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## DOCTOR OF PHILOSOPHY

### Exploring Older Peoples' Experiences of Place and Wellbeing a Qualitative Study

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**EXPLORING OLDER PEOPLES'  
EXPERIENCES OF PLACE AND  
WELLBEING  
A QUALITATIVE STUDY**

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## Glossary

Age-related macular degeneration (AMD): a medical condition where the central vision starts to deteriorate gradually and as a result, the affected person finds it difficult to read and/or recognise people's faces (NHS 2014a)

Alzheimer's: a type of dementia, this is a progressive medical condition most common in persons over 65, is accompanied by loss of brain functions such as mental ability and as a result, the affected person can suffer from memory loss, confusion and/or disorientation (NHS 2014b)

'Genuine opportunity': The term 'genuine opportunity' has been used interchangeably with the term 'capability'.

Opportunity: The term 'opportunity' refers to the dictionary meaning of the term and is not the same as 'genuine opportunity'.

Parkinson's: a progressive medical condition that results in damage/loss of nerve cells in the brain, and as a result, the affected person suffer from tremors and slow movement of hands/legs (NHS 2014c).

## Abbreviations

AMD	Age-related macular degeneration
BBC	British Broadcasting Corporation
CoSLA	Convention of Scottish Local Authorities
CPC	Centre for Population Change
DCC	Dundee City Council
DCLG	Department of Communities and Local Government
ESRC	Economic and Social Research Council
ETHOS	Electronic Thesis Service
GDP	Gross Domestic Product
JIT	Joint Improvement Team
OECD	Organisation for Economic Cooperation and Development
ONS	Office for National Statistics
MRC	Medical Research Council
NEF	National Economic Foundation
NPF	National Performance Framework
NHS	National Health Service
QOL	Quality of Life
SOA	Single Outcome Agreement
UN	United Nations
WHO	World Health Organization

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Manik D Gopinath

May 2015

## Declaration

I, Manik Deepak Gopinath, declare that I am the sole author of this thesis and that unless otherwise stated all references cited have been consulted by me. I confirm that the work of which the thesis is a record has been done by me and that it has not been previously accepted for a higher degree.

Signature of candidate

Date:

I confirm that the conditions of the relevant Ordinance and Regulations have been fulfilled in relation to this thesis.

Signature of the supervisor

Date:



## Abstract

Current conceptions of place and wellbeing in literature offer limited ways to think about the interrelationships of place and wellbeing as older people age and experience change over time. What is not clear is how wellbeing affects experiences and meanings of place and how, in turn, place mediates experiences of wellbeing. Through an investigation of older peoples' experiences of living in a range of everyday settings (domestic, sheltered, very sheltered and residential care settings) the overall aim of this research is to *explore what matters for the wellbeing of older people and how this might shape and be shaped by interrelationships of place and wellbeing.*

The study is qualitative and involves in-depth interviews incorporating a biographical perspective with 26 older people between the ages of 65-96 years living in different kinds of settings from across more and less affluent parts of Dundee, Scotland. The interviews are informed in part by a conceptual framework that draws upon strands from both place literature (drawing upon Massey 1995; Kearns and Gesler 1998) and Amartya Sen's capability approach (2009). The conceptual framework is a starting point for exploring and interpreting the processes shaping older peoples' experiences. The thematic data analysis builds on the Framework approach.

A capability perspective and relational thinking in emphasising the dynamic and socially situated nature of place and wellbeing relationships show that older peoples' experiences, the capabilities they have and the capabilities that matter are in a state of flux. My research findings suggest that a number of capabilities can matter to older people. Such valued capabilities are shaped by dynamic interactions between: a) age, health, and (or) place related changes; b) diverse socio-economic

contexts; and, c) characteristic features of places and meanings attached to the place (at different scales of for example, the residence, neighbourhood, city). The findings also indicate that where older people have health related impairments, how interrelationships of place and wellbeing are framed and understood can have implications for who they are able to be and what they are able to do.

This research has implications for both policy and practice. The findings suggest that *a priori* assumption about different kinds of settings as being enabling or disabling cannot be made. Rather, as the study demonstrates, paying attention to the complex and manifold processes that shape capabilities would permit nuanced insights into how, under what circumstances, and for whom particular place settings might generate enabling and (or) disabling encounters. Paying attention to the processes that shape capabilities also would allow researchers, policy makers, and practitioners to contribute positively to making informed judgements to support older peoples' wellbeing both spatially and temporally.



## Chapter 1 : INTRODUCTION

Concepts of 'place' and 'wellbeing' have acquired a particular significance around issues of health and social care (Wiles 2005; Cutchin 2005; Andrew et al 2007). While in broad terms there is a consensus that the places where older people live matter in shaping their wellbeing, it remains unclear as to how the interrelationships of place and wellbeing play out as older people age and experience change over time.

The diversity in everyday living environments of older people that encompasses a range of settings, such as, domestic, sheltered, and residential care settings, poses a challenge to how we imagine and understand interrelationships of place and wellbeing. The picture is further complicated when prevailing ideas and discourses presume and make visible one particular kind of setting as being more appropriate for older people than others. Within this view as Golant (2003) and others observe, much of the environmental gerontological literature focuses on the "...the undesirable aspects of residential change..." and favours, "...the desirability of environmental continuity versus change to account for a person's well being"(p. 642).

Given that some older people might not or cannot maintain continuity of place of residence suggests that simplistic notions about the interrelationships of place and wellbeing cannot be assumed or taken for granted. Diversity in relation to personal attributes, material-social contexts, and, particularly, in urban areas marked by increasing socio-spatial inequalities (Phillipson 2007; Smith 2009) points towards heterogeneity in older peoples' life experiences and circumstances. If the diversity of human life is a given, then it is not clear whether

straightforward assumptions about some everyday living environments as being better than others can be made and to what extent these are grounded in the varied contexts within which older people live. Change, an on-going feature of older peoples' lives too holds implications for how the relationship between place and wellbeing is understood: as stable, dynamic, or both.

Research on the wellbeing of older people suggests connections between place and wellbeing and also confirms the multidimensionality of wellbeing (Gabriel and Bowling 2004; Gilleard, Hyde, and Higgs 2007; Gale et al 2011; Cooney, Murphy and O'Shea 2009; Burton and Sheehan 2010). While place (variously understood as the home, neighbourhood, urban built environment comprising of the physical, social, and symbolic dimensions) and its links to wellbeing constitute an important domain, other domains (for example, health, social relationships, financial resources, choice and control) too have emerged as being significant in contributing to wellbeing. What is not clear, however, is how multiple valued domains shape experiences and meanings of place for an older person and how, in turn, place mediates and shapes experiences of wellbeing across multiple valued domains in diverse contexts and over time.

Given the current lack of clarity in interrelationships of place and wellbeing, this research sets out to *explore what matters for the wellbeing of older people and how this might shape and be shaped by interrelationships of place and wellbeing* through an investigation of older peoples' experiences of living in a variety of settings. These settings include domestic (rented and/or owned) and supported settings (sheltered, very sheltered and residential care homes, for key differences between these settings, see Table 2.1).

This opening chapter sets out the broad context and rationale for the study by framing it in relation to existing policy and academic research on older people. The overall aim and the research questions are then outlined. The chapter concludes with a brief chapter wise description of the structure of the thesis.

## **1.1 Background**

The United Nations (2013) report on World Population Projections points out that the ageing of populations is a worldwide trend. For instance, the proportion of older people (aged 60 years and over) was 9.2 % in 1990, 11.7 % in 2013 and is expected to reach 21.1 % by 2050. And yet as the report notes, there are variations by context. For instance, although in absolute numbers, there are more older people in developing regions than in developed countries, the proportion of older people (and rate of growth) in developed countries is far higher than those in developing countries.

Paralleling these trends in the UK context, population projections suggest that by 2030, one in four people in the UK will be over 65 years as compared to one in six in 2008, with the fastest growth amongst those aged 85 or over (ONS 2012). Within the UK, by 2035, Wales followed closely by Scotland is projected to have the highest proportion of people aged 65 years and over (ONS 2012).

In addition to these demographic changes, is what the UN (2013) refers to as the socio-economic and health aspects of ageing. For instance, the growing number of single older person households in the UK concentrated in urban settings reflects changes in long-term relationships, childlessness, rising living standards, and, housing availability (Bennett and Dixon 2006). Falkingham et al (2010) also

highlight that with increased life expectancy, the likelihood of, “[...] average years spent with a disability and/or in poor health will continue to increase [...]” (p.3) with implications for health, support, and care.

Consequently, increased concerns are being expressed by policy makers about the implications of a rapidly ageing post-industrial society in the UK, Scotland and other western countries, and as a result, older people are now becoming a focus for priority policy action (Biggs 2001; Rummery 2009; MRC 2010). In particular, the dynamics of health and social care and its implications for the public purse present a major cause for concern. More broadly, in the UK, such cost concerns are also accompanied by a recent policy emphasis on promoting wellbeing as a social and public policy goal (Audit Commission 2004; NEF 2004; Scottish Government 2007a; Scottish Government 2011).

## **1.2 Scottish Policy context: Emphasis on Wellbeing**

Wellbeing has emerged as a national and policy-making concern since the publishing of the Stiglitz report (2009) on measuring economic performance and social progress. The report emphasizes the need for shifting attention from measuring the gross domestic product (GDP) to *measuring peoples' wellbeing*. Subsequently, considerations of capturing, measuring, and reporting wellbeing in the broadest sense are high up on the political agenda in UK as in other countries around the world.

Within UK, Scotland has been known to pursue distinctive policy approaches, for example, in matters of education or in the policy of free personal care for older people (those above 65 years of age) from time to time. In launching the National Performance Framework (NPF) in 2007, the Roundtable report on Scotland (2011) described the Scottish Government as being ‘...ahead of the curve of political thinking’ (pg.: 34)

as far as commitment to the measurement of economic and social progress was concerned. The NPF (launched in 2007 and last updated in 2011) is an organisational framework setting out a 10-year vision for Scotland. Underpinned by an '*outcomes based approach*' the framework aims to measure economic and social progress towards the Scottish Government's overarching purpose of providing, '*opportunities for all of Scotland to flourish, through increasing sustainable economic growth*'. The framework comprises of complex multi level tiers of 7 purpose targets, 5 strategic objectives, 16 national outcomes, and 50 national indicators to track progress on national outcomes. The national outcomes and the indicators are the building blocks of the framework to assess performance towards meeting the purpose targets and the core strategic objectives of providing opportunities to flourish for all.

