducted in the day centres and people's homes (in the case of clients involved in the visiting scheme). The length of time for each interview varied from 21 to 82 minutes. In the day centres, I interviewed participants in separate rooms or reserved areas—in cases when we were not able to talk privately. I informed clients, staff members and volunteers about the purposes of the interview. Given the fact that they had been informed about research objectives, I could establish a more appropriate rapport before each meeting. The font size of the Information Sheet (Appendix 3) was increased to enable clients with sight limitations to read it. I also delivered an information sheet to staff members and volunteers (Appendix 4). I also presented an Informed Consent Sheet (Appendix 5) to all participants to ensure that participation was informed and voluntary, and that informants had the right to withdraw at any time without having to justify their decision.

For the visiting scheme, I contacted the visiting scheme manager and asked her to circulate an email explaining my research purposes and inviting participation in the study. She forwarded me the details of those who responded positively. I asked her to forward the invitation email to volunteers at the areas of Fenland/East Cambridgeshire and Cambridge City/South. A suitable time and place for the volunteers was arranged. As a second step, I asked the volunteers to contact their clients and enquire about their availability for interviews. This procedure aimed at undermining any stress caused by being invited to an interview by a

³³ Despite this methodological flexibility, I kept the focus on participants' understandings of well-being in later life.

stranger. Before each interview, I sent an information sheet via email explaining the reasons for the study. In each meeting, I presented an Informed Consent Sheet and allowed participants to ask me any questions about the nature and implications of the study. Conversations with visiting scheme volunteers happened at people's homes, coffee shops and public spaces. The time range of each encounter varied from 45 to 108 minutes.

Interviews were recorded and transcribed verbatim. Four research assistants helped me to transcribe all data.³⁴ They all signed a confidentiality agreement and received instructions on transcribing the material adequately. I used the qualitative data analysis software ATLAS.ti 7 (Frieze, 2014) to organise, code and systematise data from observations and interviews. This will be discussed in full later in this chapter.

3.8 Selecting *relevant informants* for the interviews

From my negotiation with the day centre's coordinators, my initial contacts with different groups, and participant observation in the day centres I invited *relevant informants* to in-depth interviews. These participants are regarded as trustworthy and representative of the groups of people being investigated; moreover, they hold strategic positions within an organisation (Hammersley & Atkinson, 2007). They were able to discuss concepts, rituals and practices in the day centres. In this context, I did not regard the interview stage as distinct from the ethnographic study, but rather as a constitutive part of it (Flick, 2007; Hammersley & Atkinson, 2007).

Two groups were actively involved in giving and receiving support: older adults and

³⁴ Given the fact that this work involved data from a vulnerable group, I sought research assistants with previous background in typing and dealing with confidential issues. Therefore, two linguistic therapists, one psychologist, and one journalism student with experience of handling confidential data were recruited.

staff members/ volunteers. In total, I interviewed 54 informants during the fieldwork. Additionally, I included informal conversations with clients and volunteers in the analysis. Informal conversations are relevant data sources in ethnography (see Foster, 2003b, for an example). They uncovered contextual meanings of daily practices in a more *natural* way. In the Table 2, I describe the main socio-demographic characteristics of all participants who were interviewed.

Table 2
Socio-demographic characteristics

	Settings	
	Clients	Staff Members & Volunteers
Characteristics		
Number of Respondents	27	27
Average Age	82,5	70,5
Settings		
Field Maple	10	10
Aspen	8	3
Tulip Tree	6	3
Visiting Scheme	3	11
Sex		
Male	19%	26%
Female	89%	74%
Living Arrangements		
Living Independently	74%	96%
Sheltered Accommodation	7%	--
Living with Family	7%	4%
Nursing Home	4%	--
Mental Health Unity	4%	--
Area		
Urban	11	20
Relatively Rural	9	4
Rural	7	4

Clients' age ranged from 65 to 95 years old. Most of them live independently in their own homes and only one lives in a nursing home. The age range of staff members and volunteers varied from 26 to 89 years old and their experience of working and volunteering in day centres or the visiting scheme varied from six months to 28 years. Staff members and volunteers live predominantly in urban areas in Cambridgeshire.

Initially, I also aimed to recruit family members who were involved in supporting their relatives. Active ageing policies have placed family members as significant groups of community support (DoH, 2005; Mayhew, 2005). Nevertheless, recruiting relatives outside the daily life experiences of day centres proved to be difficult. Despite the efforts of staff to introduce me to families, some of them did not show interest in the study or were not geographically located near the research setting. The most accessible ones were those who constantly visited the day centre, and interacted with staff and volunteers to support their older relatives. In total, I recruited five family members who were not only the primary carers of frailer older adults but also were very involved in the routine of the day centres. For these reasons, I have focused on the clients, staff members, and volunteers' perspectives on well-being promotion in the community.

As described in the table above, I sought to include volunteers and clients who were enrolled in the visiting scheme. I hypothesised that this segment presents different expectations, experiences, and representations of services and care. The organisation's administrative board was also interested in knowing volunteers' and clients' views on *well-being* in different settings (day centres *versus* visits at homes). As is evident in Table 2, fewer older adults who are visited by *befrienders* were interviewed. Given the nature of the scheme, most of the older adults were in a vulnerable situation (e.g. illness, physical limitation, frailty) and were not willing to be interviewed at home.

3.9 Matters of reflexivity and my position in the fieldwork

Reflexivity in this research project was ‘ubiquitous’ (Hertz, 1997, p. viii) and permeated all steps of data collection, analysis and writing up. It involved my constant reflection upon the social processes and contingencies that affect access and representation of data (Brewer, 2000). During the fieldwork, I consistently took reflexive notes of my interactions with participants and interpretations of their practices. This was aimed at enhancing the legitimacy of my claims, seeking contextual information, and improving the quality of my research (Brewer, 2000). Detailed handwritten notes were taken during the transcription stage to keep an analytical approach to more *mechanical* tasks. Memos, analytical notes and a reflective account were the main strategies used to ensure a critical stance toward knowledge generation.

The fact of being a foreigner and non-native English speaker added to the complexity of exploring local practices and knowledge. I constantly considered my position as that of an *outsider*. It helped me to situate myself different day centres. However, the distinction between *insider* and *outsider* is not fixed as defining a static social identity in the field (Reinharz, 1997). Thus, processes of negotiation and renegotiation of social identities between myself and participants during the fieldwork influenced the degree to which I was perceived as an ‘outsider’ or ‘insider’ by participants (Naples, 1997). Moreover, being considered an *insider* or *native* does not preclude researchers from facing challenges to understanding. As Bolak (1997) highlights, ‘while a foreign researcher runs the risk of being culture blind, an indigenous researcher runs the risk of being blinded by the familiar’ (p. 97).

My previous experience of researching psychosocial aspects of health and illness, particularly in the context of HIV/AIDS, added to my interest in understanding how vulnerable groups cope with difficulties in community settings (Medeiros, 2010; Medeiros & Saldanha, 2012; Medeiros, Silva & Saldanha, 2013). I sought sponsorship from the Brazilian Coordination

for the Improvement of Higher Education Personnel (CAPES), which is a governmental research board that aims to facilitate actions to enrich faculty and staff in higher education through grant programmes. This agency was interested in how my study would inform current policy and practice of mental health care for older adults in Brazil.

Finally, conducting a research project in collaboration with a voluntary organisation also brought challenges to the report and presentation of data. I was aware of the political implications of reporting its practices to wider audiences (service commissioners, health professionals and clients). Data report and its implications were discussed between different stakeholders (e.g. staff coordinators, county council staff) to identify areas of social care intervention. Moreover, I sought to discuss the findings with the voluntary organisation's board to address the main areas of need and highlight positive actions of support.

3.10 Ethical considerations: informed consent, participant observation, and identity in the field

Ethical considerations permeated all phases of the research. From negotiating access with gatekeepers to approaching participants within the relevant settings, I ensured that principles of informed consent, confidentiality, and no harm were observed. The project was approved by the Psychology Research Ethics Committee at the University of Cambridge. Additionally, since some of the participants were regarded as a vulnerable group, I underwent an enhanced Disclosure and Barring Service (DBS) check with Age UK.³⁵ This procedure also allowed me to be a volunteer while I was observing people's interactions in the day centres.

³⁵ In this study, older adults aged 65 and over and suffering from physical and mental health conditions were considered in a vulnerable situation.

Additionally, it gave me access to participants in their residences, thus reaching more isolated groups within this charity.

Ethnography raises unexpected ethical issues that require a more contextualised approach to investigation of social life (Hammersley & Atkinson, 2007). In this case, informed consent was the first ethical issue to be addressed in the field. It involved a comprehensive explanation of the purposes of this study, rights of participants, possible risks and freedom to participate or not in it (van der Hoonaard & van der Hoonaard, 2013). Given the intrusive and personal character of ethnography, I reaffirmed informed consent at different periods of time (van der Hoonaard & van der Hoonaard, 2013). Members of day centres were routinely reminded of my research aims during the fieldwork. Even though adopting too overt a role may sometimes undermine the quality of observations (Hammersley & Atkinson, 2007), my role as a volunteer (participant observer) helped to alleviate any stress due to my presence in the setting.

I was responsible for getting to know clients, staff members, and volunteers during the routine of activities and for building up trust and rapport before observations and interviews. Given the particularities of the methods adopted in this study, informed consent was sought in two different ways. For observations, I sought verbal informed consent from participants, given the difficulties of managing written consent forms in public settings. For instance, in public organisations like day centres, where complex and different types of interactions happen, it is usually not possible to obtain individual formal consent without affecting the purposes of the investigation or delaying data collection (Punch, 1986). Besides, I assumed that signing a written consent publicly before properly introducing myself would be stress-inducing and ambiguous to clients and volunteers as suggested by Foster (2015). I also gave a written summary of research (Appendix 6) to those I met during my first interactions. In case of clients,

staff or volunteers who refused to be observed, I made sure their interactions and conversations were not recorded, and that it would not affect our relationship in the field.

Written consent was obtained before each individual interview. Since informed consent was a reflexive and ongoing process (Pesonen, Remes & Isola, 2011), I was able to assess whether members of the day centres were able to be interviewed. In so doing, I also took advice from staff as to some clients' capacities to give their consent. This strategy may undermine some participants' agency, and thus, exclude them from participating in the study (Dewing, 2008). Nevertheless, in cases where staff regarded a potential participant as having a severe cognitive limitation, I decided not to invite them to an interview.³⁶ The in-depth interviews included rapport building to alleviate any stress that might be caused by this situation.

Obtaining the consent of clients considered to have dementia was another ethical challenge. Some clients were in the early stages of dementia, and tended to forget that the research was taking place. This observation raised two fundamental ethical questions: firstly, were those clients able to give fully informed consent; and, secondly, to which extent were they regarded as responsible for taking this decision. People living with dementia have continually been excluded from qualitative investigation (Dewing, 2008). Their views and experiences have been overlooked by traditional forms of assessing participants' capabilities to give consent (Dewing, 2002). In this context, McKeown, Clarke, Ingleton, Repper (2010) have argued that a total reliance on competency-based informed consent methods or proxy consent—although important tools to inform ethical research procedures—can lead to exclusion of people with dementia in qualitative studies. Therefore, I approached participants with a certain level of dementia taking into consideration their interest in the research, social benefits, and their immediate capacity to interact in conversation (Dewing, 2002). I also kept reminding them of

³⁶ In general, most participants, including those with mild cognitive impairment, were able to give their consent.

my identity and purposes in the day centre, and asked advice from staff in cases where there was concern over an individual's capacity to consent. I aimed to prevent deception, lack of consent, and invasion of privacy. Participants were assured that confidentiality would be respected in all observations and interviews, and that their comments, interactions, and informal conversations would remain anonymous. Furthermore, I guaranteed to participants that, although the charity was interested in the findings, I was an independent researcher with clear purposes in mind, thereby eliminating suspicion of a hidden organisational agenda.

Having considered the research and ethical procedures adopted to collect data, in the next section, I will describe the analytical approach to analyse the data set.

3.11 Thematic analysis

I adopted two analytical approaches to explore meanings and associated practices across the data: *Thematic Analysis* (Braun and Clarke, 2006) and *Thematic Network Analysis* (Attride-Stirling, 2001). The first analytical approach comprised a stepwise procedure of six phases of data scrutiny: 1) familiarising with the data set; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and renaming themes; and 6) producing the report. The thematic network analysis involved the systematic management and graphic presentation of themes to express their relationships. Following Attride-Stirling (2001), this process involved the organisation of I) lowest-order premises salient in the text (basic themes/codes); II) categories of basic themes gathered together to summarise abstract principles (organising principles); and III) super-ordinate themes which reflect the main metaphors and ideas in the text (global themes). This triangular approach towards data analysis fostered a better organisation and presentation of the thematically-oriented analysis across different cases (Attride-Stirling, 2001). In so doing, I looked for shared patterns of meanings across the

interviews and how these meanings were interrelated to form participants' representations of wellness in later life.

In social representations research, a systematic exploration of the relationship between themes within a data set may reveal important features of representations (Foster, 2015; Flick & Foster, 2008). For instance, in this study, I looked at the extent to which patterns of meanings informed identities and orientations for action in community settings (Bauer & Gaskell, 1999). This is particularly relevant given the fact that shared understandings of ageing and the new ideology of positive ageing have informed new orientations to the self in later life (Kelly et al., 2016; Westerhof & Tulle, 2007). Moving beyond the description of themes, I endeavoured to interpret data in relation to its contextual features, latent meanings, and theoretical implications (Braun, Clarke, & Hayfield, 2015; Provencher, 2011). In so doing, I drew on conceptual features of social representations theory—canonic themata and representational projects—to understand the shared nature of meaning-making about well-being and old age. In this context, thematic analysis consisted of a systematic process of categorisation and reflection which led to theorisation of meanings and promotion of well-being.

Thematic analysis was suitable for this study in numerous ways. Firstly, its theoretical flexibility was deemed suitable to analyse the data according to the theory of social representation (Braun & Clarke, 2006). 'Thematising meaning' is considered a fundamental qualitative research strategy (Holloway & Torres, 2003, p. 347). Similarly, the theory of social representations focuses on meaning-making and different cultural products (e.g. structured practice, non-conscious behaviour) (Flick & Foster, 2008; Jodelet, 1991). Secondly, thematically-oriented analysis facilitated the development of concepts, categories, and types that bore meaningful relationships with the data (Brewer, 2000). Moreover, progression from description to contextual and thick descriptions of coding added credibility to the analysis

framework (Geertz, 1973; Hammersley & Atkinson, 2007). For instance, I constantly reviewed my coding frame considering my reflexive and analytical notes and theoretical concepts. Again, a reflexive attitude helped me to acknowledge that I was also ‘embedded in a network or representations’ when I conducted the analysis (Flick et al., 2015, p. 68). Thus, my views and interpretations on the data were constantly assessed and supplemented by a reflective account of the analysis (see Appendix 7 for reflective accounts).

Rather than offering a rigid template to analyse data, the combination of *thematic analysis* and *thematic networks* enabled me to make informed decisions on indexing, articulating, and presenting themes (Braun and Clarke, 2006; Attridde-Stirling, 2001). This trajectory helped me to explore not only the content of the discourses, but also its consequences for people’s understandings of health in community settings (Zadeh, 2014). Therefore, I also examined my observations and accounts of experiences in the field. Fieldnotes enabled me to examine not only patterns of meanings, but also how local practices were situated within the symbolic context of well-being promotion in the community. What follows next is the description of the steps taken to index, compare, describe, and interpret the corpus of this research.

3.11.1 Conducting the thematically-oriented analysis

Data analysis is an iterative process which occurs from the beginning of the fieldwork (Arksey & Knight, 1999). From the onset of the project, participant observation allowed me to develop hypotheses, theories of what I observed, and themes to be discussed with informants (Foster, 2015, Gibbs, 2007). This in turn enabled me to elaborate the code frame according to my experiences in the field, reflexive notes and the analysis of the interviews. Coding was

assisted by the computer-aided qualitative data analysis software ATLAS.ti 7. According to Flick (2014), this software is based on the principles of grounded theory and coding (Glaser & Strauss, 1967). However, one can also apply pre-defined codes to the corpus of data, combining deductive and inductive analytical approaches. One hundred and eight documents were incorporated into the hermeneutic unit (HU) *Analysis Fieldwork Well-being*. The HU comprised of 49 files of fieldnotes of my interactions and conversations in three day centres, and data of 54 interviews. I combined my fieldnotes and interview data into one hermeneutic unity to construct a consistent code frame. It facilitated consistency and transparency of analytical procedures by combining in the same analytical process across different data, reflexive notes, memos, and transcriptions of interviews (Flick, 2014; Naaldenberg et al., 2011).

Following Braun and Clarke's (2006) stepwise approach to analysis, initially, I familiarised myself with the data by transcribing verbatim the content of the interviews. The main purpose of it was to display conversations clearly and provide the readers with a good representation of the interview experience (Dresing, Pehl, & Schmieder, 2012). This analytical stage was not a simply mechanical process, but it was influenced by my analytical purposes and theoretical lens (Davidson, 2009; Jaffe, 2007).³⁷ Practically, transcripts were created with a focus on readability (semantic clarity), literal wording, and the inclusion of emotional and non-verbal utterances. Interruptions and unclear words were highlighted in the text to add more transparency to this process (see Appendix 8 for samples of the interview transcripts). Throughout the transcription process, I took handwritten notes about potential themes and hypotheses. These notes assisted me to develop the initial codes.

Familiarisation with the text enabled me to start the *coding phase* (stage 2 of thematic analysis). This stage involved a systematic and continuous creation of codes. All the interviews

³⁷ Critical studies on the role of transcription in qualitative research have shown that this process is selective, theoretically-oriented, and involves epistemological positions (Davidson, 2009).

were coded based upon phrases that show meanings of well-being (e.g. well-being associated with an active mind), ageing conceptions (e.g. ageing as a burden) and the experience of support (e.g. day centre activities). Following Braun and Clarke's (2006) recommendations, I coded extracts of data inclusively; that is, I kept the surrounding data to give context to the codes. On occasions, I coded data extracts in many different themes to allow that contradictions and complexity be added to the code frame. A total of 331 codes across 54 interview transcripts and fieldnotes were generated (see Appendix 9). Co-occurrence of codes were observed and themes were assigned to the patterned data (phase 3 of Braun and Clarke's thematic analysis). A total of 32 initial themes or *subthemes* were generated and initial networks of meanings were established (see Appendix 9). These subthemes were reviewed considering my theoretical choices and the meaningful relations between data extracts. Atlas.ti assisted me with establishing relations between subthemes (e.g. Cognitive stimulation via activities *is associated with* Activity as a Protective Factor and *is a property of* Active Mind-Body; Well-being is the Result of Keeping Independent *is associated with* Well-being is the Result of Keeping an Active Engagement with Life and *is cause of* Activity as a Protective Factor (for samples of network, see Appendix 10). This approach helped me to examine the meaningful relations between themes without attributing a hierarchy of meanings (Attride-Stirling, 2001). Themes were deemed significant according to the overall organisation of the data and the main research questions. Then, I developed a second code frame with refined themes and subthemes about the data set (See Appendix 11).

Three thematic maps were developed and reviewed (steps 4 and 5). The first one displays 3 main themes (or super-ordinate themes) and 34 subthemes about clients and volunteers' views on wellness in old age (see Chapter Four, p. 99). The second map depicts 3 themes and 19 subthemes about participants' understandings of well-being promotion and

social support (see Chapter Five, p. 166). The third thematic map involves 2 main themes and 4 subthemes about participants' representations of well-being promotion via the visiting scheme (see Chapter Five, p. 208).³⁸ Visual representations of the main super-ordinate themes were generated to elucidate the main narrative of meaning-making across the data set, and to present the relationship between different representations (Attride-Stirling, 2001; Flick & Foster, 2008). This thematic organisation reflected the data set and the ways through which participants organised their views.

The final step of this thematic analysis consisted of the report of the findings. I supported the thematic maps by presenting data extracts and a thorough theoretical discussion. In this stage, I reviewed all the analytical categories by relating them back to the literature and my research questions. In keeping with Medeiros and Foster (2014) and Toepfer et al. (2014), I presented the results chapters along with the theoretical and analytical discussion. In this context, the analysis was inherently theorised (Braun & Clarke, 2006). I also narrated a story of the data 'on its own terms and according to its inner logic' (Toepfer et al., 2014, p. 239). In this process, I sought to ensure consistency in my interpretations of the empirical data, theoretical fit, and transparency in presenting the findings (Flick, 2014, Naaldenberg et al., 2011).

3.12 Quality assessment of research

The quality of the research was assessed through the two criteria of confidence and relevance (Gaskell & Bauer, 2000). These markers reflect broader principles of claims-making

³⁸ In this thesis, I also presented three more diagrams to report the empirical data (see Chapter Four, pp. 95, 132, and 139). These figures derived from the thematic maps in Chapter Four (p. 99) and assisted me with presenting the data analysis.

and public accountability in research. *Confidence* markers allow the readers to assess whether the findings reflect participants' social constructions of phenomena, whereas *relevance* refers to the 'import of the research evidence for the people involved, for the theory or concepts at stake, or for the purpose of the research project' (Gaskell & Bauer, 2000, p. 363).³⁹

During the fieldwork, I sought confidence and relevance by considering the design of research, sampling and reflectivity. The collaborative design enabled me to explore relevant areas of research and address important issues within community care (e.g. clients' lived experiences of support via the day centre). I also developed a research network across the voluntary sector, health commissioners, clients of the voluntary sector, and the University of Cambridge. I sought relevance by developing a systematic and long-term relationship with these stakeholders. I designed and executed my research plans successfully, gaining access to different areas and social groups within Age-UK Cambridgeshire. Furthermore, participant observations, informal conversations, and in-depth interviews allowed me 'to map contradictions and consistencies, and to explore the functions of representations across... different modes and mediums' (Bauer & Gaskell, 1999, p. 178).

During the data analysis process, I sought confidence by adopting procedural clarity and triangulation of analytical approaches. Thematic analysis and thematic networks were used interchangeably to appraise the data set. While the thematic analysis searched for relevant themes across different texts, thematic networks helped me to organise the thematic analysis, disclose the analytical steps, and display relations between categories (Attride-Stirling, 2001). Additionally, a systematic note-taking approach was applied to the processes of collecting and

³⁹ The quality assessment of this research reflects the relationship between an *inner* and *outer* dialogue (Seale, 2004). The first refers to the internal logic of this research project (sampling design, appropriateness of methods, sound articulation between claims, and evidence). The latter relates to its 'social significance' (Zadeh, 2014, p. 70).

analysing data. From the transcription stage onwards, analytical and reflexive notes were taken to assess possible biases and the relationship between concepts and empirical data (Flick, 2014), thus ensuring the credibility of my interpretations. I also sought confidence by providing a more transparent account of data collection and analysis. The research procedures were comprehensively described, and my position in the field was rigorously assessed to seek procedural clarity and reflexivity in the research. With the aid of a qualitative data analysis software, I organised different data sources without losing sight of my main research questions or analytical purposes. Moreover, the presentation of different steps in the development of the coding frame facilitated procedural clarity (Appendices 10 and 11).

During the analysis, I discussed some of the most relevant themes with three experienced academics in qualitative research.⁴⁰ This procedure constituted a form of audit trail (see Lincoln & Guba, 1985; Zadeh, 2014), through which procedures and analytical concepts were assessed in relation to their ‘clarity and consistency’ (Seale, 1999, p. 141).⁴¹ As a form of triangulation, this approach aided me to confront the data with different interpretations and contrasting views as well as refined the thematic analysis and check for its capacity to unearth social meanings (Brewer, 2000).

The criteria of confidence and relevance were met by my analytical efforts toward a thick description (Geertz, 1973). The rich display of verbatim citations enhanced the confidence that data reflected participants’ accounts (Gaskell & Bauer, 2000). The criterion of relevance was also met by communicative validation of the initial coding (Bauer & Aarts, 2000). In this study, initial coding of ten interviews were presented to the organisation’s board, clients and

⁴⁰ I chose the auditors based on their expertise in different socio-political contexts: two social psychologists and one sociologist were consulted.

⁴¹ Corroborating Hubermas and Miles (1998) and Flick’s (2014) recommendations, I considered the following quality criteria (i) findings were grounded in the data; (ii) inferences were logical; (iii) alternative explanations were accounted for; (iv) the category structure was appropriate; and (v) there were strategies to increase credibility of findings.

local authorities (NHS and county council) in a public meeting. This presentation provided me with an opportunity to make my analytical ideas known to research participants, check for their understandings of my interpretations, and to assess the extent in which findings were considered relevant to their ‘practical and political projects’ (Seale, 2004, p. 380). Lastly, unexpected results within the data set were perceived as robust indicators of relevance and confidence. Unexpected interpretations and negative cases were deemed necessary to avoid the ‘fallacy of selective evidence’, in which the researcher may undermine the value of facts or data contrary to their explanatory frameworks or ideological position (Boyce, 2000). In this study, the display of themes as dichotomies reveal a rather complex representational field around the concept of ageing and health (see Chapter Four). Despite clients, staff members, and volunteers’ emphasis on positive ageing, I also included their views on the problems associated with ageing—experience of frailty, lack of mobility, and loneliness were some of their counter narratives of positive ageing. By embracing divergence and contrast, I aimed to add depth and complexity to the analysis (Hammersley & Atkinson, 2007).

In the next chapter, I will discuss the main analytical themes which refer to participants’ conceptions of well-being in later life. These themes will be discussed in relation to the main literature in social gerontology and social representations as well as according to the entire data set.

CHAPTER 4 –THE SHARED NATURE OF WELLNESS IN COMMUNITY SUPPORT

4.1 Introduction

In this chapter, I will explore the understandings of well-being in later life held by two groups involved in community support: clients and voluntary sector practitioners. The groups of ‘staff members’ and ‘volunteers’ have been categorised as voluntary sector practitioners since they execute similar functions within day centres and tend to share similar views on well-being promotion. However, any differences between kinds of practitioners will also be explored. The report and discussing of data are largely based on the interviews as they address what people specifically say about well-being. The theory of social representations is adopted as the main social psychological framework to analyse clients and voluntary practitioners’ views on well-being in later life. Three theoretical concepts will be used to analyse the sharedness, complexity, and repercussions of concepts of well-being in community settings: canonic themata (Moscovici, 1993), hegemonic representations (Moscovici, 1988), and identity formation (Duveen, 2001; Moloney & Walker, 2007). Finally, I will discuss the multiple ideas about well-being in later life. In so doing I will analyse the polysemy of concepts associated with wellness amongst clients and practitioners (Moscovici, 2008). This has important implications for examining public understandings of wellness in later life, top-down policies, and professional frameworks of successful and active ageing. Moreover, this analysis will uncover how older adults and staff and volunteers anchor their views of well-being in the context of their culture and daily interactions (Bauer & Gaskell, 1999).

4.2 Preliminary remarks: thematising psychological well-being in later life

In this section, I will present the main categories associated with clients and voluntary sector practitioners' views on wellness. The description of these categories and the theoretical background employed to analyse them will be introduced. Thus, this section will display the thematic diagrams about the representations of wellness. Each major theme and sub-theme will be considered further in the subsequent sections.

As discussed in Chapter Two, people develop ideas of wellness in later life within a network of associated meanings, typically associated with the body, age, and health progression (Camargo & Wachelke, 2010; Crawford, 1984). This was also observed in this sample of older adults and practitioners. In this context, clients, staff members, and volunteers hold understandings of well-being which are deeply associated with the cultural narrative of healthy and active ageing (Bowling & Dieppe, 2005; Ranzijn, 2010; WHO, 2002). From their perspective, well-being is a result of active and independent living. These views mirror current public understandings of *what constitutes health in later life*—namely a consumerist, autonomous and independent lifestyle, as discussed in Chapter Two (Ward, 2015). Such a view is in line with current UK policies on well-being and self-care in later life, and points to the pervasiveness of an ideology of autonomy and individual responsibility with social care (DoH, 2005; Lloyd et al., 2013; Ward, 2015).

Nevertheless, clients and voluntary sector practitioners negotiate these broader ideologies of ageing and even challenge them. In this case, older adults and practitioners also mention the problems associated with ageing: physical limitations, cognitive problems, social isolation, and loneliness. Negative aspects are also present in older adults' daily lives and point to the necessity of adapting strategies and networks of care to live well. In this context, ideas of well-being are plural and reflect cognitive, behavioural and socio-cultural strategies to

address life contingencies. Moreover, wellness is not considered an individual dimension, but is the fruit of meaningful relationships and practices of support.

The thematic analysis within this project reflects a dialogical epistemology (Marková, 2000, 2003). In this context, thematised meanings of ageing well are expressed in terms of polarities and antinomies (Moloney et al., 2015). The complex representational field around wellness, ageing, and the body is constructed and enacted around fundamental categories of thinking. These underlying principles of thought, conceptualised as *canonic themata*, refer to ‘what underlies diverse representations’ regarding different phenomena (Moscovici, 1993, p. 4). They inform how contemporary societies make sense of the human longevity by drawing upon deep-seated cultural understandings of the body, health, and ageing.

The way in which clients and voluntary sector practitioners represent well-being in later life takes the form of oppositional categories, which are dichotomies referring to positive and negative features of ageing. In addition, well-being is conceptualised as a complex and multidimensional phenomenon. Social representations of well-being in old age are thus displayed around two dichotomous themes (*activity/passivity, independence/dependence*) and a major theme of *wellness* (see figure 1). Taken together, these themes are interrelated to depict social representations of wellness in later life around two fundamental categories: the mind and the body.

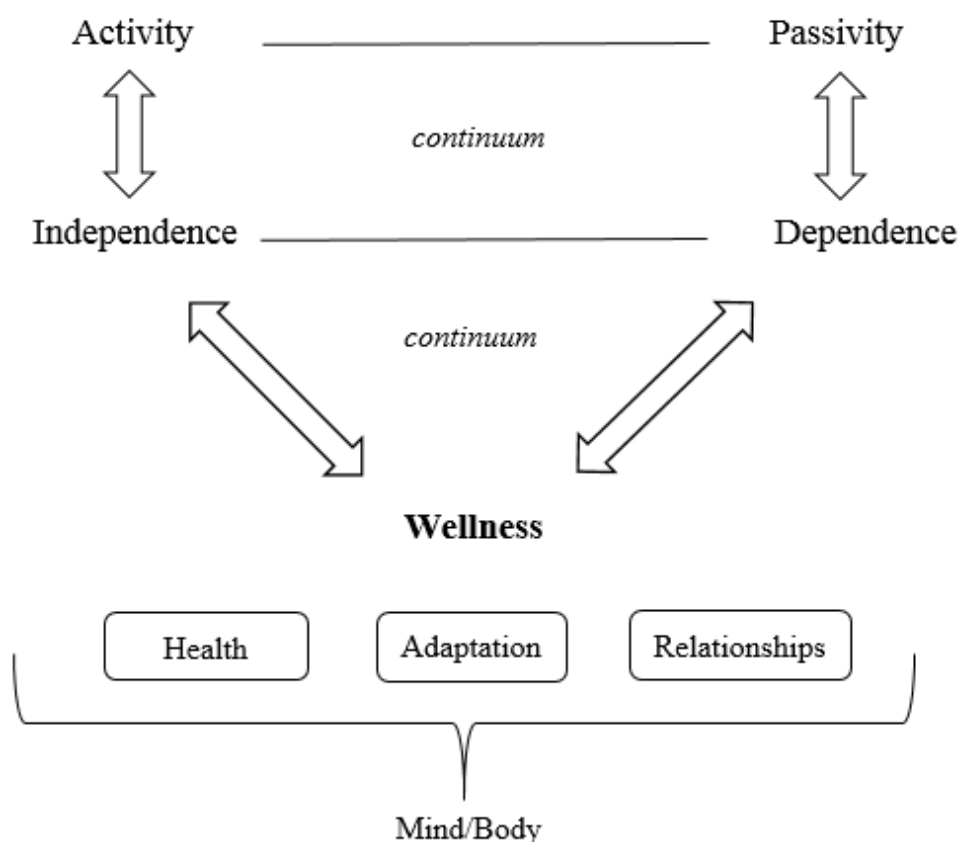


Figure 1. Interrelations of themes of social representations of well-being anchored in the fundamental categories of mind and body.

The first theme, activity/passivity, expresses clients and voluntary sector practitioners' views on well-being in later life as anchored in an active life. *Human activity* is one of the most important factors in the multifaceted representation of well-being. This broader category refers to the value older adults place on keeping themselves mentally and physically active to preserve functionality, independence, and social engagement (Quéniart & Charpentier, 2012). Mind and body are the main elements interacting to promote an active life. Overall, these domains are mentioned by both clients and practitioners. Diverse subthemes correspond to this theme, such

as well-being as the outcome of an active mind-body, activity as a protective factor, an active engagement with life, and participation in the community.

The second theme, independence/dependence, refers to social representations of psychological well-being as grounded in an autonomous self. Independence is depicted as a central value in both clients and practitioners' accounts and organisational practices.⁴² Mobility is thus considered the main indicator of well-being, as it enables older adults to remain socially connected. Nevertheless, subthemes refer to the complex experiences of body limitations with age, such as mobility impediments to an active self, physical limitations upon living an active identity, and ambivalence towards dependence. In the overarching themes of active-passive and independence-dependence, identity issues are salient among clients and practitioners. Such meanings contributed to different coping strategies for re-defining a positive identity in later life. Moreover, differences were observed in the way in which clients and practitioners position themselves and negotiate giving and receiving support.

Thirdly, the theme wellness refers to the multiple ways of understanding well-being in old age. Wellness is thus understood as a generalised state which encompasses subjective assessment and adaptation to life experiences, health, and meaningful relationships. Clients challenge individualised views of well-being by highlighting the benefits of social interactions and networked support. Contrasting current assumptions of autonomy and life satisfaction in public and professional discourse, clients define wellness in relation to significant others (family members, volunteers, and peers), past and projected identities, and places and spaces through which they navigate and live (Ward, 2015). Sub-themes depict both positive aspects of ageing—positive outlook, life satisfaction and preserved health, socialising—and negative

⁴² I observed this ethos in community meetings and official communications. Staff members and volunteers stressed the preventative character of their services (See Chapter 3, pp. 66-67). Put simply, they were interested in promoting functionality and independent living.

experiences, such as financial constraints, social isolation, and a dependent body. Some subthemes cut across themes, such as activity as a protective factor, maintaining independence, and participation in the community, which are relevant to both activity/passivity and independence/dependence domains of ageing well. A dependent body and dependence as a burden are relevant to both independence/dependence and wellness themes. Ageing as an attitude of mind is found to be relevant to wellness and activity/passivity themes (see Figure 2 for the visual representation of all themes). This interconnectivity of the diverse subthemes reflects the network of meanings around health and old age and how wellness is linked to bodily, material, and social conditions.

This study is also characterised by a series of common views concerning well-being between clients and voluntary sector practitioners. These ideas are largely shared across all day centres and the visiting scheme. This points to the influence of a hegemonic representation of positive ageing amongst older individuals and voluntary sector practitioners who must negotiate daily meanings and practices of support (Moscovici, 1988). Furthermore, the evidence of a hegemonic understanding of ageing and wellness points to the power relations between groups of older adults—historically represented as frail, dependent and in need of formal care—and *care-givers* or those deemed responsible for providing support (Jesuino, 2014; Rogers & Pilgrim, 2001). Below, I will reiterate this issue when discussing the influential character of staff members and volunteers' views upon the formation of clients' conceptions of well-being.

Ageing well is thus represented as an active, independent and healthy lifestyle. This view on healthy ageing represents an ideal state to be lived and a determined identity: as an active consumer and autonomous individual. The positive ageing discourse which has dominated public understandings of ageing is the ideological background from which clients construct their views on wellness (Featherstone & Hepworth, 1995; Foster & Walker, 2015;

Kildal & Nilssen, 2013; Westerhof & Tulle, 2007). Similarly, voluntary sector practitioners enact their views on wellness in accordance with this shared ideology of healthy ageing and the professional frameworks of active ageing (Walker, 2009; Walker & Foster, 2013; WHO, 2002). Nevertheless, clients and practitioners negotiate these beliefs and enhance the scope of care in community settings. Clients stress relationality and social support as core elements of well-being in community settings. Practitioners also place value on the day centres as spaces for socialising and belonging, but they highlight the importance of structural support to maintain older adults functional and participative in their larger communities.

Themata are also enacted according to specific contexts and identity constructions (Marková, 2000; Moloney, Williams, & Blair, 2012). Acknowledging that themata ‘facilitate the merging of old ideas with modern, past beliefs with present, the traditional with the new,’ (Moloney et al., 2012, p. 02), cognitive polyphasia is a process inherently linked to these structures of historically grounded meaning. Overall, psychological well-being was represented as a broad phenomenon in respondents’ accounts. Results resemble previous studies that show multidimensional definitions of well-being amongst older adults (Bowling, 2006, 2008; Fisher, 1992; Fisher & Specht, 1999; Tate et al., 2013). In this case, wellness is defined in terms of the interaction of diverse factors such as emotions, cognitive functioning, psychological resources, social support, meaningful relationships, and demographic changes.

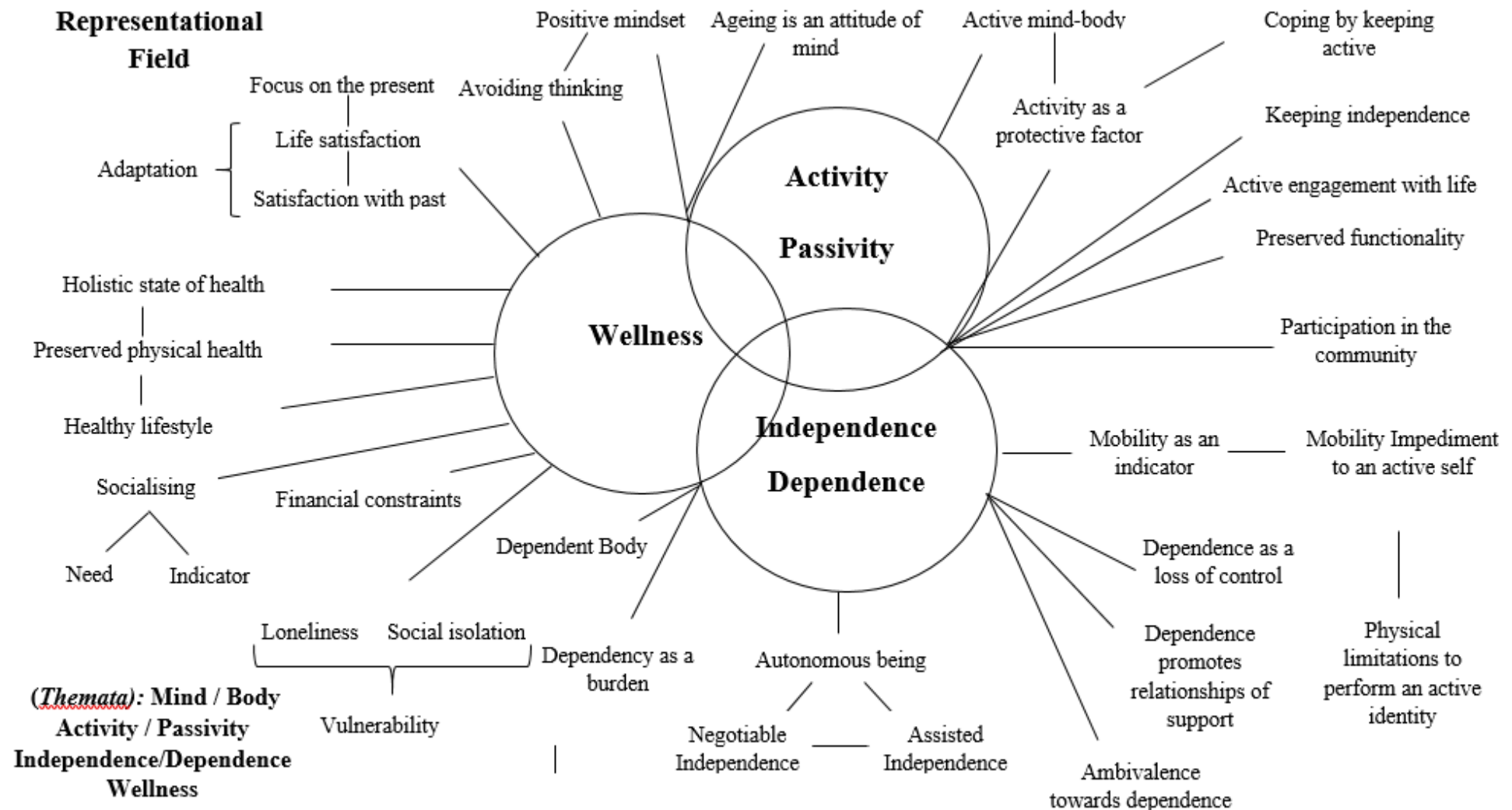


Figure 2: Thematic map depicting interrelated themes in participants' social representations of well-being in later life.