Two distinctive features of the NPF are '*Scotland Performs*' and '*Single Outcome Agreements*' (SOA). Scotland Performs is a reporting and assessment system comprising of a dashboard of multidimensional indicators (individual and societal, objective and subjective) to measure progress towards objectives over time and the first of its kind in the UK. SOAs are shared and binding agreements between the Scottish Government and each of the 32 local authorities that set out how local authorities (working together with private and voluntary sector partners) would support progress and achievement on national outcomes through addressing locally responsive concerns and priorities. Through Single Outcome Agreements the NPF has become the joint responsibility of both the national and 32 local authorities across Scotland.

Wellbeing of older people is a priority concern as set out in the national outcome- '*Our people are able to maintain their independence as they get*



*older and are able to access appropriate support when they need it'* (NPF 2011). The national outcome is also reflected as a priority local outcome in the case study area of this research, i.e., Dundee City Council. A list of 14 national indicators (central level) and 9 indicators at the local level that cover primarily health and social care related services for older people and carers have been set out against which to measure performance towards targets. Taken together the indicators focus on increasing targeted delivery of health and social care services within community settings. Although, the Dundee SOA also sets out their intention to revise assessment processes to introduce more choice and control for service users as well as to address issues of social isolation, no corresponding indicators have been set out. Issues of safety and security, social inclusivity, housing, transport, and services are set out as separate local outcomes within Dundee SOA addressing a wider cross section of people including though not specifically focussing on older people.

While the Roundtable Report (2011) has rightly applauded the Scottish Government's aim to offer opportunities for all in Scotland to flourish, the report has however recommended that the focus should be on economic growth as a means to an end, i.e., peoples' wellbeing. Some recommendations following on from the report in terms of the kinds of national indicators that could be useful were incorporated in the last review of the NPF in 2011. Although work on the NPF is on going, perhaps, the biggest challenge, as the Roundtable Report identified is the top down nature of the framework. The NPF has till date been an in house government exercise with national outcomes being set by Ministers. *'When the Scottish Government chooses what it measures, it is by default defining what matters'* (pg.: v; Roundtable Report 2011). The Scottish Government has been urged to engage with the question of what

matters to people by encouraging participation of the Civil Society organisations and the wider public of Scotland.

### **1.3 Scottish Policy context: Older People**

Issues of older peoples' wellbeing and place in diverse ways have therefore gained prominence within policy. Current policy interest is reflected in two broad sets of Scottish policy initiatives<sup>i</sup> and these are discussed in the following subsections in further detail. One broad set of policy initiatives (Table 1.1) reflect the discourse of 'ageing in place' at home ('home' as referring to one's domestic home), that has come to define policies relating to older people particularly, on housing, health, and social care in the UK (Wiles 2005; Means 2007).

The other broad set of policy initiatives (Table 1.2) are framed within the discourses of opportunity and active ageing. Tackling ageism and reinventing, "... adult ageing: from being a problem of burden to an age of opportunity" (Biggs 2001: 309) is a key aim of this discourse.

#### **1.3.1 Ageing in place initiatives**

The term 'ageing in place' emerged in the works of Tilson (1990) and Callahan (1993) to capture the, "...societal image of the desirability of growing old in a familiar environment" (Rowles 1993: 65).

Andrews et al (2007) further note that the term 'ageing in place' has become synonymous with 'attachment to place' and both are popular in academic and policy circles in the UK. The broad policy support for 'ageing in place' at home builds upon the notion of place attachment and which might be particularly strong in the case of older people. 'Attachment to place' may contribute to maintaining a sense of self and

competence (Rowles 1993, Cristoforetti et al 2011). Maintaining continuity of place of residence is therefore an important aspect of 'ageing in place' (Wahl, Iwarsson and Oswald 2012; Fange, Oswald and Clemson 2012).

Key policy documents	Policy aim
National Health Service and Community Care Act 1990	A statutory framework for community care to support the policy aim of shifting the balance of care from hospitals and institutions to community based settings. Local authorities are responsible for community care services applicable to older people, disabled people, and, those with physical/mental health problems.
Community Care and Health (Scotland) Act 2002	Under this act, the Free Personal and Nursing Care Policy was introduced for people aged 65 years and over. While applicable to older people living in their own homes and those in care homes, Bell et al (2006) note that the policy supports the Scottish government's vision of enabling older people to remain in their own homes.
Better Outcomes for Older People: Framework for Joint Services, 2005	The framework focuses on joint working between local partnerships of NHS Boards and local authorities to deliver integrated services, such as, equipment and adaptations, extra care housing, and increased care at home to proactively support older people to remain in their own homes.
Energy Assistance Package 2009	Aimed at addressing fuel poverty through a range of measures to reduce bills, improve energy efficiency of homes targeted at people who are fuel poor including older people.
Reshaping Care for Older People: A Programme for Change 2011-2021:	A long-term framework that has been developed using extensive public engagement to address the challenges of an ageing population. The framework is underpinned by the following vision, "Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting." (p.5)
Age, Home and Community: A Strategy for Housing for Scotland's Older People: 2012-2021	Includes housing related strategies to enable older people to live at home as well as emphasizes the need for the provision of low level preventive services to reduce need for intensive services. These preventive services include: physical improvements to existing housing (adaptations, repair & maintenance, keeping warm); preventive support services (handyperson services, housing support and telecare); and, new housing provision that is affordable, adaptable and maximizes choice for older people particularly those who wish to downsize.

**Table 1.1: Policy initiatives with a place (domestic setting) centred perspective**

### 1.3.2 Discourses of opportunity and active ageing

The policy discourse of opportunity and active ageing too has a historical context. Particularly in the UK, this is mirrored in broader policy narratives where the social identity of older people has been reimagined: from that of a 'dependent' (as viewed in the traditional welfare state), to 'a consumer' in 1980s and 1990s to 'active and autonomous' since the Blair era (Biggs 2001). Within this discourse, the emphasis of policy is on exploring and expanding the possibilities of later life through, 'promoting entrepreneurial activity' among the over 50s, providing 'volunteering and lifelong learning' opportunities, setting up flexible policies for 'employment and retiring' amongst others (Scottish Government 2007a).

Framed by concerns about the cost implications of health and social care, a preventive stance has been adopted. The key strategy underpinning the preventive stance relates to increasing social participation and civic engagement (Deeming 2009; Menec et al 2011) as ideals of later life. There is also a growing evidence base in wellbeing literature on associations between isolation, loneliness, poor health, and the positive impact of participation on physical and mental health (Hawton et al 2011; Dahlberg and McKee 2014).

Key policy documents	Policy aim
Let's Make Scotland More Active: 2003-2023	Emphasizes health promotion and preventive strategies to improve and increase physical activity levels across the entire population with support for older people to remain active as a specific focus within the strategy. Along similar lines is the more recent Active and Healthy Ageing: An Action Plan for Scotland (2014-2016).
National Concessionary Travel Scheme (2006)	As part of Scotland's National Transport Strategy the scheme allows people aged 60 years and over and (eligible) disabled people to free bus services throughout Scotland with the aim of enabling access to a range of services and increased opportunities for participation.
All Our Futures: Planning for a Scotland with an Ageing Population (2007)	Aims at challenging ageist assumptions and practices by setting out a positive societal perception of older people (starting at 50 plus) as 'assets'. Through the setting up of local and national forums (e.g., Scottish Older Peoples' Assembly) provides opportunities to older people to voice their views and concerns. Recognising older peoples' contributions and improving their opportunities for employment, volunteering, caring and learning are a priority focus.
Social Care (Self-directed Support) (Scotland) Act 2013	Underpinned by themes of person centred care and personalisation in delivery of social care, the act gives service users more control and choice over their support arrangements.

**Table 1.2: Policy initiatives – Discourses of opportunity and active ageing**

### 1.3.3 Discussion of policy initiatives

There are several key significant ideas underlying the two broad sets of initiatives outlined above: a) challenging discrimination, ageist assumptions, and practices about older people is a positive and highly prominent policy and research agenda in the UK (Biggs 2001; Dalziel 2008); and, b) personalisation and person-centred approaches are at the heart of delivery of health and social care services (Dalziel 2008). The notion of personalisation and person-centeredness in moving away from universally defined one size fit all approaches endorses autonomy,

independence, inclusion, respect, and empowerment as key to improving the quality of care and service as well as making a positive difference to older peoples' lives (McCormack 2003; Dowling, Manthrope and Cowley 2006). Various government documents set out how meaningful choice and control is to be promoted including: embedding participation and involvement of older people in services they use; seeing older people as active partners rather than passive recipients; joined up approaches to service provision; and, by involving service users, their families, and local communities as meaningful partners.

Low-level preventive services, housing adaptations, and the concept of lifetime homes and neighbourhoods are amongst the several ways that policy envisages supporting 'ageing in place' at home and promoting independence (Secker et al 2003; Rabiee 2012; Hillcoat-Nalletamby 2014). The term 'independence' (the meaning of which is open to contestation) has conveniently come to dominate housing policies for older people worldwide and in the UK (Tinker 1999). Independence has become linked to place of residence, such that living at home signifies independence. Regardless of various meanings and experiences that could be associated with independence, linking continuity and independence to 'ageing in place' at home emerges as a powerful narrative employed by policy and that supposedly reflects older peoples' preferences (Parry et al 2004; Scottish Government 2011).

Notwithstanding the relevance and appeal of the key ideas mentioned above that reflect an orientation towards prioritising what matters to older people, it seems that embedded within these two sets of policy initiatives are also assumptions about place and wellbeing. While a majority of the older population are and may continue to age in place at home (according to Scottish Government 2007b, approximately 95% of

Scotland's over 65s live at home or specialized housing and only 4% in care homes), the emphasis on the notion of 'ageing in place' at home as advocated by policy nevertheless seems problematic. Policy discourse of 'ageing in place' at home accompanied by the refrain of independence by making legitimate and visible some places over others excludes and marginalizes both other places and people within them. For instance, it might hold implications for those who for various reasons cannot or do not desire to age in place at home.

The Scottish policy vision for older people to age in place, '...in their own home or in a homely setting' is directly linked to and presented as the (best) solution for reducing institutional care and supposedly reflecting the values of older people. But in using the phrase, 'in their own home or in a homely setting' the policy document (Scottish Government, 2012) does not expand on what constitutes a homely setting. As such there is an ambiguity about the role of residential care homes as institutional or homely settings. At the same time, while serious moves are afoot in policy on promoting housing options of older people by developing new models of housing and care (Kneale and Smith 2013) and which might be a good thing, these are not presented as one option amongst many others. Rather, the emphasis is on how much better these options are in comparison to residential care homes.

Whether intended to marginalize and exclude or not, discourses and labels such as 'independence' implicitly and explicitly might pervade and become embedded in the social consciousness. Older people themselves often internalize these, and, as is evident from research on prospective housing decisions of older people (Croucher 2008), residential care settings are often perceived as a 'last resort'. Generalized beliefs about older people and stereotyping, also has implications for how society as a

whole and in particular, practitioners relate to older people (Dalziel 2008).

Behind the terms, 'independence' and 'autonomy' that underpin personalisation and person centred care approaches as they relate to older people, are a gamut of practices that often draw upon narrow conceptions of such terms (Fine and Glendinning 2005). Such terms might hide within them assumptions about the older person that in turn may work towards marginalising and stigmatising rather than enhancing wellbeing and promoting choice. Active ageing discourses too might seem to discriminate against those who by virtue of ill-health or lack of access to resources are unable to exploit opportunities for participation in social, economic and civic life to enhance wellbeing (Scherger, Nazroo and Higgs 2011; Means and Evans 2012).

The context of a rapidly ageing population, its relevance to policy and practice, has fuelled academic research on issues of place and wellbeing.

#### **1.4 Rationale of the study**

There is a sizeable body of literature on place and wellbeing in relation to older people but current conceptions of place and wellbeing (as set out in Chapters 2 and 3) offer limited ways to think about interrelationships between place and wellbeing. There are increasing calls for understanding places as being actively constructed and negotiated rather than existing as passive backdrops (Wiles 2005; Andrew et al 2007). In much place literature on older people, however, place has largely been conceptualized either as a static backdrop and a bounded entity (environmental gerontological research) or draws upon the metaphor of the home as a stable entity (place attachment



literature). The former sees older people in an atomistic manner with a focus on functional limitations and the latter sees older people as a bounded group with shared attributes (e.g., having homogeneous and positive attachment to place). Both overlook diversity and differences in socio-economic contexts, personal attributes, experiences, and variations in health status. Therefore it is unclear whether places matter in the same way to all older people.

In assessing the quality of peoples' lives, wellbeing literature, while highlighting the multidimensionality of wellbeing, has often approached wellbeing from particular disciplinary perspectives, all of which are relevant but partial. These perspectives in turn are underpinned by particular assumptions about the individual and about the nature of the relationship of the individual and the context. For instance, when environmental perspectives are employed, social and psychological aspects are ignored or vice-versa. While the role of societal attitudes as a barrier to wellbeing is highlighted, how age and health related impairments affect people-place relationships and wellbeing is largely overlooked.

The dynamic nature of people-place relationships in shaping wellbeing has not been captured. This despite the fact that age and health related changes are part and parcel of growing old and that some places (neighbourhoods) are subject to more rapid changes than others. Though broadly placed within the context of change in older peoples' lives, the starting point in research of place and wellbeing is often concerned with: how continuity of place of residence can be maintained despite change in individual circumstances; enumerating what (person and contextual) factors contribute to change; how change can serve as a proxy for identifying alterations that need to be made to the physical and

social environment; and (or) what contributes to wellbeing in the face of change. So it is unclear how individual and contextual factors dynamically interact to shape older peoples' experiences of living in different place settings and their wellbeing over time.

Growing recognition of the importance of place and wellbeing in policy, and current academic research on older people suggests the need for furthering our understanding of what matters to older people and the implications of where they live for how well their lives go. For doing so, this research adopts a qualitative approach. The study is based upon in-depth interviews incorporating a biographical perspective carried out with twenty-six older people between (living in a variety of settings, from across more and less affluent areas of Dundee, Scotland).

The conceptual framework that has informed this research brings together key concepts of 'wellbeing' from Amartya Sen's capability Approach (2009) and the notion of 'place' (Massey 1995; Kearns and Gesler 1998) to explore and interpret older peoples' experiences of living in different kinds of settings (domestic, sheltered, very sheltered and residential care settings).

## **1.5 Older people in the study**

The term 'older people' as used in this study implies a group that is of interest to this research and includes older people between 65-96 years of age living in a variety of domestic and supported settings. In delineating a segment of older people of interest to this study based on chronological age has however required engagement with the problematic question of who is old and what old age is. Old age is at once a category and a social construction. It can be described and depicted in

terms of, for example, age in years, life stage, physical ability and appearance, intergenerational terms (Degnen 2007) and holds implications for conducting research as discussed at length in section 5.7.1 (Chapter 5). Pragmatic considerations of undertaking research in supported settings where a cut off age of 60 years or above is a criterion in gaining access to public health and social care services in UK has shaped the older group of interest to this study. At the same time, however, this research is mindful that the personal and lived experiences of older people or their self-perceptions may (or may not) match the labels and classification that are often used to categorise them.

The overall aim of the study and the supporting research questions are as follows:

### **1.5.1 Overall aim**

To explore what matters for the wellbeing of older people and how this might shape and be shaped by interrelationships of place and wellbeing.

### **1.5.2 Research questions**

- (1) What opportunities and constraints do different place settings offer in shaping the valued capabilities of older people?
  
- (2) How are relocation trajectories into different settings shaped for those who move? What are the implications for older peoples' valued capabilities?

## 1.6 Thesis structure

This chapter so far has set out the timeliness and relevance of this research and presented the overall research aim and supporting research questions.

Chapters 2 and 3 review the literature on place and wellbeing in relation to older people drawing from relevant academic gerontological literature from various disciplines (Human and Health Geography, Environmental Psychology, Gerontology, Sociology, Public Health, Social Work, Nursing, Housing). The review offers useful insights to the study in terms of what matters to older people and the significance of places in older peoples' lives. Gaps in current understanding are highlighted that provide the basis for building the conceptual framework in the following chapter.

Chapter 4 details the relational perspective adopted in this study by building a conceptual framework. It first identifies a number of key components of the capability approach and notions of 'place' with which to build this framework. It then brings together key components within the framework to explore older peoples' experiences of living in different settings and forms the basis for collecting and analysing empirical data.

Chapter 5 discusses in detail the methodological approach adopted in the study. It describes the research process, the qualitative methodology, and the philosophical considerations informing the research. It further specifies the methods used for gathering data (in-depth interviews with a biographical perspective) and recruiting participants. And lastly, the chapter sets out the strategy for analysing data.

Chapters 6 to 8 report on the analysis from empirical findings under key themes. Chapter 6 sets the scene for the next two chapters and dwells on

theme of 'health' as it emerged from the empirical accounts. Chapters 7 and 8, respectively, look at participants' current experiences of living in different settings and their experiences of relocation.

Chapter 9 brings together key findings from the three analyses chapters and reflects on some of the study's contributions in relation to key components that were earlier identified in the conceptual framework in Chapter 4. The chapter also offers some methodological reflections and highlights the strengths and limitations of this research.

The thesis ends in Chapter 10 by summarising how this study has addressed the research questions set out at the start and discusses key contributions of this research that can inform current thinking on place and wellbeing. It then goes on to discuss the potential implications this research has for policy and practice and in identifying areas for future research concludes the thesis.

## Chapter 2 : LITERATURE REVIEW – PLACE

### 2.1 Introduction

This chapter sets out to review contemporary understandings of place in relation to older people. The focus is on everyday living environments that could be categorised as ‘domestic settings’ and ‘supported settings’. Domestic settings refer to private dwelling (either owned or rented) occupied by the individual/household and where one can receive care and services from the local authority and/or other service providers. Supported settings, on the other hand denote a collective term for a range of settings, including sheltered, very sheltered and residential care homes. Such settings imply a shared/communal living environment (for example, shared dining, communal spaces for social activities) with different levels/mix of support services and care (see Table 2.1 for meanings of terms ‘sheltered’, ‘very sheltered’ and ‘residential care homes’).

The purpose of taking a closer look at these everyday living environments is twofold: one, to understand the diverse ways in which places matter and are significant for older people, and, two, exploring what conceptions of place underpin older people-place relationships. Places where older people live are a part and parcel of everyday experiences of life and living. Gaining insights into what ideas and thinking about place inform older people-place relationships become important to unravel given the diversity amongst older people (e.g., in personal attributes, goals and priorities, socio-economic contexts, living arrangements, age and health related changes). How different conceptions of place attend to diversity amongst older people and their circumstances, what they emphasise, and what they do not emphasise

might hold quite different implications for older peoples' experiences and how well their lives go.

The chapter is organized as follows: section 2.2 sets out the literature search strategy. There exists a sizeable body of literature on older people both from the perspective of place and wellbeing. While each of these perspectives has been reviewed under separate chapter headings (chapter 2 on place and chapter 3 on wellbeing), the literature search strategy outlined in the following section pertains to both of these perspectives. Section 2.3 reviews place experiences of older people across domestic settings drawing upon the key themes of: significance of material dimension of place, place attachment, dynamic nature of place and home as a site of care. Place experiences across supported settings are examined and reviewed in section 2.4. Here I frame the discussion around the key themes of perceptions of place, reasons for moving into supported settings and experiences of transition and living in new settings. Within these key themes I look at transitions and experiences as older persons move from: (1) domestic to domestic; (2) domestic to sheltered and very sheltered, and; (3) domestic to residential care settings. Section 2.5 presents a discussion highlighting gaps in literature followed by a concluding chapter summary.