4.2.1 *Thema: activity-passivity*

The first thema associated with representations of well-being in later life is *activity-passivity*. The duality of activity-passivity structures the representation of well-being as a function of an active life. Clients and voluntary sector practitioners understand well-being as a result of preserving an active lifestyle. In this way, social groups involved in community support draw upon the category of activity and its opposite pole, inactivity or passivity, to represent wellness or lack of it with age. Marková (2003) stresses that social thinking—expressed in common sense—relies on the use of antinomies or polarities. However, both groups do not draw a clear line of separation between activity and passivity in ageing. One is not totally active or passive when one is ageing. Instead, both clients and voluntary sector practitioners depict the relationship between activity and passivity as a continuum, namely, ageing well involves a negotiation between an active lifestyle and diminishing abilities to perform common tasks.

4.2.1.1 Well-being as a function of an active mind and body

Corroborating Bowling's (2008) study on British lay views of active ageing, clients also view well-being as a function of keeping oneself mentally and physically healthy. They highlight the need to keep their minds and bodies functioning in order to avoid deterioration. Therefore, stimulating the body (via exercises, going out, household tasks) and the mind (via crosswords, puzzles, social interactions) are relevant resources to keep oneself functional. When asked about definitions of well-being, older adults particularly emphasise the role of activity in maintaining health and wellness. Such representation challenges the current theoretical understanding that there are clear-cut

definitions of lay concepts of active ageing, successful ageing, and healthy ageing (Bowling, 2008). Rather, the findings concur with other research that suggests an overlap of social meanings associated with ageing well (Bowling, 1993, 2006; Bowling & Gabriel, 2007; Fisher, 1992; Tate et al., 2013).

R⁴³: For you, what is psychological well-being?

P: [Sighs] Oh, it's to keep your mind busy, keep your mind alert...

Victoria, 66, client, Field Maple Day Centre

R: What things in your life make you feel well and happy?

P: I think it's, if I've got good friend around me and if I am able to get out. I like to walk and have plenty of exercises, which I think I am lucky that my time of life I can still do that.

R: Lovely. Do you usually go for exercising? What kind of exercises do you usually do?

P: I don't do much actual exercises except that I walk as much as I can. As long as I can walk, I think that is quite helpful.

Helen, 90, client, Aspen Day Centre

Underlying these representations are the fundamental categories of mind and body. Social representations are developed within the 'framework of pre-existing thought' (Moscovici & Vignaux, 2000, p.157). These deep-seated meanings enabled clients, staff members, and volunteers to anchor psychological well-being in later life. In this context, along with the thema activity-passivity, clients and practitioners draw upon

⁴³ Throughout the next chapters, I will use the initials R and P for researcher and participant respectively.

the thema mind-body to represent their experiences of ageing. This dichotomy is anchored in the mind-body problem of Cartesian dualism (Ludwig, 2003).

In this context, psychological well-being is not only seen as a function of the mind, but it involves bodily experiences, namely the possibilities and constraints imposed by the body. Both dimensions are intertwined in clients' representations as they draw a closer link between mind and body when defining well-being. Thus, psychological well-being is a reflex of positive interactions between an active mind and a fit body. A longitudinal study on determinants of successful ageing in a sample of 204 Harvard College sophomores indicated a closer relationship between psychosocial aspects and physical health in healthy ageing (Vaillant, 1990). This led Vaillant to theorise that the mind and the body are intertwined in the experience of ageing well. A balanced interaction between different domains of life is also a recurrent theme in social representations studies of health in later life (Flick et al., 2003; Murray et al., 2003). The absence of this balance allows *natural deterioration* to occur.

R: What in your life make you feel happy and satisfied? ...

P: When I can get more back into my own with thinking, and working, and meeting people and going out. Erm, I am sort of excluded from all those sorts of things now quite a lot to an extent, because I can't walk very far. And there is that, there's that physical thing, and there is also the fact that I've got Alzheimer's and ... I can't remember anything.

Martha, 83, client, Field Maple

R: What can mostly produce well-being in older people?

P: Just keep positive and active physically and mentally if possible... You know, I just hope I keep my mind and keep happy, and I just, the worst thing that worries

me Bruno, is if I have a stroke, because if I have a stroke I wouldn't be able to use my hands. I don't, I try not to even think about it, because I could drive myself mad, but that's what worries me most, is having a stroke. I could cope with having a heart attack. I think I could cope with having cancer too, it might be a shock, but I could cope with that, because you have to. But whether I'd cope [with] having a stroke and being even more limited to what I could do, I don't know.

Victoria, 66, client, Field Maple

In the extract above, Victoria is more concerned with loss of functionality than necessarily with her physical health. This emphasis contrasts with previous studies on successful ageing which point to the prominence of health status as an index of ageing well (Rowe & Kahn, 1987, 1997). Moreover, as will be further discussed below, loss of functionality affects clients' identities as active and participative individuals. This might shed light on findings from quantitative studies which show that older adults rate themselves as ageing successfully despite the presence of physical problems (Cernin, Lysack, & Lichtenberg, 2011; Phelan et al., 2004; Strawbridge et al., 2002). In this case, functionality and health status are relevant components of ageing well inasmuch as they enable older adults to maintain an active lifestyle. In this context, the body is regarded as an important component in their representation of well-being. Being able to move, use the body and be fit are the main conditions for positive functioning. In this context, ageing well is possible by a continual subscription to *youth values* or the *Third Age* experience—preserved functionality, healthy lifestyle, power of consumption, and responsibility for self-care (Laslett, 1987; Ylanne, 2017). In this study, clients do not subscribe to the social category of *old age* by keeping a lifestyle congruent with the social expectations of active ageing (Twigg & Martin, 2015). This shared lifestyle enables clients to preserve their

value and place in the communities where they navigate and share their life experiences (Oberg & Tornstam, 2001, cited by Wigg & Martin, 2015; p. 4).

On the other hand, the opposite pole, *passivity*, was represented as the first marker of the ageing process. Clients generally equated old age with a lack of vitality and activity. As explored in Chapter Two, ideas of passivity and decay associated with ageing tend to be prevalent not only amongst older adults, but also amongst other groups, including children (Burke, 1982; Kwong See, Rasmussen, & Pertman, 2012). Such stereotypes are deemed to be pervasive across the entire lifespan and prescribe determined identities to older adults (Levy, Hausdorff, & Hencke, 2000; Robinson, 2014). In this project, clients resist the subscription to the category *old age* and its negative meanings associated with ideas of passivity, decay, and, consequently, a spoiled identity (Burroughs et al., 2006; Goffman, 1963; Levy, 2009). The negative views about passivity held by clients in this study also reflect the cultural bounds of concepts of ageing well (Ryff, 1989a). UK citizens, drawing upon current ideologies and normative orientations of active and healthy ageing, construct their social identities in terms of an active lifestyle (Holstein & Minkler, 2003; Marhánková, 2011). Nevertheless, studies in different cultural groups have shown that passivity is not always associated with negative meanings (Torres, 2003). For instance, in Torres' (2006) research on Iranian immigrants' views on successful ageing, passivity was associated with wisdom and *acting according to one's own age*, which are aspects related to respectability in Iranian culture.

These findings have relevance in the assessment of how older individuals—a less empowered group—make sense of ideological shifts in societal concepts of ageing and good life. On the one hand, clients resist identification as *old* and *passive* (Duveen, 2001). On the other hand, they subscribe to an individualistic ethos of care (Sánchez & Hatton-Yeo, 2012). Such discourse of an active lifestyle may also constitute a way of disciplining

the ageing self-body in order to conform to current normative frameworks of ageing (Boudiny & Mortelmans, 2011; Marhánková, 2011).

The concern with keeping oneself active and functional is also shared by older volunteers. This may be partly explained by the fact that many of them are also ageing, although in a different social role. As described in Chapter Three, most of the volunteers were also at an advanced age and signed up to volunteer as a way of preserving participation in society. In fact, their social roles as volunteers do not preclude them from identifying the challenges of ageing well as located in the body. This emphasis on keeping physically fit and active as a sign of health and wellness could be observed in the conversation below.

R: ...from your views what does contribute to promote wellbeing to older people?

What is wellbeing?

P: A safe environment. But, what is safe today? ... so, we live in the apartment, it's great because once we are upstairs it's all on the level and it's done nicely, but my eldest son was saying to me 'Mum you are going to have think about, you are not going to be able to stay here forever because you might fall down the stairs...'. I say, 'well we'll get a stair lift.' He says, 'Yes, but that's not the answer!' But, you know, you do think about, but as long as we can still, it's good for us to go up and down stairs to keep ourselves, we try to keep ourselves as physically fit as we can...

Laura, 76, volunteer, Field Maple

Other clients refer to the split between their active mind and their limited body: '*I wish I had a new body*' (Rachel, 93, client, Field Maple), '*... if I wasn't like this (pointing to his arthritis in his legs), I would be a different person altogether*' (Bob, 65, client, Field Maple). This discourse demonstrates that the relationship between mind and body in old

age is understood in a complex way. A coordinated relationship between mind and body is not always possible. Frail bodies do not follow active selves, hence acceptance and adaptation to constraints are necessary. Thus, the focus of the clients on maintaining a healthy mind counterbalances their perceived physical limitations (Teixeira et al., 2002). The perception of having an active mind but a limited body was reported elsewhere as the genesis of the ageing process (Prieto-Flores, Fernandez-Mayoralas, Rosenberg, & Rojo-Perez, 2010). In fact, research on social representations of the body in later life has found that health decline is the main meaning attached to it (Camargo & Wachelke, 2010; Veloz, Nascimento-Schulze, & Camargo, 1999). Other studies have shown that loss of control over the body (Gherman, 2014), body decay and death (Nascimento-Schulze, 2011), and loss of vitality (Santos, Tura, & Arruda, 2013) are considered markers of *old age*. Therefore, clients endorse the need to develop an active lifestyle to prevent the deteriorating consequences of the ageing process.

4.2.1.2 Activity as a protective factor

Participants refer to the necessity of keeping themselves active mentally, physically and socially in order to flourish in the community and avoid any form of decline.

P: So, I don't know whether you feel the same as I do, if you don't use your brain, you lose your brain.

R: Mm. Very interesting, yes. What kind of things can you do to not lose your brain?

P: Well, I do crosswords, I do jigsaws, I do crocheting, I do knitting.

Victoria, 66, client, Field Maple

In the process of acquiring consent from participants, I had a chat with Rachael and Beatrix. They were both 94 years old and suffer from (what seems to be) macular degeneration... in response to my explanation about what can bring well-being in later life, Beatrix said: 'The most important thing is keeping the mind active... at least I didn't lose my memory'.

Fieldwork note, Week 3, 01/12/2013, Field Maple

Activity is seen as a protective factor against the negative outcomes of ageing. Cognitive deterioration, social isolation, and structured forms of care are some of the main concerns expressed by both clients and practitioners in the day centres. In order to avoid them, one must keep himself active and involved with social life.

R: Why do you think it's so important to use your brain to remember things?

P: It keeps you going. Yeah, I mean I think if you just sit and do nothing that's when you deteriorate, I think. You've got to be doing something or going somewhere, yeah.

Jenny, 81, client, Aspen

I think the well-being part is, keeping active, I think that is so, so important. If you just sit there and vegetate then your mind will go to mash, basically your brain will go... and you do get people that will sit and stare out of windows. You need that stimulus...

Harry, 56, volunteer, Tulip Tree

Efforts to maintain an active lifestyle point to the enactment of a representational project which focuses on community participation. Such a project of support will be

further discussed in Chapter Five. Suffice to say that, at this stage, pervasive images of old age as a time of deterioration and passivity have been challenged by clients and practitioners (Hummel, 1998; Jesuino, 2014). These findings corroborate previous studies on emerging representations of ageing as a period of positive gains, activity, and community participation (Nascimento-Schulze, 2011; Quéniart et al., 2012). Consequently, both clients and older volunteers resist common negative public views of old age as a period of decline, passivity, and physical and cognitive deterioration—images present in Western mass media, arts and literature (Jesuino, 2014; Robinson et al., 2007; Wainwright & Williams, 2005). Instead, they construct their identities as *active agers*, as individuals involved in a project of wellness which is characterised by a functional and active lifestyle (Twigg & Martin, 2015). According to Moscovici (1988), these largely shared views—hegemonic representations—become emancipated in the lived experience of older people. In this way, their understandings of well-being as a consequence of an active lifestyle are used to recreate the way in which they see themselves in community settings (Freitas et al., 2013).

Nevertheless, it is important to reiterate that the thema activity-passivity constitutes a continuum in participants' representations. Their representations are not clearly defined as positive or negative, but rather involve complexity and both positive and negative elements. In this case, clients make sense of their experience of wellness as a continuum with both positive and negative dimensions interacting with each other. Attention is given to both self and body in their attempts to preserve functionality. Rather than an idealised view of activity—with a focus on productivity—participants allow the presence of limitations and frailty in their representations of wellness. This indicates clients' resistance to make sense of ageing well without the presence of frailty (Bowling, 1993, 1999; Holstein & Minkler, 2003; Strawbridge et al., 2002; Walker, 2002).

Moreover, clients' views pose a challenge to the moral orientation of *active ageing* policies as expressed in European contexts (Foster & Walker, 2015; Stenner et al., 2011). Productivity is not a sphere of ageing well according to clients. Similarly, clients' perspectives on well-being are broader than the functional model of *successful ageing* (Rowe & Kahn, 1997) for allowing physical limitations to be part of their experiences of ageing well. As discussed in Chapter Two, there is a need to comprehend ageing well from the perspective of frail groups (Bowling, 2008, 2009; Holstein & Minkler, 2003; Walker, 2002).

4.2.1.3 Active engagement with life

Clients also represent well-being as an outcome of a daily engagement with life. Performing household tasks, walking, shopping, and driving all seem to contribute to a feeling of satisfaction with life. Daily management of domestic tasks is reported to be an important indicator of mental health amongst the elderly (JSNA, 2012; Stuart-Hamilton, 2012). In this context, social support for daily tasks and promotion of independence are considered important elements in mental health promotion (DoH, 2001; Bäumker et al., 2012).

In this study, clients reflect these professional and societal goals in stating the importance of functionality on a daily basis. These findings also corroborate previous research on the value of unpaid activities in promoting a sense of wellness in later life (Boudiny & Mortelmans, 2011; Clarke & Warren, 2007; Ranzijn, 2010).

R: In your life Jenny, what makes you feel happy and satisfied?

P: When I'm cooking, you know I like to cook as well, and seeing my friends, and going out and about. I wouldn't know what to do if I had to stay indoors all day.

Jenny, 81, client, Aspen

I'm not really a strong person, but I make myself do things, you know, because I don't believe in just lying down and, so I keep my little house tidy and I put all my pictures up and I walk out to the little shop next door and go into cafes ... and then I go across the way and talk to this other man, you know, and get a spare loaf of bread or something like that, but I do it, but they said they'd do it for me, but I make sure I can do it.

Victoria, 66, client, Field Maple

In the context of recent policy developments, particularly associated with the concept of *active ageing* (EU, 2012; WHO, 2002), older adults' representations constitute important markers of what sort of active engagement brings satisfaction. In this study, active ageing means an active engagement with daily issues, and the ability to remain connected to previous social roles and daily occupations. If, on the one hand, European social policies advocate a meaning of ageing based firmly on a normative framework of participation and economic productivity (Foster & Walker, 2015; Walker & Foster, 2013), on the other hand, older adults in community support share more modest views of activity. This was further supported by the absence of the categories of *work* and *paid job* in clients' social representations of wellness. Categories such as *work*, *paid job*, and *career* have been found to be salient in social representations of wellness held by younger generations (Moreira et al., 2015). Absence of the category *work* in the representation of active life may also be a result of the advanced age of most clients in this study. As a

result, this group tends to ascribe a different meaning to activity in advanced later life; one which reflects both their adjustments to daily issues and a cultural orientation towards healthy ageing.

Clients' representations also point to their efforts to prevent social disengagement. This is well explored in social gerontology, particularly within activity theory (Havighurst, 1961). In this context, the normative orientation to engage in daily tasks falls within the cultural narrative of activity and participation as the main values of the good life (Martin et al., 2015). Therefore, social disengagement and passivity are devalued within social *professional* and *lay* systems of thinking (Foster & Walker, 2015). In this context, the thema of activity gains considerable attention amongst clients. This is particularly relevant in the light of cultural changes in the meaning of *old age*. As discussed in Chapter Two, the *new gerontology* with its emphasis on functionality, and new social expectations for the elderly have brought activity to the centre of defining ageing well (Bowling, 2005; Holstein & Minkler, 2003). Thus, anchoring ageing and wellness into human activity becomes a necessity in common sense.

The emphasis on preserving functionality was also seen as important in the group of visitors. This group supports clients who are deemed more isolated and less functional than the ones attending the day centres. Again, passivity is associated with the category *old age*, whereas an active lifestyle challenges this stereotype.

... But the way I look at it, if you are 90 years old, you may as well keep doing what you are enjoying because, you know, you are not gonna live forever at 90, and do what keeps you happy and, you know, if it causes her... not [to] feel as well, still she needs to do it because it's something that is important to her. And I

never tell someone that they are old, you should take it easy. They know when they need to take easy, you know, just keep doing what you are doing.

Michelle, 69, visitor

Now, the chickens give Rob [client] a lot of pleasure. I think that gives them, that gives him a sense of doing something, mhm, being able to get out and he will feed the chickens, he will collect the eggs... it gives him something to do without sort of having, you know, totally to be caring for Julie.

Mary, 59, visitor

In the second account, the volunteer emphasises how daily activities can provide support against the background of dementia caregiving. She visits both a husband who is also a dementia caregiver and his wife who is in an advanced stage of dementia. During that interview,⁴⁴ the caregiver constantly stressed the full-time commitment of caring for his wife and the burden associated with it. In that context, the volunteer stressed that remaining functional through engaging in different tasks provides respite and a coping strategy to deal with the experience of full-time care. Contrasting this view, the family caregiver/ client placed more value on actions to promote respite from his care activity instead of an active daily routine. He puts it clearly thus:

If I will be honest ... if I get a break every, every three months, if she does go into a home, where she's been now, I think she likes it, it's a nice place. And I was going away for a normal week, that puts ... revitalises me. I felt ... you know; I've

⁴⁴ Despite the methodological decision of not including family caregivers, in this example, I included this participant for his double role as client/ family caregiver. He also benefits from the visits. Therefore, he was also included as a client

got some more strength in my own. And that's the only what I would say, yes, that's something I would really want.

Rob, 92, client, Visiting Scheme

In this case, that client acknowledges his need to be supported in daily life, particularly in caring for his wife. Respite and rest is privileged over activity due to his specific care needs.

4.2.1.4 Participation in the community

Well-being is also seen as the outcome of being engaged with neighbours, family members and fellow older adults. The realisation of being helpful, of participating in society or contributing to people's lives is relevant to life satisfaction and the reinforcement of an active identity. Again, these views parallel the WHO's (2002) framework of active ageing. At a policy level, activity ought to be translated in opportunities to participation in different domains of social life (e.g. political and economic spheres). In this ethos, different forms of social activity and participation are considered necessary to ageing satisfactorily (Foster & Walker, 2015; Walker, 2002). Therefore, clients emphasise their willingness to contribute either personally or financially, and giving back to society all care and support received. This form of reciprocity has been observed in sperm donors in France (Kalampalikis, Haas, Fieulaine, Doumergue, & Deschamps, 2013). In that study, reciprocity, manifested as the act of giving freely and giving something back to society, mediated a more personal satisfaction

in donating amongst French sperm donors.⁴⁵ Similarly, as discussed in Chapter One, reciprocity has been considered an important motivation for volunteering in later life (Stephens, Breheny, & Mansvelt, 2015; Townsend et al., 2006). Findings in this study also point to the value of reciprocity in enabling older adults to receive care while still maintain positive view of themselves—as participants in society (Breheny & Stephens, 2009).

I think... [older people] should have care, but I would encourage them to pay a little bit, for their own well-being, because then they know they're not living off the system.

Victoria, 66, client, Field Maple

Because I like, I like coming down and looking after other people as well from the lounge... because I want to give some care back. If you've been given care, you want to give it back.

Olga, 78, client, Field Maple

R:⁴⁶ And tell me John. Nowadays, what are the things in your life that make you feel well?

P: That make me feel well?

R: Yes, in your life nowadays?

⁴⁵ Kalampalikis et al., (2013) have also found that underlying French people's refusal to receive any financial compensation for donating sperm is the possibility of returning to society what they believed to be given to them naturally. This belief mediated a more altruistic approach to sperm donation.

⁴⁶ This interview occurred when I joined one volunteer from the visiting scheme. I also "visited" this client in the process of gaining consent and trust to ask him questions about the support he receives.

P: Ah, well it. I am able now to do what I couldn't do perhaps in the past. And that is, I can help people. And, which I do if I can. And the only way I can help people is, erm, give money. That is the only thing I have got to give.

John, 94, client, visiting scheme

Through participation, clients understand well-being as the result of an active lifestyle within community support (Campbell & Jovchelovitch, 2000). In this context, their views on participation reflect the moral imperative of an active citizenship presented in the active, successful, and productive ageing frameworks (Johnson & Mutchler, 2014; Lloyd, 2004; WHO, 2002).

Staff members and volunteers from the day centres and the visiting scheme stressed the value of participation in community settings. These groups are the most active in providing support to older adults. For some, community support enables clients to '*participate in something and feel as [if] it is worthwhile [...] a sense of achievement [...]*' (Carol, 51, staff member, Field Maple) or to participate in a reality that is not provided outside the realm of the day centre: '*[they] come out and it's the world*' (Ann, 72, staff member, Field Maple). Furthermore, staff members and volunteers in both settings justified their involvement in social support as a desire to participate in the community. Such commitment would serve as an important coping strategy to deal with loss of social roles as one progresses into later life or to the *retirement age*.

... everybody knows that, what makes people, not the old people, but just the rest of society happy, and makes people feel happy. It's doing, it's actually doing things for other people... that's what gets people, makes people feel more fulfilled and so, you know. It's something that is definitely two-way street.

Meryl, 66, visitor

... when you've finished work if you've been working full time it's easy I think and probably a lot of elderly people feel that as well, that 'cause you're working and it's taken up such a big part of your life, hasn't it? Er and then all of a sudden nothing. So, unless you've got lots of hobbies or whatever... but sometimes, for financial reasons, you can't do all these things... So, I think for older people the danger is that they just become isolated and they're stuck at home erm, perhaps don't see many people, erm... so that was why when she said that erm you know I thought 'oh yeah well that would be quite good'. I had thought of volunteering anyway, not necessarily with [this organisation], but that's sort of mainly the reason.

Sally, 67, volunteer, Aspen

The same representation underlies the reasons for clients and practitioners to participate in community support, one group in the role of supported, the other in the provider of support. Either by participating as supported or giver of support, both groups benefit from engagement in the voluntary organisation. However, the roles of *helper* and *supported* are blurred in the experience of some volunteers who also face physical and social challenges associated with ageing. As described in Chapter Three, the age range of volunteers varied from 26 to 89 years old ($M = 60$). Some of them have a long experience of volunteering in that organisation. Therefore, supporting others also serve as an important coping strategy to keep active and re-state value in old age.

R: Why is so important for your coming here?

P: Well, because, otherwise, 'What the f-.'. I was gonna say a naughty word. [laughs]... What in the world would I do [get] stuck at home, ... But, mhm, well I couldn't, I couldn't. I'd have to come here! If not, not here as a helper, as a bloody

member [laughs]...

Julie, 89, volunteer, Field Maple

This study corroborates findings from previous research highlighting the role of reciprocity in later life (Ward, 2014). Reciprocity in giving and receiving help has been shown to enable older people to negotiate their own need of help (Breheny and Stephens, 2009). Older people may negotiate and accept their need of help if they realise their potential to give support to others in need. Giving support thus contributes to reinstating a positive identity, retaining a sense of self-worth, and to accepting their own need for help (Barnes et al., 2014). The attempt to preserve a positive identity is also at the centre of older adults' participation in social life. *'If I could honestly feel that they [children] could say, 'she was good old mum, weren't she?' This is alright by me. I don't want any more than that'.* (Martha, 84, client, Tulip Tree). In so doing, they renegotiate meanings about old age and refuse to be categorised as *old* and *passive* individuals. Identity work is thus at the core of representing well-being in later life.

4.2.1.5 Identity work in representing well-being in later life

The hegemonic representation of ageing as a period of activity and participation in society has an impact upon how clients enact their identities. Overall, clients see themselves as active and independent agents. Ageing well is thus seen as a result of active and functional older adults maintaining their space and functionality in society. According to Marková (2000), the enactment of themata involves the formation of new identities. Thematising and representing socially relevant concepts such as dignity, mental illness, AIDS, positive ageing, and the body, mediate new orientations of the self

(Jodelet, 1991; Joffe, 2003; Berger, 1996, as cited in Marková, 2000). In this specific case, the ideology of *new ageing* as expressed by the active ageing and successful ageing frameworks constitutes a normative context for the development of *active identities* (Sánchez & Hatton-Yeo, 2012).

Clients negotiate this active identity in their daily routine of activities (e.g. *I'm not really a strong person, but I make myself do things*, see quote on p. 119). Their efforts to keep themselves functional and active reflect their daily attempts to enact a positive identity (Quéniart & Charpentier, 2012). In so doing, they refuse to be categorised as passive, frail and dependent; in other words, they refuse to be defined as *old*.

... on the whole I'm fairly fit, which I'm fortunate, but, that, that is what... keeps me going, keeps me happy. If, if I'm at home because I've got a bad cold or something like that and I feel miserable [laugh] then, but, because I can't get out. You know, so, when, when I can't get out, I can imagine I shall be [a] miserable older, old lady [laugh]...

Betty, 83, client, Field Maple

The last thing I want to do is to go into a sort of stupor. [laughing] I am slipping into that, but I am trying to fight it.

Sarah, 82, client, Field Maple

Older adults in community support are not immune to the detrimental effects of negative representations of ageing. Public views of later life, particularly associated with *passivity* and *burden* force clients to renegotiate their views of themselves and challenge these representations (Howarth, 2001). In this case, *being old* and *inactive* constitutes a

spoiled identity (Goffman, 1963), which is resisted by clients in their daily community experiences. Identity protection has been a salient feature of social representations, particularly in more marginalised and less powerful groups (Joffe, 2003). As explored in Chapter Two, an ideology of *decline with age* has been predominant in public images of ageing (Gullette, 2003). Older adults are constantly confronted by negative stereotypes and social expectations associated with ageing, the body, and their value in consumerist societies (Covey, 1991; Jesuino, 2014; Kelly et al., 2016). Against this background, clients assert a positive view of themselves by assuming an active lifestyle and stressing the need to be independent. In this case, pervasive stereotypes of ageing, often objectified in the images of *doddering but dear* (Jesuino, 2014; Pike, 2013) are resisted by clients in community support.

In clients' views, old people are always *others*, and old age is always *out there*. Joffe's (1995, 1996a) study of social representations of risk corroborate findings in this project. In Joffe's study, different social groups represented HIV/AIDS as an experience of *others* (or out-groups), therefore protecting the in-group status and identity. In this study, an active lifestyle and community support seem to delay or even prevent older clients from subscribing to the social category of *old*. On the one hand, clients adopt more positive views of ageing to challenge ageism and lack of participation in society (Nelson, 2004; Ylanne, 2017), on the other hand, they subscribe to another form of anti-ageing ideology (Haber, 2002; Westerhof & Tulle, 2007). Frailty and bodily limitations are not considered meaningfully in their experiences of ageing well. Understanding ageing well as an active lifestyle therefore constitutes one of the main socio-psychological processes of symbolically coping with the ageing process and constructing it as a positive experience (Toepfer, et al., 2013; Wagner, Elejabarrieta, & Lahnsteiner, 1995).

The social representation of ageing well as a function of an active life and the social identity which is developed concomitantly are held by clients across all settings. As discussed above, this representational field and identity work emerges in the context of making sense of new concepts of ageing and wellness. Amongst volunteers, social representations of active ageing are behind their justifications for giving support.

R: What do you think motivated them to be engaged with volunteer work?

P: I think we are there, again, they want something to do, a lot of them, you know, because we all like to be active, you know, because, you know. I feel so sorry for my age group, because they've got nothing to do, you know, they just die of loneliness and boredom. Just sitting home like this, you know.

Julie, 89, volunteer, Field Maple

R: What would motivate people in general to volunteer, to visit elderly people from your view?

P: Hum, I suppose they feel like they would like to give something back to society...

Terry, 68, Visitor

R: Jennifer, just in simple terms when did you become a volunteer? How was the process?

P: Erm, it's about a year and... I wanted to do something in the caring type role because I've spent my whole career in that sort of role erm but since I retired which is... six years ago I haven't really done anything like that.

Jenny, 66, Visitor

Volunteers pursue an *active identity* by maintaining an active role in support. This social position differs from the less empowered one of older adults as recipients of

support. In representing voluntary work as a way of ageing well (and actively), volunteers position themselves as givers of support. This creates a new different set of roles and power positions within this organisation, particularly between older volunteers and older clients. Considering that identities 'can be construed as points or positions within the symbolic field of culture' (Duveen, 2001, p. 257), volunteers establish their place as active agents of support. In so doing, they follow cultural aspirations of ageing well and, at the same time, benefit from being involved in reciprocal care relationships (Ward, 2014). Nevertheless, as Jovchelovitch (1996) states, 'some groups have a greater chance than others to assert their version of reality' (p. 127). This points to the power imbalance between staff members/volunteers and clients in representing ageing well. In this context, top-down policies of active ageing and an emphasis on independence as a core element of well-being take priority over clients' definitions of well-being in local settings. Power relations may explain the largely acceptance of such views amongst clients.

Nevertheless, clients also voice context-specific views on well-being. They constantly negotiate their meanings of support and wellness in relation to the ideologies of active ageing and wellness. Similar findings were shown by Foster's (2007) ethnography of mental health service users. Users had to negotiate their labels and identities in relation to more dominant (and powerful) representations of mental illness held by mental health professionals and the public. In the context of mental health provision, differences in social positions and defining mental illness may have a negative impact upon the clinical relationship, disclosure and treatment (Howarth et al., 2004). On the other hand, this study shows that staff members and volunteers identify themselves as 'suitable helpers', which may better enable clients to welcome support. This representation was also shared by clients who trusted in staff members' and volunteers' constructed expertise to provide support. Although this may have contributed to

undermining older adults' social positions in the community, these representations mediated positive relationships in community support.

Another aspect is evident: wellness is understood in relation to others. Social comparison is at work amongst those clients who constantly compare themselves with others who are less fit. Clients distance themselves from the category *old* by projecting to *others* frailty, dependence and passivity. Old age is something which characterises others, not themselves. *Otherising* health issues such as mental illness (Jodelet, 1991), AIDS (Joffe, 1996a), and old age seems to be at the core of dealing with threats to the self. In so doing, social groups and individuals protect their identities from stigma and negative consequences of being labelled old.

R: What in, what can promote well-being for older people in general?

P: Well, to keep occupied, uh, to, to keep active, if possible. Now, it's difficult for me to say things like this, because then I come to a place like this, and I see somebody like Mike, who is, on the whole, cheerful. But I mean, there he is in a wheelchair, been in a wheelchair all his life, just about. And uh, and Mark, little Mark, he's got the same as me, which is Macular, ... he's also very deaf, I think.

Clara, 95, client, Field Maple

R: In your daily life, what things make you feel well?

P: I think just as I said, being able to get out and about, if anybody, because I am still well. I think that I almost always try to help anybody... I would say, with Becky, because she can't see, then I will read her letters for her. And you know, it's just the simple thing to do, but it helps her, and I think well I am able to do things like that... That helps, it makes you feel better yourself. Because if you see

people not well, you feel [laughs] you are so fortunate, if you can get out and about.

Claire, 90, client, Aspen

The process of social comparison has been shown to be a common social-psychological mechanism in which individuals engage in to assess their life satisfaction (Ryff & Keyes, 1995). The anchoring of old age to *otherness* (Joffe, 1996) is objectified in the association of age with passivity, dependence and burden; hence, clients' refusal to depend upon family members and close neighbours. On the other hand, anchoring ageing well in an active lifestyle brings value to their selves, given the socially validated norms promoted by major health and public health policies. In this context, another core value is entwined in this representation of active ageing, namely the pursuit of independence in later life.

4.2.2 Thema: independence-dependence

The second binary opposition in participants' conceptions of well-being is *independence versus dependence*. The dichotomy independence-dependence may be better displayed as a continuum. Such an ideal state of autonomy is not possible due to physical and cognitive constraints related to age. Therefore, volunteers and staff members do not depict a clear-cut definition of being dependent or independent in later life. On the contrary, they affirm that clients experience both poles. Nevertheless, there is an orientation towards a more autonomous lifestyle albeit frail and supported by others. Independence is regarded a central component in people's subjective evaluations of ageing well (Knight & Ricciardelli, 2003). This thema refers to the centrality of

independence as constitutive of older adults' identities. Thus, in order to enact these normative orientations, older adults engage in different strategies to accept/give support as well as maintain a positive evaluation of themselves.

4.2.2.1 Well-being via keeping oneself independent

Independence is an important component in older adults' representations of well-being. In this case, an idealised state of independence is projected in their representations. Such views were salient in the group of clients whose physical and cognitive limitations threatened their participation in the community. Here, their understandings of independence related to being autonomous in taking decisions and being able to move across different social settings.

Well, psychologically... while I can keep active [laughs] you know. I don't know whether I'd be quite so good if I, if I couldn't get around, and be independent. That would make me feel a bit more depressed, I think.

Becky, 83, client, Field Maple

R: What is well-being for you?

P: Well, the fact that I can still [be] mobile, I suppose. I can go out when I like, I mean, when I like. But the main thing is I can still do for myself, which a lot of people of my age... cannot do for themselves.

Jess, 82, client, Aspen

R: What is 'being well' for you? How do you feel that you are well?

P: Because I can do most of the things that I like to do.

Clare, 88, client, Tulip Tree

Similar findings were evident in Quénart and Charpentier's (2012) study of representations of ageing well in three generations of older women in Quebec. In that study, independence, as expressed by an active involvement in social life, constituted a central component of *successful ageing*. Indeed, it is not surprising that clients regard independence as a core aspect of their daily life. Physical limitations, social isolation and loneliness are the main threats for those unable to move socially. This explains the value placed on mobility and autonomy as safeguards to prevent deterioration and social isolation.

4.2.2.2 Preserved functionality

This subtheme refers to the notion of independence as a functional state. One is independent when able to perform physically daily. Therefore, it also involves being physically mobile and moving across different settings. Functionality is regarded as a central domain in professional models of successful and active ageing (Bowling, 2009; Rowe & Kahn, 1997; Tate et al., 2003), and in social gerontology it has been associated with life satisfaction (Bowling et al., 1991). This subtheme is also present in the theme activity/ passivity and relates to the way in which clients perceive themselves, particularly how they reassert an active identity.

R: What does being independent mean for you?

P: I got a scholarship to grammar school, that made me feel independent, you know. I'm a spiritualist medium, that helps. And um, it's nice for anyone to know they've got a gift that a lot of other people haven't got.

Clara, 78, client, Field Maple

P: No, I'm very independent. Yeah. I love to do things for myself. I couldn't have my daughter waiting on me.

R: Nice. What kind of things do you usually do?

P: I read a lot and I love to cook. I do a lot of cooking.

Jenny, 81, client, Aspen

A sense of continuity in social roles is evidenced in the extracts above. Functionality is relevant as long as it enables clients to maintain a view of themselves as active agents in society. Again, this representation parallels the cultural expectations that older people will preserve their functionality and active lifestyle in society (Twigg & Martin, 2015). In this study, clients' emphasis on functionality also corroborates the psychosocial models of eudaimonic well-being (Ryff & Singer, 2008)) as well as the preventive and proactive model of stress management (Kahana & Kahana, 2003). As discussed in Chapter Two, autonomy and environmental mastery have been considered core aspects of ageing well in the aforementioned frameworks (Hahn & Oishi, 2006; Ryff & Keyes, 1995). Paralleling these perspectives, clients' social representations of activity as a condition to ageing well set a normative focus on functionality as an important life goal (Kahana & Kahana, 2003, cited by Kahana, Kahana, & Kercher, 2003). Moreover, clients' representations of well-being as a result of autonomy to take decisions, and environmental mastery highlight the importance of the socio-psychological processes of adaptation and identity formation in well-being (Ryff, 2013).

In the extracts above, clients also emphasise the importance of not relying on significant others (e.g. family members, community workers, and neighbours). A functional status expresses an independent lifestyle. The same representation is verified in volunteers' opinions of their clients in both day centres and the visiting scheme.

R: What do you think makes elderly people feel independent in their lives?

P: Independent. Only if they can do things, darling, that's all. You know, if they can do a bit of cooking, I think, do their own washing and, because, women are ... they used to do all that sort of thing. When you can't, it's very frustrating. Because that sort of has been your main sort of problem, you know, activity in life, that in shopping and, you know, looking after other people. And, suddenly that's all [gone], you know, you can't do it.

Julie, 89, volunteer, Field Maple

As discussed above, an active identity is negotiated and enacted through management of daily tasks. Satisfaction with life and positive affect are attached to their perceptions of an active self. When asked to rate their clients' level of independence, volunteers from both settings anchored their assessments in the ability to function daily. Shopping, cooking, reading, and doing household chores are seen as signposts to a preserved health and functionality. These views parallel clients' representations of well-being as an active engagement with life, as discussed above. This corroborates a hegemonic view of ageing well as a reflex of an active lifestyle. Furthermore, staff members and volunteers subscribe to local frameworks of community care which establish domestic tasks as markers of mental health (DoH, 2001). Such commonality has implications for the way in which staff members and volunteers promote and assess well-being. A social model of care gains preponderance over a biomedical framework of wellness in voluntary work. Voluntary sector practitioners are aligned with major policy orientations in the UK regarding well-being in later life (DH, 2005; 2006). In this context, staff members and volunteers stress the value of services with a focus on maintaining independence of older adults and enhancing their choice and autonomy. Nevertheless, as

will be discussed below, this idealised functionality and the preponderance of independence are challenged by bodily and cognitive limitations. According to staff and volunteers, one is not capable of being functional (independent) unless assisted by the community.

4.2.2.3 Independence reflects an autonomous being

Another sub-theme associated with the positive pole of the dichotomy independence-dependence is *autonomy*. Independence is seen as the possibility of being in control of different aspects of life (time, activities, friendships, etc.). On the other hand, clients emphasise the negative attitude towards dependence often objectified in expressions such as *waiting on others* or *relying on* significant others (family members and neighbours).

R: How important is it for you to feel independent in your life?

P: Vitally I think. If I had to rely on somebody to do absolutely everything for me, like my younger sister is, stuck in bed in a nursing home, I would hate it.

Clare, 88, client, Tulip Tree

Staff and volunteers also shared this representation of well-being associated with an autonomous status. However, the idealised state of autonomy depicted by clients is not shared by community supporters. They tend to see autonomy as a desirable but not fully-achievable state, given the level of support older clients need to maintain themselves as active in the community.

And I think it's definitely nice for people to feel they have elements of independence certainly, isn't it? It's you know, it's very good for your

psychological well-being to know that 'oh, if I want I can do that, if I want I can just pop down to the shop' ... So, it's definitely nice to know you have the ability to be independent I suppose if you are dependent in one area of your life it's nice to be ... have a feeling of independence in another, but yeah it's not as straightforward as

Amanda, 35, volunteer, Field Maple

Despite the hegemonic representation of well-being as a function of an active lifestyle held by all groups, differences are observed in the way in which they position themselves. In this case, clients, staff members and volunteers diverge in their meanings of independence and dependence in later life. Such constructions have an impact upon participants' social positions and identities in community support.

4.2.2.4 Construction of an independent identity in later life

More than expressing a need to keep themselves functional, a preserved level of independence serves to establish a positive sense of identity in later life. Both groups of clients and voluntary sector practitioners acknowledge independence as a constitutive component of a positive view of self and, thus, of wellness in life.

R: Do you see yourself an independent person, or a dependent person?

P: Well, independent, I suppose, because I look after myself on the whole. I was a State enrolled nurse (..). I worked at Addrenbrooks for a while. Have done all sort of things, things...

Joy, 70, client, Field Maple

I've always been taught to encourage independence at all costs...

Yeah, [just] don't do things for people if you know they can do it for themselves.

Laura, 72, staff member, Field Maple

Dependence is resisted and an active identity is enacted in the context of day centre support. Rather than a functional state, independence is an expression of identity in later life. It is thus inherent to the personal narrative of each participant. Nevertheless, this ideal representation of autonomy is challenged by the day to day trials faced by some older adults: physical limitations, financial constraints, cognitive problems, family control over finances and leisure, and limited mobility. As a result, a perceived loss of functionality and autonomy is seen as a threat to an individual's identity. It is mostly manifested as a form of ambivalent thinking, a conflict between a previous (and more active) way of being and a new and more limited mobile life.

4.2.2.5 Ambivalence towards dependence

Depending on others may be a challenge to clients' social identities. Older adults who see themselves as independent may be challenged by the experience of social support and help. The ambivalence present in clients' accounts is expressed as a form of polyphasic thinking. Contrasting views of oneself are at play in participants' daily interactions with social support. They acknowledge both dependence and independence as common features of their experience of ageing. Therefore, one cannot be totally independent given the bodily and cognitive limitations experienced in later life. Here, the continuum independence-dependence represents an ambivalent relationship between *mind* and *body* in clients' views of their functionality.

I feel sort of, I don't wanna do nothing, I can't do nothing on my own. I want somebody to guide me, to help me; but, then, I sit there sometimes and say 'Why should I let other people do things for me while I can do [them] myself?' And then, another thing is telling me 'No, let somebody else to do, somebody else do for you.' So, you've sort of like got two minds: one saying 'Do it!' And the other one saying 'Don't do it!'. And it is a choice on which one... I am gonna pick.

Bob, 65, client, Field Maple

I am master [of] everything, yeah. I can go up the pavement, but the trouble is I can't go in a wheel chair to the doctors, not until I've got somebody with me. I can't cope with that, I can't cope with that, I've got to give in.

Caroline, 89, client, Tulip Tree

4.2.2.6 Coping strategies to maintain a positive identity

Clients and voluntary sector practitioners come up with two different, but interrelated strategies, to undermine the ambivalence of dependence and reaffirm an active identity: *negotiating independence (symbolically)* and *assisting independence*. Figure 3 displays the interconnections between these symbolic and social actions and the complexity of issues faced by both groups involved in community support.

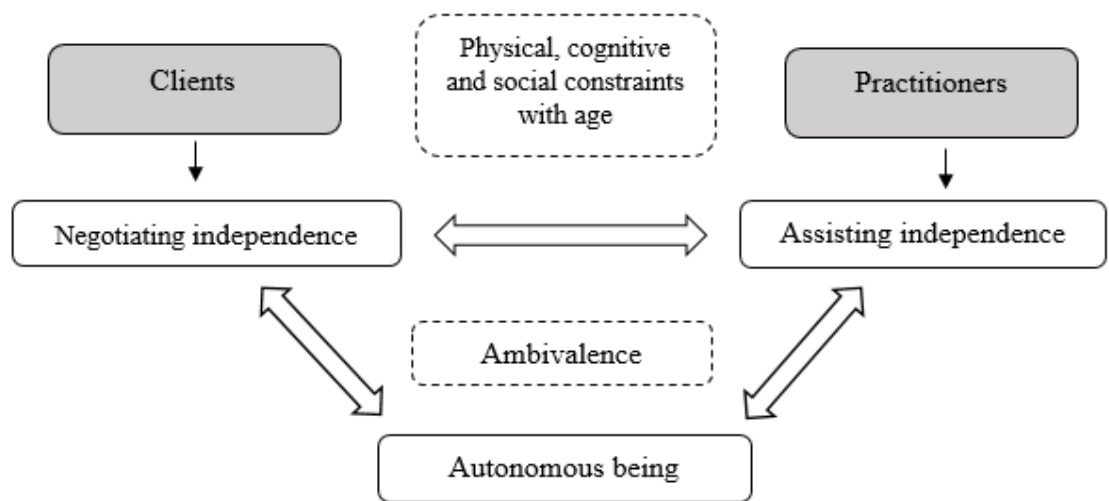


Figure 3: Identity negotiation to affirm an ‘independent self’ |

4.2.2.6.1 Negotiating independence

Clients represent dependence and care as aspects that are out of their control and over which they do not have the power to decide. However, they still hold a sense of independence, mainly related to autonomy in decision-making. There is a sense of support via reliance on family and friends. In spite of the fact that clients see independence as non-reliance on others, their relationships with family members entail some level of dependence. In this context, they negotiate their views of themselves in order to maintain an active identity while allowing a certain measure of dependence.

R: Do you see yourself as independent in your daily life?

P: To some extent, yes, because I can do a small amount of shopping and once a week my son takes me [to] a big supermarket.

Betty, 83, client, Field Maple

R: How do you feel when you see you can do things by yourself?

P: Well, I just think I am glad I can do things by myself, you know. I am not like some people [who] got to have people into doing things for them. I mean, I have a carer everyday but that's not of my power. Erm, but just to make sure that I take my tablets.

Hillary, 84, client, Aspen

Clients negotiate the amount of support they perceive as necessary. Such support may be seen as a *top-down* decision; however, they do not regard it as a threat to their *autonomous being*. Dealing with daily affairs, adapting to physical demands, and allowing family members and neighbours to provide support (if needed) are some of the negotiated actions clients reported during my interactions in the day centres and the visiting scheme. Moreover, there seems to be a difference between *receiving help from carers* and *receiving help from others*. The former category involves a more consumerist and active social role, whereas the latter entails passivity and dependence.

P: I do worry about other people, yes, I don't want to put them to any trouble. If you understand what that means?

R: What kind of trouble do you put them?

P: Well people have got... like here... but it's alright here because they're getting paid for it. But people in everyday life...you know, you don't want to bother your neighbours and that sort of thing. Because you have to when you can't do a thing on your own, I mean I was a lively, as I say, 90-year-old. I was dancing every week, going away on holidays. Now I can't do any of that. But I'm trying to make

the best of it. I can see people worse off than me. But I'm afraid I'm losing my sight, and then I will have to go in a home.

Helen, 93, client, Field Maple

Similarly, one day centre volunteer acknowledges the need to negotiate practices of support with clients. Behind this concern is the fear of associating ageing with decay and vulnerability. The ambivalence is not completely removed through their actions of support. In fact, volunteers face ethical dilemmas in promoting support. The policy ideals of activity, independence, and autonomy are challenged by the acknowledged need to support frail clients. In this context, care and dependence is a necessary dimension in community support (Ward, 2015).

... even when you are meaning well sometimes, maybe you could come across as patronising. But these are, you know, that lived a full life, aren't they? And had a lot of experiences, and suddenly they are just seen as kind of old, and vulnerable, and need looking after. And I think it is a really difficult balance to get that, they are still independent and in charge of their own life, but they are looked after at the same time; and, look out for ... without someone feeling kind of threatened by that.

Paula, 48, volunteer, Field Maple

4.2.2.6.2 Assisting independence

As discussed above, independence is defined as a state of autonomy regardless of functional limitations. However, one is not able to enact such an identity unless supported

by the community. This view was largely shared by staff and volunteers from the visiting scheme and the day centres as a form of justification of their actions of support.

... yeah you can be as independent as possible, you still need some sort of support to keep an eye on you to make sure you are not being abused you know... If it was me I would want to be as independent as possible in my own home as much as possible...[but] if I was at a stage where I had mobility problems I would still need a carer to come in and watch over me.

Harry, 56, volunteer, Tulip Tree

Independence is seen as a function of social support. Volunteers and staff members regard their work as necessary to enable older adults to live independently in the community. Without social support older adults may not be able to continue their participation in the social sphere.

And I think it is a really difficult balance to get that, they are still independent and in charge of their own life, but they are looked after at the same time...

Paula, 48, volunteer, Field Maple

That would be to me like what, independence means, it doesn't mean you do everything yourself, it's having that, having that support around you and then, being able to ask for it, if you need it.

Laura, 26, visitor

Clients also define themselves as independent regardless of depending on others for certain tasks. They do not relate this level of dependence to their identities. For instance, in the next extract, one of the clients stresses her independence in her daily life, despite her need of using a wheelchair. Her definition of independence was mostly related to *being autonomous* in making some daily decisions.

R: Definitely. So, how do you see yourself? Do you see yourself dependent or independent?

P: I live independently. But, everything is laid on, you know, my meals. So, just like here, right? You know. Go in a meal time ... And I can please myself when I come here, and go out. I am not restricted.

Ailsa, 89, client, Aspen

Overall, clients perceive independence differently from the voluntary sector practitioners. Clients see themselves *independent despite the presence of support*, whereas staff members and volunteers see the older adults as *independent via support*. This negotiation also has an impact upon people's well-being—the fact of seeing oneself as independent, although in need of assistance, brings security and a positive sense of identity. Furthermore, the idea of independence relates to their ability to decide on daily matters and use their minds to counterbalance physical limitations. Independence is not located in the body, but in the mind, that is, in people's conscious awareness of their reality and ability to make autonomous decisions. In clients' views on independence, the mind-body duality is better described as a dichotomy of the *young mind* and *the old body*. In this case, autonomy and agency take preponderance over mobility, vitality, and physical health as markers of independence. For instance, one may be considered

independent regardless of their level of mobility and functionality. On the other hand, loss of perceived control over life, mostly manifested by cognitive deterioration, implies a state of dependence (regardless of fitness and mobility).

Mhm, I think she is dependent, erm, physically, because she can't do anything, but independent in her own mind and quite OK with that.

Meg, 67, visitor

Mhm, yeah, I think, if you talk to anyone of them they will say, 'Can I have new legs?' Because they know in their minds they can do a lot of things, but it's just their bodies. So, they are never gonna be a hundred percent independent, you know... most of them need [a] little help with something.

Katie, 53, staff member, Aspen

Here, the mind and the body are intertwined in enabling or hindering independence in later life. This complex relationship calls for negotiating identities and actions of support in later life. Well-being is a function of such dynamics.

4.2.3 Thema: generalised wellness

Psychological well-being is also seen as the product of the interaction between emotional, physical, and social aspects. In this context, clients and voluntary sector practitioners extend their concepts of well-being to comprise health and quality of life. Again, this polysemy of concepts regarding psychological well-being challenges unidimensional and decontextualised frameworks of wellness (Steptoe et al. 2015; Ward,

2015). For instance, in the context of this study, a sole reliance on the constructs of hedonic well-being and life satisfaction would fail to capture the subjective, material, and social character of clients' understandings of wellness. Clients' representations hold a strong affective component for referring to complex life experiences (social isolation, support to daily tasks, physical limitations, good health). Nevertheless, their views challenge an individualistic emphasis on well-being as it is often presented by professional frameworks and policymakers: the self-fulfilled, independent, and active older adult (Arber & Timonen, 2015; DH, 2005, 2006). Instead, adaptation and recognition of limitations are important actions to reassert quality of life amongst individuals who face different physical and cognitive problems.

Beyond health, the physical body, and quality of life, well-being is also related to social relationships. The presence of social support is seen as a protective factor against isolation and deterioration. On the other hand, loneliness and social isolation are the main hindrances to participation in the community and receipt of adequate support. In the following sections, differences between groups will be explored, particularly in relation to local meanings associated with such concepts. Finally, adaptation will be discussed as a key symbolic anchor to deal with gains and losses in later life. Figure 4 depicts the organisation of meanings about a generalised sense of well-being according to clients and voluntary sector practitioners.

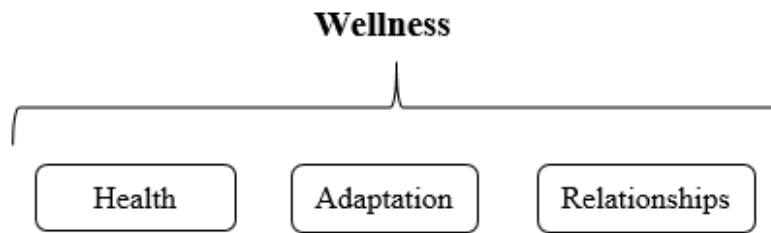


Figure 4. Dimensions of wellness according in later life

4.2.3.1 Well-being involves extended health

Health status is highly valued among clients and voluntary sector practitioners. In this case, well-being is possible due to a preserved health status. Nevertheless, participants stress that physical and cognitive limitations directly affect people's mobility and sense of autonomy in daily life; thus, preservation of health status is paramount. Similarly, studies on lay views of successful and active ageing point to a hegemonic representation of wellness as a preserved health status (Bowling, 2006; Jopp et al., 2015; Tate et al., 2013). Both groups share an understanding of health as a generalised state of well-being (Crawford, 1984; Flick, 2000). This ideal of health is reflected in the way they understand health progression with age.

Cognitive polyphasia characterises the content of these understandings. Clients and voluntary sector practitioners draw upon biomedical and psychosocial models of support to make sense of wellness in old age (Tate et al., 2013). Top-down policies and the immediate context of lived experiences in later life mediate the enactment of these different, and sometimes, contrasting views of ageing well. For instance, staff members and volunteers highlight the notion of health as a holistic state of mental and physical wellness. Their views are in line with well-being public health policies in the UK which

emphasise the connection between material, economic, physical and psychological aspects in people's health (DoH, 2014a). Considering that the voluntary sector has been recognised as a key partner in social and health care policies, it is not surprising that staff members and volunteers align themselves with the governmental frameworks of active ageing and well-being policies (DoH, 2005, 2006). Therefore, physical health and functionality are regarded as essential features of ageing well in community settings.

R: For you, what is well-being in later life?

P: Primarily, erm, health because, you know, as long as, as long as you are healthy then there is always something you can do.

Diana, 73, visitor

R: For you, what is well-being?

P1: Oh, as I said, 'enough' food and drink, and company coming. That's well-being to me. Yeah.

P2: And health.

P1: Oh, and health, yeah. Keep taking the pills.

Clara, 93, client, visiting scheme

Diana, 73, visitor

In the quotation above, both client and volunteer anchor well-being in a preserved state of health. Corroborating Herzlich (1973) and Flick (2003), one can observe a modern representation of health as a form of reserve. It is worth remarking that visitors stressed more the idea of health as a core element of well-being. This might be explained by their closer relationship with frail clients. Alternatively, visitors are instructed about what to

expect from clients and their role in supporting them. These might add to the understanding that ageing involves physical and social losses (which ought to be addressed by the visiting scheme). For these participants, absence of illness or disability is also related to wellness. However, health is also relevant to clients who attend day centres as one client at Tulip Tree clearly puts it, ‘... *I think if [your] health is right then you can honestly say ‘oh yes, I really haven’t got anything’’* (Martha, 84). Such understanding is not only associated with their experiences of physical and cognitive limitations, but also with a desire to maintain functionality, corroborating what was previously discussed about clients’ active identities.

4.2.3.2 Well-being is a holistic state

Volunteers and staff members stressed the notion of well-being as an overall quality of life. This refers to an idealised concept of health in which physical health, financial resources, life satisfaction, and social support are important factors. These views resemble the WHO’s (1997) framework of quality of life which extends health beyond physical or mental states.

As long as I am healthy and my mind is good, fine, that I turn 96, but if I start having all sorts of problems, physically and mentally. Do I want to be around until I am 100? ... If I am not healthy, and I don't have the quality of life I would like to, and I think that affects a lot of older people... I am 64, but I think, ‘Do I really want... that and not have a quality of life?’ You know, as long as you are enjoying life, you are healthy, it's fine, but I see so many elderly people that don't have that quality.

Laura, 64, visitor

This volunteer sees old age as a project for the future, a project that although resisted, ought to be lived with quality. In this sense, longevity is not a defining characteristic of positive ageing but the possibility of experiencing life satisfaction, functionality, and a positive health status. Furthermore, a sense of well-being operates as a protective factor against potential losses in cognitive and physical mobility. This is clear from practitioners' understandings of potential problems faced by older adults.

R: what kind of problems come with a lack of well-being?

P: ... I say, poor health. Be it mental health, ill health or physical ill health because, erm, if you're mentally, erm, not feeling very well, then, it'll impact on your physical well-being because you'll probably stop doing things and therefore that will, because you're not doing things, then it'll impact on your physical well-being which will then erm make you feel worse mentally. So, it's like a vicious circle sort of thing ...

Charles, 51, staff member, Field Maple

This health-related conception of ageing well acknowledges biological limitations as possible experiences in later life (Martin et al., 2015). However, it entails a *successful* way of ageing, one which involves preserved functionality. Thus, their understandings corroborate professional definitions of successful ageing, healthy ageing and quality of life for highlighting optimal (and normative) states of being (WHO, 1997, 2002; Rowe & Kahn, 1997). In this case health is a relevant dimension. Furthermore, the relationship between mind and body in well-being promotion is again enacted in the practitioners' representations of different facets of ageing well. In this case, psychological well-being is also translated into a holistic state, in which mind and body are interconnected.

4.2.3.3 Well-being as a healthy lifestyle

Clients are more likely to define wellness as a product of their healthy behaviours during their lifespan. In fact, they attribute the responsibility for ageing well to themselves—namely, a healthy lifestyle which they themselves have developed. Keeping oneself cognitively and physically active, eating properly, sleeping well, exercising, and maintaining a stress-free life are considered adequate actions to age with quality. Such actions reveal a representation of health and well-being as an individual concern. These ideas resonate with public understandings of ageing well as a synonym of an active, consumerist, and participative lifestyle (Blaikie, 1999; Ylanne, 2017). In the UK, media advertisements and literature have portrayed a new image of older people: active agers to whom health and social care are products of their power of choice and responsibility (Westerhof & Tulle, 2007; Ylanne et al., 2009). Moreover, health is determined by an engagement with a project of independence and participation, as promoted by the active ageing and successful ageing policies (WHO, 2002; Ylanne, 2017; Rowe & Kahn, 2015).

R: What do you think is most important, to live well?

P: Well, you've got to have good food I think, and then you've got to keep well. I mean, I never go to the doctors. I go to the doctors once a year to get a blood test and blood pressure... I can't remember the last time I went for something. But I do go every year just for a blood test and blood pressure, but they keep a check, you know.

Jenny, 81, client, Aspen

Yeah, of course it is. Yeah. I live healthy, I have fruit. Now, I have breakfast food. I am looking after myself. Everybody keeps saying, 'Look after yourself!' 'Oh, what am I doing in my life?' I said. 'Do I look bad? No.' 'Well... I must be alright then.' Yes, I do look after myself. Now, I am doing [well], since I've been coming here. I've got back up again. I ain't giving up.

Caroline, 89, client, Tulip Tree

In the first account, going to medical practitioners is seen as a sign of illness rather than health prevention. The second client places the responsibility for living with quality only on herself, despite acknowledging the help provided by the day centre.⁴⁷ The need for support may be overlooked as clients see wellness and health as their own responsibility. Social representations examined at the level of immediate social interactions (Duveen & Lloyd, 1990) reveal meanings shared on a macroscale. Current ideologies associated with *positive ageing* promote independent living as a way of reducing the burden of social and health care (Bowling & Dieppe, 2005; Walker, 2009). In Western societies, health and illness have been represented as a function of lifestyle (Flick, 2000; Murray, Pullman, & Rodgers, 2003). Consequently, these views structure the way in which older individuals respond to health issues. In this case, these representations bring a moral orientation towards a healthy functioning and the construction of a collective identity, as discussed above (Marková 2011; Smith, 2003).

The idea of well-being as a healthy and individual lifestyle challenges the scope of support within the day centre. This was particularly evident in the staff members and volunteers' representations of clients' level of independence. Even though staff members

⁴⁷ This client mentioned that she was referred by a doctor who thought she was experiencing depression due to bereavement and social isolation. She was overtly positive about the influence of the day centre in her life, helping her to overcome her sadness and the experience of loneliness.

draw boundaries on what they can provide as a voluntary organisation, they perceive their role as more vital than what is perceived by some clients. One of the day centres' drivers used the metaphor of *lifeline* to represent the support given to socially isolated individuals. In one of our meetings, Jack emphasised the benefit of the day centre in older adults' sense of wellness. '*So, it's really, really important that these day centres are kept open. It's not just a social thing. It really is [a] lifeline. It can be the only time they have contact with people*'.

This divergence in terms of responsibility for health and social needs could be explained by clients' identity work. The experience of illness, and cognitive and physical limitations may threaten their *active identities* as it demands further support and dependence. As a consequence, they seek to reaffirm an active and independent identity in later life. In this case, psychological well-being entails self-responsibility and protection for the self. Preserving autonomy constitutes a gain in later life, and might counterbalance their perceived loss in the physical domain. Furthermore, in order to preserve a sense of well-being, older adults refer to different adaptive actions. From accepting physical limitations, to adjusting to lower income, to focusing on preserved abilities, clients and practitioners also represent well-being as the outcome of adaptation. Pursuing wellness in community settings involves a continual negotiation of someone's abilities and participation in the social life.

4.2.3.4 Well-being is a result of adaptation

Adaptation has been suggested elsewhere as an important mechanism in positive ageing (Craciun & Flick, 2014). In this study, by adapting to different life situations, clients deal with the complex field of gains and losses that accompanies later life. These

results corroborate other studies which show that accepting life circumstances and adjusting expectation levels of satisfaction are positive measures to attain psychological well-being (Pavot & Diener, 2013).

Openness to new experiences and a positive outlook are regarded as necessary to cope well as Clara (95, client, Field Maple) states, '*But to, to feel well is to just accept what comes along and deal with it, and if you take that attitude, you just get used to it, don't you? Mm. You get on with it*'. In this way, clients represent losses of different kinds as unavoidable outcomes. Another client at Tulip Tree highlights the need to adapt to losses in social life: '*... and your loneliness ... you also got to live with it, you know, it's yours for the rest of your life. You got to live with it, learn to live with it, adjust to it.*' (Martha, 84) Therefore, they ought to adapt in order to maintain a sense of well-being and positive identity. Two main strategies represent this coping approach to well-being: developing a positive mindset and preserving a satisfaction with life.

4.2.3.5 Well-being is a positive mindset

Well-being is also associated with experiencing positive emotions and cognition. Both groups refer to a positive *state of mind and heart*, to be *happy* and *positive* despite physical constraints. In this case, the mind is preponderant in participants' representations of well-being. Conversely, the experience of sadness, anxiety and frustration defines someone's lack of well-being. Furthermore, feeling positive about life implies a coping mechanism to deal with physical losses.

What makes me feel well? When I'm happy. If I'm happy and I'm positive and I feel good and I'm not tired, ... as long as I keep positive, and think of the positive things I can do, and not dwell on what I can't do...

Victoria, 66, client, Field Maple

... if you're feeling really down then any slightest ache or pain is probably magnifying whereas if you're feeling well you probably don't even think about it and don't even notice some of the aches and pains sort of thing which is probably more prevalent when you're getting older anyway ...

Charles, 51, staff member, Field Maple

Both clients and practitioners emphasise the well-established relationship between mind and body in the representations of well-being in later life. Psychological well-being operates as a protective factor against experiencing pain and physical loss as one's body ages. Clients often stress positive aspects of their life experiences as another way of dealing with losses in later life. A sense of contentment with one's life, which also relates to adaptation, is seen as an important symbolic resource for ageing positively.

4.2.3.6 Life satisfaction as an indicator of well-being

Life satisfaction is also accommodated in clients and practitioners' representations. Satisfaction with life in the past and present relates to this concept. It embodies an important coping strategy for dealing with physical limitations and cognitive problems as well as personal financial concerns.

R: Yes. What is well-being for you?

P: For me it's just, I feel quite good about myself and I am quite satisfied with my life... and I don't think about what I can't do anymore, anything like that, I put it all under the cover and just care about what I do really now.

Jess, 30, client, Tulip Tree

R: ... What do you think is psychological wellbeing?

P: I would think of it as... feeling comfortable within yourself, feeling I suppose a feeling of contentment with yourself and your sort of kind of your position in life...

Teresa, 35, volunteer, Field Maple

The belief that satisfaction with life facilitates well-being is also related to coping strategies for dealing with life limitations. Expecting less from life was considered one important strategy for ageing well. As one visitor (Meg, 67), stated '*If you are OK. If you feel quite comfortable with yourself..., it's expectations. If you are expecting lots, then, I don't think you will get it*'. However, it is not always possible to be satisfied with present life, and in such cases, participants focused on contentment with life in the past as a form of symbolic coping with losses in later life. Older adults show a sense of closure in their life experiences, and a preserved satisfaction with their identities. Their narratives explore positive elements of their identities and life experiences, which help them to cope with difficulties in the present.

... my life is not finished. The best part of my life is finished... I was happy with it, very happy with it. So, now I have [am] dithering about on the back edge, [I am] dithering about on the back edge.

Martha, 84, client, Tulip Tree

I was a very, quite intelligent person, I won a special scholarship when I was a teenager, and I got my A levels and got my, erm, the next one, educational degree at the university. And erm, now I still can't remember what day of the week it is! But I am not grumping I just, I mean, I am 83 and I had a very, I married the right man, and two lovely children, and you know, I've been very fortunate.

Sarah, 82, client, Field Maple

The second account above describes how the client copes with dementia by reaffirming her identity in the past as an active, productive, and valued being. In recollecting significant memories of their life stories, clients do more than reminisce. They reassert relevant and positive aspects of their life experiences, regardless of their current situation.

4.2.3.7 Company as an indicator of well-being

Psychological well-being is not only seen as a function of positive emotions, life satisfaction, and adaptation to life. All groups integrated the value of social relationships, contact, and support in their definitions of ageing well. As one visitor (Laura, 26, visitor) mentioned, *'well-being is situated in your relationship with other people'*. Company operates as a protective factor against social isolation and mental health problems. It is

also linked to social recognition and social presence. Company operates as a protective factor against social death in old age.

R: What can promote well-being? What can make you feel well?

P: Just company, you know. I think, you know, people do need company. Well I do anyway. I think other people do as well.

Erika, 70, client, Field Maple

Older adults, staff members, and volunteers stress that companionship depends on *proper spaces*. They regard the day centre and the visiting scheme as the appropriate settings where socialising can take place. This theme was clear since the beginning of my fieldwork, when I was introducing myself and the purposes of my research to participants.

... I went further and introduced the theme of mental health in old age: 'I want to know what makes you feel well, what promotes mental health?' Then she said, 'Well, it is good to have a place to talk to people. When you are on your own you don't talk... I like to come here and talk.'

Fieldwork note, Week 3, 05.12.2013, Field Maple

R: What in your life makes you feel happy and well?

P: I just like going out. Going out [to] places, yeah.

Hillary, 84, client, Aspen

Places or spaces are settings that mediate social contacts and interactions between older adults. Staff members and volunteers anchor the relevance of their practices within

this conception of well-being as a relational feature. There is an emphasis on a more structured environment in the community; one which facilitates social interaction and binds people together.

... if I thought oh this person is showing me that they are psychologically well it would be someone who was ... in a day care setting, happy to talk to the people that they are sat with...

Teresa, 35, volunteer, Field Maple

Yeah, yeah. I think for me I would, mhm, I would want to know that there was somewhere for me to be with others, mhm, if I couldn't drive or get out, I would like to think that this organisation would provide something.

Meg, 67, visitor

Social representations of well-being in later life held by clients and voluntary sector practitioners challenge purely hedonic perspectives on happiness, which focus on individualistic standards of pleasure and life satisfaction (Ryan & Deci, 2001). Like Ryff's (1989c) findings on lay views of positive functioning, both groups seem to express an *others orientation* when they represent psychological well-being in later life. In this case, closeness in relationships with friends and family as well as spaces that promote such interactions are deemed necessary to age well. Clients' emphasis on an active and independent identity does not preclude them from establishing significant relationships via social support. As Julia (95), a client at Field Maple Day Centre clearly puts it, *'I'm not particularly, physically active, I'm getting old now, you see. But I like mixing with people, you know.'* Clients welcome social support as an indirect way of establishing social relationships.

Within the theme of well-being as relational, family relationships and support constitute important elements in older adults' assessment of well-being. Thus, family support is also regarded as a core sphere in community life. For some clients, family support is regarded as a symbolic group in their own life stories: family is part of their life narratives, identities, and daily interactions. *For instance*, help with daily issues (shopping, finances, walking etc.) and emotional support are some of the outcomes of family involvement in later life. Beyond daily support, family is regarded as an important part of older adults' identities.

R: ... What things nowadays in your life makes you feel well? Makes you feel psychologically well?

P: Well, the fact that I speak to my kids every day. That is the most important thing for me. And then, I speak, as I said, to my surviving sister...

R: Why do you think these are very important?

P: Well, because they are part of me, aren't they?

Helen, 82, Aspen Day Centre

R: What makes you feel well in your life?

P: What makes me feel well in my life. Well, I've got a brother for a start, and, well, when he is around I feel more, I feel more comfortable, that he is around... and my sister as well, she's been in part of my life as well... she is always here.

Bob, 65, client, Field Maple

Well I love to see my family. My daughter comes once a week. And she's very good - if I want anything or I want to go somewhere, she'll take me... I've only got to ask her...

Melina, 81, client, Aspen

Despite the absence of some family members due to demographic changes and loss of relatives, some clients perceived themselves as supported by family members. Distance was not enough to interfere in their views of family support. Clients seem to position their family members as their overseers. A form of *social support by distance* characterizes some of the interactions between clients and their family members.

... they are not with me, but they are always in touch, you know. We have conversations. And I know they are always there.

Claire, 90, client, Aspen

Contentment with being supported by distance may also relate to how clients socially represent themselves. Active and independent individuals—although in need of assistance—may regard family involvement as a contentious issue in their lives. Thus, they do not see family support over distance as a negative aspect of their experiences. Nevertheless, clients highlight the losses associated with social isolation and loneliness. For most of them, the experience of ageing in the community is not accompanied by adequate support or meaningful relationships.

4.2.3.8 Loneliness and social isolation in the community

Loneliness is expressed as a form of detachment from previous meaningful relations and locations. Family members, friends, and social settings are the main losses in later life. Loneliness is also seen as an outcome of different conditions: bereavement, mobility problems, and social isolation may have an impact upon social mobility and contribute to social detachment. Therefore, socialising and company via institutional support are seen as the main safeguards against the loss of social bonds in later life.

R: And, in general, with elderly people, what do you think are the main problems that older people face?

P: Loneliness is the main thing. You find people they commit suicide over loneliness, a lot of them. Cos they've got nobody to care for them or anything like that and they just feel very lonely, and that's a killer I think.

Jess, 82, client, Aspen

R: What kind of mental health problems worry elderly people nowadays? If any of course.

P: I think it's loneliness. I think that's the main one. Fear.

R: What does loneliness and fear do? What does it cause?

P: It takes the personality away. And, so, they get withdrawn. Just frightened.

Victoria, 66, client, Field Maple

Clients' accounts of their experience of loneliness holds a strong affective component, particularly related to their feelings of separation from the community. In fact, they regard experiencing loneliness and social isolation as more problematic than mental health problems or physical illnesses. Some organise their daily routines around

socialising in different places: *'Sometimes I go to exercise class on the Friday morning, and on Wednesday I go to church, and then after we have church, so we have coffee afterwards'* (Erika, 70, client, Field Maple). Volunteers share this representation but with a less affective component, which is mainly due to their lack of personal experience with loneliness. On the contrary, they emphasise how a situation of isolation may increase vulnerability to other problems.

R: What can be the main problems they face that affect their well-being, from your experience? What are the main problems?

P: ... loneliness is a big one, that's a big one, not being able to prepare their own food... these things can affect well-being but these things when they come to day centre, they talk about them or we will recognize that people are going down and they're losing weight so, why are they losing weight? Are they feeling poorly? Are they eating? ... and we find out these things so you know being on their own is not good for their well-being because people don't see changes in them, they can't see that there's something wrong.

Katie, 53, staff member, Tulip Tree

Social isolation is thus another common concern related to loneliness. According to staff members and volunteers, it creates a situation of vulnerability to depression, physical limitations, and lack of appropriate care. In this context, depression and physical deterioration are the main concerns of practitioners.

R: What are the main challenges to promote psychological well-being? To promote well-being to other people?

P: Well isolation is the big one yeah... cos it, especially when things go wrong because if you can't see properly and you can't hear and maybe you haven't got a phone so you don't know if someone's knocking on the door and all sorts of things that make you even more isolated because you're becoming infirm and then when you're, when there's dementia which is getting more and more and more it's even harder cos there's fear then, you get very frightened.

Laura, 72, staff member, Field Maple

The experience of social detachment is the main hindrance to well-being as expressed above. The groups of clients and voluntary sector practitioners differ in terms of the meanings of these phenomena for their lives. Clients emphasise the detrimental effect to their social identities and well-being caused by social detachment, whereas volunteers emphasise the vulnerability to physical, mental, and social problems. The first group focuses on socialising and being part of the community, while the second stresses the need for care and support for the elderly. The way in which they define independence in later life may underlie their conceptions of support in the context of social isolation and loneliness. In this context, clients may refer to their need to enact their active and participative identities, whereas practitioners stress the relations of dependence which enable the elderly to remain in the community.

4.3 Summary and concluding remarks

In this chapter, I explored how clients and the voluntary sector practitioners defined well-being in the immediate context of social support. Both groups shared a hegemonic representation of well-being as the outcome of an active lifestyle,

characterised by increased independence and self-fulfillment. Although this understanding is largely found in public understandings of the *Third Age* and successful ageing, clients adapt their views to deal with different demands in later life: adaptation to bodily limitations, structural support, and social detachment. On the one hand, their views corroborate Western ideologies of active ageing which emphasise the '[older] individual as a rational cognitive actor in possession of a clear set of goals and capabilities to achieve them' (Barnes et al., 2013, p. 476). Thus, individual responsibility—represented by the value of an active and healthy lifestyle—is raised as a condition for quality of life. On the other hand, clients challenge this individualistic ethos by raising the need to social support and meaningful relationships. Ageing well is possible through the reciprocal relationships of support between clients, staff members, and volunteers. Moreover, the dichotomies (activity-passivity and independence-dependence) that I adopted to represent wellness by receivers and providers of care point to the complex lived experiences of ageing. In order to attain a sense of wellness, adaptation to life changes, a healthier lifestyle, and relationships of support are necessary.

Differences were observed in the way in which clients and practitioners position themselves to give and receive support. The first group stress the importance of independence as a state of mind, despite the frail body. Support is welcome if it does not threaten their *active identities*. For the latter group, independence is not always possible for clients, so they position themselves as helpers to promote independent living. These views are always ambivalent; therefore, negotiation of care is necessary to facilitate interdependence between clients, staff members, and volunteers.

This research project, therefore, addresses the important question of which social representations of well-being in later life are most salient amongst groups involved in community support. Answers to these questions may assist policy makers and social

psychologists in comprehending context-specific meanings of happiness and their relevance to older adults (Bowling, 2006; Jopp et al., 2015; Lamb et al., 2011; Lauri, 2009). In this context, how are these meanings related to practices of support in the day centres and the visiting scheme? To address this question, I will explore the meanings associated with common practices of support in this organisation. These aspects will be reiterated in the next chapter, particularly through empirical evidence of how ideas of well-being promotion link subjects and a project of support in different settings. In this thesis, I contend that, in addition to social and political contexts, representational projects play a crucial role in shaping practices and eliciting specific understandings of well-being in later life.

CHAPTER 5 – SOCIAL REPRESENTATIONS OF WELL-BEING

PROMOTION IN THE COMMUNITY

5.1 Introduction

Having outlined the representations of well-being in later life amongst clients and voluntary sector practitioners in Chapter Four, this chapter will illustrate how these representations are enacted as part of a representational project of well-being promotion. I will first examine the concept of the representational project as has been theorised in the existing literature. Next, I will discuss how the shared views of well-being are enacted in the daily practices of both day centres and in the visiting scheme. In so doing, I will present evidence from the observational data and the interviews. This form of triangulation enabled me to examine the relationship between representations of well-being and social support in later life. I will also argue that although the representational project of well-being promotion is largely shared across these settings, two specific forms of support are mentioned in the daily interactions between staff members, volunteers, and clients. Practical support to live in the community and socio-emotive support were the main set of actions represented by clients and practitioners with which to promote well-being. Such practices illustrate which components of the complex representations of well-being are most salient when enacted in different settings. Findings show that actions of support are both influenced by—and shape—representations of well-being and a positive identity in later life. Furthermore, the themes of *time* and *space* are meaningful dimensions in clients and practitioners' understandings of well-being promotion.

5.2 Conceptualising representational projects

Social representations are not static phenomena, nor are they manifest solely in the mind of individuals (Arthi, 2012). In fact, as proposed by Jovchelovitch (1996), representations constitute ‘forms of symbolic mediation [amongst individuals and members of social groups] firmly rooted in the public sphere.’ (p. 122). Negotiation, communication, and even resistance occur in the dialogical relationship between Self, Other and the objects of representations (e.g. ideas, theories, material objects) (Marková, 2003). These theoretical understandings point to the dynamic nature of representing (Moscovici, 1998; 2008). Therefore, according to Bauer and Gaskell (1999), ‘representation is an activity [the process of representing] with an observable outcome [an elaborated idea, a designed object, a representation]’ (p. 168). This process takes place in different contexts of action, which warrant the exploration of various forms of comprehension and communication of knowledge (Bauer & Gaskell, 2008).

To comprehend the dynamic of representations and *representing*, Bauer and Gaskell (1999) theorised how representations are developed and enacted over time. In fact, social representations (and representing) are not disinterested (Duveen, 2000), but are enacted in the context of ‘mutual interests, goals, and practices’ of groups (Bauer & Gaskell, 1999, p. 170). The concept of *representational project* refers to the pragmatic context in which representations are relevant to social groups and individuals. In this context, representational projects link subjects (Self-Other) to objects in meaningful relationships; representations are meaningful within a project, as a form of a meta-narrative that guides members of a group in a common orientation (Bauer & Gaskell, 1999, 2008).

Foster (2011) stresses three important aspects of the concept of representational projects: firstly, projects emphasise action and interaction in representing. Social representations are ‘held and shaped within the context of action and interaction; they influence and guide our behaviour and communication’ (Foster, 2003a, p. 634). As highlighted by Bauer and Gaskell (1999), social representations can be embodied in behaviours and structured practices. Secondly, projects develop over time, where the dimensions of *past* and *future* are implicated in making sense of relevant social issues (Bauer & Gaskell, 1999). As will be discussed later, transformation in representational projects and groups’ identities is possible as groups actively enact them longitudinally (Arthi, 2012; Foster, 2011). Thirdly, the examination of representational projects elucidates power relations operating in meaning-making processes. Not all groups are empowered to hold and communicate their representations of certain issues (Foster, 2003b). As discussed in Chapter One (pp. 20-22), older adults are hardly consulted when professionals promote views of active and successful ageing (Bowling, 2006). As highlighted by Foster (2011), social groups may not hold one single project in a given context. In fact, a complex number of projects and representations associated with them will be held by different groups according to their interests, dynamics and needs. The strength of a project is thus defined not only by the object of representations but also by the power positions different groups hold in community spaces (Foster, 2011; Howarth et al., 2004).

Despite the relevance of this concept to explore the process of representing relevant issues, few empirical studies have explored the way in which projects operate in relation to different communities (Foster, 2011). However, there are a few exceptions. For instance, Foster’s (2001, 2007) ethnography of mental health service users explored the way in which projects are enacted amongst mental health service users in different

day centres. In that study, clients were engaged in one broader project of mental health promotion. That project was objectified as a ‘journey through mental illness, which involves activity and [personal] responsibility’ (Foster, 2001, p. 119). On the other hand, that project was lived out differently across three day centres, corroborating Bauer and Gaskell’s (2008) attention to the specific dynamics of social groups in enacting projects. Similarly, Zadeh et al. (2013) examined the way in which single mothers by donor insemination represented their experience and themselves and how those views changed over time. Her study also pointed to the operation of a project at both micro and sociogenetic levels (Duveen & Lloyd, 1990). Women’s accounts of their experience of single motherhood by donor insemination reflected not only the immediate context of social encounters with other mothers or groups related to this issue. Mothers’ views were also salient in public understandings of this topic. In the same way, Arthi (2012) examined how an ethnic community in Singapore, the Tamils, represented mental illness. She showed that various groups within this community drew upon different forms of thinking (cognitive polyphasia) to conceptualise mental illness, its causes and consequences. Different ways of conceiving mental illness were associated with distinct projects of mental health management.

Although these studies show robust evidence for the way in which projects operate in different social groups, there is a dearth of studies on how projects operate between groups in immediate interaction. This is particularly relevant given the fact that social positions and contexts of interaction mediate the enactment of distinct representations of social issues (Arthi, 2012; Howarth, 2002b). Moreover, there is a dearth of studies on how groups involved in community support for the elderly make sense of well-being promotion. The exploration of how these groups transform ideas into projects of support

may help to elucidate how active ageing and well-being promotion is understood in community settings.

5.3 Findings: representational project of well-being promotion in later life

Findings indicate that the project of well-being as *active, independent and gainful living* is enacted via different actions of support. Diverse activities in the day centres and the visiting scheme aim to address the complexities of living in the community. On the one hand, activities are closely associated with the hegemonic representation of well-being as maintaining an active, independent and healthy lifestyle. The multifaceted representational field described in Chapter Four is also present in the variety of activities and actions of support adopted in both settings. On the other hand, actions within this project address the negative poles of the experience of ageing (passivity, dependence and losses). The complexity of developing this project reflects groups' attempts to manage ambivalence and tension in community living. Therefore, this project links social actors via actions of support and their desired outcome—a preserved sense of well-being.

In the voluntary organisation, the representational project of well-being promotion operated as a guiding principle for action (Bauer & Gaskell, 1999). This project was also shared in a hegemonic way across all day centres and the visiting scheme. This brings empirical evidence of the influence of hegemonic representations in different pragmatic contexts of support (Flick & Foster, 2008; Moscovici, 1988). Contrasting Foster (2007) and Arthi's (2012) studies on the way in which projects vary according to specific social contexts, this study points to commonalities in living out a project of well-being promotion. The project of support is developed consensually amongst clients and volunteers in different day centres and the visiting scheme, although contextual

differences were also observed. This might point to the operation of a project on a societal level as indicated by Zadeh et al.'s, (2013) study on views on donor insemination. In this case, public discourse and professional views on ageing well might offer a more persuasive narrative of living well in later life.