## **2.2 Literature Search Strategy**

Identification of relevant literature began with topic areas focused on different residential settings (domestic, sheltered and very sheltered and residential care homes) and wellbeing, specifically on older people, published from 2000 onwards, and has been a continuous, cumulative and iterative process. At one level, while carrying out an initial search of literature, I was hoping to sensitize and familiarize myself with the general topic area and establish the breadth of research within a

Western context. This also helped me identify and expand on specific literatures to include and understand: (1) varied meanings, labels, and conceptions of constructs of 'place' and 'wellbeing'; (2) range of terms associated with these concepts (for example, health related quality of life, ageing in place, place attachment). As further references were acquired from various journal articles, more key words were added. At another level I was concerned with depth and looking to build my understanding of, as well as, critically review the links between place and wellbeing in relation to older people. A further literature search was then specifically oriented towards exploring and examining key ideas and concepts around place and wellbeing.

Search for relevant literature was carried out from a number of sources: (1) electronic databases such as Scopus, Web of Knowledge, Zetoc, Psychnet, and Pubmed; (2) specific journal publishers such as Cambridge journals, Oxford journals; (3) websites of key organisations involved in research (e.g. Joseph Rowntree Foundation, ESRC, Social Policy Online.), policy (Scottish and UK government departments) or practice (e.g. Age UK); (4) and general web searches using Google. Additional resources for identifying research included, ETHOS (electronic theses online service) and bibliographies, references in key textbooks and journal articles. Some references pre date 2000 and these either pertain to seminal work or because of paucity of independent research in particular areas.

In scoping the research, certain exclusions were made. As this research is focused on exploring the wellbeing of older people in a post-industrial society, a decision was made to exclude research on countries other than UK, Europe, USA, Canada, Australia and New Zealand. Empirical, conceptual and literature review pieces were included but research looking at quality of life and wellbeing at city and national level was



excluded. Dementia related research, research carried out with older people within the context of rural settings or settings such as, hospices too was excluded.

## **2.3 Domestic Settings**

This section reviews research relating to the experiences of older people across domestic settings drawing upon the following key themes: significance of material dimension of place, place attachment, dynamic nature of place and home as a site of care.

### **2.3.1 Significance of the material dimensions of place**

As set out earlier in the introduction, within policy there is a specific emphasis on 'ageing in place' at home. Such a focus has overlaps with a substantial body of academic research that draws upon the ecological model of ageing (Lawton and Nahemow 1973). The emphasis of this work is on adapting the (home) environment to accommodate declining competencies of older people. A largely functionalist approach has guided this body of research (Hockey, Phillips and Walford 2013) in developing an understanding of the relationship between the older person and his/her environment.

Drawing upon 'ecological model of ageing' (Lawton and Nahemow 1973; Lawton 1982, 1987, 1989) and 'person-environment models' (Kahana and Kahana 1983; Carp 1987), such literature has established the significance of physical aspects of the (home) environment as a potentially 'enabling' (or 'disabling') resource. The emphasis is on determining 'competence', 'congruence' or a 'fit' between the person and environment, particularly as older people's functional capacities (e.g., physical mobility or sensory abilities) may decrease over time. Achieving person-environment fit entails both reactive and proactive adaptive

responses to modify the physical environment (e.g., making alterations and adaptations to the house) or behaviour (e.g., disengaging from certain activities).

Until recently, a focus on the person-environment relationships (drawing upon Lawton and Nahemow model) has also ignored: the role of individual socio-economic contexts (Renault, Ogg, Petite, and Chamhian 2014); emotional-social dimensions of the environment (Thomese and Broese van Groenou 2006); temporal aspects of the relationship between older people and their environment (Wahl and Lang 2004; Shank and Cutchin 2010); and the wider environment beyond the home (Ziegler 2012; Ewart and Luck 2013). Some have also criticized the limited view of the older people who are seen as defined by functional limitations (Golant 2003; Johansson, Josephsson and Lilja 2009).

Renault and colleagues (2014) point to complexity in the person-environment interaction in relation to making home adaptations to support functional losses. These authors note, that older people make assessments of the relevance and the need for adaptations in light of structural factors (e.g., type of housing structure, the nature/ type of adaptation required, household tenure), availability of personal resources (e.g., social, economic and cultural resources), and their perceptions and experiences of growing old. Others have pointed out that older people not only adapt the physical environment in event of declining health or functional loss but also seek to adapt their social environment by mobilising informal/formal care and support (Thomese and Broese van Groenou, 2006).

In critiquing the rather meagre view of the individual defined in terms of 'behavioural competence', Golant (2003) advocates a shift in focus from

'competence' and 'fit' to the appreciating the 'value' and 'importance' of the fit to older people in terms of what such a fit facilitates or prevents, e.g., ability to do things confidently and safely within the house, maintaining engagement in valued arenas of one's life. Home adaptations also carry symbolic meanings for older people both positive (e.g., feeling safe and secure, independence) and negative (e.g., emphasizes frailty, aesthetically undesirable) (Tanner, Tilse and De Jong 2008; Sixsmith et al 2014).

By viewing older people in terms of their functional limitations, home modification services can undermine the positive impact of adaptations. For instance, Johansson and colleagues (2009) in their study about experiences of older people receiving home modification services highlight a need for services to look beyond notions of providing services to manage functional limitations, to addressing recognising, and supporting the 'agency' of older people. Older people in their study did not see home modifications in terms of functional independence but as one of many ways to enhance opportunity to engage in important everyday routines and activities in accordance with their values and preferences.

Focus on the microenvironment of the home also does not take into account the importance of the wider environment (beyond the home) in older peoples' lives. Ewart and Luck (2013) uncover the changing priorities and meanings associated with living at home in a qualitative study with a group of older people in domestic settings. In conceptualising living at home as a 'process' (Ingold 2000), their findings suggest that older people were less concerned about what went on inside the home (e.g., formal/ informal support was not a privacy issue and the home was not necessarily construed as an extension of self). Instead

older people in their study were more interested in maintaining links and (social) engagement beyond the home.

A contribution to highlighting the significance of material dimensions of place is based upon assumptions about place as a 'bounded' and 'static' backdrop in which older people live. Older person-place relationships are presented as uncomplicated and linear, wherein, health and age related changes could be compensated for and mediated by the physical environment. What is ignored in the process is the individual socio-economic context, how age and health related changes might influence priorities and (or) meanings attached to place as well as what adaptations mean for an older person's identity.

### **2.3.2 Domestic Settings: Place attachment**

Another strand of research on domestic settings builds on the concept of 'place attachment'. Literature under this strand largely focuses on developing an understanding of how 'home place' is experienced by older people, its importance and meaning in growing old. Place attachment captures an emotional and physical bonding to place (home as a particular kind of place) that emerges from a mix of physical (e.g., length of time in residence, routines and rituals; functional characteristics of place), social (e.g., social roles, relationships, expression of self and personal identity), and psychological affinity (e.g., sense of security, privacy, belonging and familiarity) that people develop with a place (Rowles 1993; Shenk, Kuwahara and Zablotsky 2004; Twigg 2006).

Though attachment to home is not exclusive to ageing, it may, "...as we grow older, become increasingly significant in preserving a sense of

identity and continuity amidst a changing world” (Rowles 1993: 66). Places become infused with personal and social meanings (Rubinstein and De Medeiros 2004) that are kept alive and enacted through valued possessions or objects, practices, (Evans, Kantrowitz and Eshelman 2002; Rowles, Oswald and Hunter 2004) and memories (Hockey, Penhale and Sibley 2001; Rosel 2003). In critiquing the ecological models of ageing, place attachment literature drawing upon anthropological and geographical perspectives repeatedly highlights the importance of taking note of the less obvious and experientially meaningful dimensions of home to older people (e.g., familiarity, routines, preferences, privacy, comfort) in addition to the functional aspects. The range of meanings that older people might attach to their home place has profound implications for design and delivery of services. As Sixsmith and Sixsmith (2008) highlight, many a times support services are seen as stigmatising because of insensitivity to the experiential and symbolic dimensions of home for an older person.

The concept of ‘self’ and ‘identity’ is closely related to a ‘home’ place. Place attachment supports identity maintenance and home becomes a meaningful experience and extension of self. Meanings, knowledge, and memories grounded in experiences of home and neighbourhood are drawn upon to sustain a positive sense of self or self-identity. A positive sense of self in turn supports ageing in place despite increasing challenges associated with declining health and/or due to rapid area depopulation, loss of services (Taylor 2001; Tahara and Kamiya 2002; Rosel 2003). Because of its significance for identity maintenance and preservation paying attention to the processes and role of place attachment becomes a crucial component in developing nuanced understandings of older people-place relationships. Research has also identified that this attachment is stronger in the case of older people

(Gilleard, Hyde and Higgs 2007; Peace et al 2007) if only because of length of time spent at home. Home as a particular kind of place therefore is symbolic and contributes to the older person's sense of identity, comfort, security, familiarity, belonging, and privacy.

While not denying positive experiences of home, Manzo (2003) however, notes that the focus of place attachment literature has mostly been on positive people-place relationships. And, such a focus usually is in relation to the 'home as a place' because it represents the "archetypal landscape" (p.49). Furthermore, in highlighting how much older people are attached to place, it presents a very particular, homogenous, and stable experience of place. Some literature on place attachment has paid attention to changing meanings and experiences of home. Empirical work on place attachment in the situated context of widowhood (Hockey, Penhale and Sibley 2001; Cristoforetti, Gennai and Rodeschini 2011) has highlighted how following loss of a spouse, older women, and men socially and spatially reconstruct meanings of 'home' by reorganising the home and (or) by stopping participation in 'spatialised practices' that serve as reminders of loss.