As described in Figure 5, clients and practitioners' views on well-being promotion display a project that links different practices of support to desired outcomes. The multiform view of well-being (via adaptation, a positive outlook, participation, and activity) justifies the selection of diverse actions of support. Cognitive and physical stimulation, activities for reminiscence and socialising, and peer support are some of the main strategies to promote wellness in the day centres. Practitioners stress that these actions aim to promote support for older and frail individuals to remain in the community. Thus, they emphasise the importance of a routine to promote purpose and structure to life, and actions to preserve mobility, and a sense of independence. Clients—although acknowledging the need for structured support—highlight the relational value of activities. Tackling social isolation and loneliness and promoting a sense of belonging and a common positive identity are the main functions of actions of support.

This visual representation does not entail a simplistic account of the relationship between representations and action. Wagner (2015) criticises the belief-behaviour causal unity in social interactions, namely the assumption that *representations (beliefs) cause behaviour (action)*. Instead, the relationship between representations and actions is more complex as in social interactions 'representations, beliefs, volition, and action are integrated with each other beyond contingency' (Wagner, 2015; p. 19). In fact, as discussed above, social representations are activities with determined outcomes to individuals and groups (Bauer & Gaskell, 1999). The enacting of a project is an activity in and of itself, with a determined course of actions and outcomes. This theoretical aspect

was illustrated in Chapter Two by empirical evidence on the consequences of positive and negative representations of ageing to individuals' physical and mental health status (Craciun et al., 2015; Craciun & Flick, 2014; Levy et al., 2000).

In this case, I will discuss the way in which clients and practitioners assess the main activities and actions of support. First, I will explore the sphere of action within the day centres. I will describe the two main actions of support within the day centres, namely practical (or instrumental) help with daily issues and socio-emotive support. These practices have positive implications for the enactment of a project of well-being in the community. Three set of activities will be described as the main ways of promoting well-being via participation in the day centres: cognitive stimulation, physical stimulation, and activities of social interaction. The first two set of actions are associated with practical support, whilst the third one relates to socio-emotive support. These specific actions are also congruent with the multifaceted and complex representational field of well-being in later life, as discussed in Chapter Four. Later in this chapter, I will examine how the project of well-being promotion is enacted in the visiting scheme. This section will cover the discussion on how time, space, and needs operate to change representations of wellness in later life. Finally, I will summarise the main findings and their implications for the context of social care via the voluntary sector.

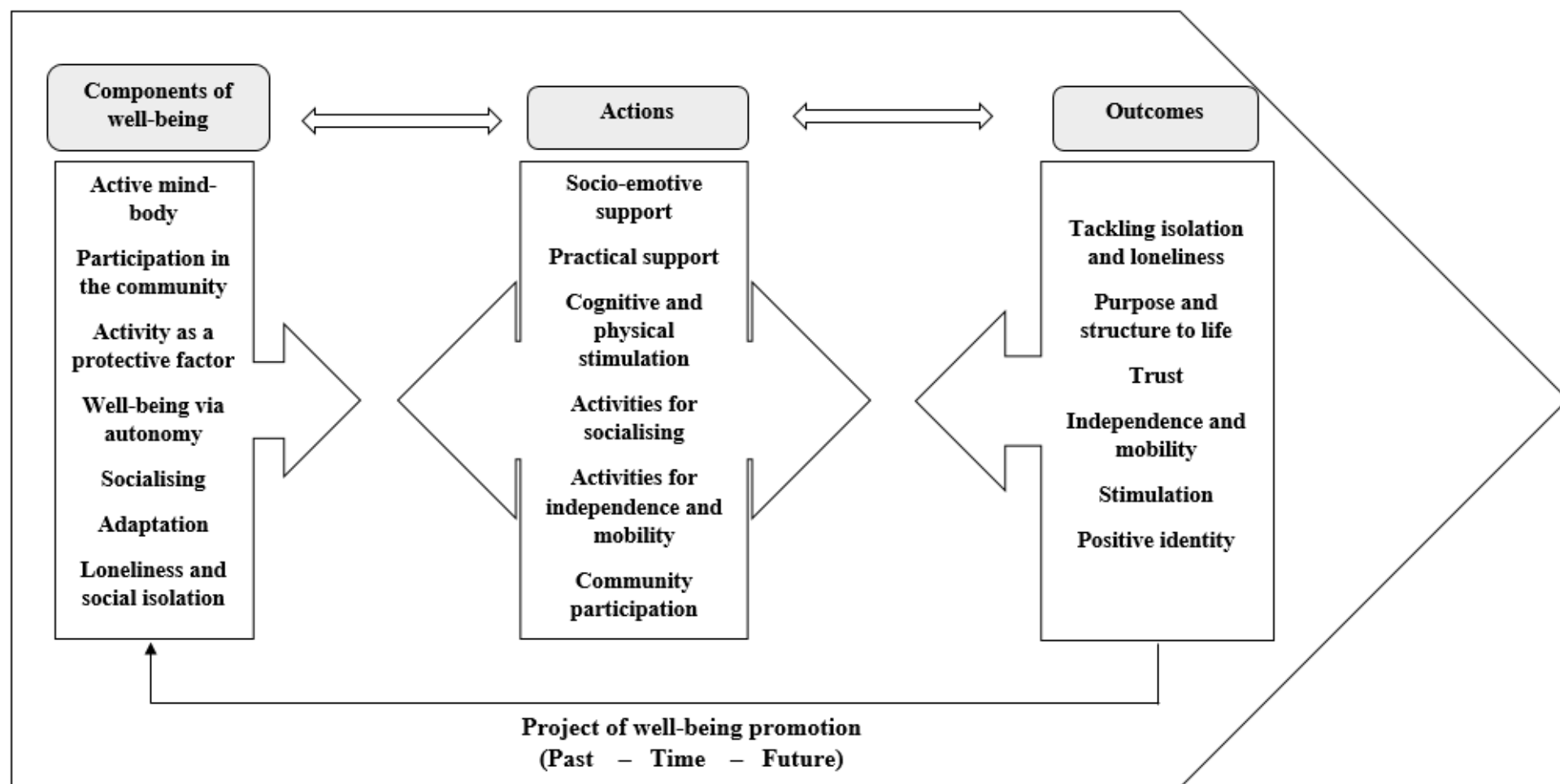


Figure 5 | Project of well-being promotion in the day centres

5.4 Representations in action: well-being promotion in the day centres

As described in Figure 5 (see above), in the promotion of well-being, clients and practitioners act with the purpose of promoting not only an active and independent lifestyle, but also meaningful relationships in the community. In this pragmatic context, actions of support are deemed relevant to develop this project in the day centres and the visiting scheme. The hegemonic project of well-being promotion is characterised either *for* or *within* the community. Two main sets of representations of support are enacted and negotiated amongst clients and voluntary sector practitioners in day centres: *practical* or *needs-oriented support* and *socio-emotional support*. These categories resemble some of the main types of social support functions according to the reported literature (Cohen & Wills, 1985; Rodrigues, Gierveld, & Buz, 2014; Thoits, 2011). However, they bear contextual meanings that go beyond well-established constructs of social support. They are personal and institutional ways of preserving the project of wellness in later life.

The first set of actions involves the awareness and management of needs (well-being *for* the community). Actions that foster mobility, a sense of independence, and an active identity are the focus of support in the day centres. To promote this, practitioners position themselves as reliable sources of support, enabling clients to rely on their services. The second set of actions emphasises socialising and human interaction in service provision (well-being *within* the community). Clients regarded the day centre as a space for socially rewarding interactions, whilst peer support was the main factor to promote group cohesion and wellness among frail, socially detached, and, at times, stigmatised older adults.

5.4.1 Support to live in the community: practical help and the emphasis on mind-body stimulation

Well-being is promoted through practical help with daily needs. Staff members and volunteers adapt their actions in order to meet complex needs in the community. In so doing, they also represent well-being promotion within the course of actions which enable older people to *live in the community*. They also represent the day centre as an essential space where instrumental support and stimulation are provided to the elderly. Support extends to help clients to remain active and functional in their daily lives. Therefore, practitioners highlight the value of their work to the extent that it facilitates active ageing and independence. They choose activities and strategies which focus on promoting independence and autonomy for frailer older adults. Simultaneously, practitioners stress the value of stimulating clients' bodies and minds. Cognitive stimulation and the use of exercises are seen as valuable resources to cope with daily life demands: going shopping, opening cans, moving across social settings, remembering dates, and social encounters etc.

These actions of support are in line with the policy context of well-being promotion in the UK (DH, 2005, 2006, JSNA, 2012). UK policies have focused on promoting 'preventative services through the wider well-being agenda and through better targeted, early interventions that prevent or defer the need for costly intensive support' (DH, 2005, p. 11) In that context, voluntary organisations are considered to be central agents in promoting active ageing and independence. Consequently, the voluntary sector has been commissioned to reduce the *burden* of care and 'prevent costly long-term conditions as people age'. (Ward, 2015, p. 53). These institutions have been incorporated into a system of support which prioritises an active lifestyle and independence at home

as core policy aims (DH, 2001, 2006). In this context, voluntary sector practitioners draw upon the normative frameworks of active ageing, and well-being via independence, to justify their practical help. As reported below, staff members highlight the importance of actions of support to enable older people to maintain their place and functionality in the community, hence maintaining well-being via an active lifestyle. In the same way, in my interactions in Field Maple, Aspen, and Tulip Tree, staff members and volunteers emphasised their role in supporting the clients to remain active, independent, and functional. My observations of the routine of day centres point to this emphasis on supporting the clients to remain functional in their communities.

Erm, the purpose [of day centres] is, yeah, to maintain independence with people, give them something, give them a reason to get out of bed in the morning... an example really would be somebody who is physically well, mobile but starting to struggle a bit with their mobility or something. So, they may come into the day center and say, 'I don't know... where would I get hold of a frame?', 'where would I get hold of a wheelchair for when my family take me out?'. We've got a list of telephone numbers, ring the mobility people, tell them to go around to the house, agree with the client, liaise between ... So, we sort of, we protect the client but we can organize mobility aids, ... doctors' appointments, things like that...

Clare, 44, staff member Field Maple

Later today, I noticed that Peter was not feeling well. He is an 89 years-old client who regularly comes to the day centre, usually in good health. He drives his own car and takes a friend with him every time he comes to the day centre. However, today he was suffering from constipation. In the end, staff members were trying to help him to get his car. I could clearly notice that he was not in conditions to

drive—he was shivering, mainly because he had not eaten any food. Eventually, staff decided to take the responsibility for his situation. They asked him whether he would be happy to take a lift to his home and leave his car at the day centre. Furthermore, staff also asked whether he was happy to cancel the appointment with a nurse and reschedule to his house.⁴⁸ Staff seemed very careful with his physical health as well as respecting his wishes. He was very weary and suffering, so Bob (day centre volunteer) was called to give him a lift to go home. After helping Peter to reach Bob's car, Clare and Sarah (day centre staff) came back to the day centre and we discussed his condition. Suddenly, Clare addressed me 'See this is what we try to do here, but I can't explain [with words].' She was clearly referring to our interview meeting, when she had problems to describe what sorts of actions she performs in daily situations (and why she chooses certain approaches to promote well-being).

Fieldwork note, Week 10, 17.02.2014, Field Maple

Staff members and volunteers seem to present a form of tacit or taken-for-granted knowledge about their role and forms of support. This form of practical help is put into practice via the institutional label of *preventative services*. The ethos of preventative services is actualised within the daily routine of day centres: services, activities, and advice to prevent deterioration and promote independent living. Instrumental support has been theorised as the provision of practical help such as financial assistance, management of daily tasks, and provision of material aids (Cohen & Willis, 1985). These forms of help were mentioned as integral parts of preventative care.

⁴⁸ Staff members were suggesting some options to Peter, being very careful of respecting his wishes while overseeing his needs.

Before leaving the day centre, I distributed the information sheet to staff members and emphasized my purposes and plans with them. They seemed to be happy with my ideas and welcomed me as a volunteer. I also met Becky, the activity assistant, who talked to me about her experiences of caring for older adults. Helen (day centre manager) was also very helpful and talked to me about her experiences of managing this day centre for 7 years. She emphasizes how this day centre helped to support older people who used to live in isolation. Additionally, she commented on the preventative aspect of activities and purposes of this service.

Fieldwork note, Week 1, 30.04.2014, Tulip Tree

When they finished this exercise, Sally (client) told me. 'Bruno, do you know I got 500 hundred in the other game? ...' I replied, 'No I didn't'. She added, 'Yes, you've to be concentrated'. Becky (a volunteer) also interacted in our conversation saying emphatically, 'Yes, you've got to be concentrated. It is good for you, especially if you do physiotherapy. You know these exercises. Even me, I do appreciate them, because [you] get moving ... It is good to you, especially if you sit long enough [for a long time]. I observed their emphasis on the benefits of these activities for the clients, something that was mentioned elsewhere by Helen, the manager's assistant.

Fieldwork note, Week 7, 19.06.2014, Tulip Tree

... there was one lady, she doesn't come anymore, but she was getting really... well struggling. I think she lived with her son but he wasn't in the best of health and she needed just a practical thing like a wheelchair. Well she spoke to Susan [staff member] and the next time she came in, Susan knows who to contact and

she'd organised a wheelchair for her at home so erm 'cause a lot of people you don't know who to go to get these aids you know for the house to enable you to be more... quite independent and get out and about...

Sally, 67, volunteer, Aspen

The representation of well-being as a function of independent living seems to be behind these practices. As reported in Chapter Two, functionality and independence have become mainstream policy targets (EU, 2012; WHO, 2002). In the context of the UK, the active ageing framework gains renewed attention in this voluntary organisation's ethos of support. Preventative services fit well into this hegemonic representation of ageing (Moscovici, 1988). Moreover, current shifts in community care have placed voluntary organisations as strategic partners of health and social care commissioners (DoH, 2001; JSNA, 2012). The recognition of extended needs in later life such as management of domestic tasks, shopping, and house cleaning has called to psychosocial interventions in the community (JSNA, 2012). Consequently, *care by the community* has become a normative pattern of well-being promotion (Brown, 2010).

It is beyond the scope of this project to explain how the ideologies of active ageing and well-being as presented in the UK policies are transmitted from practitioners to clients. Nevertheless, findings point to the role of this voluntary organisation as a partner in promoting those policy orientations. In the same way, this project of well-being promotion is also shared amongst clients who see the day centres as spaces where their active identities might be preserved. Clients' emphasis on an active identity is not surprising given the normative context of active ageing in the UK (Bowling, 2005; DoH, 2006). In this context, clients are deemed responsible for contributing to their own healthy ageing by 'not only limiting demands they make on public services, but also by

contributing through volunteering, grand-parenting, and in other ways being active, responsible citizens' (Ward, 2014, p. 295) Consequently, to perform (and preserve) these social roles, practitioners stress the need to support clients daily.

The day centre is also perceived as a space of support network where staff members and volunteers oversee clients' needs and act to support them in different areas: social care, advocacy, information on different services, etc. As such, practitioners anchor their support within the framework of family care. In so doing, they legitimise their practices and define the day centre as a secure harbour for family members and clients to receive adequate support and advocacy.

... once they are here, we are their family for the day, and we have to care for them and just make sure that they have a really good day, really enjoy themselves...

Harry, 56, volunteer, Tulip Tree

The representation of the day centre community as a *family* is passed to the group of clients who also anchor their relationships in familial relationships. This is particularly relevant in the context of social isolation and loneliness which characterises the lived experience of most of clients, as mentioned in Chapter Four.

That is why I like about it. Everybody, everybody says things to each other and nobody has got really, nobody has got really nasty about anything. Everybody is like, is like one big happy family.

Bob, 65, client, Field Maple

Well, when we come to a day centre, that's what makes us feel happy, because we're mixing with people of our own kind, and we're like a little family here...

Ailsa, 89, client, Field Maple

Previous studies in different demographic context such as Italy, Cuba and Brazil have pointed to how family relationships affect people's subjective assessments of wellness (Ferreira, Maciel, Silva, Sá, & Moreira, 2010; Magnabosco-Martins, Vizeu-Camargo, & Biasus, 2009; Sotgiu et al., 2011). In this study, clients reported the absence of family contact. Peer groups and voluntary sector volunteers are then represented as the symbolic substitutes of family care. Here, clients not only subscribe to a specific social position of receiving support, but also cope with limited social interaction and support daily (Hazan, 1994). Alternatively, the family metaphor might constitute another form of negotiating dependence in the community and acknowledging the need of support.

R: You said you feel safe coming here...

P: Well I know it's safe, you look after us! [Laughs] it's a good place. It's, it's organised for elderly people. ... John [family caregiver] knows I'm safe and I can't get into mischief...

Clara, 95, client, Field Maple

They keep an eye on you here... I mean they're looking after you.

Jess, 82, client, Aspen

Clients also represent the day centre as a space where protection against mistreatment is offered. The day centre is thus seen as a space where the elderly will be properly *looked after*. In summary, clients construct their identities in the day centres as

the recipients of care, with the others (staff members and volunteers) as the reliable sources of help. At the same time, clients and practitioners represent well-being promotion on a much larger scale as support is necessary beyond the context of day centre. In this case, practical help with daily tasks and maintenance of functionality are core purposes of actions beyond the day centres.

5.4.1.1 Support *in* and *beyond* the day centres

Generally, older adults respond positively to the amount of support they receive daily. They stress the help received with food preparation, gardening, company, mobility, and health issues. In this case, the immediate network of social ties, that is family members, doctors, and neighbours play a relevant role in mediating functionality. Rather than challenging their active identity, social support is seen as a natural part of their daily lives.

I have a carer coming to me every day like, they come in the morning, and they come in for tea so I like, and about five, six o'clock of nowhere to make sure I am alright, I take my tablets, ... because of my tablets, because I said, I wasn't taking them.

Hillary, 84, client, Aspen

Dependence on others can be seen as an important way of addressing social isolation and loneliness. Some clients refuse to be seen as *too independent* due to their lack of family bonds and friends in later life. Depending on others may therefore strengthens relationships and support. Across all day centres clients emphasise the necessity of support *outside* the context of day centres. In fact, clients locate practical help outside their purposes of attending the day centre.

R: So, you said you love to come here. Why?

P: Oh, yes! It gets me out. I don't go anywhere otherwise, not being in a wheelchair. I have a neighbour doing my gard[ening], mhm, shopping, and she goes to make my pension. And does my housework, like Hoover up I can't do.

Caroline, 89, client, Tulip Tree.

Clients highlight the need for instrumental support inasmuch as it enables them to enact their active and functional identities. In this case, for clients, instrumental support is located *beyond* the scope of the day centres. These views are in keeping with current research on lay views of successful ageing, which has demonstrated that social engagement, environmental, and financial support are regarded as relevant psychosocial components of ageing well (Cosco, et al., 2014). However, this distinct view of support seems to be incongruent with clients' representations of well-being as the result of exercising autonomy and independence. One explanation for this discrepancy is that these representations seem to fulfil their desire of maintaining their presence in the community. Therefore, *instrumental support* is negotiated and viewed as necessary to achieve this goal.

5.4.1.2 Cognitive stimulation via actions of support

In addition to practical help, practitioners provide a set of activities that aim to promote cognitive stimulation and memory use. Staff members usually justify the elaboration of quizzes, word games, memory tasks as ways of tackling cognitive limitations and preventing deterioration. These activities are relevant to clients as they

enable them to develop their project of well-being as active and socially connected living. Interactions between staff members and clients revealed a shared concern of cognitive deterioration and its consequences to the clients' project of an active and independent living, as in one of the activities at Field Maple.

One of staff members keeps asking other clients; then, after asking Tracey about a name of food starting with the letter 'F'. She gets the answer 'Fish'. Then she says to the whole group 'It [fish] is very good to the brain' [pointing to her head while talking]

Fieldwork note, Week 2, 26.11.2013, Field Maple

Concerns with cognitive deterioration and actions to delay it were observed across all day centres. However, Field Maple and Tulip Tree participants seem show a more holistic view of promotion of well-being than those interacting at Aspen. They more often applied terms like *brain stimulation*, or *mental stimulation* to refer to the purposes of their activities. Their representations of activities as a protective factor against mental and physical deterioration are intertwined with their views of an active lifestyle as a protective factor against the losses in later life, as discussed in Chapter Four. Staff members and volunteers highlight the preventative character of stimulation. In their views, *passive* older adults are vulnerable to mental deterioration and age-related problems.

After this activity, I approached Claire, the facilitator, and asked 'What did you have in mind when you elaborated this activity?' She then answered, 'I want to promote thought stimulation'. Then, I asked her whether she knew the cognitive conditions of her clients. Then, she answered that some of them present memory

problems and that she tries to stimulate them with different activities, 'They know this activity from a long, long time ago'. I said: It might be in their long-term memory. 'Yes, I try to use different ones. I know I have them for [only] 45 minutes'.

Fieldwork note, Week 2, 26.11.2013, Field Maple

Well-being is partially located in the brain according to participants' understandings in general. Such a view corroborates biomedical and clinical models of successful ageing (Baltes & Baltes, 1990; Rowe & Khan, 1997), and has also been found in other studies on lay perspectives of ageing well (Bowling, 2009; Tate et al., 2003). Nevertheless, staff members and volunteers do not rely solely on expert views of ageing well to elaborate *brain activities*. In fact, they draw on their traditional experiences in day centres to formulate their views of the purposes and efficiency of those practices. Again, polyphasic thinking characterises the representational field around the purposes of these activities, such that they select them according to different needs and contingencies experienced in their daily practices.

Voluntary sector practitioners seek daily to help clients to feel active and functional. According to their representations, cognitive activity is a factor which interacts with their sense of well-being, an aspect also found in their views of well-being as a protective factor against deterioration and passivity, as discussed in Chapter Four. Passivity is avoided as it is considered a marker of cognitive deterioration, and, therefore, the main indicator of *old age* (Kwong See, Rasmussen, & Pertman, 2012; Santos et al., 2013).

R: What you think about the purpose of the activities in the day centre?

P: Well, the activity, erm. Well, some of them I suppose is mental stimulation because if they're doing things like... they're having to look at lists and then look out for the numbers and whatever... So, it's the mental stimulation.

Sally, 67, volunteer, Aspen

R: What do you think about the role of the activities in the day center?

P: Extremely important, er, because... basically I think it helps promote well-being because, erm, stimulation is what keeps the brain active which helps prevent dementia. You know, if someone sits and doesn't speak and just vegetates that's when things go downhill, they need that.

Laura, 47, staff member, Tulip Tree

Similarly, clients represent these activities as part of their attempts to preserve their minds active and maintain themselves functional in the community. They assess the value of quizzes, word games, and memory tasks in terms of the degree in which these activities offer stimulation to accomplish the goals.

Well, [pause] things like puzzles and stuff like that, I quite like. Or games, not physical games but mental games. Trying to get your brain to work if you can.

[laughing]

Sarah, 82, client, Field Maple

R: Why do you think the quizzes are important for everyone here?

P: Well it makes them think, you know. Whereas they'd just be sitting there and chatting amongst one another... You know - it keeps your brain active.

Melissa, 81, client, Aspen

Here, clients express a specific form of cognitive polyphasia when representing well-being promotion, namely selective prevalence (Jovchelovitch & Priego-Hernández, 2015). They hold distinct systems of knowledge (biomedical and psychosocial) around ideas of well-being and social support, and enact them according to the orientation of their projects of support. Representations of well-being provide them with the *tools* to assess practices of well-being within the day centres. The representation of wellness as a function of physical and cognitive activity also entails a moral orientation towards the maintenance of an active self. Such an identity implies specific meanings of well-being promotion, particularly as expressed via specific activities. In this specific case, *stimulating the brain* constitutes a relevant strategy to promote wellness in later life. These patterns of meaning have been identified previously in studies on lay views of ageing well, such as the pursuit of a *healthy mind* and autonomy by health services users (Teixeira et al., 2002), the relevance of cognitive functioning for ageing actively (Bowling, 2009), and the interrelation between biomedical and psychosocial models of ageing in longitudinal studies (Tate et al., 2003, 2013).

5.4.1.3 Physical stimulation via activities

As discussed in Chapter Four, psychological well-being is not merely a state of mind, but it involves a sound relationship with the body. The mind-body duality is also present in the choice of activities that aim at promoting mobility and fitness. In this study, *the body* is a relevant dimension in the representational field around the theme of ageing well (Camargo & Walchelke, 2010). Studies on social representations indicated the negative associations of ageing with bodily decay (Pike, 2013), physical losses (Soares, et al., 2014), and functional limitations (Ferreira, et al., 2010). However, *modern*

representations of ageing also depict positive elements of the *bodily experience of seniors* such as independence, activity, mobility, and participation in the community (Quénart & Charpentier, 2012; Soares et al., 2014; WHO, 2002). At an ontogenetic level (Duveen & Lloyd, 1990), these representations mediate a new social identity in later life, which refers to being productive and active in the community (Foster & Walker, 2015).

In this study, practitioners and clients acknowledge the need for physical stimulation in order to maintain functionality and preserve their place in the community. However, clients' meanings of activities are not drawn directly from active ageing policies as discussed above (Foster & Walker, 2015; WHO, 2002). Instead, they hold a contextual ethos of thinking and practice; one which is mediated by their negotiated and shared project of well-being promotion. For instance, clients do not equate activity with productivity, but rather with participation in the various communities in which they are immersed. These representations might explain the shared commitment between staff members and clients to engaging in physical activities in Tulip Tree day centre. I observed that physical activities were one of the main actions of daily support in that day centre.

The day activities happened as usual. Helen [activities coordinator] conducted them as she usually does. After the raffle, she does the exercise. A recorder presents the instructions to the participants and Helen facilitates the activity. All clients, with a few exceptions (John and Paul) engage with the exercises. They move arms, legs, and wrists following Helen and the audio's recommendations.

Fieldwork note, Week 3, 22.05.2014, Tulip Tree

Mike was leading the morning exercise, followed by Becky and myself. We all participated and followed the moves. Clients seemed to regard this time as very

important, and followed carefully all instructions—hands, arms, wrists, shoulders etc. Everything should be moved and all instruction carefully followed.

Fieldwork note, Week 7, 19.06.2014, Tulip Tree

... It's been proved if you keep your muscles strong, then, that helps your bones to keep strong. It helps you so that you don't fall, and also if you can keep your wrist strong you can turn your taps on and off at home. It helps you to get dressed, it helps you to walk.

Megan, 60, staff member, Tulip Tree

At Tulip Tree, staff members and volunteers tailor the exercises to assist clients to remain functional and active in their homes. Similarly, Tulip Tree clients refer to the benefits of keeping active and functional after participating in physical activities.

... I keep exercising, I put my legs at the side of my bed to get out of the bed. I keep sitting down, because, I've got to walk a bit... So, I've been doing... ankle twists and all of that, that we've been doing this morning.

Caroline, 89, client, Tulip Tree

R: So, do you think these exercises help you?

P: Yes, oh yes. I'm sure they do!

R: How?

*P: The fact that you're doing something instead of sitting on your bottom all day!
And not doing anything that's what aggravates me just sitting. 'Only 3 PM
goodness what am I going to do for the next 7 hours?*

Martha, 84, client, Tulip Tree

In addition to physical stimulation, these activities provide clients with ways of challenging *ageing* and preserve an active identity. As discussed in Chapter Two, loss of mastery over the body (Gherman, 2014) and passivity have been represented as triggers to the ageing process (Stenner, et. al., 2011). Therefore, in Tulip Tree, both groups regard these activities as means to maintain functionality in the community and delay deterioration with age.

The ethos of support is expanded beyond functionality to involve the impact of meaningful relationships on people's assessment of well-being. Considering that wellness is represented in the context of social interactions, clients and practitioners stress the relational ethos of day centres.

5.4.2 Socio-emotive support to be in the community: actions to promote social interaction and a positive identity

Overall, clients see the day centre as a significant space for meeting up and *socialising in the community*. Those receiving support represent the day centres as *the outside world*, a space beyond a routine of isolation. Clients associate going to the day centres with the possibility of socialising with peers, who provide a sense of support, encouragement, and social inclusion. Socialising is more than being involved in social activities. It also involves a sense of connection to others and companionship. The

enactment of the project of well-being promotion via socialising is particularly relevant to frail and more isolated older adults. As examined in Chapter Four, clients stressed that social isolation and loneliness were the main barriers to a sense of well-being in later life. Staff members and volunteers also emphasised these barriers, but also stressed the structural problems and vulnerability that come with a life socially detached from the community. Therefore, this representation was largely shared among all groups of participants, and it refers to the ethos of support of the day centre work. Clients and practitioners stress a relational and generative approach to well-being promotion (Barnes et al., 2013; Taylor, 2011; Ward, 2014). Cultural and material conditions (spaces of socialising, advocacy, information regarding care and support, and help with mobility) and meaningful relationships (peer groups) are core dimensions of well-being promotion in the community settings.

Across all day centres, both groups highlight the need to socialise to cope with loneliness. This is a common challenge to older people who experience a greater longevity at home. Clients and practitioners emphasised the importance of *going out* or *being out* through the day centres. Thus, clients and practitioners represented the day centres as appropriate spaces for social support, connectedness, and social belonging. As Ann, 72, a staff member at Field Maple stresses, ‘I don’t know... [whether] they ever make friends outside of this [day centre].’ In this context, actions of support are relevant to the extent that they enable clients to socialise and receive support from peers. Staff members and volunteers add that socialising and peer support may assist clients with their structural issues: mobility, lack of structure and daily purpose, and social isolation. The extracts below exemplify these emphases.

Later, a potential client with her daughter arrived at the day centre. Her daughter was assessing whether the day centre would suit her mother’s needs. We had a

chat and I explained my purposes in this day centre. They seemed to be very interested in my research and the relevant for this. The daughter also shared that her mother had lost her husband a few weeks ago. Therefore, they were trying to find a day centre to promote more socialisation and support to her mother as she lives [abroad]. It is interesting to observe families visiting the daycentre to accommodate their older relatives. Different reasons are involved: isolation, support to care, socialisation etc.

Fieldwork note, Week 4, 12.03.2014, Aspen

... it as I said I'm probably repeating myself, it's a reason to get up, it's a reason to come out of the house, erm. They, they care, they care about getting themselves ready to do something that day rather than sitting in the chair next to the fire at home seeing nobody. So psychologically, erm... that's only going to be beneficial to them.

Theresa, 44, staff member, Field Maple

The value of relationships and social support were heavily stressed within the multifaceted representations of well-being in later life. Both groups emphasised the role of community in protecting the elderly against psychological deterioration and social death (Knight & Ricciardelli, 2003; Ryff, 1989c). As discussed by Thoits (1985), social-psychological processes mediate the way in which psychological well-being is affected by support. In this context, the development of a sense of belonging via the assimilation and enactment of specific identities correspond to a possible positive outcome of socialising in the day centres (Cobb, 1976; Thoits, 1985, 2011). In this case, being looked after or giving support constitute two specific social roles for both groups of clients and practitioners respectively. These two social positions have specific outcomes to

individuals promoting well-being: a sense of *security from support* and *satisfaction in giving support* are represented as positive outcomes of support.

Well-being is located within the realm of community participation, social interaction, and support. These representations go beyond individualistic and hedonic perspectives of wellness and involve a contextual and social emphasis on ageing well, namely participation in *places* or *spaces* of support and interaction (See Chapter 4, pp. 149-153). Therefore, clients justify their involvement in these practices of support as a way of counteracting their perceived loneliness and social isolation. This is particularly relevant due to the evidence of the detrimental effect of a sense of exclusion from society on people's sense of wellness (Chandler & Robinson, 2014).

According to Jovchelovitch (2012), public spaces can also be understood as psychosocial contexts 'of mediation and communication, where self and other come together in a variety of forms to create identity, representations, and imaginations' (p. 164). In these contexts, groups engage in representational work in different social spaces, constituted by both objective (historical, political, and material dynamics) and subjective features (socially constructed beliefs, emotions) (Jovchelovitch, 1996). In representing the day centres as *spaces* of socialising, participants not only locate practices of well-being in a concrete institutional setting, but they engage in a project of support which involves creating communities of peers (Bauer & Gaskell, 1999, 2008). In this case, a *community of practice* (Howarth, Cornish, & Gillespie, 2015) is constituted as the inter-symbolic space of identity formation and solidarity between members (Calhoun, 2002; Jovchelovitch & Priego-Hernández, 2015). Two important outcomes derive from participants' involvement in these symbolic-concrete spaces of well-being promotion: firstly, a sense of belonging via the participation in a mutual project of support where one 'belongs to a network of communication and mutual obligation' (Cobb, 1976, p. 300).

These aspects have been considered mediators of health and well-being (Thoits, 2011). Previous research with older adults in community settings in the UK has pointed to the role of social spaces and relationships developed within them as mediators of wellness (Barnes et al., 2013). Secondly, via participation in different social spaces, individuals involved in community support are able to draw upon different systems of knowledge to define well-being (Jovchelovitch & Priego-Hernández, 2015). In doing so, they not only adapt to move successfully in different social spaces, but also to cope with ambivalent experiences in later life (Howarth et al., 2015; Jovchelovitch & Priego-Hernandez, 2015).

In this study, clients represent the day centres as their *community* or *society* which they access to preserve their social value and maintain interaction. Thus, the representation of the day centre as a space of socialising is enlarged to involve the dimension of community. Overall, practitioners also represent the day centre as a space where socialising takes place outside clients' houses. Expressions such as *going out* and *getting out* of seniors' houses are commonly used to refer to the action of participating in community support settings.

We are here just to sit here and talk, and at least to have, their purpose is to get out of their flat and come and chat. So, yeah, I think it does do its purpose. Definitely.

Katie, 53, staff member, Aspen

R: Why is it important to come to a day centre?

P: ...Well, because it gets me out of the house, if I'm, if I'm at home I'm always asleep, so it gives me a chance to wake myself up and coming out and listen to people...

Grace, 80, client, Aspen

These findings contrast with previous research on the value of day centres for those with substance abuse problems (Weinberg, 2005). In Weinberg's ethnography, the *outside world* represented a space of loneliness, insecurity, and deprivation, particularly for day centre users in difficult socio-economic conditions. In that context, the day centre operated as detached space for users in need of community support. Similarly, Foster's (2001, 2003, 2007) ethnography of community mental health service users showed that day centres were regarded as safe places for controlling and managing mental illnesses. Given the character of *Otherness* present in public understandings of mental illnesses, day centres were considered safe havens for those involved in projects of managing and maintaining their own mental health (Foster, 2001). In that context, mental health was promoted away from the community which was seen as a threat to their identities (Foster, 2007). In both studies, there was a clear separation between wider (and threatening) society and safe (but detached) spaces for support. In this study, clients of day centres merge the social spaces of *society* and *day centre* into one symbolic space. This enables clients to feel that they participate in society and engage meaningfully with different groups. Social inclusion and belongingness were common outcomes of participating in activities for socialising as will be further explored below.

The findings of this study also contrast with older adults' experiences of residential care. In a study conducted by Chandler and Robinson (2014), residents of retirement villages perceived themselves as excluded from society despite the opportunities for social engagement and community building amongst themselves. Furthermore, practitioners represented the experience of attending the day centre as an *intermediate stage* before entering a more isolated space (e.g. a nursing home). In this case, the day centre was objectified as a preventative space (the community) against social exclusion, which is objectified as living in residential care homes.

R: Is it a purpose of this day centre also to promote independence to them?

P: Yes, yes, to keep people able to live in their own home. So, they don't have to move to a residential home. I mean, Julie is another example, she was very lonely, didn't want to carry on living when her husband died, but she's come here, made friends, comes twice a week, and it's made all the difference in the world.

Megan, 60, staff member, Tulip Tree

The project of *well-being promotion* via socialising is not an individual quest. Clients mention the shared nature of socialising in spaces of support, as Sara, client, aged 82, remarks, '*I am in several groups like this, when I go and see, it's really the same people*' (Field Maple). Another client (see the extract below) emphasised that well-being promotion in the community differed from her individualised view of life satisfaction and promotion of wellness. This aspect could help to explain why clients do not draw on all aspects of their theories of well-being present in their representations to justify their involvement in receiving and giving support.

R: And what makes you feel happy?

P: Listen to, just listening to other people, listening to their stories, and um, what makes me happy is, just trying to find myself, and I find it through music, sometimes through reading...

R: And what do you think make older people feel happy?

P: Older people?

R: Yes, elderly people. What do you think makes them feel happy?

P: Well, when we come to a day centre, that's what makes us feel happy, because we're mixing with people of our own kind, and we're like a little family here, and we all tease each other and all, and there's a lovely atmosphere and we do activities, and that's what makes me happy, coming to Field Maple, that, that's one of the main things, because I get out the house and away from all the problems of the people, you know, and it's nice.

Ailsa, 89, client, Field Maple

In the extract above, *being old* changes the way in which clients represent well-being promotion. There seems to be a *we-project*⁴⁹ in seeking happiness and social support for older adults in the community. The client above stresses that being identified as elderly entails a determined orientation to actions of well-being promotion and a social identity. Research has shown that social groups share different representations about ageing according to how they position themselves generationally (Freitas, Ferreira, & de Freitas, 2013; Gherman, 2014; Nascimento-Schulze, 2011; Wachelke & Contarello, 2010). In this context, when individuals represent *old age* in association with actions to promote *well-being*, they enact distinct representations of wellness which involve peer support and a sense of connectedness with people from a similar generation and background.

Staff members and volunteers position themselves as mediators of this project of socialising in the community. They use the metaphors of *sociable environments* or *outlets* to refer to the day centres. In this case, the day centre is a mediating space between the clients and the public sphere. Practitioners differentiate between two social spheres: the client's home, which is an private, intimate, and personalised space of life, and the day

⁴⁹ In fact, all representational projects are *we-projects* as they refer to a collective effort of groups and communities to think and behave in relation to an object (Bauer & Gaskell, 1999). Here, I used this expression to distinguish a representational project from individualised definitions of happiness as proposed by hedonic approaches to well-being (See Steptoe, Deaton, & Stone, 2014).

centre, which is communal and public space outside their isolated sphere. Paradoxically, social reality *outside* the day centre is a space of social isolation, exclusion, and loneliness, whereas *inside* the day centre it is characterised by communication, interaction, and belonging. Below, a staff member at Field Maple, stresses this dichotomy in her representation of older adults' social life.

... this [day centre] is somewhere they can think, psychologically, 'this is my home and that is my day centre'. There are two bits of life and both of them are valuable so they like to go home and they've got their own little bits and pieces around, em you know, the warmth, the telly, whatever it is that's important, you know, and then they come out and it's 'the world' and we've got all these people that we see every week...

Ann, 72, staff member, Field Maple

Having considered the relational ethos of day centres, I shall explore three different set of actions of socio-emotive support which brings specific outcomes to clients and practitioners involved in well-being promotion. Help via peer support, promoting structure and purpose to live, and activities which promote socialising are seen as important actions of well-being promotion via the day centres. I will argue that these actions have particular implications for the way in which well-being in later life is represented. The analysis of these practices will elucidate the way in which clients and practitioners develop their shared representational project of well-being promotion.

5.4.2.1 Help via peer support

As discussed above, the community support provided by members of day centre contrasts with the individualised atmosphere of other settings (houses and care homes). Social interactions amongst peers have been reported to alleviate losses and transitions associated with ageing (e.g. bereavement, limited mobility, and income) (MacKean & Abbott-Chapman, 2012). In this context, groups that share similar life experiences—*similar others*—mediate emotive support in different ways (Thoits, 2011). This sort of support is theorised to enable the self to adapt to different demands and provide a sense of belonging (Cobb, 1976). Secondly, community relations appear to mediate health outcomes (Baum, 1999; Campbell & Jovchelovitch, 2000), and to provide referent points from which older adults assess their health behaviours (Thoits, 2011). In this study, the peer groups enable clients to cope with negative experiences and to construct a more positive and *active* identity.

R: How do you think this day centre helps these people to feel supported?

P: Well, it helps you because you are mixing with other people.... So, you get a chance to go out... But the main thing is you are mixing with other adults of your own age group.

Frankie, 82, client, Aspen

R: Why are day centres so good for your life?

P: Well, first of all, they get you out of the house. And, you meet other people, and you just meet other people who are not completely 100% in this world. Like, you are not as bad as me. ... It's just... coming into a different world, coming here.

Sarah, 82, client, Field Maple

Getting out has the purpose of social interaction with peers. Clients' views on their peer group involve a common experience, or a *common fate* (Bauer & Gaskell, 1999, p. 170) linking older adults via their mutual needs, aspirations and identities. Therefore, their common project of well-being promotion is materialised by their participation in different activities and social meetings. Moreover, this representational project contributes to the formation of a particular social identity amongst older adults in community support. According to Foster (2001), when a particular representational object is socially and affectively relevant to groups, identity and projects will be more interrelated. This is also the case for older adults who constantly renegotiate their identities as active and independent individuals in the community.