Other literature, too reveals that experiences of place (s) may not remain universally positive, meanings attached to place may change over time and (or) attachment to place may not be significant. While home ownership is positively associated with attachment to place, home ownership can also become a 'liability' or a 'trap' if experiential dimensions of home no longer remain positive (Oldman and Quiglars 1999; Sixsmith & Sixsmith 2008). Similarly, for older people in diverse housing situations (e.g., tenants, homeless), attachment to home may not be singularly important (Means 2007; Phillipson 2007). The salience of attachment to where older people live notwithstanding, Smith (2009)

highlights how notions of stable place attachment have been drawn from research carried out with older people in rural settings. She further notes that such understandings of place attachment may not be applicable to rapidly changing urban contexts and neighbourhoods marked by deprivation and decline.

In understanding place attachment as a key component of the broader notion of 'sense of place' (a concept to which I return later in Chapter 4), Buffel et al (2014) similarly draw attention to role of place characteristics (e.g. physical environment of neighbourhood and residential turnover) in more and less affluent localities in differentially influencing place attachment. Their findings too suggest that older peoples' experiences of living in particular places may change over time and particularly in less affluent localities affect attachment to place. Such research hints at the need to be sensitive to and acknowledge the diversity amongst older peoples' values and changing circumstances.

### **2.3.3 Dynamic nature of place: neighbourhood environments**

An understanding of the impact of neighbourhood change on older people offers a critique of a 'universal and positive' experience of place as well as draws attention to the temporal dimension of places. Contributions from this body of literature highlight different aspects and issues related to person-place relationships. Phillipson (2007), Smith (2009) and Burns, Lavoie and Rose (2012) draw attention to dynamic nature of neighbourhoods.

Burns and colleagues (2012) drawing upon a qualitative case study of two contrasting and changing neighbourhoods undergoing gentrification in Canada, explore older peoples' experiences of neighbourhood change. Findings suggest that participants' experiences of neighbourhood and

sense of belonging are variable. Factors such as, availability of local services, nature and perception of social networks, length of residence, perceptions about the ethnic mix of neighbourhood and continuity/loss of important local institutions such as the church, bingo clubs etc., mediated feelings of security/insecurity, familiarity/strangeness and/or inclusion/exclusion. Similarly, based upon an empirical study of deprived neighbourhoods both in the U.K. and Canada, Smith (2009) reveals older peoples' differential experiences and attachments both positive and negative, as well as disruption of place attachment over time as an outcome of interplay between personal and place characteristics.

Diverse individual circumstances and socio-economic contexts may be significant in mediating relationships between person and place in context of neighbourhood change. For instance, Phillipson (2007) argues that the impact on older people both in terms of hostile urban environment in disadvantaged neighbourhoods and/or urban gentrification is creating a social polarity: of the 'elected' (those with the ability and resources to choose a particular lifestyle and place), in contrast to, the 'excluded' (those who are not only experiencing a displaced sense of place without moving but at the same time do not have the ability to mobilize resources and make choices). Scharf, Phillipson and Smith (2002) in an English study of social exclusion in later life, identified, five multiple forms of exclusion including: exclusion from material resources, social relations, civic activities and basic services, and neighbourhood exclusion. They defined neighbourhood exclusion as reflecting, "...negative views about the neighbourhood relating to physical decay, loss of amenities, and certain types of social change linked with population turnover and rising crime rates" (92).



Buffel, Phillipson and Scharf (2012) undertook a qualitative exploration of the neighbourhood dimension of social exclusion (or inclusion) in later life in urban deprived neighbourhoods in England and Belgium using the definition of neighbourhood exclusion by Scharf and colleagues. Their findings indicate that changes in the composition of the neighbourhoods over time, feelings of insecurity, and colonisation of certain spaces within the neighbourhood by anti-social groups led to experiences of exclusion. Different strategies were employed in the process, a major one amongst older women in light of their own physical vulnerability being, avoiding use of particular places both spatially and temporally. Other individual and collective strategies variably included installation of security devices, keeping an eye out, neighbourhood watch strategies, as well as, going out with someone rather than venturing out alone.

Scharf and colleagues (2002) also note how the process of neighbourhood exclusion can be tied to individual life course. Their findings suggest that some older people, who had lived in a particular neighbourhood for a long time, were acutely sensitive to the deterioration and erosion of services and amenities over time in the neighbourhood. This awareness for some was further accentuated by age and health related losses, which eroded their confidence particularly in keeping up with changing nature of neighbourhood and contributed to feelings of insecurity. And very few had an opportunity that personal material resources afforded to move to better and safer neighbourhoods.

However, as these authors note, there is a need for more research to understand the 'processes' by which familiar places become unfamiliar. 'Ageing in place' research by presupposing familiarity and stable

attachments has ignored the issue of changing nature of places and its implications for some older people.

#### 2.3.4 Home as a site for care

Challenge to conceptions of a homogenous, uniformly positive experience and meaning of place emerges from geographical research that explores impacts of care provision in domestic settings from the perspectives of both care recipients (Wiles 2005) and care givers (Milligan 2000; Williams 2002). This body of literature though focusing on different aspects of health and social care provision however, brings out competing contestations, negotiations and tensions about what the 'home' represents: a private sphere or a public space. Angus et al (2005) in an ethnographic study including a sample of older people receiving long term care at home present a sensitive portrayal of the 'struggles' surrounding preserving meanings of home in the face of disruptions brought about by bodily changes and inflow of care.

Meaning of 'home' and spatial practice(s) at the scale of body, the home, and beyond the home is impacted by bodily impairments. Care interventions further disrupt and alter the physical, social and experiential dimensions of home. Struggles and negotiations emerge around the aesthetics of the home, ordering and organisation of space and who has the final say in these negotiations. The authors conclude that care recipients largely ended up occupying a receiving and subordinate position in their own homes mediated in some instances by the individual command over resources.

Others similarly hint at the blurring of boundaries between private and public, formal and informal, and a 'medicalisation of home' - at the centre of which are care practices that may disrupt and alter meanings of home

as well as peoples' relationship with place (Williams 2002; Milligan 2003). Experiences may however vary. A qualitative study exploring experiences of receiving low level home support (personal care and help with domestic work) amongst older people in New Zealand reveals the positive meaning attached to such support that was additionally socially and emotionally valued (Hambleton, Keeling and McKenzie 2008). Instead of undermining values of identity, control, and independence, receiving support enabled participants' continued engagement in various spheres of their lives. Whether these variations in experiences of receiving support at home relate to the nature or type of support or other factors is unclear.

To summarize, empirical work on person-environment interactions drawing upon 'ecological model of ageing' and 'person-environment fit' models, as well as work underpinned by concept of 'place attachment' make valuable contributions to highlighting the role and significance of place in older peoples' lives – *they confirm that places matter*. Other empirical work (though limited) in highlighting the dynamic experiences of places (home and neighbourhood) questions *the assumptions underlying a static, bounded, and a homogeneous conception of place and consequently, its meaning to older people*.

The next section reviews notions of place in relation to supported settings.

## **2.4 Supported settings: dynamics of relocation**

In the following sections, I focus on the reasons for and experiences of moving from domestic to other domestic and (or) supported settings. I argue, that in the literature on relocation, conceptions and experiences of living in supported settings are embedded in and inextricably tied to: a

perception of the setting the older person moves into; decisions relating to the move; reasons for the moving; and, the transition experiences of moving into such settings.

Incorporating and reviewing research on moving from domestic to domestic settings alongside investigating moves from domestic to supported settings was a conscious decision. While examining literature on relocation from domestic to various new settings (both domestic and supported), I felt that placing and viewing literature on domestic to domestic moves alongside enabled a clearer understanding of the differential emphasis on particular types of moves (section 2.4.1; dichotomies and binaries), commonalities (section 2.4.2: reasons and factors for moving) as well clearly highlighted the gaps (section 2.4.3: experiences of transition and living in new settings and section 2.5: discussion). Table 2.1 provides a glossary of the key terms used to describe various types of supported settings, their key features, and comparable terms used in countries other than the UK.

Settings	Features associated with settings	Comparable terms
Sheltered	Although varying in size, design, tenure and by providers, sheltered settings refer to purpose built housing schemes (with community alarms), communal facilities (e.g. laundry, a common room) and support services that include on-site/off-site scheme manager/warden for access to emergency services.	'Congregate senior housing', 'independent living facility' in US, 'senior cohousing' in Netherlands & Sweden (Choi 2004; Pannell and Blood 2012)
Very sheltered/ extra care	Very sheltered/extra care housing in UK combines features of sheltered housing but with high levels of support and care. These include for instance, wide range of communal facilities, choice to have meals in communal dining facilities, support with domestic tasks, and in some schemes, on-site personal care support (Croucher, Hicks and Jackson 2006).	'Assisted living facilities' in US falls within this category (Hillcoat-Nalletamby 2014; Kneale and Smith 2013)
Residential care homes	Residential including nursing homes combine living environments with communal facilities (typically shared social spaces, dining facilities) and provide highly specialised levels of care and support for people with a range of physical, medical and cognitive impairments. These include small-scale and large-scale residential care homes. Since April 2002, residential care homes in the UK no longer distinguish between residential and nursing homes and both are now subsumed in the category of residential care homes (Laing 2008)	In other Western contexts, the term 'nursing home' is commonly used

**Table 2.1: Different types of supported settings and key features**

#### 2.4.1 Dichotomies and binaries: perceptions of place

In both academic and policy circles, particularly in the case of older people, having to move out from the domestic home into a supported setting is usually portrayed in negative terms even when that is understood as exercising 'active choice' (Oldman and Quilgars 1999). 'Ageing in place' at home is widely advocated as upholding values of independence and attachment.

Separate reading of literature on moves variously to other domestic, sheltered or residential settings confirms the importance of perceptions

about 'place' in both academic and policy literature. All moves whether to other domestic or supported settings apparently involve immense physical and emotional upheaval, may even involve change/loss of tenure and yet, moves to residential care settings are singled out and glossed over to be the most significant of relocations. Moving into a residential care setting is associated with discontinuity of lifestyle, loss, decline and dependence, so much so that such a move signifies a complete break from the older person's past life, ties, and identity (Reed, Payton and Bond 1998).