As discussed in Chapter Four, these identities are partially formed as a resistance to negative images and metaphors associated with old age. At the same time, clients' identity work is influenced by hegemonic representations of ageing well as anchored in an active lifestyle (Sánchez & Hatton-Yeo, 2012). This ambivalence and complexity in representing ageing well (and themselves) is reflected in the way in which they enact the thema of *activity-passivity*. Both poles refer to positive and negative experiences of ageing in the community. Therefore, corroborating Foster's (2001, 2007) research with mental health service users, older adults in community support construct their identities within their framework of support as forms of symbolically positioning themselves in their social contexts. These forms of positioning involve the work of accepting, renegotiating or resisting negative understandings of ageing—as a period of passivity, decay, and burden—and enacting positive social identities (Duveen, 2001, Foster 2001, Joffe, 1995, Tajfel, 1981).

Clients renegotiate the meanings of their identities as active and independent actors in the face of physical and cognitive limitations, and potential stigma attached to

not being productive in society (Ekerdt, 1986; Sánchez & Hatton-Yeo, 2012; Walker, 2002, 2009). Moreover, negative aspects of ageing associated with longevity, frailty, and social death are accepted inasmuch as they identify themselves with *similar groups*. The *peer group* is thus constructed as *brothers in arms*, as companions of mutual support. Corroborating this, Claire (aged 90), a client in Aspen Day Centre, makes sense of her experience of attending the day centre as one of communal support. *'I think it's good just to, I think it's the community spirit of people together, and chatting.'* In this social space, cognitive and physical limitations, represented as *otherness* are not so threatening, but assimilated in a narrative of mutual encouragement and support.

But, most people seem to be. You know, they have the same as I do, they have families, and they live around their families, this sort of thing. So, all in all, we are all in the same boat [laughing].

Ailsa, 89, client, Aspen

R: What are the reasons for your colleagues to come to a day centre like this?

P: Well, I think, I think, well. I think is, you know, like Michelle, she can't get about very well, can she? And Kevin, he lives on his own, and that helps him to get out, and then [have] company... And I think that is generally, one of the main purposes of people coming here, they are getting together, you know, mixing with people and that, you know.

Kevin, 68, client, Tulip Tree

R: Do you think this day centre can help people with dementia as well?

P: ... Yes, it's going to help them feel more normal.

R: Feel more normal?

P: Umm.

R: How do you think this day centre [can help them to feel normal]?

P: Because they're treated differently

R: Do you think people with dementia are treated differently in society?

P: Well, people with dementia can be segregated and that's not always a good thing.

R: I see, of course, of course.

P: They can feel out of it but if you're able to make them feel part of it then they react differently.

Clare, 88, client, Tulip Tree

Group identity is not something that emerges only from in-group categorisation. This study points to the influential place of powerful social groups and hegemonic representations in assigning social identities to less empowered ones (Duveen, 2001; Duveen & Lloyd, 1986, 1990; Howarth, 2002a). As Duveen (2001) reflects, 'identity is as much concerned with the process of being identified as with making identifications' (p. 257). In this context, staff members and volunteers ascribe a group identity to clients based on representations of their life experiences. They anchor this social categorisation in clients' alleged common generational experiences (e.g. war, popular culture). Therefore, for the practitioners, peer support constitutes an important strategy to the maintenance of this generational identity.

Well it depends if they are in a care home. Mainly the staff will be young and they have not really got that common ground... These people have probably all lived through the war together and ... with all the anniversaries coming up of wars and

stuff, they've got a hell of a lot in common, they'll know all about theatres and films and radio shows they used to listen to and just general life as it was in the 40s, 50s and 60s, and I do quizzes based on those eras because it brings back memories for them and they need to integrate with each other. It's peer groups, isn't it?

Harry, 56, volunteer, Tulip Tree

Clients and volunteers who experienced hardship during World War II also highlighted this historical period as foundational for their social identities and a sense of value. These collective memories not only helped them to construct a *generational* identity, but also to create a sense of cohesion and group identification (Jovchelovitch, 2012). Narratives of the war were present across all day centres, although Field Maple clients were most active in associating these experiences to their identities. The label of *old age* with its negative associations was resisted by those who redefined themselves as valuable actors of social and historical change.

We are making more old age, because we had such a rough war. We won't, we won't ever feed, we had to do lot more exercises, mhm. And it made us tougher. That's why we are making old age. I am sure that's why [laugh] The others would agree. They say, 'Yes, Julie. Do you remember when a tiny bit of butter we got for the week...' I would say, 'Yes, I bloody do.' My God, all the meat and everything was on ration. It was unbelievable...

Julie, 89, volunteer, Field Maple

R: How do you think society sees the elderly?

P: [Coughs] sometimes I think they think they're a nuisance, I don't know [laughs]. We don't want to be, we've, we've done our bit. We certainly have, we've contributed, we didn't want to go into the wars... you know, my husband was in the second world war, and I was married then, cos I was married in 1936, and the war started in 1939, and I'd got a young boy. A little boy, yeah. So, I know, you know, that we have done what we were expected to do, then. But it's not easy for the young people today.

Betty, 83, client, Field Maple

5.4.2.2 Purpose and structure in life through socialising in the day centres

Attending a day centre brings purpose and structure to someone's life, and helps in coping with unstructured elements (which cause isolation and loneliness). Clients highlight the importance of a structured routine to keep themselves active. Socialising enables a sustained routine which brings purpose and scaffolding to cope with mobility and cognitive problems. A form of *busy ethics* underlines clients' participation in the routine of activities within the day centres (Ekerdt, 1986). Clients highlight that socialising enables them to remain active and prevent deterioration. These views focus on the need to preserve an active mind and prevent any form of deterioration, as discussed in Chapter Four.

Well, as I said, I got, I got things to go, places to go to, and I also have my lunch at these places, you know, I get picked up about 10:30 AM and also I am brought back in the afternoon, and we have a coffee, and we have discussions and talks and things like that...

Sarah, 82, client, Field Maple

R: What's the role of this day centre in your life?

P: Oh, yes, mhm. Well, you know (...), this gives me, gives me a purpose, but I know for certainty I've got to be, hmh, up in about on the Wednesday and on Friday...

Kevin, 68, client, Tulip Tree

Tulip Tree was characterised by a stronger emphasis on conducting activities with the purpose of promoting meaning and structure to older adults' lives. Puzzles, memory games, chair exercises, wrist-band exercises were repeatedly conducted during a common day in that day centre. Noticeably, Field Maple and Aspen day centre placed less structured emphasis on physical and cognitive activities than Tulip Tree. In conversations with staff members from these settings, I noticed that the level of qualification to work with older adults played a role in defining the set of activities. For instance, the events coordinator at Tulip Tree facilitated more exercises than the one at Aspen due to her participation in a specialised course.

R: What sort of preparation did you have ...[?]

P: Well, ... I've done a four-day course with the Training for Later Life. So, that I've learned how to do them, how to do the exercises, and how to teach the exercises, and to be aware of there are different medical conditions or any problems they might have.

Megan, 60, staff member, Tulip Tree

They've got to think, part when you are doing quiz, they've got to sort of think of the questions, and when they are making their hats they had to think where they would put their bits. This give them, it keeps their hands moving and that, because part of them do get arthritis bad in their hands, you know. We would like to do, like chairs exercises here. But we can't just do it. You've got to have, you've got to go in a course and get qualified, so. The lady who was here before, she used to do it, and they enjoyed a bit of move, they can stretch, not standing up, obviously, because they all will be on the floor. But arms and legs, but you are not allowed to, so.

Katie, 53, staff member, Aspen

In general, staff members plan and execute activities that form a routine for clients. They seem to reinforce the need of routine and structure in later life to prevent them from deterioration and needing institutional care. In this way, the day centre constitutes a reliable place for promoting independence in the community. Some justify the use of repeated activities as a strategy of promoting emotional security to their clients. This was salient in one of my interactions in Tulip Tree day centre and the interview which followed it.

After the cup of tea, Helen led the raffle and the seat exercises. During this time, I was speaking to one of the clients, Cameron, and showing him some pictures of Herb Alpert—a singer and player. Cameron thought I resembled him and kept stressing this during my time in that day centre. I was using my mobile to show the images to him, when the activity started. During this time, I was still using my mobile phone—sharing the attention between the Internet and the physical

activity. Suddenly, Katie [activity facilitator] told me that although these activities seemed to be repetitive, the clients feel comfortable with them. They enjoy the routine of activities rather than exploring new things. She also mentioned that she tried to propose something different, but the clients do not engage with new activities happily. I noticed that the use of my mobile during that activity transmitted a message that I was not enjoying the repetitive activities in that day centre.

Fieldwork note, Week 3, 22.05.2014, Tulip Tree

Well, they do like to know what is happening, mhm, and they like certain routine because this gives you a sense of security.

Katie, 60, staff member, Tulip Tree

Activities are also justified according to the main ethos of support in the voluntary organisation: *socialising in the community*. Activities that foster community participation are also ways in which staff members and volunteers operationalise their representations of well-being promotion in later life.

5.4.2.3 Activities for socialising in the community: the role of participation in community support

Clients and voluntary sector practitioners put into practice this shared project of well-being as a product of community engagement. Participation in community settings and activities is a core feature of a representational project of well-being promotion. As theorised by Jovchelovitch (2007), communities ‘offer a new mediating site for the

development of participation in the public sphere' (p. 73). This is particularly relevant in this project for two reasons: firstly, segregation and loneliness are commonly experienced by older adults living in the community (Victor, Scambler, Marston, Bond, & Bowling, 2006). Secondly, clients' representations of loneliness have a strong affective component, which is associated with their feelings of detachment from the larger community (as discussed in Chapter Four).

Community participation is therefore the vehicle which enables positive outcomes in later life such as peer support, cognitive and bodily stimulation, and social confidence in daily life. Campbell and Jovchelovitch (2000) stress that it is through participation in communities of support—via projects—that groups access material and symbolic resources, and become aware of determined identities. Some activities mediate social interaction and cooperation between clients and the social sphere. In this process, different organisations (e.g. schools, sport centres, health commissioners) collaborate with the day centre to promote advocacy and social support. Socialising in the community is the main justification for planning those activities. For instance, in Field Maple I observed a group of students conducting a project on exercising and fitness in later life. Although physical activities were not central to the ethos of support at Field Maple, staff members justified this sort of activity as a bridge to link clients to other social groups.

The atmosphere of the day centre seemed very busy as not only volunteers but also secondary students arrived to promote physical activities with the day centre. They are mentored by a teacher who guides them to conduct physical activities with different groups. The group of four students and their teacher conducted physical exercises with the elderly as part of a school project. They will come back in the next week to conduct a series of different exercises.

Fieldwork note, Week 3, 28.11.2013, Field Maple

Some activities were planned and executed with the help of clients, which enabled more participation. In Aspen Day Centre and Tulip Tree, I noticed that staff members and volunteers provided clients with opportunities to do art, craft and play games. Despite the repetitive character of some of these activities, staff members and volunteers stressed the social benefits of participating in them.

I noticed that two tables had been set up for an art activity. Clients would have to decorate Easter hats with a broad range of pieces, figures and forms. The day centre has started preparations for the Easter, and staff let the clients know about the schedule for the Easter holidays.

Fieldwork note, Week 4, 12.03.2014, Aspen

R: What kind of benefits do you think these games could bring them?

P: ... the feeling of sort of togetherness as well, the group and then also the games are always having a sort of mental [focus] ... or it could be more of a physical game where they are trying to throw something to aim for an area in which case it's still a mental and physical task...

Amanda, 35, volunteer, Field Maple

When asked about the benefits of engaging with these activities, clients highlighted the value of being socially connected and participating in activities as a group. Beyond individual stimulation, well-being promotion is a social experience.

R: And what are the benefits that you see by coming here and coming to Friday's day centre?

P: Well, I mean, I've done things I wouldn't [have] done, you know, I mean. For one, mhm, for one thing, I mean, I wouldn't work with pastry and make tarts and lemon curds, and no mince pies, and all of that sort of things... then, the rest of is, you know, just being in the company of other people, you know, rather than sitting at the telly overall, you know.

Kevin, 68, client, Tulip Tree

However, diverse challenges limit the use and scope of activities across all day centres. Staff and volunteers raise three main challenges to the enactment of support: increasing number of clients with cognitive and physical limitations, financial constraints, and lack of staff members and volunteers. In Aspen Day Centre, where socialising was overtly emphasised, increasing numbers of clients with mobility problems and a lack of staff members challenged their plans for more events outside the day centre.⁵⁰ Clients also acknowledged their physical limits to participate in some activities.

R: What things in this day centre could change, could improve from your view?

P: Well, I don't really know. I mean, maybe different activities or something, but then, that means getting up, and sometimes that is a bit awkward. Because my foot swells...

Frankie, 82, client, Aspen

⁵⁰ Institutionally, Aspen Day Centre was characterised by a stronger emphasis on socialising. Staff members and volunteers organised more outings and social events (Christmas dinner, Easter celebration, walk on the coast) than at Field Maple and Tulip Tree. I observed several pictures of past events on their walls as well as different forms of entertainment.

Oh, round about Christmas we went to Haildoor, you know a shopping centre... and we went to Park Theatre which is up the A1 but of course the thing now is... there's quite a few when you go on outings that would need to be pushed around. You know Helen needs to be in a wheelchair, Bethy does... well there's just not enough people to push them around.

Sally, 67, volunteer, Aspen

In this context, re-negotiation and adaptation of services is necessary. Changes will be welcome by clients inasmuch as they are aligned with the hegemonic project of wellness as a gainfully relational living. The fieldnote below exemplifies how staff members and clients may negotiate the enactment of this project when confronted with daily contingencies.

Beth told us that Clare (day centre organiser) wanted to have a word with us. Clients (and I) knew she wanted to explain something serious to the group. I sat down near Julie, Luke and Laura. Then, Clare explained that they had to change their usual plans for going out to visit some places... she explained that they had to deal with many clients with wheelchairs and there are not many volunteers to help. Therefore, she suggested that instead of taking them out, they would bring in more entertainment.... She suggested they could 'have a goal' and check whether this would be a good idea. She then stressed, 'It is your day', referring to their responsibility and right to decide on what they would do in the day centre.

Fieldwork note, Week 5, 21.03.2014, Aspen

The interaction above seems to reflect a consumerist ethos within that day centre (Rogers & Pilgrim, 2001). The very fact that older adults are labelled *clients* to whom support is directed justify the need for negotiation in the decision-making of certain activities. Nevertheless, staff members and volunteers seem to exert a more influential role in defining the course of actions. This power position is also validated by the way in which this group represent themselves: mediators of community support. Despite the salience of a consumerist ethos in social care, the project of well-being promotion must be collectively agreed. In this context, participation in decision-making amongst clients is encouraged.

From the extracts above, it is clear the relationship between lay conceptions of wellness and the development of a project of support. This project is associated with the larger context of public understandings of ageing in the UK; one which highlights activity, vitality, and independence. Nevertheless, practitioners and clients transform this project to adapt to different demands in later life. Socialising, peer support, and the development of a common identity (or common fate) are at the core of well-being promotion in the day centres. To examine whether this project would also be shared in a different social context, I included the views of visitors and clients on well-being promotion as enacted in their interactions. In the next section, I shall explore the enactment and development of the project in this specific context of social interaction and communication.

5.5 Focus of the visiting scheme: the evolving nature of projects

The visiting scheme represents an important strategy to address social isolation and loneliness. In my initial interactions with volunteers and clients, I noticed that social

interaction and company were the main purposes of this scheme.⁵¹ More isolated individuals and people with mobility problems were the main clientele of this service. However, this social ethos was not stable across time. Volunteers' accounts revealed that *time progression* and *the acknowledgement of different needs* had an impact upon how they see support and well-being promotion.⁵² These findings corroborate current theoretical considerations of how representational projects change over time, and which factors in a given context are related to these changes (Bauer & Gaskell, 2008; Foster, 2011). Thus, by using a multi-methods approach to explore social representations, I was able to access their meanings on changes in their project across time, that is, the 'diachronic transformation of social representations through social exchange' in the visiting scheme (Jodelet, 2008, p. 424).

According to Sammut, Tsirogianni, and Wagoner (2012), contextual meanings and purposes of action change over time as a result of communities' adaptation to ecological changes. Furthermore, as pointed by Foster (2003, 2011), representational projects have also an impact upon the objects of representation. Bauer and Gaskell (2008) highlighted how projects and representations are enacted in relation to communities and different material contexts. In this way, different projects may hold together in the same social milieu, although social groups hold unequal power to enact them (Foster, 2003b). What is yet to be further explored empirically is the extent to which representational projects change over time, and what this informs us about the changing nature of thinking and acting. As mentioned above, a few exceptions are Foster's (2001, 2007) ethnography of mental health service users, Sammut's et al., (2012) study on Maltese immigrants, and

⁵¹ During the process of acquiring consent for the interviews, I also shadowed some volunteers when they visited their clients. This enabled me to grasp the context of interaction between clients and visitors.

⁵² Data from this section covers mainly my interactions with visitors. As explained in the Chapter Three, most of the clients who receive visits were unable to be interviewed. Frailty was the main reason for their refusal to participate in the interviews.

Zadeh's (2014) study on social representations of single mothers by sperm donation in the UK. These studies point to the evolving character of representational projects and corresponding identities.

In the next section, I will highlight how my own findings elucidate the way in which the changes in the project of well-being promotion is perceived by volunteers and clients in the visiting scheme. Figure 6 highlights how volunteers changed their views about the visiting scheme over time: initially, their actions of support focused solely on providing social interaction (A, Figure 5). Nevertheless, with the time progression in their relationships, visitors were confronted by numerous issues presented by clients: help with shopping, mobility problems, frailty, information on services, etc. These contextual aspects had an impact upon the way in which they provided support to older adults: these aspects challenged their initial ideas about the scheme and invited them to enhance the scope of support. Thus, visitors stressed the need to promote practical help with daily issues (B, Figure 5). Time progression and needs were important components influencing the project. From their accounts, well-being promotion via the visiting scheme involved a combined set of actions: visits to promote company and structural support for daily issues (A +B, Figure 5).

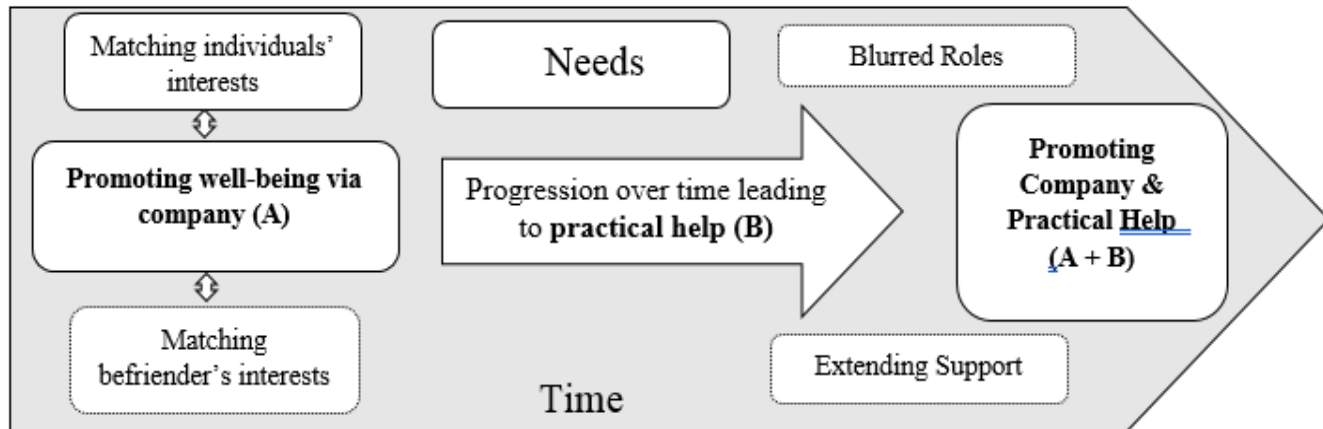


Figure 6. Progression of the project of well-being promotion over time.

5.5.1 Visits to promote human interaction

Evidence suggests that educational and group activities are more efficient to tackle social isolation and loneliness than one-to-one support (Cattan, White, Bond, & Learchmouth, 2005). Nevertheless, research is yet to explore how home visits in the community benefit older adults (Cattan, et. al., 2005). Visitors regard the visiting scheme as a unique strategy to address older adults' main problems: social isolation and loneliness. They applied different metaphors to make sense of their role as befrienders such as *springboard to talk* (alleviate concerns) and *scaffold to socialise* (promoting confidence to engagement in social life). In this context, volunteers define their roles as mediators of company. Initially, they differentiate themselves from health and social care service providers and embraced the guidelines of listening and talking during the visits. In this context, the purpose of the visiting scheme is to provide '*contact, to be dealing with someone who is pretty lonely, who doesn't see anybody other than a nurse or whatever*' (Ashley, 68, visitor). On one level, this social orientation was largely shared amongst the visitors.

But, as a volunteer we, we don't do anything carewise, our role is just to be friend...

Joana, 59, visitor

My role is, erm, to provide company, I think...

Stephen, 80, visitor

During visits, visitors highlight the importance of discovering their clients' needs and interests. Shared activities have been considered an important element in older adults' definitions of friendship (Adams, et al., 2000). Moreover, adequate matching of clients and befrienders' interests is found to be foundational in a relationship of support (Andrews, Gavin, Begley, & Brodie, 2003). This is regarded as an important step from the matching of client-visitor to the progression of visits. Therefore, common interests are determinants of a successful relationship of support.

The volunteer scheme I think is better if it can match people well. ... Somebody who, you know, they've got common interests or something like that, when they can talk about, you know, what the person wants to talk about, not just play snap.

Hannah, 66, visitor

And then she rang me one day, Helen [visiting scheme supervisor], and said 'Do you play chess?' [laughs]... She said, 'Well, there is somebody who wants somebody to go and play chess with him each week...' I went to play chess with him each week. And he, he really appreciated it.

Ashley, 68, visitor

Matching a client's needs is seen as the main purpose of social support. Volunteers are sensitive to the clients' interests and needs over the course of visits. In fact, some volunteers highlight the need to be attentive to the clients' interests in order to meet the visiting scheme purposes.

R: What does consist of your work? What do you do in this organisation?

P: OK, I have a lady, she is 90 years old, lovely... lady. Mhm, and I go once a week to her home, and I stay about two hours, we just talk. She lost her husband just over a year ago. He loved to sing, and he used to make CDs of him singing...

Esther, 64, visitor

Volunteers highlight that they become more aware of their clients' complex needs during their long-term experience of visits. Progression in visiting leads to changes in the scope of support and the relationship between the visitor and clients. In so doing, volunteers extend their scope of care to adapt to clients' needs. What starts with a clear social focus, extends to practical support.

5.5.2 Progression in visiting leads to changes in the relationship between volunteers and clients

Social roles become less defined in the visiting scheme. The passage of time challenges their initial conceptions of well-being promotion via social relationships. This representational project evolves according to the actions and needs of clients and volunteers. Time is a key element in participants' representations of social support via the

visiting scheme. Time progression facilitates changes in the social roles of clients and volunteers; however, it also presents a challenge to volunteers.

R: What are the main challenges that you face when visiting her?

P: ...blurred lines... because in a way it's sort of [the] professional formal role you've got visiting her a bit. But you also over time, it doesn't feel like that now, it just feels like a true friend, and I think it's... it's is very difficult actually to manage that.

Laura, 26, visitor

As the relationship progresses, volunteers enhance their scope of help. Visitors not only provide social interaction, but also become increasingly involved in helping clients with daily issues: buying food, paying bills, managing bank accounts and outings are some of the extended help visitors give to clients. Volunteers see their relationship with clients differently over time, extending their contact beyond the organisational boundaries. Similar findings were reported by Andrews et. al., (2003) in a qualitative study on befriending users in the UK. In that study, users of a visiting scheme placed value on the *extra* work done by volunteers in the progression of their friendship.

R: How do you think of the role of the volunteer? Do you see yourself in relation to her? Are you a volunteer, her friend?

P: We are more of friends, definitely friends. I see her once a week as for this organisation, but I can see her other times during the week as a friend. It is not bound to just my 'want'. I can go out and take her out, but it's not gonna be this organisation's thing, because then you get into all these comfort and safety

situations, or you know. So, as I just get to make a point of, OK, if I go out and we go for a coffee or something, that's not gonna be [via] this organisation, that's gonna be as a friend.

Esther, 64, visitor

However, this progression leads to blurred roles between visitors and clients. Volunteers feel confused about their roles, duties and actions toward clients, particularly as their relationship progresses over time. They feel ambivalent about providing different types of help, or inviting *relevant others* to the relationships.

... and they can start to ask you to do things, stuff, becoming more and more dependent on you, which is not what we are supposed to do, we are supposed to just be a visitor, we are not even supposed to change light bulbs... this sort of health and safety, all this sort of stuff. So, that can be a problem, I mean it's on the day I visit, she sometimes rings up and says, ... 'Can you bring a loaf of bread or something?' And there is a shop just near, I can do that. I don't mind doing that.

Terry, 68, visitor

Findings in this study shed light on Bauer and Gaskell's (1999, 2008) initial theoretical construction of representations evolving through time. Before discussing this issue, it is important to consider that I was unable to access longitudinally change over time. Nevertheless, volunteers represented their relationships and practices of support as subject to such changes. As suggested by Sammut et al. (2012), change in a representational project is a result of groups' adaptive efforts to deal with different

constraints. In this way, a project rearranges representations of the past and evokes a potential and desirable future (Jovchelovitch, 2012).

In Bauer and Gaskell's (1999) toblorone model, projects not only involve an orientation to the future, but also refer to the past. There is an evaluative component in participants' representations of actions of support; one which draws upon past memories of actions of help, but adapts to deal with different contextual demands. These actions of support have a clear impact not only on clients but also on volunteers' social positions. There seems to be an element of unpredictability in their representations of support over time, which causes ambivalence in the way in which they define themselves as volunteers. These findings are particularly important to understanding how individuals and social groups' representations and identities are transformed via the enactment of a project (Foster, 2011). In this project, ambivalence may constitute an unintended consequence of this change in the representation of well-being.

5.5.3 Visits to oversee needs

As stated above, the relationship between volunteers and clients over time brings awareness of the specific needs and interests. In addition to a social ethos, a need-oriented approach emerges in volunteers' accounts of support. Visitors see themselves as potential overseers of help.

And this other lady that I used to visit in Coventry, like they had so many problems that I can't help with. So, I went once, and everybody used to think, 'Oh, you know, she's got this befriending person going there once a week. So, it's sort of problem solved.' Because, because it's definitely, it's definitely not...

Laura, 26, visitor

Ah, Ah, yes. Well, for me it is another relationship, which is important, like to have a relationship with other person, conversation, engagement, all of that. And the sense of one is providing something for someone that otherwise it wouldn't [have] been met... I would think I've wanted to take her around, and we took her, my wife and I took her to this garden centre, are hoping to do that again with her. Mhm, probably once a month, we are trying to do in six weeks take her out. The thought that I am giving someone something that they really want, that they wouldn't otherwise get, is very important to me.

Ashley, 68, visitor

Concerns with clients' needs may be partially related to age-related issues. Rodrigues, De Jong Gierveld, and Buz (2014) suggest that older adults' needs and expectations of support may change over time due to problems associated with the aged body. In such a scenario, instrumental support is more relevant than emotional help in promoting well-being. Additionally, the progression in the befriending relationship involves the re-definition of clients and volunteers' conceptions of friendship. Previous research has pointed to the dual character of friendship: interactive spaces of companionship and practical help (Andrews et al., 2003; Nocon & Pearson, 2000; Piercy, 2000).

Volunteers also see themselves as reliable sources of support. Like day centre volunteers, they regard the visiting scheme as an adequate space for community help. In this way, Age UK adopts an *ad hoc* approach. However, volunteers report that daily issues such as mobility problems, health needs, and house chores are not sufficiently discussed with staff members, particularly visiting scheme supervisors. They report the need of improving advice and communication about service provision in the community. Their

set of actions adapts to deal with different demands of personal and closer social contacts. Furthermore, they maintain socialising as an important domain of social support within this needs-oriented project. In this case, I contend that these representations point to the evolving character of the representational project of well-being: one which guides adaptive actions of support in the context of companionship.

5.6 Summary and concluding remarks

In this chapter, I examined the relationship between social representations of well-being and different practices of support. In this process, the representational project of well-being promotion constituted the main mediator between social groups' definitions of wellness and specific actions. I sought to examine how the hegemonic representation of well-being as active, independent, and gainful living evolved in the day centres and the visiting scheme. Well-being promotion via support aimed to enable older adults to *be in the community*, either by fully participating or receiving support in it. In the visiting scheme, this project was examined in relation to participants' views of change over time. Time, space, and needs were important dimensions in the participants' representation of change in way they give support. Findings may enable social researchers to examine policy and practice regarding well-being in later life from the point of view of those marginalised and less empowered groups (Howarth, et. al., 2004). In this context, the shared project of well-being promotion not only shed light on how ideas of ageing and health are enacted in the voluntary sector, but also how relevant groups challenge public views on ageing well in the UK. Next, I will further explore the implication of lay views on ageing well for well-being policy and social care. The limitations of this study and its implications for theory and practice of well-being promotion will also be further

discussed. Most importantly, I hope to discuss how older adults, staff members and volunteers' representations of well-being are multifaceted and complex and challenge current expert models of ageing well.

CHAPTER SIX: CONCLUSIONS

6.1 Introduction

In this final chapter, I will summarise the main findings of the research and point to how they address the theoretical and empirical gaps in research into later life. I will consider their theoretical, methodological, and empirical implications. Finally, I will discuss the policy implications for well-being promotion in later life.

6.2 Summary of the findings

The manifold ways in which people understand ageing well have considerable implications for community-based care in the UK. What lessons can we learn the views on wellness of clients and voluntary sector practitioners? How do the direct recipients of active and successful ageing policies understand ageing well in the community? In an attempt to address these questions, I adopted the theory of social representations as a framework through which to explore wellness in later life.

This study indicates a hegemonic representation of ageing well as an active, independent, and gainful living. It demonstrates the pervasiveness of the professional models of active and successful ageing in common sense (Fernández-Ballesteros et al., 2010). As highlighted throughout this thesis, activity, independence, and autonomy are regarded as contemporary cultural indicators for life satisfaction and enjoyment in old age (Clarke & Warren, 2007; Flick et al., 2003; Foster & Walker, 2015; Nascimento-Schulze, 2011; Ryff, 1989b). For instance, research has indicated that older adults score

higher on measures of subjective well-being as a result of their adopting a more active role in society (see Diener, Suh, Lucas, & Smith, 1999, for a review of studies).

Nevertheless, this idealised state of wellness which is often advocated by the professional frameworks of active ageing and successful ageing is challenged by clients and voluntary sector practitioners. The oppositional binaries they employed in order to represent well-being also reflect the complexities of ageing. On the one hand, well-being was associated with *activity, autonomy, and gains*. These ideas bring forth new frameworks to anchor the experience of ageing positively. On the other hand, all groups addressed the negative aspects of ageing in the community. The negative poles of *passivity, dependence, and losses* reflect the difficulties of ageing. The normative orientation towards activity, health, and autonomy is challenged by the lived experiences of older adults.

In equating wellness in later life with an active lifestyle, clients and practitioners reiterate the image of youth as the main symbolic domain in which to anchor positive experiences in later life. Conversely, the passage from a younger stage to *old age* is characterised by cognitive, physical, and social markers, namely, cognitive and physical deterioration, and a context of social isolation. Therefore, passivity and dependence are represented as signs of the genesis of the *ageing process*. These representations were particularly salient amongst clients and older volunteers, who positioned themselves differently according to their self-orientations. In the group of clients, the ideals of youth as applied to later life are better translated into efforts to keep fit and active. Older volunteers engage in support as a way of preserving participation in the community and resisting the progress into *passivity* in later life (Rozanova, 2010). Following Ekerdt (1986), voluntary involvement in later life is ‘morally managed and legitimated on a day-to-day basis in part by an ethic that esteems leisure that is earnest, occupied, and filled

with activity—a “busy ethics.”” (p. 239). In this context, volunteering constitutes a form of social engagement which is in line with the normative ethos of the activity theory (Havighurst, 1961; Morrow-Howell, 2010). Moreover, the reciprocal relationships of support underlie practitioners’ motivations to volunteer. This was particularly evident in the group of visitors who desired to connect with others who are more isolated as a way of giving back to society what they had received, and of keeping active socially. Despite the differences in how they position themselves in relation to giving support, the boundaries between volunteers and clients were blurred—staff members highlighted that both groups benefit from being involved in community support.

Findings also point to the need to consider well-being as a *generative* and *relational* concept. Clients’ views on well-being are generative in that they are related to material, historical, cultural, and institutional contexts (Taylor, 2012). Such contexts offer the possibilities and symbolic material for older adults to make sense of wellness (Barnes et al., 2013). Secondly, well-being promotion is relational. Challenging individualistic emphases on ageing well, both groups of participants represent wellness as a consequence of meaningful relationships of support (EU, 2012; Rowe & Kahn, 1997). Despite the emphasis on active and independent ageing, clients still stress the importance of social relationships and family support to age well. These aspects corroborate previous participatory research conducted with older adults on what well-being means to this group (Ward, 2014; Barnes et al., 2013). In this context, community participation, belonging, and interdependence are core elements of well-being promotion in the day centres and the visiting scheme.

Clients, staff members, and volunteers were involved in a *hegemonic project* of well-being. Two sets of actions were adopted to develop this project in the institutional settings of day centres and the visiting scheme: *socio-emotive practices of support* and

help with practical issues (or instrumental support). These actions were assessed by clients, staff members and volunteers as the main strategies by which to promote wellness in community settings. In this context, day centres and home visits were represented as *spaces* where the promotion of well-being is possible.

What are the implications of these multifaceted views of wellness for policymakers and social gerontology? This question will be further addressed below. Furthermore, the implications of this study for a social psychology of well-being promotion in later life will be considered.

6.3 What does this study contribute to policy on well-being promotion in later life?

As described in Chapter Three, my first interactions with the voluntary organisation's board revealed their concerns with promoting well-being and active ageing in the community. Preventative services—with an emphasis on reducing hospitalisation, promoting independence, and life satisfaction—reflect the international policy of active ageing (EU, 2012; WHO, 2002; Foster & Walker, 2013). In this context, I sought to examine the main conceptions of well-being held by clients and voluntary sector practitioners and how the normative frameworks of ageing well are understood in community support. In so doing, I explored social representations in a naturalistic and exploratory study design. Therefore, ethnography enabled me to explore views of well-being and support and to assess major policy orientations from the point of view of the recipients and givers of support.

In this study, lay views of ageing well were relevant not only to assess the adequacy of social and health interventions, but also to suggest a *negotiated* and participative approach to promote well-being (Howarth et al., 2004; Lamb et al., 2011;

Lauri, 2009). Involving older adults in a project like this enabled them to think about collective mechanisms of shaping policies, practice, and community services that might have an impact on their quality of life (Barnes et al., 2013). With this regard, Ward (2014) suggests that researchers and policymakers employ a *full care deliberation* when asking older adults about their well-being. This would involve discussions of the affective, rational, and social domains of older adults who strive to ‘live [well] as an older, particularly in the face of change and loss of different types’ (Ward, 2014, p. 488).

A normative emphasis on an active lifestyle in policy and practice may exclude those unable to enact an *active identity* or *age successfully* (Walker, 2002, 2009). This may have deleterious consequences to older adults’ sense of well-being, as discussed in Chapter Two. Self-representations of ageing characterised by the failure to attain such ideals of activity and autonomy may foster the stigma attached to being *old* and *inactive* in the community. Bodily limitations, the experience of social isolation and loneliness and the stigma attached to these conditions threaten not only clients but also volunteers’ sense of identity. Thus, clients and practitioners’ perceptions of ageing both as a period of possibilities and constraints may constitute a more realistic account of successful ageing than what has been presented in public discourse. The ambiguity in defining the term *successful ageing* has been a target of much debate (see Martin et al., 2015). This concept has been subject to different theoretical frameworks and measurements, as explored in Chapter Two. Therefore, a more comprehensive (e.g. involving subjective and objective indicators of wellness) and experiential notion of success, based on older adults’ perspective, might enhance current theoretical models. This view may encompass the complexity, plurality, and experiential nature of living longer. Moreover, this perspective will also include frail groups, those previously considered as a failure

according to the modern sense of successful and active ageing frameworks (Bowling, 2008, 2009; Holstein & Minkler, 2003; Walker, 2002).

In this study, both groups represented ageing as a period of meaningful engagement with the community, preserved functionality, and the enactment of an *active (and positive) identity*. In the group of clients, the renegotiation of identities to accept support constituted an important psychological resource with which to deal with physical and cognitive limitations in their daily lives. This may inform the voluntary organisation about new ways of fostering a sense of independence whilst stressing their need to negotiate practices of support with the clients. In this case, interdependence has been suggested as an important value to be fostered in both successful and active ageing frameworks (Sánchez & Hatton-Yeo, 2012; Sánchez, Sáez, & Pinazo, 2010). This is particularly relevant in the context of intergenerational solidarity, cooperation, and interdependence in the community. Gon (2010) raises this issue when asserting how the normative orientation of active ageing may undermine the quality of relationships of support in the community. He states clearly,

Furthermore, daily lives of old people are filled with various relationships with children, spouses, friends, neighbours or social workers. Nevertheless, too much emphasis on the ideal image of ‘active’ old people makes all these relationships fall into the negative value ‘dependence’. That means the new model has a risk of disconnection of the relations with others. (Gon, 2010, p. 92)

In this study, evidence that older adults engage in a project of socialising and peer support points to a relational approach to well-being promotion. This was shown to be particularly relevant in clients’ emphases on activities as instruments to achieve

companionship. Therefore, community actions will benefit from a more relational approach in which activities have a purpose inasmuch as they enable socially isolated individuals to develop ‘mutually beneficial relationships through processes of cooperation, interaction, and exchange... [experiencing] *being with* others, and *feeling connected* to others’ (Sánchez, Sáez, & Pinazo, 2010, p. 136, italics in original). In the same way, reciprocity could be reinforced as a positive feature of care relations (Stephens et al., 2015; Ward, 2014). The view that older adults can still contribute to their neighbours and be valued despite frailty might challenge the ageist belief—often latent in policymaking—of older adults as a burden to society (MacKean & Abbott-Chapman, 2012; Ward, 2014; WHO, 2002). Thus, interdependence through relationships of support could be emphasised in the voluntary sector as a way of including a broader range of older people, either in need of receiving or giving support.

6.4 Assessing the research and looking forward

This study highlights the contributions of older adults in discussing, questioning, and challenging current models of well-being in later life (Rowe & Kahn, 2015; Ward, 2014; WHO, 2002). Nonetheless, this project is limited in that it focused on views of wellness in groups within a particular voluntary organisation. No attempt was made to generalise findings beyond the context of community support in that organisation. Nevertheless, the relevance of this research can also be attributed to the fact that clients and voluntary sector practitioners share a hegemonic representation of well-being. This warrants a consideration of how representations are shared beyond local spaces (Doise, 1986). Moreover, these findings point to the influence of more powerful groups—in the context of this study, professionals and public media—in shaping communities.

Methodologically, this study enabled me to examine the microgenetic level of representations, that is, representations that are developed in the immediate context of social interaction (Duveen & Lloyd, 1990). Ethnography enabled me to contact *hard-to-reach-groups*, namely frail older adults (Craciun & Flick, 2014; Lamb et al., 2011). Despite the microgenetic level of analysis, the *hegemonic projects of well-being promotion* pointed to macro views of ageing. Therefore, further analysis of societal norms and beliefs about ageing well, as communicated by media and official reports, may enhance knowledge on the interaction between micro and macro levels of social representations (Lopes & Gaskell, 2015).

Power issues were not absent in community support. Staff members and volunteers positioned themselves as the reliable sources of care. In doing so, they represented themselves as mediators of older adults' needs. This representational project might have influenced the way in which practitioners positioned themselves in promoting well-being in the community. This identity confers them the status of providers of care, which implies privileged knowledge about well-being promotion. Their knowledge about support is practical in nature, and corresponds to different demands faced in their daily experiences with the elderly. Therefore, staff members and volunteers seem to exert a more influential role in defining the set of actions and practices of support. This might partially explain why notions of well-being were shared amongst both clients and practitioners—the latter have a more influential role in promoting professional views on ageing well. However, as observed in the visiting scheme, clients seem to influence some decisions and actions of support. In this context, adaptation to clients' needs is an evolving feature of support. Further research with different groups within Age UK (e.g. the administrative board and the visiting scheme supervisors) might elucidate the extent to which a hegemonic view of wellness is shared within this charity.