In emphasising the community setting of the domestic home, residential settings are perceived to be located outside this. As Gilleard, Hyde and Higgs (2007) note the term 'community' has come to denote both the traditional notion of 'communities of place' and the broader notion of 'communities of interest'. 'Communities of place' refer to places where people live, and, 'communities of interest' underpinned by notions of social capital focus on social networks and relationships. Whichever way the term 'community' is understood, residential care settings to which older people relocate more than often are located within the same wider geographical setting as their domestic homes and whether the older person becomes completely disconnected from his/her community of interest, for example, family and friends, is also doubtful.

Perception about different settings that an older person might relocate to is perpetuated both through policy and research and is rooted in 'binaries' and 'dichotomies'. Binary opposites are frequently used and emphasized in discourses around continuity/discontinuity, independence/dependence, place attachment/mobility and autonomy/loss of control (Golant 2003; Hillcoat-Nallemtaby 2014). Different settings have thus come to acquire particular identities that in

turn shape perceptions. 'Ageing in place at home' policies are not simply presented as offering older people a wider canvass of options in relation to living and care arrangements but are emphasized as being an alternative to residential care settings. As Lundgren (2000) notes, the 'home' and 'residential care setting' have become binary opposites such that one cannot be understood without reference to the other and one is what the other is not.

Boyle (2004) and Lee, Simpson and Froggatt (2013) too observe the prevailing notion of 'superiority of home' as a place for care as against the perceived stress and fear of receiving care in a residential care setting seen as a 'last resort'. Despite the introduction of National Care Standards and setting up of the Care Commission to regulate and inspect a range of services in UK, negative perceptions about quality of living and care in residential care settings persist. Older people have been observed to explain their preferences for living at home in relation to negative perceptions about care settings rather than based upon their own lived experiences of living at home. Fears are not entirely unfounded as media exposés time and again bring out the neglect and abuse that some people living in residential homes experience. Some authors however, reflect that policy potentially capitalizes upon the above-mentioned 'binary' opposites to promote ageing in place at home in order to offset costs associated with residential care provision (Biggs 2001; Golant 2003; Martin et al 2005).

In addition, there is evidence of shifting policy attitudes towards different supported settings. In the UK, before the Community Care reforms in 1990s, one can see the role of policy in promoting and popularising sheltered settings as places for independent and secure living by presenting these again as an alternative to residential care

settings (Nocon and Pleace 1999). It is important to note that the popularity of sheltered settings amongst older people when originally set up related to security of having a warden/scheme manager at hand, a way out of social isolation, and not having to do house maintenance (Nocon and Pleace 1999). Older people themselves did not envisage sheltered housing as a step on the continuum to care. As many authors repeatedly observe, with increasing emphasis on receiving community care at home since the 1990s, at least in policy circles the role of sheltered housing has become obscure (Oldman and Quilgars 1999; Croucher et al 2008).

In academic research as well, whether sheltered housing represents a 'home' or 'institution' is unclear and debated (Oldman and Quilgars 1999). Pannell and Blood (2012) in a recent review of sheltered housing note that although sheltered housing is still popular amongst residents, cutbacks in the form of changes to warden services have been negatively perceived by older residents. More recently however, policy interest has shifted to very sheltered or extra care housing as allowing independent living and providing an alternative to institutional care (Wright et al 2010; Kneale and Smith 2013).

The problematic nature of perceptions about place(s) rooted in binary opposites of home and institution lie not in the normative treatment of the domestic home as the ideal place but that in doing so *it homogenizes older people*. Weighting and juxtaposing places in binary opposites of continuity/change or independence/dependence may reduce options for older people to live in appropriate environments.

Societal perceptions of place(s) consciously or unconsciously stigmatize those who cannot/may not for various reasons want to age in place at



home. Policy not only contributes to these discourses by legitimatising and making visible some places for growing older, but, by privileging narrowly defined meanings of independence also marginalizes some older people. The next section focuses on older peoples' reasons for relocating while paying particular attention to (place specific) experiences that lead to moving or considerations of relocation.

#### **2.4.2 Reasons and factors for moving: individual and place factors**

Broadly, literature on why older people relocate documents moves from: (1) domestic to domestic; and, (2) domestic to various supported settings and more specifically to residential care settings. Some draw upon retrospective accounts of reasons for moving into a particular setting. Others tease out prospective accounts of considerations that would influence relocation to a variety of domestic and supported settings. Empirical research has also been undertaken to examine, 1) whether older people move proactively or reactively and, 2) if they do anticipate moving, whether they actually move. Empirical studies include cross-sectional and a few longitudinal designs, draw upon both qualitative and quantitative data, and, include a range of age groups. The role of health related events, episodic or declining, (Robison and Moen 2000; Croucher 2008) and death of spouse (Hays 2002; Hansen and Gottschalk 2006) as potential triggers for residential relocation in late life are well established in literature. The presence of a range of mediating factors too has been documented and includes both individual and place related factors.

Various theoretical frameworks inform work on residential relocation of older people, namely, Lawton and Nahemhow's (1973) 'ecological model of ageing' (cited earlier in the review), 'typology of relocation' put forth by Litwak and Longino (1987), and Wiseman's (1980) 'behavioural

model of late life migration'. Building on the 'ecological model of ageing' are 'stress-threshold' (first developed by Wolpert 1965, 1966; and later modified by Brown and More, 1970 and Fokkema, Gierveld and Nijkamp 1996) and 'residential satisfaction' models (Speare 1974). Both models incorporate individual and place factors (to include, housing, physical and social neighbourhood environment) and hypothesize that residential mobility will depend upon the level of stress or satisfaction that people experience and perceive in their current settings.

Litwak and Longino (1987) advance three typical types of late life relocation moves from a lifespan development perspective paralleling significant life events. The first type of move is following retirement and is usually a lifestyle or amenity move; the second move occurs as older people become less able to manage everyday tasks due to health decline and hence move closer to children or other family to secure help with care; and, the third move is to a residential care setting when care needs increase to such an extent that informal support and care may not be enough.

Wiseman's (1980) 'behavioural model of late life migration' draws attention to a range of push and pull factors, that could relate to the individual, environment (physical and social) or larger context. Push and pull factors play a role in evaluating the current living environment as satisfactory or not and influence considerations of moving or staying put. The model also highlights the role of resources (e.g., health, perceptions about outcome of move, ties to the neighbourhood, social support, financial viability) that act as mediating factors in facilitating or impeding the move.

The following sub-sections review reasons for moving from domestic to other domestic and supported settings.

#### Domestic to domestic moves

In exploring moves from domestic to domestic settings, Hansen and Gottschalk (2006) in a Danish study of older people between 50-80 years of age (those who had moved as well as those who had considered moving but not moved) reported individual factors such as health, status of current living arrangements (living alone or with someone), feelings of isolation or loneliness and place related factors such as, social ties with the neighbourhood, length of residence, accessibility of the house, and financial viability of move, as moderating the relationship between considerations of moving and actual mobility.

Similarly, Boldy et al (2011) in a mixed methods study examined factors influencing moving amongst older Australians (age groups ranging from 50 to 75 plus) who: had already moved; were considering moving; or, had decided to stay put. Their findings suggest that amongst the older group (65 and over), individual factors such as, feelings of safety and security, ability to manage and maintain house and place related factors such as comfort of the house in terms of space, layout, adaptation and maintenance, availability and proximity of services and amenities, mediated influences on moving or staying put. Those who had moved or considered moving additionally reported deteriorating health (self and/or partner). Amongst those who had decided to stay put, financial viability, and maintaining continuity of residence were important considerations. However, participants who had moved or considered moving did not report moving closer to family as a priority reason.

The relocation motive of moving closer to where adult children live and/or moving in with adult children/kin has also been examined. Litwak and Longino's (1987) second typology of move hypothesizes older adults moving closer to family to seek assistance with increasing care needs. Cultural variations across different countries challenge the notion that older adults move closer to children and family mainly to seek assistance with increasing support needs. Empirical work carried out in Sweden and Denmark highlights that older adults do not move closer to children to receive support/help with care because of the availability of a well developed system of home care services (Fransson and Teeland 2004; Hansen and Gottschalk 2006).

Another set of studies undertaken in United States point out that older adults co-residing with adult children is as much a strategy to reduce cost of living and pool resources as it is about securing/providing support (Walters 2000). Also, in some instance it was not the parent who moved in with children but vice-versa (Zhang et al 2012; Renault et al 2014). Peace, Holland and Kellaher (2011) from their research with older people in England note that reasons for relocating/or not closer to children have to be understood in wider socio-historical context that places emphasis on 'independent living'. In their study, participants living at home in prospective accounts of relocating mentioned a preference for moving into a care home than live with or impose upon their children. A study using quantitative datasets conducted in Netherlands however, notes that where adult children live in close proximity, likelihood of moving into a care home is less (Van Der Pers, Kibele and Mulder 2014).

### Domestic to sheltered and very sheltered settings

A range of reasons have been reported by older adults for relocating to sheltered and very sheltered housing in the UK, and congregate facilities in United States. These reasons are not dissimilar to those reported by older adults making domestic-to-domestic moves and include a range of diverse and multiple individual and (or) place related factors shaping the decision to relocate.

The reasons include individual factors such as: (1) difficulty in managing and maintaining the residence due to ill health (self or spouse) (Krout and Wethington, 2003; Behket, Zauszniewski and Nakhla 2009); (2) change in marital status and living arrangements (Peace, Holland Kellaher 2011; Ewen and Chahal 2013); (3) fear and anxiety about becoming socially or geographically isolated and/or experiences of anti-social behaviour in the neighbourhood (Nocon and Pleace 1999); (4) wanting to keep functioning independently but knowing help was available if needed; (5) making a planned move to deal with uncertainties of life (Croucher et al 2008). And, place related factors such as; (1) difficulty in maintaining large domestic homes and related issues of heating/warmth (Ewen and Chahal 2013); (2) unavailability of particular kinds of housing in the mainstream housing stock (Nocon and Pleace 1999; Croucher et al 2008); (3) the presence of a warden service in sheltered housing (Nocon and Pleace 1999; Ewen and Chahal 2013), and; (4) moving closer to where family and/or friends live (Behket, Zauszniewski and Nakhla 2009; Peace, Holland and Kellaher 2011).