6.5 Is there a conclusion for this topic?

Sánchez, Sáez, and Pinazo (2010) stress that ‘ageing is just one of many social processes whose understanding may only be achieved through an analysis of several interconnected social issues (social order, political structures, cultural symbols, economic trends, and so on)’ (p. 133). Thus, this study provided an exploratory and critical approach to understand wellness in later life. Clients and voluntary sector practitioners actively engaged in representing wellness in community support. In this case, ageing was re-signified and new categories were presented to promote a relational and active form of ageing in the community. Rather than concluding this topic, this study confirms the necessity of including lay views when assessing policy frameworks of health and social care. In this case, common sense and the context of practice of support constitute the main sites of negotiation, resistance and the enactment of representations of ageing well.

The evidence of a hegemonic project of well-being characterised by an active, independent, and gainful living raises two fundamental questions for policymakers and social health researchers: firstly, what are the components of *a good life* in old age? and, secondly, who is the older adult living this good life? In addressing these questions, this study sheds light on how the processes of making sense of ageing well influence how the elderly see themselves. In this context, older adults not only make sense of the complexity of ageing but also develop new identities in the community. Thus, well-being promotion constitutes an ongoing project in later life.

References

- Abel, T. (1948). The Operation called Verstehen. *American Journal of Sociology*, 54 (5). 211-218.
- Abric, J. C. (1993). Central system, peripheral system: their functions and roles in the dynamics of social representations. *Papers on Social Representations – Textes sur les Représentations Sociales*. 2 (2), 75-78.
- Abric, J.C. (2001). A structural approach to social representations. In K. Deaux and G. Philogène (Eds.). *Representations of the Social*. Oxford: Blackwell, pp. 42–47.
- Achenbaum, A. (1995). Images of old age in America, 1790-1970: a vision and a revision. In M. Featherstone & A. Wernick (Eds.), *Images of aging: cultural representations of later life* (pp. 19–28). London: Routledge.
- Adams, R. G., Blieszner, R., & de Vries, B. (2000). Definitions of friendship in the third age: Age, gender, and study location effects. *Journal of Aging Studies*, 14(1), 117–133. [http://doi.org/10.1016/S0890-4065\(00\)80019-5](http://doi.org/10.1016/S0890-4065(00)80019-5)
- Age UK. (2013). *Improving later life. Understanding the oldest old*. London. Retrieved from <http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Improving Later Life 2 WEB.pdf?dtrk=true>
- Augoustinos, M., Tiffin. K. and Rapley, M. (1999) Racism, history and nationalism in Australian talk. *Discourse and Society* 10 (3)
- Andreouli, E., & Howarth, C. (2012). National identity, citizenship and immigration: Putting identity in context. *Journal for the Theory of Social Behaviour*, 43(3), 361–382. <http://doi.org/10.1111/j.1468-5914.2012.00501.x>

- Andrews, G. J., Gavin, N., Begley, S., & Brodie, D. (2003). Assisting friendships, combating loneliness: users views on a befriending scheme. *Ageing and Society*, 23(3), 349–362. <http://doi.org/10.1017/S0144686X03001156>
- Arcidiacono, C., & Di Martino, S. (2016). A critical analysis of happiness and well-being. Where we stand now, where we need to go. *Community Psychology in Global Perspective*, 2(1), 6–35. <http://doi.org/10.1285/i24212113v2i1p6>
- Arksey, H., & Knight, P. T. (1999). *Interviewing for social scientists meanings and data analysis*. London: SAGE Publications. <http://doi.org/10.4135/9781849209335>
- Arthi. (2012). Representing mental illness: a case of cognitive polyphasias. *Papers on Social Representations*, 21, 5.1-5.26.
- Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, 1(2), 385–405.
- Backman, L., Mantyla, T., & Herlitz, A. (1990). The optimization of episodic remembering in old age 786. In B. B. Paul & M. B. Margret (Eds.), *Successful aging: Perspectives from the behavioral sciences* (pp. 118–163). Cambridge: Cambridge University Press.
- Baltes, P. B. & Baltes, M. B. (1990). *Successful ageing: perspectives from the social sciences*. Cambridge: Cambridge University Press.
- Banister, P., Burman, E., Taylor, M., Tindall, C. & Parker, I. (1994) *Qualitative Methods in Psychology: A research guide*. Buckingham: Open University Press.
- Barnes, M. (1997). *Care, communities and citizens*. Addison Wesley Longman.
- Barnes, M., Taylor, D., & Ward, L. (2013). Being well enough in old age. *Critical Social Policy*, 33(3), 473–493. <http://doi.org/10.1177/0261018312471163>

- Barnes, M., Gahagan, B., & Ward, L. (2013). *Older people , well-being and participation*. Brighton and Hove.
- Bauer, M. W., & Aarts, B. (2000). Corpus Construction: a principle for qualitative data collection. In M. W. Bauer & G. Gaskell (Eds.), *Qualitative Researching with text, image and sound: a practical handbook* (pp. 19–37). London: Sage Publications.
- Bauer, M. W., & Gaskell, G. (1999). Towards a paradigm for research on social representations. *Journal for the Theory of Social Behaviour*. 29(2), 163-186
<http://doi.org/10.1111/1468-5914.00096>
- Bauer, M. W., & Gaskell, G. (2008). Social representations: A progressive research programme for social psychology. *Journal for the Theory of Social Behaviour*, 38(4), 335–353.
- Baum, F. (1999). Social capital: is it good for your health? Issues for a public health agenda. *Epidemiology Community Health*, 195–196.
<http://doi.org/10.1136/jech.53.4.195>
- Bauman, Z. (2008). *Happiness in a society of individuals*. Retrieved from <http://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:Happiness+in+a+societ>
- Bäumker, T., Callaghan, L., Darton, R., Holder, J., Netten, A., & Towers, A. M. (2012). Deciding to move into extra care housing: residents ' views. *Ageing & Society*, 32, 1215–1245. <http://doi.org/10.1017/S0144686X11000869>
- Becker, H., & Geer, B. (1957). Participant Observation and Interviewing: A Comparison. *Human Organization*, 16(3), 28–32. <http://doi.org/10.2307/2092290>

- Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. Penguin United Kingdom.
- Biggs, S. (2001). Toward critical narrativity stories of aging in contemporary social policy. *Journal of Aging Studies*, 15(4), 303–316. [http://doi.org/10.1016/S0890-4065\(01\)00025-1](http://doi.org/10.1016/S0890-4065(01)00025-1)
- Blaikie, A. (1999). *Ageing and Popular Culture*. Cambridge: Cambridge University Press.
- Bolak, H. C. (1997). Studying one's ow in the Middle East: negotiating gender and self-other dynamics in the field. In R. Hertz (Ed.). *Relfexivity and voice* (pp. 95-118). London: Sage Publications.
- Bond, J., & Cabrero, G. R. (2007). Health and dependency in later life. In J. Bond, S. Peace, F. Dittmann-Kohli, & G. Westerhof (Eds.), *Ageing in Society: European perspectives on gerontology* (pp. 113–141). London: Sage Publications.
- Boudiny, K., & Mortelmans, D. (2011). A critical perspective: Towards a broader understanding of ‘ active ageing .’ *Electronic Journal of Applied Psychology*, 7(1), 8–14. <http://doi.org/10.7790/ejap.v7i1.232>
- Bowling, A. (1993). The concepts of successful and positive ageing. *Family Practice*, 10(4), 449–53. <http://doi.org/10.1093/fampra/10.4.449>
- Bowling, A. (2005). Just one question: If one question works, why ask several? *Journal of Epidemiology and Community Health*, 59(5), 342–345. <http://doi.org/10.1136/jech.2004.021204>

- Bowling, A. (2006). Lay perceptions of successful ageing: Findings from a national survey of middle aged and older adults in Britain. *European Journal of Ageing*, 3(3), 123–136. <http://doi.org/10.1007/s10433-006-0032-2>
- Bowling, A. (2008). Enhancing later life: how older people perceive active ageing? *Aging & Mental Health*, 12(3), 293–301. <http://doi.org/10.1080/13607860802120979>
- Bowling, A. (2009). Perceptions of active ageing in Britain: Divergences between minority ethnic and whole population samples. *Age and Ageing*, 38(6), 703–710. <http://doi.org/10.1093/ageing/afp175>
- Bowling, A., & Dieppe, P. (2005). What is successful ageing and who should define it? *British Medical Journal*, 331(7531), 1548–1551. <http://doi.org/10.1136/bmj.331.7531.1548>
- Bowling, A., & Gabriel, Z. (2007). Lay theories of quality of life in older age. *Ageing and Society*, 27(6), 827–848. <http://doi.org/10.1017/S0144686X07006423>
- Bowling, A., Farquhar, M., & Browne, P. (1991). Life satisfaction and associations with social network and support variables in three samples of elderly people. *International Journal of Geriatric Psychiatry*, 6(8), 549–566. <http://doi.org/10.1002/gps.930060803>
- Boyce, R. W. D. (2000). Fallacies in interpreting historical and social data. In: M. W. Bauer & G. Gaskell (Eds.). *Qualitative researching with text, image and sound. A practical handbook* (318-335). London: Sage Publications.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology, *Qualitative Research in Psychology*, 3(2), 77–101. <http://doi.org/10.1191/1478088706qp063oa>

- Breakwell, G. M. (1993). Social representations and social identity. *Papers on Social Representations*, 2(3), 198–217.
- Breakwell, G. M. (2015). Identity process theory. In G. Sammut, E. Andreouli, G. Gaskell, & J. Valsiner (Eds.), *The Cambridge handbook of social representations* (pp. 250–266). Cambridge: Cambridge University Press.
- Breheny, M., & Stephens, C. (2009). ‘I sort of pay back in my own little way’: managing independence and social connectedness through reciprocity. *Ageing and Society*, 29(8), 1295. <http://doi.org/10.1017/S0144686X09990134>
- Brewer, J. (2000). *Ethnography*. McGraw-Hill Education (UK).
- Brown, K. (2010). *Community vulnerable adults* (2nd ed.). Exeter: Learning Matters.
- Bülow, M. H., & Söderqvist, T. (2014). Successful ageing: A historical overview and critical analysis of a successful concept. *Journal of Aging Studies*, 31, 139–149. <http://doi.org/10.1016/j.jaging.2014.08.009>
- Burke, J. L. (1982). Young children’s attitudes and perceptions of older adults. *The International Journal of Aging and Human Development*, 14(3), 205–222.
- Burningham, K., & Cooper, G. (1999). Being constructive: social constructionism and the environment. *Journal of Composite Materials*, 33(2), 297–316. <http://doi.org/0803973233>
- Burroughs, H., Lovell, K., Morley, M., Baldwin, R., Burns, A., & Chew-Graham, C. (2006). ‘Justifiable depression’: How primary care professionals and patients view late-life depression? A qualitative study. *Family Practice*, 23(3), 369–377. <http://doi.org/10.1093/fampra/cmi115>

- Butler, R. N. (1969). Age-ism: Another form of bigotry. *Gerontologist*, 9(4), 243–246.
http://doi.org/10.1093/geront/9.4_Part_1.243
- Calhoun, C. (2002). Imagining Solidarity, *I4* (July 2000), 147–171.
- Camargo, B. V., & Wachelke, J. (2010). The Study of Social Representation Systems : Relationships Involving Representations on Aging , AIDS and the Body. *Papers on Social Representations*, 19, 1–21.
- Cambridge County Council. (2012). *Cambridgeshire Joint Strategic Needs Assessment JSNA Older People Services and Financial Review*. Cambridge. Retrieved from <http://www.cambridgeshireinsight.org.uk/currentreports/jsna-older-peoples-services-and-financial-revie>
- Campbell, C., & Jovchelovitch, S. (2000). Health, community and development : towards a social psychology of participation. *Journal of Community & Applied Social Psychology*, (10), 255–270. [http://doi.org/10.1002/1099-1298\(200007/08\)10](http://doi.org/10.1002/1099-1298(200007/08)10)
- Carstensen, L. L., Fung, H. H., & Charles, S. T. (2003). Socioemotional selectivity theory and emotion regulation in the second half of life. *Motivation and Emotion*, 27(2), 103–123. <http://doi.org/0146-7239/03/0600-0103/0>
- Carstensen, L. L., Isaacowitz, D. M., & Charles, S. T. (1999). Taking time seriously: A theory of socioemotional selectivity. *American Psychologist*, 54(3), 165–181. <http://doi.org/10.1037/0003-066X.54.3.165>
- Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Over- coming challenges and developing strategies for effective learning. *The Psychologist*, 26(2), 120–123.

- Clarke, V., Braun, V. & Hayfield, N. (2015) Thematic analysis. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (3rd ed.) (p.222-248). London: Sage.
- Craciun, Gellert, P., & Flick, U. (2015). Is healthy ageing for all? The role of positive views on ageing in preparing for a healthy old age in a precarious context. *The European Health Psychologist*, 17(2), 79–84.
- Cattan, M., White, M., Bond, J., & Learmouth, A. (2005). Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions. *Ageing & Society*, 25(1), 41–67.
<http://doi.org/10.1017/S0144686X04002594>
- Cernin, P. A., Lysack, C., & Lichtenberg, P. A. (2011). A Comparison of Self-Rated and Objectively Measured Successful Aging Constructs in an Urban Sample of African American Older Adults. *Clinical Gerontology*, 34(89–102).
- Chandler, R. C., & Robinson, O. C. (2014). Wellbeing in retirement villages: Eudaimonic challenges and opportunities. *Journal of Aging Studies*, 31, 10–19.
<http://doi.org/10.1016/j.jaging.2014.08.001>
- Chiripanhura, B. (2010). Measures of economic activity and their implications for societal well-being. *Economic and Labour Market Review*, 4(7), 56–65.
<http://doi.org/10.1057/elmr.2010.97>
- Christensen, K., Doblhammer, G., Rau, R., & Vaupel, J. W. (2009). Ageing populations: the challenges ahead. *Lancet*, 374(9696), 1196–208. doi:10.1016/S0140-6736(09)61460-4.

- Chung, S., & Park, S.-J. (2008). Successful ageing among low-income older people in South Korea. *Ageing and Society*, 28(8), 1061. <http://doi.org/10.1017/S0144686X08007393>
- Clarke, A., & Warren, L. (2007). Hopes, fears and expectations about the future: what do older people's stories tell us about active ageing? *Ageing and Society*, 27(4), 465. <http://doi.org/10.1017/S0144686X06005824>
- Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine*, 38(5), 300–314. <http://doi.org/10.1097/00006842-197609000-00003>
- Cohen, S., & Wills, T. a. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98(2), 310–357. <http://doi.org/10.1037/0033-2909.98.2.310>
- Cole, T. 1992. *The Journey of life: A cultural history of aging in america*. Cambridge University Press, Cambridge.
- Cosco, T. D., Matthew Prina, A., Perales, J., Stephan, B., & Brayne, C. (2014). Whose' successful ageing'? lay-and researcher-driven conceptualisations of ageing well. *The European Journal of Psychiatry*, 28(2), 124–130. <http://doi.org/10.4321/S0213-61632014000200006>
- Costa, M. S., Leite, E. de S., Pinho, T. A. M. de, Lubenow, J. A. M., Silva, A. O., & Moreira, M. A. S. P. (2015). Social Representations, Vulnerability and Religious Beliefs of the Elderly About HiV/AidS: an integrative Review. *International Archives of Medicine*, 8, 1–12. <http://doi.org/10.3823/1858>
- Covey, H. C. (1991). *Images of older people in western art and society*. New York: Praeger.

- Craciun, C., & Flick, U. (2014). I will never be the granny with rosy cheeks: Perceptions of aging in precarious and financially secure middle-aged Germans. *Journal of Aging Studies*, 29(1), 78–87. <http://doi.org/10.1016/j.jaging.2014.01.003>
- Cracknell, R. (2010). *The ageing population*. House of Commons.
- Crawford, R. (1984). A cultural account of ‘health’: control, release, and the social body. In J. B. McKinlay (Ed.), *Issues in the political economy of health care* (pp. 60–103). London: Tavistock Publication.
- Cromby, J. (2011). The Greatest Gift? Happiness, Governance and Psychology. *Social and Personality Psychology Compass*, 5(11), 840–852. <http://doi.org/10.1111/j.1751-9004.2011.00398.x>
- Crown. (2013). *Government Response to the House of Lords Select Committee on Public Service and Demographic Change: Ready For Ageing?* London.
- Cummings, S. M., & Kropf, N. P. (2009). Formal and informal support for older adults with severe mental illness. *Aging & Mental Health*, 13(4), 619–627. <http://doi.org/10.1080/13607860902774451>
- Dallaire, B., McCubbin, M., Carpentier, N., & Clément, M. (2009). Representations of elderly with mental health problems held by psychosocial practitioners from community and institutional settings. *Social Work in Mental Health*, 7(1–3), 139–152. <http://doi.org/10.1080/15332980802072488>
- Dannefer, D. (2012). Enriching the tapestry: Expanding the scope of life course concepts. *Journals of Gerontology - Series B Psychological Sciences and Social Sciences*, 67B(2), 221–225. <http://doi.org/10.1093/geronb/gbr148>

- Davidson, C. R. (2009). Transcription: Imperatives for Qualitative Research. *International Journal of Qualitative Methods*, 8(2), 35–52. <http://doi.org/Retrieved> from <http://www.ualberta.ca>
- Degnen, C. (2012) *Ageing Selves and Everyday Life in the North of England: Years in the Making*. Manchester: Manchester University Press.
- Degnen, C. (2015). Ethnographies of ageing. In: J. Twigg and W. Martin (eds). *The Routledge Handbook of Cultural Gerontology*. London: Routledge.
- Dewing, J. (2002). From Ritual to Relationship: A person-centred approach to consent in qualitative research with older people who have a dementia. *Dementia*, 1(2), 157–171. <http://doi.org/10.1177/147130120200100204>
- Dewing, J. (2007). Participatory research: A method for process consent with persons who have dementia. *Dementia*, 6(1), 11–25. <http://doi.org/10.1177/1471301207075625>
- Dewing, J. (2008). Process Consent and Research with Older Persons Living with Dementia. *Research Ethics*, 4(2), 59–64. <http://doi.org/10.1177/174701610800400205>
- Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin*, 125(2), 276–302. <http://doi.org/10.1037/0033-2909.125.2.276>
- Dockray, S., Grant, N., Stone, A. A., Kahneman, D., Wardle, J., & Steptoe, A. A. (2010) comparison of affect ratings obtained with ecological momentary assessment and the day reconstruction method. *Soc Indicators Res*, 99: 269–83.
- DoH. (2001). *National service framework for older people*. London. Retrieved from

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf

DoH. (2005). *Independence, Well-being and Choice*. London. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272101/6499.pdf

DoH. (2006). *Our health our care our say: a new direction for community services*. London. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf

DoH. (2010). *Healthy Lives, Healthy People: Our strategy for public health in England*. London.

DoH. (2014a). *Ageing Well. A compendium of factsheets: wellbeing across the lifecourse*. London. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277584/Ageing_Well.pdf

DoH. (2014b). *Care Act 2014*. London.

Dolan, P., Layard, R., & Metcalfe, R. (2011). Measuring Subjective wellbeing for public policy. *Office for National Statistics*, (February), 19. <http://doi.org/10.2752/174589311X12961584845846>

Doise, W. (1986). *Levels of explanation in social psychology*. Cambridge: Cambridge University Press.

- Dolan, P., & White, M. P. (2007). How Can Measures of Subjective Well-Being Be Used to Inform Public Policy? *Perspectives on Psychological Science*, 2(1), 71–85.
<http://doi.org/10.1111/j.1745-6916.2007.00030.x>
- Santos, V. B., Tura, L. F. R., & Arruda, A. M. S. (2013). As representações sociais de ‘pessoa velha’ construídas por Idosos. *Saúde E Sociedade*, 22(1), 138–147.
<http://doi.org/10.1590/S0104-12902013000100013>
- Dresing, Thorsten/Pehl, Thorsten/Schmieder, Christian (2012): *Manual (on) Transcription*. Transcription Conventions, Software Guides and Practical Hints for Qualitative Researchers. 2nd English Edition. Marburg Available Online: <http://www.audiotranskription.de/english/transcription-practicalguide.htm> (Access: 07.2015).
- Dundes, L. (2001). Disney’s modern heroine Pocahontas: Revealing age-old gender stereotypes and role discontinuity under a façade of liberation. *Social Science Journal*, 38(3), 353–365. [http://doi.org/10.1016/S0362-3319\(01\)00137-9](http://doi.org/10.1016/S0362-3319(01)00137-9)
- Durant, J., Bauer, M. W., & Gaskell, G. (1998). Biotechnology in the public sphere: a European source book. London: Science Museum.
- Duveen, G. (1993). The development of social representations of gender. *Papers on Social Representations*, 2(3), 1-7.
- Duveen, G. (2001). Representations, identities, resistance. In K. Deaux & G. Philogène (Eds.), *Representations of the Social*. Oxford: Blackwell.
- Duveen, G., and Lloyd, B. (1986). The significance of social identities. *British Journal of Social Psychology*, 25, 219–230.

- Duveen, G., & Lloyd, B. (1990). Introduction. In G. Duveen & B. Lloyd (Eds.), *Social representations and the development of knowledge* (pp. 1-10). Cambridge University Press.
- Duveen, G., & Lloyd, B. (1993). An ethnographic approach to social representations. In G.M. Breakwell & D. Canter (Eds.), *Empirical approaches to social representations* (pp. 90-109). Oxford University Press.
- Ekerdt, D. J. (1986). The Busy Ethic: Moral Continuity Between Work and Retirement. *The Gerontological Society of America*, 26(3), 239–244.
- Erickson, K. I., Gildengers, A. G., & Butters, M. A. (2013). Pshysical activity and neuroplasticity in late adulthood. *Dialogues in Clinical Neuroscience*, 15(1), 99–108.
- European Union (2012). *The 2012 Ageing Report: economic and budgetary projection for the EU-27 Member States (2010-2060)* (pp. 1–470). doi:10.2765/19991.
- Farr, R. (1995). Representation of health, illness and handicap in the mass media of communication. In I. Marková & R. Farr (Eds.), *Representations of health, illness and handicap*. (pp. 3–30). Harwood Academic Publishers.
- Falb, M. D., & Pargament, K. I. (2014). *Perspectives on the Intersection of Multiculturalism and Positive Psychology*, 7, 143–157. <http://doi.org/10.1007/978-94-017-8654-6>
- Falcão, D. V. S., & Carvalho, I. S. (2010). Idosos e saúde mental: demandas e desafios. In D. V. da S. F. & L. F. Araújo (Ed.), *Idosos e saúde mental* (pp. 11–31). Campinas, SP.

Featherman, D. L., Smith, J., & Peterson, J. G. (1990). *Successful aging in a post-retired society*. Baltes, Paul B [Ed]. Retrieved from <http://login.ezproxy.library.ualberta.ca/login?url=http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=psyc3&AN=1991-97212-003%5Cnhttp://resolver.library.ualberta.ca/resolver?sid=OVID:psycdb&id=pmid:&id=doi:&issn=&isbn=0-521-37454-5&volume=>

Featherstone, M., & Hepworth, M. (1995). Images of positive aging: a case study of retirement choice magazine. In M. Featherstone & A. Wernick (Eds.), *Images of aging: cultural representations of later life* (pp. 29–47). London: Routledge.

Fernández-Ballesteros, R., Garcia, L. F., Abarca, D., Blanc, E., Efklides, A., Moraitou, D., ... Patricia, S. (2010). The concept of 'ageing well' in ten Latin American and European countries. *Ageing and Society*, 30(1), 41–56. <http://doi.org/10.1017/S0144686X09008587>

Ferreira, O. G. L., Maciel, S. C., Silva, A. O., Sá, R. C. D. N., & Moreira, M. A. S. P. (2010). Significados atribuídos ao envelhecimento: idoso, velho e idoso ativo. *Psico-USF (Impresso)*, 15(3), 357–364. <http://doi.org/10.1590/S1413-82712010000300009>

Fisher, B. J. (1992). Successful aging and life satisfaction: A pilot study for conceptual clarification. *Journal of Aging Studies*, 6(2), 191–202. [http://doi.org/10.1016/0890-4065\(92\)90012-U](http://doi.org/10.1016/0890-4065(92)90012-U)

Fisher, B. J. (1995). Successful aging, life satisfaction, and generativity in later life [Abstract]. *Aging and Human Development*, 41(3), 239–250.

Fisher, B. J., & Specht, D. K. (1999). Successful aging and creativity in later life. *Journal of Aging Studies*, 13(4), 457–472. [http://doi.org/10.1016/S0890-4065\(99\)00021-3](http://doi.org/10.1016/S0890-4065(99)00021-3)

- Flick, U. (1998). The social construction of individual and public health: contributions of social representations theory to a social science of health. *Social Science Information*, 37(4), 639–662. <http://doi.org/0803973233>
- Flick, U. (2000). Qualitative Inquiries into Social Representations of Health. *Journal of Health Psychology*, 5(3), 315–324. <http://doi.org/10.1177/135910530000500303>
- Flick, U. (2007). *Managing quality in qualitative research*. London: Sage Publications.
- Flick, U. (2014). *An introduction to qualitative research* (5th ed.). London: Sage Publications.
- Flick, U., Fischer, C., Neuber, A., Schwartz, F. W., & Walter, U. (2003). Health in the context of growing old: social representations of health. *Journal of Health Psychology*, 8(5), 539–556. <http://doi.org/10.1177/13591053030085006>
- Flick, U., & Foster, J. (2008). Social Representations. In *Qualitative Research in Psychology* (pp. 195–214). London: Sage Publications.
- Flick, U., Foster, J., & Caillaud, S. (2015). Researching social representations. In G. Sammut, E. Andreouli, G. Gaskell, & J. Valsiner (Eds.), *The Cambridge handbook of social representations* (pp. 64–80). Cambridge: Cambridge University Press.
- Foster, J. L. (2001). The social representations of mental illness held by clients of the mental health services. Unpublished PhD, University of Cambridge.
- Foster, J. L. H. (2003a). Beyond otherness: controllability and location in mental health service clients' representations of mental health problems. *Journal of Health Psychology*, 8(5), 632–44. <http://doi.org/10.1177/13591053030085012>

- Foster, J. L. H. (2003b). Representational Projects and Interacting Forms of Knowledge. *Journal for the Theory of Social Behaviour*, 33(3), 231–244+347. <http://doi.org/10.1111/1468-5914.00216>
- Foster, J. L. H. (2007). Journeys through mental illness: clients' experiences and understandings of mental distress. Basingstoke: Macmillan Press Ltd.
- Foster, J. H. (2011). Reflections on Bauer and Gaskell's Towards a Paradigm for Research on Social Representations. *Papers on Social Representations*, 20 (23), 1–12.
- Foster, J. (2015). Ethnography. In P. Rohleder & A. Lyons. *Handbook of qualitative research in clinical and health psychology* (pp. 238-256). Palgrave, MacMillan Education.
- Foster, L., & Walker, A. (2015). Active and Successful Aging: A European Policy Perspective. *The Gerontologist*, 55(1), 83–90. <http://doi.org/10.1093/geront/gnu028>
- Frawley, A. (2015). Happiness Research: A Review of Critiques. *Sociology Compass*, 9(1), 62–77. <http://doi.org/10.1111/soc4.12236>
- Freitas, M., Ferreira, M. M. D. A. M. A., & de Freitas, M. C. (2013). Old age and elderly people: social representations of adolescent students. *Revista Latino-Americana de Enfermagem*, 21(3), 750–7. <http://doi.org/10.1590/S0104-11692013000300014>
- Frey, B., & Stutzer, A. (2002). *Happiness and economics*. Princeton: Princeton University Press.
- Friedman, E. M. (2012). *Well-Being, Aging, and Immunity. The Oxford Handbook of Psychoneuroimmunology*. <http://doi.org/10.1093/oxfordhb/9780195394399.013.0003>

- Friese, S. (2014). *Qualitative data analysis with ATLAS. ti*. London: Sage Publications.
- Gaskell, G., & Bauer, M. W. (2000). Towards public accountability: beyond sampling, reliability and validity. In M. W. Bauer & G. Gaskell (Eds.), *Qualitative Researching with text, image and sound: a practical handbook* (pp. 336–350). London: Sage Publications.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York, NY: Aldine.
- Gervais, M., & Jovchelovitch, S. (1998). *The health beliefs of the Chinese community in England: A qualitative research study*. Health Education Authority.
- Geertz, C. (1973). *The interpretation of cultures. Selected essays*. New York: Basic Books.
- Gherman, M.-A. (2014). Social Representations of the Process of Ageing in Young and Mature Romanian Adults Mihaela-Alexandra Gherman. *Romanian Journal of Applied Psychology*, 17(2), 45–54.
- Gibbs, G. (2007). *Analyzing Qualitative Data*. London: Sage Publications
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Harmondsworth, Middlesex: Penguin.
- Gon, E. (2010). The light and shadow of the active and independent senior: From life history of Japanese pre-elderly. In H. Blatterer & J. Glahn (Eds.), *Times of our lives. Making Sense of growin up & growing old* (pp. 91–100). Oxford: Inter-Disciplinary Press.
- Gullette, M. M. (2003). From life storytelling to age autobiography. *Journal of Aging Studies*, 17, 101–111.

- Gullette, M. M. (2015). Routledge Handbook of Cultural Gerontology. In J. Twigg & W. Martin (Eds.), *Handbook of Cultural Gerontology* (pp. 21–28). London: Routledge.
<http://doi.org/10.4324/9780203097090>
- Haber, B. C. (2002). Anti-aging: why now? A historical framework for understanding the contemporary enthusiasm. *Generations*, 25(4), 9–14.
- Hahn, J., & Oishi, S. (2006). Psychological needs and emotional well-being in older and younger Koreans and Americans. *Personality and Individual Differences*, (40), 689–698. <http://doi.org/10.1017/CBO9781107415324.004>
- Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice*. Routledge.
- Hausdorff, J. M., Levy, B. R., & Wei, J. Y. (1999). The power of ageism on physical function of older persons: reversibility of age-related gait changes. *Journal of the American Geriatrics Society*, 47, 1346–1349.
- Havighurst, R. J. (1961). Successful Aging. *The Gerontologist*, 1(1), 8–13.
<http://doi.org/10.1093/geront/1.1.8>
- Havighurst, R. J. (1963). Successful aging. In R. H. Williams & C. T. Wilma Donahye (Eds.), *Processes of aging* (pp. 299–320). New York: Atherton Press.
- Hazan, H. (1994). *Old Age: Constructions and Deconstructions*. Cambridge: Cambridge University Press.
- Hertz, R. (1997). *Reflexivity & voice*. Sage Publications.
- Herzlich, C. (1973). *Health and illness: a social psychological analysis*. London: Academic Press.

- Hess, T. M., Hinson, J. T., & Statham, J. a. (2004). Explicit and implicit stereotype activation effects on memory: do age and awareness moderate the impact of priming? *Psychology and Aging*, 19(3), 495–505. <http://doi.org/10.1037/0882-7974.19.3.495>
- Holloway, I., & Todres, L. (2003). The status of method: flexibility, consistency and coherence. *Qualitative Research*, 3(3), 345-357.
- Holstein, M. B., & Minkler, M. (2003). Self, society, and the ‘new gerontology.’ *The Gerontologist*, 43(6), 787–796.
- House of Lords (2013). *Ready for Ageing? Select Committee on Public Service and Demographic Change. Report of Session 2012-13*. London.
- Howarth, C., Cornish, F., & Gillespie, A. (2015). Making community : diversity , movement and interdependence. In G. Sammut, E. Andreouli, G. Gaskell, & J. Valsiner (Eds.), *The Cambridge handbook of social representations* (pp. 179–190). Cambridge: Cambridge University Press.
- Howarth, C., Foster, J., & Dorrer, N. (2004). Exploring the potential of the theory of social representations in community-based health research--and vice versa? *Journal of Health Psychology*, 9(2), 229–243. <http://doi.org/10.1177/1359105304040889>
- Howarth, C. S. (2001). Towards a Social Psychology of Community: A Social Representations Perspective. *Journal for the Theory of Social Behaviour*, 31(2), 223–238.
- Howarth, C. (2002a). Identity in whose eyes? The role of representations in identity construction. *Journal for the Theory of Social Behaviour*, 32(2), 145–162+i. <http://doi.org/10.1111/1468-5914.00181>.

- Howarth, C. (2002b). Using the theory of social representations to explore difference in the research relationship. *Qualitative Research*, 2(2), 21-34.
- Howarth, C. (2006). A social representation is not a quiet thing: Exploring the critical potential of social representations theory. *British Journal of Social Psychology*, 45(1), 65-86.
- Huberman, A. Michael & Miles, Matthew B. (1998). Data Management and Analysis Methods. In Norman K. Denzin & Yvonna S. Lincoln (Eds.), *Collecting and Interpreting Qualitative Materials* (pp.179-210). California: Sage.
- Hummel, C. S. (1998). Les représentations sociales de la vieillesse. *Cahiers Psychiatriques*, 25, 25–35.
- Israel, B. a, Schulz, a J., Parker, E. a, & Becker, a B. (1998). Review of community-based research: assessing partnership approaches to improve public health [Abstract]. *Annual Review of Public Health*, 19, 173–202. <http://doi.org/10.1146/annurev.publhealth.19.1.173>
- Iwamasa, G. Y., & Iwasaki, M. (2011). A New Multidimensional Model of Successful Aging: Perceptions of Japanese American Older Adults. *Journal of Cross-Cultural Gerontology*, 26(3), 261–278. <http://doi.org/10.1007/s10823-011-9147-9>
- Jaffe, A. (2007). Variability in transcription and the complexities of representation, authority and voice. *Discourse Studies*, 9(6), 831–836. <http://doi.org/10.1177/1461445607082584>
- Jeste, D. V, Depp, C. a, & Vahia, I. V. (2010). Successful cognitive and emotional aging. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA)*, 9 (2), 78–84. <http://doi.org/10.1097/01.nmd.0000369417.73882.da>

- Jesuino, J. C. (2014). Images of Old Age. *Papers on Social Representations*, 23, 15.1-15.22.
- Jodelet, D. (1991). *Madness and social representations*. Hemel Hempstead: Harvester Wheatsheaf.
- Jodelet, D. (2008). Social representations: The beautiful invention. *Journal for the Theory of Social Behaviour*, 38(4), 411–430. <http://doi.org/10.1111/j.1468-5914.2008.00383.x>
- Joffe, H. (1995). Social representations of AIDS: towards encompassing issues of power. *Papers on Social Representations*, 4(1), 29–40.
- Joffe, H. (1996a). AIDS research and prevention: a social representational approach. *The British Journal of Medical Psychology*, 69, 169–190. <http://doi.org/http://dx.doi.org/10.1111/j.2044-8341.1996.tb01863.x>
- Joffe, H. (1996b). The Shock of the New: A Psycho-dynamic Extension of Social Representational Theory. *Journal for the Theory of Social Behaviour*, 26(2), 197–219. <http://doi.org/10.1111/j.1468-5914.1996.tb00529.x>
- Joffe, H. (1997). Commentary on Joffe (1996) AIDS research and prevention: A social representation approach. *British Journal of Medical Psychology*, 70(1), 65–73. <http://doi.org/10.1111/j.2044-8341.1997.tb01886.x>
- Joffe, H. (2003). Risk: from perception to social representation. *The British Journal of Social Psychology / the British Psychological Society*, 42(1), 55–73. <http://doi.org/10.1348/014466603763276126>

- Johnson, K. J., & Mutchler, J. E. (2014). The Emergence of a Positive Gerontology: From Disengagement to Social Involvement. *Gerontologist*, 54(1), 93–100. <http://doi.org/10.1093/geront/gnt099>
- Jopp, D. S., Wozniak, D., Damarin, A. K., De Feo, M., Jung, S., & Jeswani, S. (2015). How could lay perspectives on successful aging complement scientific theory? Findings from a U.S. and a German life-span sample. *Gerontologist*, 55(1), 91–106. <http://doi.org/10.1093/geront/gnu059>
- Jordan, B. (2008). *Welfare and well-being: social value in public policy*. Bristol: The Policy Press.
- Jovchelovitch, S. (1996). In defence of representations. *Journal for the Theory of Social Behaviour*, 26(2), 121–135. <http://doi.org/10.1111/j.1468-5914.1996.tb00525.x>
- Jovchelovitch, S. (2007). *Knowledge in context: representations, community and culture*. East Sussex: Routledge.
- Jovchelovitch, S. (2012). *Narrative, Memory and Social Representations: A Conversation Between History and Social Psychology. Integrative Psychological and Behavioral Science* (Vol. 46). <http://doi.org/10.1007/s12124-012-9217-8>
- Jovchelovitch, S., & Priego-Hernández, J. (2015). Cognitive polyphasia, knowledge encounters and public spheres. In M. W. Bauer & G. Gaskell (Eds.), *Qualitative Researching with text, image and sound: a practical handbook* (pp. 19–37). London: Sage Publications.
- Kahana, E., & Kahana, B. (2001). Successful aging among people with HIV/AIDS. *Journal of Clinical Epidemiology*, 54(12 SUPPL. 1), 54–57. [http://doi.org/10.1016/S0895-4356\(01\)00447-4](http://doi.org/10.1016/S0895-4356(01)00447-4)

- Kahana, E., Kahana, B., & Kercher, K. (2003). Emerging lifestyles and proactive options for successful ageing. *Ageing International*, 28(2), 155–180.
<http://doi.org/10.1007/s12126-003-1022-8>
- Kahana, E., Kahana, B., & Lee, J. E. (2014). Proactive Approaches to Successful Aging: One Clear Path through the Forest. *Gerontology*, 60(5), 466–474.
<http://doi.org/10.1159/000360222>
- Kahana, E., Kelley-Moore, J., & Kahana, B. (2012). Proactive aging: A longitudinal study of stress, resources, agency, and well-being in late life. *Aging & Mental Health*, 16(4), 438–451. <http://doi.org/10.1080/13607863.2011.644519>
- Kahn, R.L. (2002). Guest editorial: On 'successful aging and well-being: Self-rated compared with Rowe and Kahn.' *The Gerontologist*, 42, 725-726.
- Kahneman, D. (2004). A survey method for characterizing daily life experience: The day reconstruction method. *Science*, 306(5702), 1776–1780.
<http://doi.org/10.1126/science.1103572>
- Kalampalikis, N., Haas, V., Fieulaine, N., Doumergue, M., & Deschamps, G. (2013). Giving or giving back: New psychosocial insights from sperm donors in France. *Psychology, Health & Medicine*, 18(1), 1–9.
<http://doi.org/10.1080/13548506.2012.668195>
- Kane, M., & Terry, G. (2015). *Dementia 2015 : Aiming higher to transform lives*. *Dementia 2015: Aiming higher to transform lives* (Vol. 2015).
- Katz, S. (1999). *Old age as lifestyle in an active society*. Berkeley: Hunza Graphics.
Retrieved from <http://escholarship.org/uc/item/86t8z02t.pdf>

- Kelle, U. (2000). Computer-assisted analysis: coding and indexing. In M. W. Bauer & G. Gaskell (Eds.), *Qualitative Researching with text, image and sound: a practical handbook* (pp. 282–298). London: Sage Publications.
- Kelly, J., Watson, R., Pankratova, M., & Pedzeni, A. M. (2016). Representation of age and ageing identities in popular music texts. *Journal of Advanced Nursing*, 72(6), 1325–1334. <http://doi.org/10.1111/jan.12916>
- Kildal, N., & Nilssen, L. (2013). Ageing policy ideas in the field of health and long-term care. Comparing the EU, the OECD and the WHO. In: R. Ervik & T. S. Lindén (Eds.). *The making of ageing policy. Theory and practice in Europe*. (pp. 53–77). Cheltenham: Edward Elgar Publishing Limited.
- Knight, T., & Ricciardelli, L. A. (2003). Successful Aging: Perceptions of Adults Aged Between 70 and 101 Years. *J. Aging and Human Development*, 56(3), 223–245. <http://doi.org/10.2190/CG1A-4Y73-WEW8-44QY>
- Kwong See, S. T., Rasmussen, C., & Pertman, S. Q. (2012). Measuring Children's Age Stereotyping Using a Modified Piagetian Conservation Task. *Educational Gerontology*, 38(3), 149–165. <http://doi.org/10.1080/03601277.2010.515891>
- Laditka, S. B., Corwin, S. J., Laditka, J. N., Liu, R., Tseng, W., Wu, B., ... Ivey, S. L. (2009). Attitudes about aging well among a diverse group of older americans: Implications for promoting cognitive health. *Gerontologist*, 49(SUPPL. 1). <http://doi.org/10.1093/geront/gnp084>
- Lamb, J. D., Bower, P., Rogers, A., Dowrick, C., & Gask, L. (2011). Access to Mental Health in Primary Care: A Qualitative Meta-Synthesis of Evidence from the Experience of People from 'Hard to Reach' Groups. *Health* (London, England: 1997), 16(1), 76–104. doi:10.1177/1363459311403945.