Three factors that prompted relocation were however distinct from domestic to domestic moves. Two of these reasons related to place and included, experiences of neighbourhood crime/ burglary and unavailability of particular kinds of housing (in the UK context), for

example, bungalows in the mainstream housing stock. The motivation for making a planned move in anticipation of future needs was another distinct factor. Planned moves challenge the notion of staged moves put forth by Litwak and Longino (1987), particularly, as such moves are associated with amenity migration by younger groups of older people.

#### Domestic to residential care setting

Empirical evidence from a longitudinal study with older people aged 65 years and above conducted over 12 years in Australia highlights various individual factors that predict relocation to a residential care setting (Kendig et al 2010). Functional limitations in carrying out day-to-day activities, health (cognitive impairment and multiple chronic medical conditions), age, marital status (never being married and/or widowhood), lack of adequate nutrition, were identified as significant in influencing relocation. Factors indicated a gender specific trend. Marital status and functional limitations were likely to precipitate a move into care setting for women while for men, cognitive impairment and multiple chronic medical conditions were significant. Their findings also revealed that availability of informal support and housing tenure were not significant factors while issues of housing/neighbourhood and availability of community care were not examined.

International variations in social and health care policies across various countries may account for the differential association between housing tenure and relocation to a care setting. McCann, Grundy and O'Reilly (2012) specifically focused on the home ownership and house value utilising data from Northern Ireland Longitudinal Study to understand why home ownership is associated with lower levels and low risk of admission to a care setting. While commenting that previous studies have associated home ownership with various advantages for example

sense of security and flexibility, the authors' findings suggest that the requirement of selling the property if admitted to a residential care setting is a significant deterrent. Such a requirement stops homeowners from moving into a care setting. Instead, homeowners may choose to rely on informal and paid care at home. This issue has been recognized in policy as is evidenced from recommendations of the Dilnot Commission report (Dilnot 2011) for fairer ways of funding care that have been incorporated into the Care Bill that has been placed before the parliament (Humphries 2013).

While there is an agreement that age, functional limitations in carrying out day to day activities, marital status and cognitive impairment are significant factors in relocation (Friedman et al 2005; Booth et al 2007; Heppenstall et al 2014), the role of informal support as a mediating factor in relocation is contested. While Kendig and colleagues (2010), did not find informal support to be a significant factor influencing relocation, Jorgensen et al (2009) drawing upon a six-month longitudinal sought the views of older people 65 years and over with high support needs in three New Zealand cities. They identified non-availability of informal support, perceived strain on caregivers where support was available, being alone at home for long periods, as significant in influencing relocation to care settings. In contrast, accessible housing, availability of both informal care and formal care and support at home, despite high support needs allowed older adults to continue to live in domestic settings. Other studies too echo similar findings vis-a-vis the role of informal care and support in influencing decisions to move (Nygren and Iwarsson 2009). Additionally, not being able to manage even with available support (Heppenstall et al 2014), and fear and anxiety relating to some untoward event happening whilst living alone too might influence relocation (Lee, Simpson and Froggatt 2013). What becomes evident from these studies

is the need for contextualised understandings of the role of informal support in influencing decisions to relocate to care settings or not. The role of informal support as a mediating factor in moving (or not) has to be understood in a situated way – in relation to the support needs and preferences of the older person together with the characteristics of the informal carer (e.g., carer's health, conflicting caring and work/family related demands, and filial obligations).

#### [Pro-active and reactive moves](#)

Various studies have also tried to explore why some move proactively while others move in response to some life events. The complexity and uncertainty of knowing in advance how health /circumstances might change or deteriorate and plan ahead for such eventualities has been highlighted. Pope and Kang (2010) drawing upon data from three waves (1994-2000) of a longitudinal study of ageing investigated whether a sample of older adults (70 years and over) had moved proactively or reactively. Although utilising pre-determined categories of reasons, their findings revealed that twice as many older adults moved in response to a crisis or stressful event and deteriorating health was the most frequently cited reason. Stoeckel and Porell (2010) utilized a longitudinal dataset to investigate whether older people experiencing deteriorating health, in this instance, falls, anticipate relocation. Their findings illustrate that likelihood of relocating amongst this group is higher, although, they hasten to add that falls is one amongst multiple factors that may influence considerations of relocation.

The uncertainty generated by health in decisions to relocate aside, multiple considerations such as: older peoples' expectations in terms of housing choices; their perceptions about various kinds of settings; and, choices and options that are available and open to older people at a given



point in time might also influence where they move and whether they move or not. Croucher (2008) in a qualitative study with older people regarding housing expectations, choices and options, provides some insight into the complexity surrounding prospective and retrospective accounts of housing decisions. Her study reveals that prospective assumptions and expectations about where to live are not only diverse and involve competing priorities and values but are made from particular and current positional perspectives. For instance, some participants who currently did not have any particular health issues felt that they could adapt their homes if the need arose, while, others, were concerned that adaptations would negatively affect the value of their house. In retrospective accounts, participants however pointed out how numerous adaptations were required and hence it was more feasible to move out or that it was not possible to adapt the house, for instance for wheelchair mobility.

Samsi and Manthrope (2011) carried out a study to explore whether older people make contingency health and social care plans. Their findings indicate that while those who live alone, as well as, do not have any family anticipate and make plans, others do not. Personal dispositions about taking one day at a moment, religious beliefs, family taking on the responsibility, if required, variably might influence whether older people make contingency health and social care plans.

While moving into a residential care setting is often regarded negatively, residential care as an option may not be available unless an older person has the resources or considerable health needs to be eligible. Portacolone's (2013) study on older adults living alone in United States highlights this point. Some older people in her study were willing to move into more supportive environments, but high costs of residential

care, low individual resources, conditions of eligibility, combined with, notions of quality of public versus private facilities meant such options were not available to them. Deciding to move into a supported setting does not guarantee access. Nygren and Iwarsson (2009) in a Swedish study highlight the role of formal assessment procedures in negotiating access. Apart from a few notable exceptions (Nygren and Iwarsson 2009; Peace, Kellaher and Holland 2011) the mediating role of attachment to place amidst other competing concerns in influencing decision making regarding moving or staying put has been overlooked. As the findings of these studies indicate, it may take a long while to arrive at the decision to move.

To sum up, at a very broad and general level, identified triggers and motives for relocating to different kinds of settings are not so dissimilar and include both individual and place specific factors. Under place specific factors, in addition to the suitability and accessibility of housing, positive (social ties, availability of amenities and services) and negative experiences (threat to safety and security, crime/burglary) of neighbourhood environment too have been captured. Factors that mediate the relationship between moving or not moving have been reported and documented and are not so dissimilar for different types of moves. *Yet, it is not clear how particular relocation trajectories into domestic, sheltered or residential care settings are influenced and shaped.*

In relation to health, research on relocation to residential care settings by conducting research with older people who are variously frail, have high support needs, are cognitively impaired or have multiple and/or chronic medical conditions draws attention to the wide diversity in health conditions across older people and its implications for varied levels of support and care. Oswald et al (2002) have also usefully noted

the diversity in motivations and needs of older people and multiple factors underlying motivations for relocation. It also emerges that values and preferences around accessing informal support vary even where informal support is available. It therefore appears that research on relocation motives has paid less attention to *the inter-linkages and interplay between various factors and the diverse, situated and context specific nature of circumstances that may shape particular relocation trajectories.*

Another body of literature on supported settings focuses on the experiences of moving into and living in new settings. The following section provides a brief critical overview of these contributions.

### **2.4.3 Experiences of transition and living in new settings**

#### Domestic settings

Experiences of relocating to and living in supported settings including residential care settings have received much more attention than experiences of relocation from domestic to domestic settings. Luborsky, Lysack and Van Nuil (2011) and Oswald et al (2002) investigate relocation from domestic to domestic settings that focus respectively on process of downsizing and outcomes of relocation. That experience of downsizing is inextricably linked to 'one's sense of place in time' and informs decisions to downsize and relocate is highlighted in the empirical work carried out by Luborsky, Lysack and Van Nuil (2011). 'One's sense of place in time' incorporates a temporal dimension that simultaneously signifies change and questions the suitability of where the older person lives. Markers of time in their study were variously linked to the ageing body, culturally defined life course stages, family, wider economic and political conditions that influence and shape

decisions about selling and buying, perceptions of neighbours/friends and adaptability of house.

The authors importantly highlight two things: that one, downsizing is not always just about the emotional struggle about deciding about what to keep, throw off, or give away but needs to be understood against the context of decisions shaping downsizing. And two, downsizing as other findings (Ekerdt et al 2004; Ekerdt and Sergeant 2006) too confirm is neither about possessions per se nor a staged process, but is tied to a continuous process of change and adjustment that for some may involve multiple moves. A few may even perceive relocation as an opportunity to start afresh. Their findings indicate diversity in contexts and meanings attached to downsizing thereby suggesting that relocation may not necessarily be a negative experience.

Oswald et al (2002) examined relocation motivations, improvements in socio-physical environment post relocation and relationship if any between motivations and experienced changes post relocation. The study was carried out with a sample of well off older urban adults in Germany over a 3 year period. Utilising concepts from 'environmental proactivity model' (Lawton 1985) and 'complementary -congruence model' (Carp and Carp 1984) of person-environment fit, their findings revealed that participants noted improvements after relocation in four pre-coded domains of: a) household amenities; b) visual stimulation; c) availability of resources; and, d) social networks. The authors also observe that motivation to relocate originally arose from the desire to enhance/optimize their living environment. However the relationship between motivations and experienced changes was found to be statistically low, for instance, some participants' motivations for

relocation were expiry of lease on their tenancy and yet they too recorded improvements in housing environment.