- Lane, R. E. (2002). *The loss of happiness in Market Democracies*. New Haven & London: Yale University Press.
- Langan, D., & Morton, M. (2009). Reflecting on community/academic 'collaboration': The challenge of 'doing' feminist participatory action research. *Action Research*, 7(2), 165–184. <http://doi.org/10.1177/1476750309103261>
- Lansford, J. E., Sherman, a M., & Antonucci, T. C. (1998). Satisfaction with social networks: an examination of socioemotional selectivity theory across cohorts. *Psychology and Aging*, 13(4), 544–552. <http://doi.org/10.1037/0882-7974.13.4.544>
- Laslett, P. (1987). The emergence of the third age. *Ageing and Society*, 7(2), 133–160. <http://doi.org/10.1017/S0144686X00012538>
- Lauri, M. A. (2009). Metaphors of organ donation, social representations of the body and the opt-out system. *British journal of health psychology*, 14(Pt 4), 647–66. doi:10.1348/135910708X397160.
- Lawton, M. P. (1975). The Philadelphia Geriatric Center Morale Scale: a revision. *Journal of Gerontology*, 30(1), 85–89. <http://doi.org/10.1093/geronj/30.1.85>
- Layard, R. (2011). *Happiness: lessons from a new science*. London: Penguin Books.
- Leibing, A. (2005). The old lady from Ipanema: Changing notions of old age in Brazil. *Journal of Aging Studies*, 19(1), 15–31. <http://doi.org/10.1016/j.jaging.2004.03.010>
- Levy, B. (2000). Handwriting as a reflection of aging self-stereotypes [Abstract]. *Journal of Geriatric Psychiatric*, 33(1), 81–94.
- Levy, B. (2009). Stereotype embodiment: A psychosocial approach to aging. *Current Directions in Psychological Science*, 18(6), 332–336. <http://doi.org/10.1111/j.1467-8721.2009.01662.x>

- Levy, B., Ashman, O., & Dror, I. (2000). To be or not to be: the effects of age stereotypes on the will to live. *Omega - Journal of Death and Dying*, 40(3), 409–420. <http://doi.org/10.2190/Y2GE-BVYQ-NF0E-83VR>
- Levy, B., & Langer, E. (1994). Aging free from negative stereotypes: Successful memory in China among the American deaf [Abstract]. *Journal of Personality and Social Psychology*, 66(6), 989–997. <http://doi.org/http://dx.doi.org/10.1037/0022-3514.66.6.989>
- Levy, B. R. (2003). Mind matters: cognitive and physical effects of aging self-stereotypes. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, 58(4), P203–P211. <http://doi.org/10.1093/geronb/58.4.P203>
- Levy, B. R., Hausdorff, J. M., Hencke, R., & Wei, J. Y. (2000). Reducing cardiovascular stress with positive self-stereotypes of aging. *Journal of Gerontology: Psychological Sciences*, 55(4), 205–213.
- Lewis, J. P. (2011). Successful aging through the eyes of Alaska Native Elders. What it means to be an elder in Bristol Bay, AK. *Gerontologist*, 51(4), 540–549. <http://doi.org/10.1093/geront/gnr006>
- Lincoln, T., & Guba, E. (Eds.). (1985). *Naturalistic inquiry*. Beverly Hills: Sage.
- Lloyd, L. (2004). Mortality and morality: ageing and the ethics of care. *Ageing and Society*, 24(2), 235–256. <http://doi.org/10.1017/S0144686X03001648>
- Lloyd, L., Tanner, D., Milne, A., Ray, M., Richards, S., Sullivan, M. P., ... Phillips, J. (2013). Look after yourself: active ageing, individual responsibility and the decline of social work with older people in the UK. *European Journal of Social Work*, 0(0), 1–14. <http://doi.org/10.1080/13691457.2013.829805>

- Löckenhoff, C. E., Terracciano, A., McCrae, R. R., & Alcalay, L. (2009). Perceptions of Aging across 26 Cultures and their Culture-Level Associates. *Psychology and Aging*, 24(4), 941–954. <http://doi.org/10.1037/a0016901>.Perceptions
- Lopes, C. A. & Gaskell, G. (2015) Social representations and societal psychology. In Sammut, G., Andreouli, E., Gaskell, G., and Valsiner, J. (Eds.). *The Cambridge Handbook of Social Representations* (pp. 12-28). Cambridge: Cambridge University.
- Ludwig, Kirk (2003) 'The mind-body problem: an overview', in Stephen P. Stich and Ted A. Warfield (eds). *The Blackwell Guide to Philosophy of Mind*, Malden, Oxford: Blackwell Publishing Ltd, pp. 1–46.
- Lum, T. Y., & Lightfoot, E. (2005). The Effects of Volunteering on the Physical and Mental Health of Older People. *Research on Aging*, 27(1), 31–55. <http://doi.org/10.1177/0164027504271349>
- MacKean, R., & Abbott-Chapman, J. (2012). Older people's perceived health and wellbeing: The contribution of peer-run community-based organisations. *Health Sociology Review*, 21(1), 47–57. <http://doi.org/10.5172/hesr.2012.21.1.47>
- Magnabosco-Martins, C. R., Vizeu-Camargo, B., & Biasus, F. (2009). Representações sociais do idoso e da velhice de diferentes faixas etárias. *Universitas Psychologica*, 8(3), 831–847. <http://doi.org/10.11144/627>
- Marhánková, J. H. (2011). Leisure in old age: Disciplinary practices surrounding the discourse of active ageing. *International Journal of Ageing and Later Life*, 6(1), 5–32. <http://doi.org/10.3384/ijal.1652-8670.11615>

- Marková, I. (2000). Amedee or how to get rid of it: Social representations from a dialogical perspective. *Culture & Psychology*, 6(4), 419–460.
<http://doi.org/10.1177/1354067X0064002>
- Marková, I. (2003). *Dialogicality and social representations: The dynamics of mind*. Cambridge University Press.
- Martin, P., Kelly, N., Kahana, B., Kahana, E., Willcox, B. J., Willcox, D. C., & Poon, L. W. (2015). Defining successful aging: A tangible or elusive concept? *Gerontologist*, 55(1), 14–25. <http://doi.org/10.1093/geront/gnu044>
- Martinson, M., & Berridge, C. (2015). Successful aging and its discontents: A systematic review of the social gerontology literature. *Gerontologist*, 55(1), 58–69.
<http://doi.org/10.1093/geront/gnu037>
- Martinson, M., & Minkler, M. (2006). Civic Engagement and Older Adults: A Critical Perspective. *The Gerontologist*, 46(3), 318–324.
<http://doi.org/10.1093/geront/46.3.318>
- Matsubayashi, K., Ishine, M., Wada, T. and Okumiya, K. 2006. Older adults' view of 'successful ageing' : comparison of older Japanese and Americans. *Journal of American Geriatrics Society*, 54, 1, 184–7.
- Matzke, S. (2011). 2012 European year for active ageing. *Gerontechnology*, 10(1).
<http://doi.org/10.4017/gt.2011.10.01.014.00>
- Mayhew, L. (2005). *Active ageing in the UK - issues, barriers, policy directions*, 18(4).
<http://doi.org/10.1080/13511610500384202>

- McAdams, D. P., Diamond, A., Aubin, E. de St., & Mansfield, E. (1997). Stories of Commitment: the psychosocial construction of generative lives. *Journal of Personality and Social Psychology*, 72(3), 678–694.
- McKeown, J., Clarke, A., Ingleton, C., & Repper, J. (2010). Actively involving people with dementia in qualitative research. *Journal of Clinical Nursing*, 19(13–14), 1935–1943. <http://doi.org/10.1111/j.1365-2702.2009.03136.x>
- McCrae, N., & Banerjee, S. (2011). The challenge of evaluating mental health services for older people. *International journal of geriatric psychiatry*, 26(6), 551–7. doi:10.1002/gps.2576.
- McHugh, K. 2003. Three faces of ageism: society, image and place. *Ageing & Society*, 23,2, 165–85.
- Medeiros, B. (2010). A relação entre religiosidade, sentimento de culpa e qualidade de vida em pessoas que vivem com HIV/AIDS. Unpublished MPhil. Universidade Federal da Paraíba.
- Medeiros, B., & Saldanha, A. A. W. (2012). Religiosidade e qualidade de vida em pessoas com HIV. *Estudos de Psicologia (Campinas)*, 29(1), 53-61. <https://dx.doi.org/10.1590/S0103-166X2012000100006>
- Medeiros, B., Silva, J., & Saldanha, A.A.W. (2013) Determinantes biopsicossociais que predizem qualidade de vida em pessoas que vivem com HIV/AIDS. *Estudos de Psicologia*, 18, 543-550. <http://dx.doi.org/10.1590/S1413-294X2013000400001>
- Medeiros, B., & Foster, J. (2014). Mental ill health in the elderly: medical students’ social representations in the United Kingdom. *Revista Da Escola de Enfermagem Da USP*, 48(2), 132–138. <http://doi.org/10.1590/S0080-623420140000800020>

- Miller, A. (2008). A Critique of Positive Psychology-or 'The New Science of Happiness.' *Journal of Philosophy of Education*, 42(3-4), 591-608.
<http://doi.org/10.1111/j.1467-9752.2008.00646.x>
- Minkler, M. (1990). Aging and disability: Behind and beyond the stereotypes. *Journal of Aging Studies*, 4(3), 245-260. [http://doi.org/10.1016/0890-4065\(90\)90025-4](http://doi.org/10.1016/0890-4065(90)90025-4)
- Moloney, G., & Walker, I. (2007). *Social representations and identity: content, process and power*. Palgrave Macmillan.
- Moloney, G., Williams, J., & Blair, D. (2012). Cognitive Polyphasia, Themata and Blood Donation: Between or Within Representation. *Papers on Social Representations*, 21, 4.1-4.12.
- Moloney, G., Gamble, M., Hayman, J., & Smith, G. (2015). Without anchor: Themata and blood donation. *Papers on Social Representations*, 24(2), 1-21.
- Montross, L. P., Depp, C., Daly, J., Reichstadt, J., Golshan, S., Moore, D., ... Jeste, D. V. (2006). Correlates of self-rated successful aging among community-dwelling older adults. *Am J Geriatr Psychiatry*, 14(1), 43-51.
- Moody H.R. (1992) Gerontology and critical theory. *The Gerontologist* 32, 294-295.
- Morant, N. (2006). Social representations and professional knowledge: the representation of mental illness among mental health practitioners. *The British Journal of Social Psychology / the British Psychological Society*, 45(Pt 4), 817-838.
<http://doi.org/10.1348/014466605x81036>

- Moreno, X., Sánchez, H., Huerta, M., Albala, C., & Márquez, C. (2016). Social Representations of Older Adults Among Chilean Elders of Three Cities with Different Historical and Sociodemographic Background. *Journal of Cross-Cultural Gerontology*, 31(2), 115–128. <http://doi.org/10.1007/s10823-016-9288-y>
- Moreira, R. M., Boery, E. N., De Oliveira, D. C., Sales, Z. N., Boery, R. N. S. de O., Teixeira, J. R. B., ... Mussi, F. C. (2015). Social representations of adolescents on quality of life: structurally-based study. *Ciência & Saúde Coletiva*, 20(1), 49–56. <http://doi.org/10.1590/1413-81232014201.20342013>
- Morrow-Howell, N. (2010). Volunteering in later life: Research frontiers. *Journal of Gerontology: Social Sciences*, 65B(4), 461–469. <http://doi.org/10.1093/geronb/gbq024>.Advance
- Moscovici, Serge. (1973). Foreword. In C. Herzlich (Ed.), *Health and illness: a social psychological analysis* (pp. ix–xiv). London: Academic Press.
- Moscovici, S. (1988). Notes towards a description of Social Representations. *European Journal of Social Psychology*, 18(3), 211–250. <http://doi.org/10.1002/ejsp.2420180303>
- Moscovici (1993). Introductory address. *Papers on Social Representations*, 2(3), 160–170.
- Moscovici, S. (1998). The history and actuality of social representations. In U. Flick (Ed.), *The Psychology of the Social*. Cambridge: Cambridge University Press, pp. 209–247
- Moscovici, S. (2008). *Psychoanalysis: its image and its public*. Cambridge: Polity Press.

- Moscovici, S., & Duveen, G. (2000). *Social representations: Explorations in social psychology*. Cambridge, UK: Polity.
- Moscovici, S., & Vignaux, G. (2000). The concept of themata. In S. Moscovici & G. Duveen (Eds.), *Social representations: exploration in social psychology* (pp. 156–183). Cambridge: Polity Press.
- Mossabir, R., Morris, R., Kennedy, A., Blickem, C., & Rogers, A. (2015). A scoping review to understand the effectiveness of linking schemes from healthcare providers to community resources to improve the health and well-being of people with long-term conditions. *Health and Social Care in the Community (Print Edition)*, 23(5), 467–484. <http://doi.org/http://dx.doi.org/10.1111/hsc.12176>
- Murray, M., & Chamberlain, K. (1999). Health psychology and qualitative research. In M. Murray & K. Chamberlain (Eds.), *Qualitative health psychology: Theories and methods* (pp. 3–15). London: Sage Publications.
- Murray, M., Pullman, D., & Rodgers, T. H. (2003). Social representations of health and illness among baby-boomers in eastern Canada. *Journal of Health Psychology*, 8(5), 485–499. <http://doi.org/10.1177/13591053030085002>
- Naaldenberg, J., Vaandrager, L., Koelen, M., & Leeuwis, C. (2011). Aging Populations' Everyday Life Perspectives on Healthy Aging: New Insights for Policy and Strategies at the Local Level. *Journal of Applied Gerontology*, 31(6), 711–733. <http://doi.org/10.1177/0733464810397703>
- Nagel, M.M., Contarello, A., & Wachelke, J. (2011). Social representations and stakes across borders: studying ageing in times of change. *Temas Em Psicologia*, 19(1), 59–73. Retrieved from http://www.euophd.eu/html/_onda02/07/PDF/25th_lab_scientificmaterial/camargo/nagel_contarello_wachelcke_2011.pdf

- Naples, N. A. (1997). A feminist revisiting of the insider/outsider debate: the 'outsider' phenomenon in rural Iowa In R. Hertz (Ed.). *Reflexivity and voice* (pp. 70-94). London: Sage Publications.
- Narushima, M. (2005). Payback Time: Community volunteering among older adults as a transformative mechanism. *Ageing & Society*, 25(4), 567–584.
<http://doi.org/10.1017/S0144686X05003661>
- Nascimento-Schulze, C. M. (2011). Social representations of ageing shared by different age groups. *Temas Em Psicologia*, 19(1), 43–57.
- Nelson, T. D. (2004). *Ageism: stereotyping and and prejudice against older persons*. Cambridge: MIT press.
- Neugarten, B. L., Havighurst, R. J., & Tobin, S. S. (1961). The measurement of life satisfaction. *Journal of Gerontology*, 14, 134–143.
<http://doi.org/10.1093/geronj/16.2.134>
- Nocon, A., & Pearson, M. (2000). The roles of friends and neighbours in providing support for older people. *Ageing and Society*, 20(3), 341–367.
<http://doi.org/10.1017/S0144686X99007771>
- ONS (2017). *Overview of the UK population: July 2017*. Release on 21 July 2017. Office for National Statistics
- ONS. (2013). *Wellbeing Policy and Analysis An Update of Wellbeing Work across Whitehall*. Office for National Statistics
- Palmore, E. (1979). Predictors of successful aging. *The Gerontologist*, 19(5), 427–431.
<http://doi.org/10.1177/1559827612469762>.

- Paúl, C., Ribeiro, O., & Teixeira, L. (2012). Active ageing: An empirical approach to the WHO model. *Current Gerontology and Geriatrics Research*, 2012(2002).
<http://doi.org/10.1155/2012/382972>
- Pavot, W., & Diener, E. (2013). Happiness Experienced: The Science of Subjective Well-being. *The Oxford Handbook of Happiness*, (September 2016), 134–155.
<http://doi.org/10.1093/oxfordhb/9780199557257.013.0010>
- Pesonen, H.-M., Remes, A. M., & Isola, A. (2011). Ethical aspects of researching subjective experiences in early-stage dementia. *Nursing Ethics*, 18(5), 651–661.
<http://doi.org/10.1177/0969733011408046>
- Phelan, E. A., Anderson, L. A., LaCroix, A. Z., & Larson, E. B. (2004). Older adults' views of 'successful aging'--how do they compare with researchers' definitions? *J. Am Geriatr Soc*, 52(2), 211–216.
- Piercy, K. W. (2000). When It Is More Than a Job: Close Relationships Between Home Health Aides and Older Clients. *Journal of Aging and Health*, 12(3), 362–387.
- Pike, E. C. J. (2013). The role of fiction in (mis)representing later life leisure activities. *Leisure Studies*, 32(1), 67–87. <http://doi.org/10.1080/02614367.2012.727458>
- Prieto-Flores, M.-E., Fernandez-Mayoralas, G., Rosenberg, M. W., & Rojo-Perez, F. (2010). Identifying connections between the subjective experience of health and quality of life in old age. *Qualitative Health Research*, 20(11), 1491–1499.
<http://doi.org/10.1177/1049732310374062>

- Provencher, C. (2011). Lauri on organ donation or how to teach the theory of social representations using a quality empirical study metaphors of organ donation , social representations of the body and the opt-OUT. *Papers on Social Representations*, 20, 163–164.
- Provencher, C., Keating, N., Warburton, J., & Roos, V. (2014). Ageing and Community. *Journal of Community & Applied Social Psychology*, 24, 1–11. <http://doi.org/10.1002/casp>
- Pruchno, R. A., Wilson-Genderson, M., & Cartwright, F. (2010). A two-factor model of successful aging. *Journals of Gerontology - Series B Psychological Sciences and Social Sciences*, 65 B(6), 671–679. <http://doi.org/10.1093/geronb/gbq051>
- Punch, M. (1986). *The politics and ethics of fieldwork*. Beverly Hills: Sage Publications.
- Quéniart, A., & Charpentier, M. (2012). Older women and their representations of old age: a qualitative analysis. *Ageing and Society*, 32(6), 983–1007. <http://doi.org/10.1017/S0144686X1100078X>
- Ranzijn, R. (2010). Active ageing--another way to oppress marginalized and disadvantaged elders?: Aboriginal Elders as a case study. *Journal of Health Psychology*, 15(5), 716–723. <http://doi.org/10.1177/1359105310368181>
- Reed-Danahay, D. (2001) ‘ ‘This is your home now!’: conceptualizing location and dislocation in a dementia unit’, *Qualitative Research*, 1 (1): 47–63.
- Reinharz, S. (1997). Who am I? The need for a variety of selves in the field. In R. Hertz (Ed.). *Reflexivity and voice* (pp. 3-20). London: Sage Publications.

- Ribeiro, P. C. C. (2015). A psicologia frente aos desafios do envelhecimento populacional
Psychology facing the challenges of population aging. *Revista Interinstitucional de Psicologia*, 8(2), 269–283.
- Robinson, T. E., & Anderson, C. (2006). Older characters in children's animated television programs: A content analysis of their portrayal. *Journal of Broadcasting & Electronic Media*, 50(2), 287–304.
- Robinson, B. (2014). Death by Denigration: Psychological, Physiological and Mortality Effects of Ageism. *Journal of Gerontology & Geriatric Research*, 3(5), 1–6.
<http://doi.org/10.4172/2167-7182.1000192>
- Robinson, T., & Callister, M. (2008). Body image of older adults in magazine advertisements: A content analysis of their body shape and portrayal. *Journal of Magazine and New Media Research*, 10(1), 1–16.
- Robinson, T., Callister, M., Magoffin, D., & Moore, J. (2007). The portrayal of older characters in Disney animated films. *Journal of Aging Studies*, 21(3), 203–213.
<http://doi.org/10.1016/j.jaging.2006.10.001>
- Rodrigues, M. M. S., De Jong Gierveld, J., & Buz, J. (2014). Loneliness and the exchange of social support among older adults in Spain and the Netherlands. *Ageing & Society*, 34(2), 330–354. <http://doi.org/doi:10.1017/S0144686X12000839>
- Rogers, A., & Pilgrim, D. (2001). *Mental health policy in Britain*. Basingstoke: Macmillan Press Ltd.
- Rogers, A., & Pilgrim, D. (2010). *A Sociology of Mental Health and Illness* (4th ed.). Maidenhead: Open University Press.

- Rogers, A., & Pilgrim, D. (2014). *A Sociology of Mental Health and Illness* (5th ed.). Maidenhead: Open University Press.
- Rowe, J. W., & Kahn, R. L. (1987). Human aging: Usual and successful. *Science*, 237, 143–149. doi:10.1126/science.3299702
- Rowe, J. W., & Kahn, R. L. (1997). Successful ageing. *The Gerontologist*, 37(4), 433–440.
- Rowe, J. W., & Kahn, R. L. (2015). Successful Aging 2.0: Conceptual Expansions for the 21st Century. *Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 70(4), 593–596. <http://doi.org/10.1093/geronb/gbv025>.
- Royal College of Psychiatrists, R. (2009). *Age discrimination in mental health services: making equality a reality*.
- Rozanova, J. (2010). Discourse of successful aging in The Globe & Mail: Insights from critical gerontology. *Journal of Aging Studies*, 24(4), 213–222. <http://doi.org/10.1016/j.jaging.2010.05.001>
- Rozario, P. A., & Derienzis, D. (2009). ‘So forget how old i am!’ Examining age identities in the face of chronic conditions. *Sociology of Health and Illness*, 31(4), 540–553. <http://doi.org/10.1111/j.1467-9566.2008.01149.x>
- Rudinger, G., & Thomae, H. (1990). The Bonn Longitudinal Study of Aging: Coping, life adjustment, and life satisfaction. In *Baltes, Paul B [Ed]* (pp. 265–295). Retrieved from <http://login.ezproxy.library.ualberta.ca/login?url=http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=psyc3&AN=1991-97212-009%5Cnhttp://resolver.library.ualberta.ca/resolver?sid=OVID:psycdb&id=pmid:&id=doi:&issn=&isbn=0-521-37454-5&volume=>

- Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology*, 52, 141–166.
- Ryff, C. D. (1982). Successful aging: a developmental approach. *The Gerontologist*, 22(2), 209–214.
- Ryff, C. D. (1989a). Beyond Ponce de Leon and Life Satisfaction: New Directions in Quest of Successful Ageing. *International Journal of Behavioral Development*, 12(1), 35–55. <http://doi.org/10.1177/016502548901200102>
- Ryff, C. D. (1989b). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, 57(6), 1069–1081. <http://doi.org/10.1037/0022-3514.57.6.1069>
- Ryff, C. D. (1989c). In the eye of the beholder: Views of psychological well-being among middle-aged and older adults. *Psychology and Aging*, 4(2), 195–210. <http://doi.org/10.1037/0882-7974.4.2.195>
- Ryff, C. D. (2013). Psychological well-being revisited: Advances in the science and practice of eudaimonia. *Psychotherapy and Psychosomatics*, 83(1), 10–28. <http://doi.org/10.1159/000353263>
- Ryff, C. D., & Heincke, S. G. (1983). Subjective organization of personality in adulthood and aging. *Journal of Personality and Social Psychology*, 44(4), 807–816. <http://doi.org/10.1037/0022-3514.44.4.807>
- Ryff, C. D., & Keyes, C. L. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, 69(4), 719–727. <http://doi.org/10.1037/0022-3514.69.4.719>

- Ryff, C. D., & Singer, B. H. (2008). Know thyself and become what you are: A eudaimonic approach to psychological well-being. *Journal of Happiness Studies*, 9(1), 13–39. <http://doi.org/10.1007/s10902-006-9019-0>
- Ryff, C. D., Singer, B. H., & Dienberg Love, G. (2004). Positive health: connecting well-being with biology. *Philosophical Transactions: Biological Sciences*, 359(1449), 1383–1394. <http://doi.org/10.1098/rstb.2004.1521>
- Sammur, G., Tsirogianni, S., & Wagoner, B. (2012). Representations from the Past: Social Relations and the Devolution of Social Representations. *Integrative Psychological and Behavioral Science*, 46(4), 493–511. <http://doi.org/10.1007/s12124-012-9212-0>
- Samutt, G., Andreouli, E., Gaskell, G., & Valsiner, J. (2015). Social representations: a revolutionary paradigm? In G. Sammut, E. Andreouli, G. Gaskell, & J. Valsiner (Eds.), *The Cambridge handbook of social representations* (pp. 3–11). Cambridge: Cambridge University Press.
- Sánchez, M., & Hatton-Yeo, A. (2012). Active Ageing and Intergenerational Solidarity in Europe: A Conceptual Reappraisal from a Critical Perspective. *Journal of Intergenerational Relationships*, 10(3), 276–293. <http://doi.org/10.1080/15350770.2012.699819>
- Sánchez, M., Sáez, J., & Pinazo, S. (2010). Intergenerational solidarity: programs and policy development. In M. A. Cruz-Saco & S. Zelenev (Eds.), *Intergenerational solidarity: strengthening economic and social ties* (pp. 129–148). New York: Palgrave Macmillan.
- Santos, V. B., Tura, L. F. R., & Arruda, A. M. S. (2013). As representações sociais de ‘pessoa velha’ construídas por Idosos. *Saúde E Sociedade*, 22(1), 138–147.

- Schaie, K. W. (1990). The optimization of cognitive functioning in old age: Predictions based on cohort-sequential and longitudinal data 793. *Successful Aging: Perspectives from the Behavioral Sciences*, 94–117.
- Seale, C. (1999). *The quality of qualitative research*. London: Sage.
- Seale, Clive (2004). Quality in qualitative research. In: C. Seale, G. Gobo, J. F. Gubrium & D. Silverman (Eds.), *Qualitative research practice* (pp. 409-419). London: Sage.
- Searle, J. R. (1995). *The construction of social reality*. St. Ives: Penguin Books.
- Seefeldt, C., Jantz, R. K., Galper, A., & Serock, K. (1977). Using Pictures to Explore Children's Attitudes Toward the Elderly. *The Gerontologist*, 17(6), 506–512.
<http://doi.org/10.1093/geront/17.6.506>
- Seligman, M. E. P. (2008). Positive Health. *Applied Psychology*, 57(s1), 3–18.
[doi:10.1111/j.1464-0597.2008.00351.x](http://doi.org/10.1111/j.1464-0597.2008.00351.x)
- Singh, P., Hussain, R., Khan, A., Irwin, L., & Foskey, R. (2014). Dementia care: Intersecting informal family care and formal care systems. *Journal of Aging Research*, 2014(1), 7–9. <http://doi.org/10.1155/2014/486521>
- Sixsmith, A., & Sixsmith, J. (2008). Ageing in Place in the United Kingdom. *Ageing International*, 32(3), 219–235. <http://doi.org/10.1007/s12126-008-9019-y>
- Smith, C. (2003). *Moral, believing animals: Human personhood and culture*. Oxford University Press.
- Soares, C., Marques, A. M., Gomes da Silva, M., Cerqueira, A., Bonanca, Í., & Arguello, P. (2014). Are social representations of positive ageing really effective ? The ageing process through the eyes of elderly. *Journal of Spatial and Organizational Dynamics*, 2(2), 41–54.

- Sotgiu, I., Galati, D., Manzano, M., & Rognoni, E. (2011). Happiness Components and their Attainment in Old Age: A Cross-Cultural Comparison Between Italy and Cuba. *Journal of Happiness Studies*, 12(3), 353–371. <http://doi.org/10.1007/s10902-010-9198-6>
- Sprangers, M. a. G., de Regt, E. B., Andries, F., van Agt, H. M. E., Bijl, R. V., de Boer, J. B., ... de Haes, H. C. J. M. (2000). Which chronic conditions are associated with better or poorer quality of life? *Journal of Clinical Epidemiology*, 53(9), 895–907. [http://doi.org/10.1016/S0895-4356\(00\)00204-3](http://doi.org/10.1016/S0895-4356(00)00204-3)
- Springer, K. W., Pudrovskaya, T., & Hauser, R. M. (2011). Does psychological well-being change with age? Longitudinal tests of age variations and further exploration of the multidimensionality of Ryff's model of psychological well-being. *Social Science Research*, 40(1), 392–398. <http://doi.org/10.1016/j.ssresearch.2010.05.008>
- Stenner, P., McFarquhar, T., & Bowling, A. (2011). Older people and 'active ageing': Subjective aspects of ageing actively. *Journal of Health Psychology*, 16(3), 467–477. <http://doi.org/10.1177/1359105310384298>
- Stephens, C. (2007). Supportive Social Context and Intentions for Civic and Political Participation: An Application of the Theory of Planned Behaviour. *Journal of Community & Applied Social Psychology*, 17, 103–114. <http://doi.org/10.1002/casp>
- Stephens, C., Breheny, M., & Mansvelt, J. (2015). Volunteering as reciprocity: Beneficial and harmful effects of social policies to encourage contribution in older age. *Journal of Aging Studies*, 33, 22–27. <http://doi.org/10.1016/j.jaging.2015.02.003>
- Stephens, A., Deaton, A., & Stone, A. A. (2015). Subjective wellbeing, health, and ageing. *The Lancet*, 385(9968), 640–648. [http://doi.org/10.1016/S0140-6736\(15\)61489-0](http://doi.org/10.1016/S0140-6736(15)61489-0)

- Steverink, N., Lindenberg, S., & Ormel, J. (1998). Towards understanding successful ageing: patterned change in resources and goals. *Ageing and Society*, 18, 441–467.
<http://doi.org/doi:null>
- Stowe, J. D., & Cooney, T. M. (2015). Examining rowe and kahn's concept of successful aging: Importance of taking a life course perspective. *Gerontologist*, 55(1), 43–50.
<http://doi.org/10.1093/geront/gnu055>
- Strawbridge, W. J., Wallhagen, M. I., & Cohen, R. D. (2002). Successful aging and well-being: self-rated compared with Rowe and Kahn. *The Gerontologist*, 42(6), 727–733. <http://doi.org/10.1093/geront/42.6.725>
- Stuart-Hamilton. (2012). *The psychology of ageing* (5th ed.). London: Jessica Kingsley Publishers.
- Sugarman, J. (2007). Practical Rationality and the Questionable Promise of Positive Psychology. *Journal of Humanistic Psychology*, 47(2), 175–197.
<http://doi.org/10.1177/0022167806297061>
- Tajfel, H. (1981). Instrumentality, identity and social comparisons. In H. Tajfel (Ed.), *Social identity and intergroup relations* (pp. 483-523). Cambridge: Cambridge University Press.
- Tate, R. B., Leedine, L., & Cuddy, T. E. (2003). Definition of Successful Aging by Elderly Canadian Males: The Manitoba Follow-Up Study. *The Gerontologist*, 43(5), 735–744. <http://doi.org/10.1093/geront/43.5.735>
- Tate, R. B., Swift, A. U., & Bayomi, D. J. (2013). Older Men ' S Lay Definitions of Successful Aging Over Time : the Manitoba Follow-Up Study *, 76(4), 297–322.

- Teixeira, M. C. T. V., Schulze, C. M. N., & Camargo, B. V. (2002). Representações sociais sobre a saúde na velhice: um diagnóstico psicossocial na Rede Básica de Saúde. *Estudos de Psicologia (Natal)*, 7(2), 351–359. <http://doi.org/10.1590/S1413-294X2002000200016>
- Teixeira, M. C. T. V., Settembre, F. M., & Leal, S. B. (2007). A survey of women's social representations of aging and rejuvenation. *The Spanish Journal of Psychology*, 10(1), 104–114.
- Thoits, P. A. (1985). Social Support and Psychological Well-Being: Theoretical Possibilities. In I. G. Sarason & B. R. Sarason (Eds.), *Social Support: Theory, Research and Applications* (pp. 51–72). Dordrecht: Martinus Nijhoff Publishers.
- Thoits, P. A. (2011). and Support to Physical and Mental Health, 52(2), 145–161. <http://doi.org/10.1177/0022146510395592>
- Thoits, P. and L. Hewitt. 2001. 'Volunteer Work and Well-Being.' *Journal of Health and Social Behavior*, 42:115-31.
- Thomas, J., & Evans, J. (2010). There's More to Life than GDP but How Can We Measure It? *Economic & Labour Market Review*, 4(9), 29–36. <http://doi.org/10.1057/elmr.2010.127>
- Toepfer, N. F., Foster, J. L. H., & Wilz, G. (2014). "The good mother and her clinging child": patterns of anchoring in social representations of dementia caregiving. *Journal of Community & Applied Social Psychology*, 24, 234–248. <http://doi.org/10.1002/casp>
- Torres, S. (2001). Understandings of successful ageing in the context of migration: the case of Iranian immigrants in Sweden. *Ageing & Society*, 21(3), 333–355. <http://doi.org/10.1017/S0144686X01008261>

- Torres, S. (2003). A preliminary empirical test of a culturally-relevant theoretical framework for the study of successful aging. *Journal of Cross-Cultural Gerontology*, 18(1), 79–100. <http://doi.org/10.1017/S0144686X99007242>
- Torres, S. (2006). Different ways of understanding the construct of successful aging: Iranian immigrants speak about what aging well means to them. *Journal of Cross-Cultural Gerontology*, 21(1–2), 1–23. <http://doi.org/10.1007/s10823-006-9017-z>
- Townsend, J., Godfrey, M., & Denby, T. (2006). Heroines, villains and victims: older people's perceptions of others. *Ageing and Society*, 26(2006), 883–900. <http://doi.org/10.1017/S0144686X06005149>
- Tulle-Winton, E. (2000). Old bodies. In P. Hancock, B. Hughes, E. Jagger, K. Paterson, R. Russell, E. Tulle-Winton, & M. Tyler (Eds.), *The body, culture and society: an introduction* (pp. 63–83). Buckingham: Open University Press.
- Twigg, J., & Martin, W. (2015). The field of cultural gerontology. In J. Twigg & W. Martin (Eds.), *Routledge Handbook of Cultural Gerontology* (pp. 1–15). London: Routledge. <http://doi.org/10.4324/9780203097090.ch1>
- Vaillant, G. E. (1990). Avoiding negative life outcomes: Evidence from a forty-five year study. *Baltes, Paul B (Eds.). Successful Aging Perspectives from the Behavioral Sciences* (pp. 332–358). Cambridge: Cambridge University Press
- Victor, C. R., Scambler, S. J., Marston, L., Bond, J., & Bowling, A. (2006). Older people's experiences of loneliness in the UK: does gender matter? *Social Policy and Society*, 5(2006), 27–38. <http://doi.org/10.1017/S1474746405002733>
- Villar, F. (2012). Successful ageing and development: the contribution of generativity in older age. *Ageing and Society*, 32(7), 1087–1105. <http://doi.org/10.1017/S0144686X11000973>

- Villas Bôas, L. P. S. (2010). Uma abordagem da historicidade das representações sociais. *Cadernos de Pesquisa*, 40(140), 379–405. <http://doi.org/10.1590/S0100-15742010000200005>
- van den Hoonaard W. van den Hoonaard D. (2013). *Essentials of thinking ethically in qualitative research*. Walnut Creek, CA: Left Coast Press.
- Wachelke, J., & Contarello, A. (2010). Social representations on aging: Structural differences concerning age group and cultural context. *Revista Latinoamericana de Psicología*, 42(3), 367–380.
- Wagner, W., Duveen, G. Verma, I. & Themel, M. (2000). I have some faith and at the same time I don't believe. Cognitive Polyphasia and Cultural Change in India. *Journal of Community & Applied Social Psychology*. 10, 301-314.
- Wagner, W., Elejabarrieta, F., & Lahnsteiner, I. (1995). How the sperm dominates the ovum—Objectification by metaphor in the social representation of conception. *European Journal of Social Psychology*, 25,671–688.
- Wainwright, S. P., & Williams, C. (2005). Culture and ageing: Reflections on the arts and nursing. *Journal of Advanced Nursing*, 52(5), 518–525. <http://doi.org/10.1111/j.1365-2648.2005.03620.x>
- Walker, A. (2002). A strategy for active ageing. *International Social Security Review*, 55(1), 121–139. <http://doi.org/10.1111/1468-246X.00118>
- Walker, A. (2009). Commentary: the emergence and application of active aging in Europe. *Journal of Aging & Social Policy*, 21(1), 75–93. <http://doi.org/10.1080/08959420802529986>

- Walker, A., & Foster, L. (2013). Active ageing: rhetoric, theory and practice. In R. Ervik & T. S. Lindén (Eds.), *The making of ageing policy: theory and practice in Europe* (pp. 27–52). Cheltenham: Edward Elgar Publishing Limited.
- Warburton, J. (2015). Volunteering in later life. In J. Twigg & W. Martin (Eds.), *Routledge Handbook of Cultural Gerontology* (pp. 345–351). London: Routledge.
<http://doi.org/10.4324/9780203097090.CH44>
- Ward, L. (2014). Negotiating Well-being: Older People's Narratives of Relationships and Relationality. *Ethics and Social Welfare*, 8(3), 293–305.
<http://doi.org/10.1080/17496535.2014.932419>
- Ward, L. (2015). Caring for ourselves? Self-care and neoliberalism. In M. Barnes, T. Brannelly, L. Ward, & N. Ward (Eds.), *Ethics of care: critical advances in international perspective* (pp. 45–56). Bristol: Policy Press.
- Ward, L., Barnes, M., & Gahagan, B. (2012). *Well-being in old age: findings from participatory Report*. University of Brighton and Age Concern Brighton, Hove and Portslade. Brighton and Hove.
- Westerhof, G. J., & Tulle, E. (2007). Meanings of ageing and old age: discursive contexts, social attitudes and personal identities. In J. Bond, S. Peace, F. Dittmann-Kohli, & G. J. Westerhof (Eds.), *Ageing in Society: European perspectives on gerontology* (pp. 235–254). London: Sage Publications.
- World Health Organization. (1997). *WHOQOL measuring quality of life*. Programme on Mental Health. Division of Mental Health and Prevention of Substance Abuse. Washington, DC: Author.

World Health Organization (WHO) 2002. *Active Ageing: A Policy Framework*. WHO, Geneva. Available online at http://whqlibdoc.who.int/hq/2002/WHO_NMH_NPH_02.8.pdf

World Health Organisation. (2006). *Constitution of The World Health Organization. Basic Document Forty-fifth edition*. Retrieved from http://www.who.int/governance/eb/who_constitution_en.pdf

Willig, C., & Stainton-Rogers, W. (2008). Introduction. In C. Willig & W. Stainton-Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (pp. 1–12). London: Sage Publications.

Wortman, C. B., & Silver, R. C. (1990). *Successful mastery of bereavement and widowhood: A life-course perspective. Successful aging: Perspectives from the behavioral sciences*. Retrieved from https://books.google.be/books?hl=en&lr=&id=0oEJaiK30wUC&oi=fnd&pg=PA225&dq=successful+mastery+of+bereavement+and+widowhood:+a+life-course+perspective&ots=IIDL0__7BR&sig=q5dANTSzoaZsSW8EEM-AbXVU7_g

Ylanne, V. (2017). Representations of ageing in the media. In *Routledge Handbook of Cultural Gerontology Representations of ageing in the media* (pp. 369–376). <http://doi.org/10.4324/9780203097090.ch47>

Ylanne, V., Williams, A., & Wadleigh, P. M. (2009). Ageing well? Older people's health and well-being as portrayed in UK magazine advertisements. *International Journal of Ageing and Later Life*, 4(2), 33–62.

Zadeh, S., Freeman, T., & Golombok, S. (2013). Ambivalent identities of single women using sperm donation. *Revue Internationale de Psychologie Sociale*, 26 (3), 97-123.

- Zadeh, S. (2014). Thinking on fertile ground: a study of social representations of single mothers by sperm donation in the UK. Unpublished PhD. University of Cambridge.
- Zani, B. (1995). The mentally ill person and the others: social representations and interactive strategies. In I. Marková & R. M. Farr (Eds.), *Representations of health, illness and handicap*. (pp. 145–162). Chur: Harwood Academic Publishers.

APPENDIX 1 – SAMPLES OF FIELDNOTES

Fieldwork Notes Cherry Trees Day Centre Week 2, 26th November, 2013

I arrived at 9:30 am and helped to set up the tables for lunch. My routine starts at 9:30am when I wait for the clients to come. I wonder how I will keep the process of acquiring informed consent to the Tuesday's group. I take a Christian perspective in social sciences, where my ethics are molded to God's ethics and all procedures in the field must come out of this framework. Principles of human dignity, respect and covert research rule my research procedures. Thus, I question whether I had acquired enough consent from most of the participants to take notes on their interactions in the field. This first group comes at 10am, they sit down and receive coffee/tea and cookies. It is the second Tuesday they listen to music while gather in the hall...

Afternoon, Ally led a quiz with the group of clients. She distributed sheets of papers containing a letter from the alphabet. Then, she asked them to provide names of household objects with the letters each one received. *Can you tell me a householding object beginnings with your letter?'*

This activity seems to involve memory task and word association. The group seemed to be distracted and kept asking her to repeat her questions (and answers from other clients). The said, *'If you could listen, you would not [be] asking what did he/she say?'* Then, she changed to categories to food. In one of the interactions, Ally asked Josh about the name of a food starting with his letter. Rose tried to help him, noticing his delay to give an answer. Ally interrupted Rose, and asked her not to help this time, as she wanted Josh's

answer. AN Sarah seemed to know that Josh had any memory problem and tried to stimulate him.

Another volunteer then suggested the word 'Fish' for a food starting with F. Ally, then addressed the whole group saying *'It's very good for the brain'* (pointing to her head). This activity involved many volunteers and clients interacted well with them. For instance, Mickey was mimicking the parts of the body when Ally asked clients for them.

After this activity, I approached Ally, the facilitator, and asked *'What did you have in mind when elaborated this activity?'* She then answered 'I want to promote thought (cognitive) stimulation. Then, I asked her whether she knew the cognitive conditions of their clients. She then answered that some of them present some memory problems and that she tries to stimulate them with different activities (not only bingos, *'They know this activity from long, long time ago'*. I said: *It might be in their long term memory. Yes, I try to use different ones. I know I have them for 45 minutes'* (them she tries to stimulate them). According to her, they might forget what they do after two hours but some of them remember.

Then, I asked *'And what about Josh? You seem to stimulate him more. Do you have any previous knowledge about his condition?'* She answered: *He has a brain trauma*. I continued to ask: *Is it not dementia?* She said *'Well, it is dementia from brain trauma'*. 'I don't know exactly what happened'. I insisted 'How did you know about his condition?' She said 'His wife told me he has a brain trauma. He was brought here for 'social stimulation'. I told her 'It is important to me to know what underlies your decision to male these activities. You did not take these from granted. She said 'Yes, I know but I haven't given a thought about it'.

We agreed we could talk more about this in the future. The conversation stopped and I said goodbye to the staff presented there. I left the day centre at about 2:50pm.

**Fieldwork notes Ambury Road Day Centre, Huntingdon
Week 4, Winter, 12th March, 2014**

Today, Teresa, Ruth, Rod and Aundry welcomed my presence in the day centre. They were chatting before other clients arrived. I decided to be more involved with the day centre activities and take more notes of dynamics and interactions. I noticed that two tables had been set up for an art activity. Clients would have to decorate Easter hats with a broad range of pieces, figures and forms. The day centre has started preparations for the Eastern, and staff let the clients know about the schedule for the Easter holidays. Clients arrived and I helped them to sit down in the seats and to have their cup of tea/coffee. At 11am, they went to the tables to start the decorations. All clients sat down and started to work on their hats. They expressed extraordinary creativity and interest in doing the activity. I noticed that some volunteers also helped the less capable to decorate. I also helped older adults with the decorations. During the activity, I asked Teresa about why she chose to do it. She answered 'Just to do something different', without explaining in details the rationale for choosing this activity. She explained that the former staff used to be very artistic but she is not. I added that she kept with this sort of activity, and she confirmed that she does it because it is different. I turned to clients to observe their work. Most of them had finished while others were still decorating the hats. I complimented the result of their work. After this, they left their hats below a table with all Easter gifts. Although I had not asked it, I believe they will revisit their hats in coming weeks (near Easter) ...

Fieldwork notes Oasis Community Centre, Wisbech
Wednesday June 19, 2014

This Wednesday, I arrived at the Oasis day centre and greeted Lynne and Graham. They had arrived first. Val arrived about 9.45am and we were preparing ourselves to welcome the clients. The first one to enter in the room was Jo. She arrived and notices we were laughing and chatting. She seemed not to understand what was going on, and complained using her usual words, '*Blood hell!*' We welcome her to seat down while we helped the others. She still seemed disorientated, walking around the room and expressing dissatisfaction by her face language. Soon, other clients arrived. Some of them asked whether I was feeling better. I was glad to hear they in fact cared for me and were concerned with my health. Doris stated clearly she was glad to see I was fine. At this moment, I had the impulsive reaction to invite her for an interview, once she demonstrated interest in me. I felt guilty for enjoying this opportunity to take advantage for my research. After pondering, I decided to wait a few more minutes until she had settle down at the room and felt comfortable. I decided not to take the chance to invite her for an interview at that moment – I would have a more proper time to do it.

APPENDIX 2 – TOPIC GUIDE FOR THE INTERVIEWS WITH CLIENTS, STAFF MEMBERS, AND VOLUNTEERS

Interviews Guideline with Clients

Contextual information about the interview and the interviewee	
Date of the interview:	_____
Place of the interview:	_____
Duration of the interview:	_____
Indicator for identifying the interviewee:	_____
The interviewee's gender:	_____
Age of the interviewee:	_____
Living arrangements:	_____
Profession:	_____
Raised (countryside / city):	_____
City / village:	_____
Number of children (if any):	_____
Age of children:	_____
Gender of children:	_____
Social contacts with family:	_____
What kinds of services the interviewee uses in Age-UK Cambridgeshire:	

Peculiarities of the interview:	

RAPPORT QUESTIONS – Please, could you tell me about yourself?

- 1) What aspects in your life do make you feel happy and satisfied?
- 2) What makes you feel happy in your day?

I) UNDERSTANDINGS OF (PSYCHOLOGICAL) WELL-BEING IN LATER LIFE.

- 1) **What does make you feel well (and healthy) in your life?**
- 2) What are your main needs? What are the main needs of elderly people?
- 3) From your experience, what are the most important things to keep you well in your life?
- 4) From your experience, what can mostly make you feel well?
- 5) What are the main problems that affect your well-being? How do you prevent this?
- 6) Do you see yourself independent in your daily life?
- 7) How important is it to you to feel independent in your daily life?

II) ROLE OF THE FAMILY

- 6) **What about your family? How is your contact with them?**
- 7) How is the relationship with your family? How does your family contribute to your well-being?

III) EXPERIENCES AND CHANGES IN LATER LIFE

- 8) **Do you see yourself different from the past 10 years? If so, what did change in your life when you grew older?**
- 9) What are the main changes that came with age? How do you feel about these changes?
- 10) What are the main problems that older people face in their lives?

IV) MENTAL HEALTH ISSUES

- 11) **Many people talk about mental health for older people. What can bring mental health to the older adult?**
- 12) What do you think about dementia in old age? What can be done to help (prevention) people with dementia?

V) INSTITUTIONAL SUPPORT

- 15) **How did you come to have contact with Age-UK Cambridgeshire?**
- 16) How important is this day centre to you? Why?
- 17) What are the main activities you do here? What do you most like? Why?
- 18) How do you think Age-UK helps you? If anything could be change, what do you suggest?
- 19) What can bring people to a day centre like this one?

Interview With Staff Members And Volunteers (Day Centres and The Visiting Scheme)

Contextual information about the interview and the interviewee	
Date of the interview:	_____
Place of the interview:	_____
Duration of the interview:	_____
Indicator for identifying the interviewee:	_____
The interviewee's gender:	_____
Age of the interviewee:	_____
Profession / role in Age-UK Cambs.:	_____
Raised (countryside / city):	_____
City / village:	_____
Period of working in Age-UK Cambs.	_____
Activities in Age-UK Cambridgeshire:	

Peculiarities of the interview:	

RAPPORT QUESTION

1) How did you become a Volunteer/Staff member of Age-UK?

I) EXPERIENCE OF VOLUNTEERING IN THE DAY CENTRES

1) Why did you become a volunteer in Age-UK?

2) What is your role as a volunteer?

3) What are the main needs of older adults in your experience?

4) What do you think about care/support of older people?

6) What are the main purposes of Age-UK Cambridgeshire?

- 7) Do you see these purposes being fulfilled in your daily practice as volunteer?
- 8) Is it possible to establish collaborations with other social and health organisations to care for the elderly? What can be the benefits of these (potential) collaborations?

II) EXPERIENCES AS A VISITING SCHEME VOLUNTEER

- 1) What is the purpose of your visits?**
- 2) What is the importance of these visits for the clients?
- 3) What are the main needs of older adults in your experience?
- 4) What do you think about care/support of older people?
- 5) What are the main purposes of Age-UK Cambridgeshire?
- 6) Do you see these purposes being fulfilled in your daily practice as volunteer?

III) PSYCHOLOGICAL WELL-BEING IN LATER LIFE

- 1) How do you define psychological well-being? How do you define it in later life?**
- 2) From your activities, how do you think they promote well-being in later life?
- 3) In general, what are the main challenges to promote (psychological) well-being in later life?

IV) CHANGES IN LATER LIFE

- 1) In a scale from independence to dependency, how do you see the older people you deal with?**

V) ROLE OF THE FAMILY

- 1) What are the role of family in supporting the elderly?**

V) MENTAL HEALTH ISSUES IN LATER LIFE

- 1) What is mental health to older people? What can bring mental health?**
- 2) How does Age UK work to promote psychological well-being in later life?
- 3) What are the main barriers/possibilities to promote mental health in later life?
- 4) What are the main mental health problems in old age (that you find in your daily practices)?**

EXPLORING DEMENTIA IN OLD AGE (VISITING SCHEME)⁵³.

- 1. What are the main challenges to deal with a client with dementia?**
- 2. How do you think your activity helps to support older people with dementia?**
3. What is the role of Age-UK in dealing with dementia in older life?
4. Would you consider yourself able to identify mental health problems in older adults in your daily practice? Do you think this could be possible in social care?

⁵³ This additional set of questions aimed at exploring specific challenges of mental health problems in the visiting scheme. I added this section to the interview with visitors for their proximity of clients with dementia and the challenges associated with it.

Information Sheet for older adults

Well-being in later life

Before you take part in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

Purpose of the study

I want to understand your views on well-being in later life and Age UK Cambridgeshire's role in it. This is part of PhD research project in Psychology at the University of Cambridge. This study will finish in October 2015, and my results will be used with a view to improving your support at Age UK as well as for academic purposes (presentation at conferences, academic papers, seminars, etc.).

What does this research involve?

I would like to interview you, just once, and ask you some questions about your ideas about well-being. I would like to know what you think helps, what doesn't help and what you get out of

coming to Age UK groups. We would talk about this in private, and the interview would probably last for 20-25 minutes. It is up to you how much you say, and you don't have to answer all the questions if you don't want to. I would like to record what you say so that I can remember it, but if you do not want to be recorded, then this is fine - just tell me. Nobody else will listen to the recording, and it won't be kept after this project finishes.

What happens after the interview?

I hope to interview a lot of different people, including people who come to Age UK daycentres, their families and people who work here. I will then look at all the different interviews and write up a report for my PhD degree. I might also talk about the research at conferences, and write about it in academic journals. I would like to discuss what I think about the results with you afterwards too, and see what you think. All my notes will be kept securely so that nobody else will be able to see them.

Will anyone be able to identify me?

It is very important to me that nobody who reads my report will be able to tell who the people I interviewed are. Your privacy is very important. I will therefore change all the names of people I

interview, and will not include any details that would mean people could identify you.

What will Age UK know about my interview?

Age UK would like to know more about this subject too, so I will also write a report for them. However, this will not mention anyone's real names, nor include any details that would allow them to be identified by Age UK. Although I am working with Age UK to speak to people in their day centres, I am an independent researcher at the University of Cambridge.

Deciding whether to take part

You do not have to take part in this project if you do not want to. If you decide not to take part, this will not affect you, or your participation in Age UK groups now or in the future.

What will I get out of being interviewed?

There are no gifts or rewards available for people who take part in the interviews, but we hope that its results might help Age UK to promote psychological well-being and social support in old age.

The project has received ethical approval from Ethics Committee of the Department Psychology, University of Cambridge.

What if I have any more questions?

If you have more questions, you can discuss them now with the researcher, or contact him by telephone or e-mail.

Bruno Medeiros –07848947199

PhD Researcher, University of Cambridge.

Email: bm420@cam.ac.uk

**APPENDIX 4 – INFORMATION SHEET FOR INTERVIEWS WITH STAFF
MEMBERS AND VOLUNTEERS**

Information Sheet

Well-being in later life

Before you take part in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

Purpose of the study

I want to understand your views about well-being in later life and Age UK Cambridgeshire's role in this. This is part of PhD research project in Psychology at the University of Cambridge. This study will finish in October 2015, and my results will be used with a view to improving the service provision at Age UK as well as for academic purposes (presentation at conferences, academic papers, seminars, etc.).

What does this research involve?

I would like to interview you, just once, and ask you some questions about your ideas on well-being. I would like to know what you think helps, what doesn't help and how Age UK

Cambridgeshire is engaged in promoting it. What are the main actions, services, outcomes and plans to promote well-being? We would talk about this in private, and the interview would probably last for 30-40 minutes. It is up to you how much you say, and you don't have to answer all the questions if you don't want to. I would like to record what you say so that I can remember it, but if you do not want to be recorded, then this is fine - just tell me. Nobody else will listen to the recording, and it won't be kept after this project finishes.

What happens after the interview?

I hope to interview many different people, including people who come to Age UK day centres, their families and people who work/volunteer here. I will then look at all the different interviews and write up a report for my PhD degree. I might also talk about the research at conferences, and write about it in academic journals. I would like to discuss what I think about the results with you afterwards too, and see what you think. All my notes will be kept securely so that nobody else will be able to see them.

Will anyone be able to identify me?

It is very important to me that nobody who reads my report will be able to tell who the people I interviewed are. Your privacy is very important. I will therefore change all the names of people I

interview, and will not include any details that would mean people could identify you.

What will Age UK know about my interview?

Age UK would like to know more about how to improve well-being in later life, so I will also write a report for them. However, this will not mention anyone's real names, nor include any details that would allow them to be identified by Age UK. Although I am working with Age UK to speak to people in their day centres and home visits, I am an independent researcher at the University of Cambridge.

Deciding whether to take part

You do not have to take part in this project if you do not want to. If you decide not to take part, this will not affect you, or your work at Age UK Cambridgeshire now or in the future.

What will I get out of being interviewed?

There are no gifts or rewards available for people who take part in the interviews, but we hope that its results might help Age UK to promote psychological well-being and social support in old age.

The project has received ethical approval from Ethics Committee of the Department Psychology, University of Cambridge.

What if I have any more questions?

If you have more questions, you can discuss them now with the researcher, or contact him by telephone or e-mail.

Bruno Medeiros –07848947199

PhD Researcher, University of Cambridge.

Email: bm420@cam.ac.uk

APPENDIX 5 – CONSENT FORM

Researcher: Bruno Medeiros
bm420@cam.ac.uk
+44-07848947199

Department of Psychology
Free School Lane, CB2 3RQ

Consent Form

Well-being in later life

I confirm that I have read and understand the Participant Information Sheet (Yes/No);

- 1) *I have had the opportunity to ask any questions and have had them answered (Yes/No);*
- 2) *I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified (Yes/No);*
- 3) *I agree that data gathered in this study may be stored anonymously and securely, and may be used for future research (Yes/No);*
- 4) *I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason (Yes/No);*
- 5) *I agree that this interview can be recorded (Yes/No)*
- 6) *I agree to take part in this study (Yes/No).*

Signature

Date

APPENDIX 6 – WRITTEN SUMMARY OF RESEARCH PROJECT

Written Summary of the Research Project

Well-being in later life

Purpose of the study

I want to understand your views on well-being in later life and Age UK Cambridgeshire's role in this. This is part of PhD research project in Psychology at the University of Cambridge. This study will finish in October 2015, and my results will be used with a view to improving your support at Age UK as well as for academic purposes (presentation at conferences, academic papers, seminars, etc.).

What does this research involve?

Firstly, I will spend some time at this daycentre, and observe group meetings. I would like to understand how things work here, and what people who come here think about it. During this, I would like to take some notes. Nobody else will see these notes, but they will be available to you if you wish to read them. They won't be kept after this project finishes. I will also conduct interviews with some participants at a later stage of this research.

What happens after the observations and interviews?

I hope to observe and interview a lot of different people, including people who come to Age UK daycentres, their families and people who work here. I will then look at what has been done to promote well-being here and write up a report for my PhD degree. I might also talk about the research at conferences, and write about it in academic journals. I would like to discuss what I think about the results with you afterwards too, and see what you think. All my notes will be kept securely so that nobody else will be able to see them.

Will anyone be able to identify me?

It is very important to me that nobody who reads my report will be able to tell who the people I observed and interviewed

are. Your privacy is very important. I will therefore change all the names of people I observe and interview, and will not include any details that would mean people could identify you.

What will Age UK know about this research?

Age UK would like to know more about this subject too, so I will also write a report for them. However, this will not mention anyone's real names, nor include any details that would allow them to be identified by Age UK. Although I am working with Age UK to observe and speak to people in their daycentres, I am an independent researcher at the University of Cambridge.

Deciding whether to take part

You do not have to take part in this project if you do not want to. If you decide not to take part, this will not affect you, or your participation in Age UK groups now or in the future. Additionally, if you and your friends do not want to be observed in some days or meetings I will respect your will. If you do not want to be included in any observation, I will not take notes of your interaction and comments. Interviews will be a completely different stage and I will ask people later if they are interested in being interviewed.

What will I get out of participating in this research?

There are no gifts or rewards available for people who take part in the observations, but we hope that its results might help Age UK to promote psychological well-being and social support in old age.

The project has received ethical approval from the Ethics Committee of the Department of Psychology, University of Cambridge.

What if I have any more questions?

If you have more questions, you can discuss them now with the researcher, or contact him by telephone or e-mail.

Bruno Medeiros –07848947199

PhD Researcher, University of Cambridge.

Email: bm420@cam.ac.uk

APPENDIX 7 – REFLECTIVE NOTES

Reflexive Memo: researcher's background, 03.07.2015, 22:09:19

Language barriers might constitute another relevant issue when trying to translate mine and their experiences in the fieldwork. When describing a scene, I face the need to better translate in English what I have seen and experienced. Not always, the words come to my mouth, and I put myself in danger of not mentioning reactions and feelings from participants, and my interactions in the field. I am not a native English speaker, and have been living in England for two years (in a small context of Academy). These factors should be taking into consideration when providing explanations and questions about the experiences in the field (although they do not necessarily invalidate the data collected and interpretations provided).

I should be able to ask these questions and be aware of my cultural background.

Reflexive Memo: Ethics, 05.07.2015, 21:57:19.

In the beginning, I feared that older adults would feel uncomfortable with a written informed consent. I decided to seek verbal consent based on my belief that they were not capable of giving fully written consent. I was wrong. In conversation with my supervisor, I realise that I should seek written consent as a form of not only guarantee a formal consent from clients, but also to protect myself.

Then, I decided to ask clients to sign the written consent forms for the interviews. I did not find resistance from them.

Analysis Plan Three, 11.01.2016, 18:50:26.

My observations in the Light Day Centre continue. I feel I am more comfortable with being at that space. However, there are clear boundaries between volunteers and staff and me. Although, I feel I am included in their work routine, they still reserve some specific activities to the 'internal' ones.

Today, an unpleasant and unexpected situation happened. Clare, the activity facilitator was hospitalised, and I was asked to help more with the activities and the dynamics of the day centre. My initial plans were to interview one of the volunteers; however, I had to postpone this meeting until next time when there would be more time to remove one volunteer from the main hall.

Again, attention should be giving the BRAIN ACTIVITIES. The rationale of some activities (either puzzles, games or music) aim at fostering reminiscence, and links to clients' biographies. [See fieldnotes]

Clients seem to present problems to explain why they engage (and enjoy) the routine of activities. They seem to enjoy mostly the familiarity of actions in the day centre. This belief is shared by one staff member at Joy Day Centre. When she defended that clients prefer to be involved in familiar activities, even though they seemed to be repetitive (to me) at times.

APPENDIX 8 – SAMPLES OF INTERVIEW TRANSCRIPTS

Field Maple Day Centre, Client 5

Researcher: No need to be worried about the recorder. Just leave it here and we can talk about...And again, thank you very much for coming, it's very kind of you.

Client: That's alright.

Researcher: Be free to talk as you want. I want to know your views and ideas. There is no right or wrong to the questions. The way that you respond is the way you think, and see. It's very important you be honest enough to say what you want to say. It's a general question I'd like to ask you - what makes your life good? What things make you feel happy and well in life?

Client: Well most things, you know. I'm pleased I met Doug because otherwise I would have been on my own, so that's helped, but as he said, he's got to go home for a little while. He's got to go home for 2 or 3 nights and I shall be on my own with my cat! (LAUGHING) But I've got some good neighbours so I will (or shall/ should?) be alright.

Researcher: You have a cat?

Client: Yeah - I don't like being on my own. Yeah R. got the cat before he died. He knew he was dying. He told the lady at the back who was a carer - she used to be a carer - and he told her - they told him at the hospital. Cos he worked with that asbestos. It used to be in ceilings and there are still, not here because this is modern, but he worked there and he was an electrician and he used to swallow it you see and he got that much down the bottom of his lung. As I said, he did smoke, which didn't help but the smoking didn't kill him - it was the asbestos that killed him. And, as I said, I was 10 years older than him so I thought I'd go before him...

Visiting Scheme, Volunteer 4

Researcher: In simple terms, why did you become a volunteer?

Participant: Why did I become a volunteer?

Participant: I think that there are a couple of reasons. As I said to you, when I retired, I have been a counsellor for several years. I had a diploma in pastoral counselling, I worked privately from home, and the part of being a counsellor I enjoy more than anything was the one-to-one work. I am not a great person for big groups, but I love a one-to-one work. And I like the engagement. I like meeting people. Mhm, and when I retired I was beginning to miss that. I started to miss that quite a lot. And I thought, 'Yes, that, actually work. 'How can I work in a one-to one situation after retirement? Clearly, voluntary work, visitation was a possible answer. It doesn't give me all I want, because often I want to counsel people, and of course on a visiting scheme you don't do that, you know. It is a two-way thing, but that is fine, that is fine. Mhm, the other reasons, and I think this, this is important, because I think a lot of elderly people feel like this. It is that they actually want to give something back to society. I am sure you know from psychological studies that this time of life, you know, generally [unclear] it is really important. And it is wanting just to give something back. Mhm, and in fact, I think a lot of the time I don't feel that I am doing very much of that now, and that bothers me, because I only see this person once a week for about an hour and a quarter, something like that. Mhm, and it is a very small part of my life, and, in some ways, I would be quite happy to perhaps have another client to see as well. But I don't think Age-UK, they don't seem to do much that. They only give you a client [unclear]. I haven't asked to be perfectly honest. But it looks the same, most people just have one client. So, I think for those two reasons: one, I enjoy engaging, I enjoy one-to-one work, I also want to give something back. But I also, I think I can empathize with elderly people who are lonely, and how miserable life can be for them if they have no one to engage with. So, it is a combination of a different lots of things.

Researcher: And there is another question? Why elderly [people]? From a broad range that would give you a possibility of one-to-one? Why the elderly?

Participant: That is a good question, actually! Why the elderly? Again, there is more than one reason. From a very young age, when I was in my twenties, I've always seem to get on well with older people. I was born in late life, my mother was 43, my father 42. So, I had, and I was the last one of four. And all the others had left home. I was born very late in life. So, I grow up with two ageing parents. And so, somehow [unclear] from the very early age I had to relate to older people. And then when I was being my 20s, I was married, I was very involved in church work at that time. And, we started to doing some work from the church with older people, and I get on well with them. Somehow, they accepted me whether that has got to do with my early life and my ageing parents, who knows it? But I've always seemed to get on well with older people. So, that is one reason. Mhm, and I think secondly, I do see older people as being in society almost as a kind of 'finish to them' [unclear sentence] they are vulnerable, they are on the, they are on the outskirts, on the outside of the society in many ways, particularly the ones who are alone at home, who get missed. And I, it just feel so wrong, that they've got to spent years and years waiting to die, basically, without any kind of sense of well-being, and joy and happiness and so on, 'that it is there possibly for young people'. So, I think from those two reasons: one, I get on well with older people, but secondly, I feel for, I feel for, mhm, I have done work with mentally ill people, and I didn't really enjoy too much. And, I've got to be able to have a sensible conversation with someone. That makes sense to me.

APPENDIX 9 – INITIAL CODEBOOK

FAMILIES	SUPPORTING CODES
Well-being is an outcome of an active body (Active Body)	(5 codes) Active body to promote well-being; Well-being as a result of keeping physically active and fit; ...
Well-being is an outcome of an active mind (Active Mind)	(3 codes) Active mind to prevent mental illness; Well-being associated with an active mind; Well-being: cognitively active.
Activity is a protective factor in later life (Activity as a protective factor)	(6 codes) Active mind to promote mental health; Activity as a protective factor; Keeping active to prevent cognitive deterioration; Keeping mentally active to prevent loneliness; ...
Well-being is an outcome of company (Well-being as company)	(10 codes) Company as a need; Company as an indicator; Company as an outcome; Company associated with participation in the world; Company to tackle isolation...
Well-being is the outcome of health (Well-being as health)	(2 codes) Well-being as health; Well-being as healthy lifestyle
Well-being is the result of keeping active in later life (Well-being as keeping active)	(3 codes) Well-being as keeping active; Well-being associated with keeping active; Well-being is keeping active
Well-being as socialising	(3 codes) Socialising as social support; Well-being as socialising; Well-being is expressed via socialisation.
Well-being is a positive state of mind	(12 codes) Well-being as a lack of negative states] [Well-being as a sense of happiness] [Well-being as a sense of peace] [Well-being as a state of mind] [Well-being as happiness] [Well-being as satisfaction despite of limitations] ...
Well-being is quality of life	(2 codes) [Well-being as quality of life] [Well-being is a holistic state]
Participation in society	(8 codes) [Company associated with participation in the world] [Feel Helpful] [Financial participation in care] [Independence as promoting participation in life] [Well-being associated with community participation] ...
Satisfaction with adaptive life	(6 codes) [Accepting and adjusting to loneliness] [Well-being as a sense of

	contentment] [Well-being as adaptation] [Well-being as satisfaction despite of limitations] [Well-being is satisfaction with life] [Well-being linked to contentment]
Satisfaction with life in the past	(1 code) Satisfaction with life in the past
Social support	(2 codes) [Support by distance] [The ever-present carer]
Coping strategies to age well	(11 codes) [Coping by a positive attitude] [Coping by avoiding thinking] [Coping by being empathic] [Coping by focusing on the present] [Coping by keeping active] [Coping by peer support] [Coping by reminiscing] [Coping by socialising] [Coping by solitude] [Empathy towards the elderly] [Religious/spiritual coping]
Barrier to well-being: loneliness (Barrier: Loneliness)	(4 codes) [Barriers to well-being: Loneliness] [Changes: loneliness] [Experience of loneliness] [Loneliness as detachment]
Ageing conceptions	(21 codes) [Ageing as a concern] [Ageing as an attitude of mind] [Ageing as an experience of loss] [Ageing as deterioration] [Ageing as economic burden] [Ageing as passivity] [Ageing associated with wisdom and experience] [Health deterioration as the main change in later life] [Health deterioration with age] [Health problems] [Lack of sympathy towards later life] [Later life is worthless] [Later life support as child care] [Old age as a burden] [Old age as unproductive] ...
Burden	(9 codes) [Ageing as economic burden] [Avoiding to Be a Burden] [Caring as burden to families] [Collaborative management of burden of care] [Day centre alleviating the burden of family care] [Day centre alleviates financial burden of care] [Dependence as a burden] [Old age as a burden] [Respite care as a solution of daily care burden]
Definitions of dementia	(25 codes) [Absence from reality] [Concern about the impact of dementia on the volunteer-client relationship] [Concern over burden of dementia care]

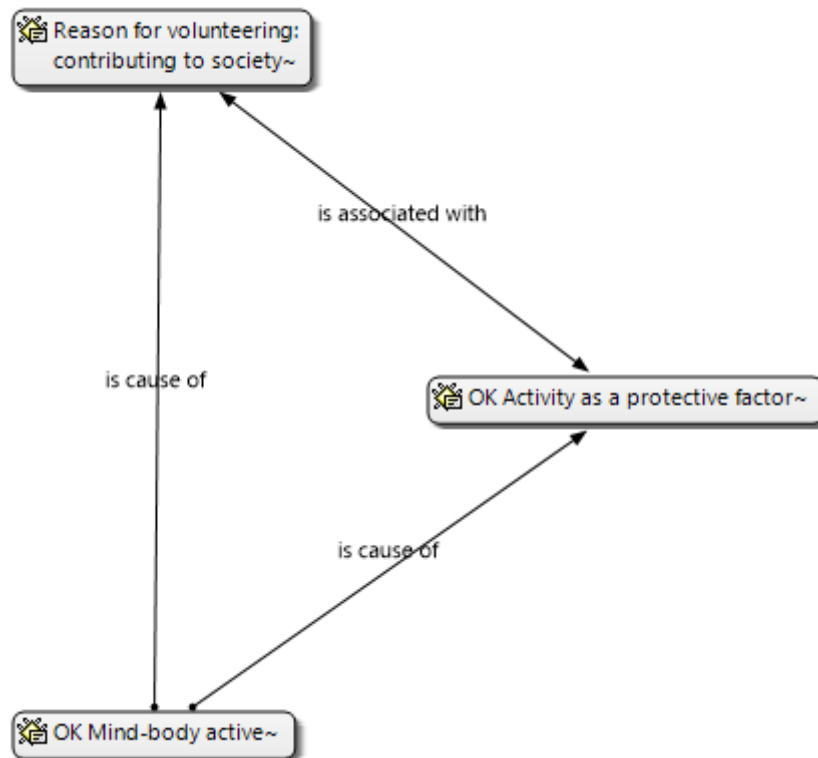
	<p>[Concern over double stigma] [Dementia - other characterisation] [Dementia as a continuum] [Dementia as a loss of control] [Dementia as a progressive deterioration] [Dementia as a progressive loss of Self] [Dementia as an inevitable deterioration] [Dementia as lack of insight] [Dementia as unpredictable] [Dementia caregiving as child care] [Dementia is a frightening onset] ...</p>
Mobility	<p>(11 codes) Activities for enhancing mobility] [Changes in life: loss of mobility] [Institutional support to independence-mobility] [Instrumental aid to mobility] [Mobility and autonomy as main admittance criteria] [Mobility as the main mediator of well-being in later life] [Mobility Impediment] [Mobility problems as challenges to outings] [Sadness due to limited mobility] [Social support to independence-mobility] [Well-being as mobility].</p>
Independence Status	<p>(16 codes) Aged care as a focus on independence] [Assisted independence] [Functional independence] [Independence as autonomy] [Independence as being mobile] [Independence as forced autonomy] [Independence as having control] [Independence as keeping active] [Independence as looking after oneself] [Independence as state of mind] [Negotiable independence] ...</p>
Associations of dependence	<p>(11 codes) [Dependence as a burden] [Dependence as loss of autonomy] [Dependence as loss of control] [Dependence as reliance on others] [Dependence as socially mediated] [Dependence cause health deterioration] [Dependence promotes relationships] [Dependence promoting routine in later life] [Dependence promoting social support] [Dependence related to full-time caregiving] [Dependent Body]</p>
Aid to independence-mobility	<p>(3 codes) [Aid to physical limitations] [Instrumental aid to mobility] [Social support to independence-mobility]</p>

Benefits of Support	(15 codes) [Benefit of day centre: purpose and structure to life] [Benefits of day centre: health progression] [Benefits of day centre: openness to others] [Benefits of day centre: socialising] [Benefits of visit: structure and purpose in life] [Benefits of visits: structure to volunteer's life] [Day centre prevents deterioration] ...
Caregiving	(4 codes) [Natural aptitude for caring] [Natural responsibility for caring] [Navigating agencies of support] [The ever-present carer]
Structured Support	(5 codes) [Community support to well-being] [Demand of structural support to caregiving] [Structural support to caregiving] [Structural support to well-being] [Structured support to independence]
Focus of Voluntary Work	(5 codes) [Reason for attending day centre: company] [Reason for attending day centre: support to loneliness] [Reason for attending day centre: tackling isolation] [Reason for day centre: engagement with society] [Reason for day centre: socialising]
Voluntary Work	(32 codes) [Contributing to society by volunteering] [Motivation to visit: tackling loneliness] ...
Volunteering as participating	(5 codes) [Contributing to society by volunteering] [Reason for volunteering: keeping active] [Reason for volunteering: sense of purpose in life] [Reasons for volunteering: feedback help] [Volunteering as reciprocity]
Purposes of Day Centre	(18 codes) Day centre alleviating the burden of family care] [Day centre alleviates financial burden of care] [Day centre as a reliable space for support] [Day centre as a resource for respite] ...
Characteristics of Settings	(14 codes) (DES) Characteristics of the setting] [(DES) Reactivity in the field] [Passive role in daily routine] [Politics of gatekeeping] [Socio-demographic characteristics] ...

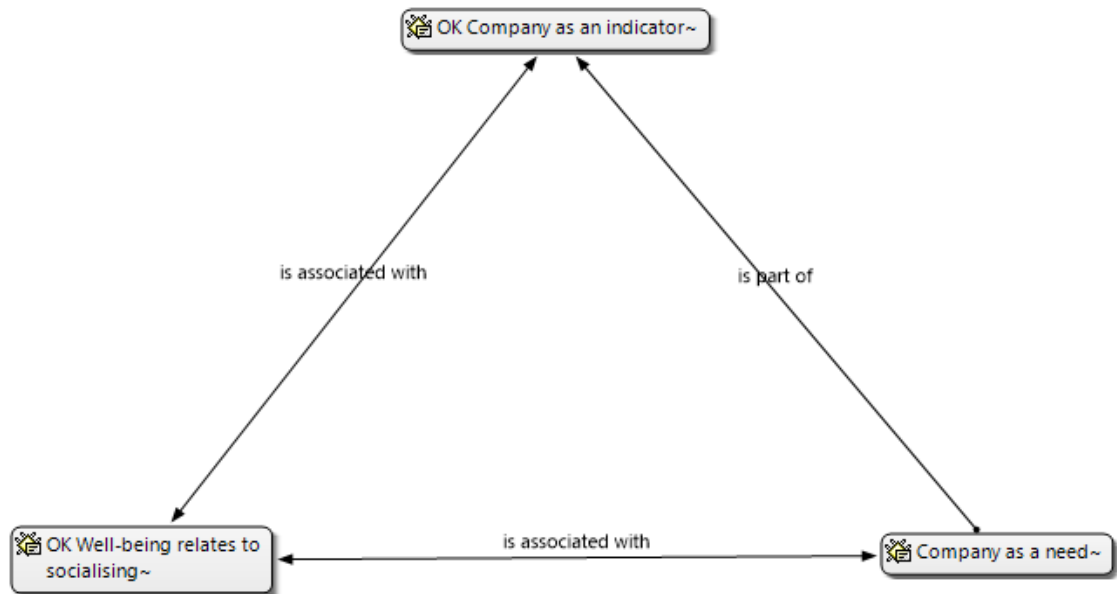
Day centre activities	(49 codes) [(DES) Day centre activities] [Activities for a sense of achievement and participation] [Activities for cognitive stimulation] ...
Reflexive Notes	(15 codes) [Active role in the field] [Challenges to fieldwork] [Changing of plans in the field] [Detaching from field] [Dual social identity] [Establishing Rapport] [Ethical concerns in seeking consent] [Insider-Outsider Roles] [Methodological flexibility] [Negotiating access] [Positive relationships in the field] [Reactivity in the field] [Recruiting participants] [Reflexive questioning] [Seeking consent]

APPENDIX 10 – SAMPLES OF NETWORKS OF MEANINGS

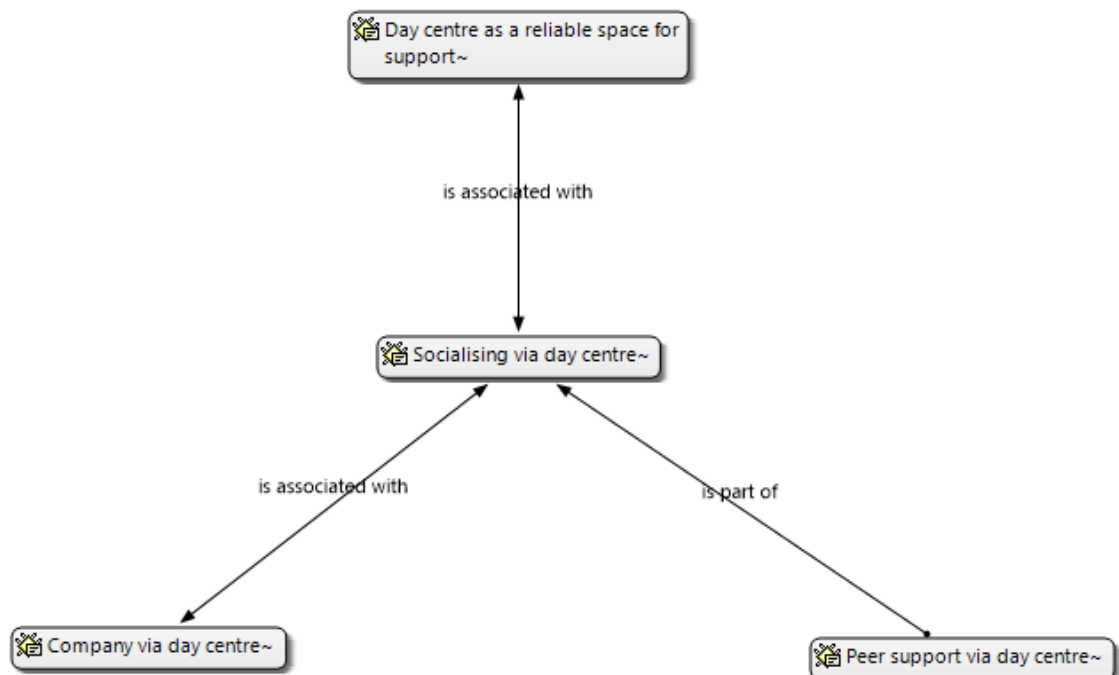
1. Connections between reasons for volunteering, activity as a protective factor and an understanding of well-being as active mind-body.



2. Associations between a conception of well-being as a relational aspect and the relevance of company



3. The day centre as a space proper for peer support, security and company.



APPENDIX 11 – SECOND CODE FRAME

Themes	Subthemes
Well-being is relational	Company as a need – Company to tackle social isolation – Coping by socialising – Company as an indicator – Well-being relates to socialising – Well-being via family support – Reason for volunteer: company as socialising – social contact with family
Well-being is extended health	Preserved physical health – Healthy lifestyle – Holistic state of health
Well-being is an outcome of activity	Coping by keeping active – Activity as a protective factor – Mind-body active – Participation in the family – Well-being equated with participation – Active engagement with life
Well-being as life satisfaction	Coping by a positive outlook – Coping by avoiding thinking – Coping by focusing on the present – Satisfaction with life in the past – Well-being as adaptation – Well-being is satisfaction with life
Losses in later life	Absence of family – Death of family members – Dependent body – Loneliness – Finances – Impediment to an active self – Physical impediment to an active identity – Social isolation creates vulnerability – Social isolation due to demographic changes – Struggle with physical problems
Independent self	Independence as a state of mind – independence as the natural self – assisted independence – preserved functionality – autonomous being – negotiable independence – keeping oneself independence – active engagement with life

Dependent body	Dependent body – mobility impediment to an active self – physical limitations to perform an active identity
Associations of dependence	Dependence as a burden – loss of control – relations of support – full-time caregiving – dependent body
Mobility	Mobility as an indicator of well-being – Mobility impediment to an active self –
Characteristics of the settings	Characteristics of the setting – liaison for care – mobility and autonomy as the main admittance criteria – social support to monitor needs – socio-demographic characteristics
Day centre activities	Day centre activities – activities for community participation – adapting activities to needs – benefit of activities: needs – challenge to activities: cognitive and physical limitations – liaison for care – activities as links to identity
Purposes of the day centre	Company via day centre – reliable space for support – resource for respite – mediate support – prevention of deterioration – peer support via day centre – purpose and structure to life – socialising via the day centre – staff and volunteers mediate support – extension of life – information point
Rationale of activities	Day centre activities – rationale for community participation – adapting activities to needs – benefit of activities: social confidence – challenge to activities: cognitive and physical limitations – challenge: financial constraints – challenge: lack of staff – collaborative decision-making to activities – link to identity – cognitive stimulation – keeping active – physical stimulation
Voluntary work	Challenge: managing complex needs – dual character (socialising and help) – extending support to oversee needs – matching befriend interests to visit – matching individuals' interests in visits – progression in visiting leads to change in roles – reason for visiting: sympathy to older adults' needs – reason for volunteering: contributing to society – reason for volunteering: tackling social isolation - volunteering as an identity – reason for volunteering: following a

	caring pattern – reason for volunteering: socialising – social support to monitor needs – visit alleviate concerns – staff and volunteer mediating support – visit promote stimulation – visit promote interaction – visit promote human interaction – visit promote structure and purpose to life – volunteering as reciprocity
Volunteering as participation	Contributing to society – volunteering as reciprocity
Social support	Absence of family in daily support – aged care as a focus on independence – well-being via family support – social support to independence-mobility – support by distance
Structured Support	Community support to well-being – structural support to well-being – structured support to independence
Socio-emotive support	Company via day centre – peer support via day centre – purpose and structure in life via day centre – socialising via day centre
Rationale of support	Absence of family – company via day centre – day centre as a reliable space of support – day centre mediate support – purpose and structure in life – monitor needs – independence-mobility – socialising via day centre – staff and volunteer mediate support
Instrumental support	Protection against health deterioration – day centre as a reliable space for support – day centre mediating support – day centre prevents deterioration – liaison for care – mobility and autonomy as admittance criteria – monitor needs – support for independence-mobility
Benefits of support	Protection against deterioration – day centre mediate support – day centre prevents deterioration – purpose and structure to life – peer support – structured support – visit promote structure and purpose to life