The authors reflect that situational factors (such as housing options, cost factors etc.) during relocation process and which may have been beyond an individual's control might explain the low statistical significance. It is however important to note that pre-coded domains for registering changes that was limited to physical-social housing related environment may not have allowed participants to record other valuable changes. Beyond these few notable exceptions literature on domestic-to-domestic relocation experiences is sparse.

#### [Sheltered and very sheltered settings](#)

Empirical research on supported settings has done much to illuminate how and what enables (or disables) older adults in 'finding home', 'becoming at home' or 'making home' in supported settings. Becoming at home is related to finding out about experiences of adjustment and adaptation following relocation and in particular, the nature of successful and positive adjustment.

'Place integration concept' (Cutchin 2003), 'occupational therapy perspective' (Marshall and Mackenzie 2008), 'phenomenological meanings of home' (Dobbs 2004; Leith 2006; Jungers 2010), and 'stress perspective' (Ewen and Chahal 2013) variously inform processes and experiences of making and becoming at home in a range of supported settings that include, assisted living facilities (U.S.), congregate housing facilities (U.S.) and hostels (Australia). Place integration emphasizes a holistic process perspective on person-place relationship dynamics. Change is understood as both creating problems in the 'integrity of the person-place whole' (p.1078) as well as providing opportunities to

reintegrate through personal or group action (activities) to resolve problematic situations, thereby emphasising a role for agency (Cutchin 2003).

Marshall and Mackenzie (2008) chose to explore participants' occupational engagements and whether 'doing' and 'engaging' in meaningful activities was significant in successful adjustment. Others have utilized phenomenological perspectives on home to examine successful adjustment. Such perspectives incorporate meanings of home that are socially constructed, and include both tangible aspects such as, material possessions, length of residence, and intangible aspects, for instance, extension of self, matters of privacy, control, independence, autonomy, meaningful relationships and memories. Another perspective locates relocation within the purview of stress. Experiences of living in supported settings therefore, examine levels of stress and coping strategies, the premise being that low levels of stress are indicative of successful adaptation.

Underpinned by various conceptual and theoretical frameworks, empirical work highlights that experiences of adjustment amongst older people are not uniform. A few common issues that differentiate positive from negative experiences too have been identified. These include, issues of control and choice related to doing things that are meaningful, deciding how to spend the day (when to get up, when to sleep) etc., and rules and regulations of the settings that contribute to a loss of independence and/or autonomy thereby constraining 'becoming at home'. While relationships with family and staff are variously valued and maintained, social relationships within the setting were found to be contributing to both positive and negative experiences. Death of acquaintances within the facility might affect some people negatively so

much so that they may stop meeting new people (Jungers 2010), while others, find and seek new friendships. Becoming at home or making home by personalising private rooms with valued and cherished possessions supports familiarity and identity maintenance (Leith 2006; Marshall and Mackenzie 2008).

The notion of successful adjustment as an endpoint rather than as an on-going complex process of change and adjustment is challenged by empirical work that examines whether models such as housing with care such as, assisted living facilities or very sheltered settings can become home for life (Cutchin 2003; Ball et al 2004; Kneale and Smith 2013). Studies suggest that such settings may support growing old in the same place for some but not all. Uncertainty of individual circumstances vis a vis health, resource constraints, changing care needs, and the ability of the setting to provide for changing care needs may be influential factors for staying in place or relocating.

#### [Residential care settings](#)

Successful adjustment following relocation to a residential care setting too has been focus of much empirical work. Various conceptual perspectives have been employed, including 'transitions perspective' (Porter and Ganong 2005), 'meaning of home' (Cooney 2012), concept of space (Petersen and Minnery 2013), and, concept of environmental experience (Granbom et al 2014). Cooney (2012) in a study of long term care settings in Ireland, uncovered factors that facilitated and hindered adjustment. Their findings suggest a role for the physical, social environment of care setting, individual outlook shaping adaptive responses, and whether moves to such settings were made voluntarily.

Maintaining continuity of personal routines, having control and choice over day-to-day activities, personalising space as an expression of identity, sense of self and belonging derived from positive relationships with staff and other residents, as well as, participating in meaningful activities is seen as crucial to finding home. Nakrem et al (2013) point out that issues of control, identity, and connectedness bring out the tension between residential care setting as a private as well as a public place and can influence the experience of living in such settings. While residential care settings provide a place for care, more than often they do not provide a place for living. Criticising the 'transitions' perspective that understands adjustment as a phased and linear process, Lee and colleagues(2013) echo similar findings in relation to identity, control and independence.

Petersen and Minnery (2013) using the concept of 'social space' drawing upon Lefebvre (1991) examined the daily lives of older people in residential care complexes in Australia. They highlighted that it was having and being able to produce space that signified as well as enabled connections differentially to material possessions and/or occupation (identity) that defined sense of place and self. The physical and social environment of the residential complex facilitated or hindered the ability to produce space in line with residents' individual identities that they sought to maintain and preserve. Deep attachments to possessions were not important for all in maintaining sense of self and for some, living in a residential care environment signified independence.

Granbom et al (2014) explored the role of individual factors such as, past environmental experiences or 'place making skills' in supporting attachment to a new place of residence. Utilising the concept of environmental experience (Rowles and Watkins 2003) their study



findings suggest that those who have never moved in their lives may struggle to find a way to transform space into place and maintain continuity of identity, more so if their sense of self is deeply implicated in home place. However, some evidence in the authors' research also points out that, for some, their sense of self is not (home) place dependent. This then raises questions about the 'universal' relevance of past environmental experiences or place making skills for enabling attachment to a new place of residence.

#### **2.4.4 Summarising experiences of living in supported settings**

What emerges from the above accounts (of supported settings) is the diversity and complexity of individual experiences even where the sample is drawn from people living within the same setting. It appears that non-uniformity in experiences therefore has much to do with the interaction between diversity in individual context (both immediate and wider), the physical and social environment of the setting and to a great extent, the role of individual values and preferences.

For some, activities sponsored by the setting are sufficiently engaging and promote their sense of self while for others they are not; some are deeply attached to the home they have had to leave, others have no such place attachments and a few others 'make home'; some benefit from communal living arrangements and develop meaningful relationships with staff and residents whilst others do not; some are able to engage in activities beyond the setting while others are not; and, some, are able to exercise choice and control over their day to day routines while others are not.

Two aspects however, remain unclear. The first relates to the dimension of health. Although, the role of health as a trigger to relocate is widely

established and acknowledged, the role of current health status as a factor that in conjunction with other factors mediates aspects of control, identity or independence is often underplayed.

That people have diverse experiences of living in supported settings begs paying attention to the fact that there is more to such experiences than the social environment of the setting. It may well be that people who have health impairments are more disadvantaged where the social setting does not facilitate appropriately or, a particular impairment is related to aspects of identity that are very highly valued. Other individual factors such as availability or lack of resources too might act as mediating factors. It could also be possible that positive outlook as identified in above accounts despite health impairments plays a significant role when people report positive experiences. Further, as some note, the notion of independence itself as utilised in research and understood by older people is subject to variable interpretations (Fine and Glendinning 2005; Hillcoat-Nalletamby 2014).

Secondly, past experiences have been identified as being significant in understanding current experiences of place. But, the status of peoples' identities and degree of control and independence they could exercise in their lives prior to entering supported settings is not clear. Within this context, it appears as if all losses in varying degrees occur due to relocating and living in supported settings. Part of the problem may lie in the way people talk about themselves. Narrative identity allows people to portray and report those aspects of self that are important and valued and in the narration of which the time dimension is dissolved. So, in giving voice to their lives prior to relocation while revealing valued aspects of sense of self that derive from their past occupation or role

identities, does not necessarily mean that it presents an accurate picture of their lives or identities just prior to relocation.

Morgan et al (2006) further observe that the exercise of agency is constrained by a multitude of factors long before older people enter supported settings. They argue that a grounded understanding would be more helpful in separating out how supported settings seek to constrain and/or facilitate. Lack of attention to diversity amongst older people particularly in relation to their health conditions (e.g., some will have stable yet chronic conditions, others may expect recovery and still others may experience instability and decline) has also been criticized (Golant 2003). Different health trajectories may differentially impact interactions with environment within an individual's life as well as across different individuals.

In explaining and differentiating successful adjustments from unsuccessful ones, particularly, in context of residential care relocations, the role of older person in voluntarily deciding to relocate has been repeatedly stressed. Empirical evidence supports the view that older people who voluntarily decide to move are more successful at adjusting to their new environment than those who do not move voluntarily. It is however, not clear whether involuntary moves represent imposition by others or choices constrained by an older person's circumstances. In addition, such research also relies upon a particular conception of individual decision making free from constraints of any kind. However, evidence from literature on motives for relocation has identified numerous and complex considerations influencing decisions to relocate.

While freedom to decide and act in accordance with one's values may be important for some, it may not be the only way older people might prefer

exercising decision-making. Some may not value it all but their contextual status of being alone and living alone may necessitate individual decision-making. Some may not be able to make decisions independently at all, while, others may not have the confidence or the desire to make such decisions on their own. A few studies have drawn attention to the complexity of decision making: decision to relocate itself may take many years (Nygren and Iwarsson 2009), is a delicate negotiation between competing priorities around maintaining the self and concern for wellbeing of significant others (Jorgensen et al 2009; Luborsky, Lysack and Van Nuil 2011) and negotiating attachment to place (Peace, Kellaher and Holland 2011).

In focusing full attention on whether older people move by choice or not, what is often ignored is whether older people have options and opportunities to exercise choice in different aspects of relocation. A few notable exceptions (Reed, Payton and Bond 1998; Eales, Keating and Damsma 2001; Leith 2006) point out the importance of location of the setting that an older person moves into. They usefully remind us that supported settings are not nameless, faceless destinations for receiving care but locales that are situated within familiar communities of place and/or communities of interest signifying maintenance and continuity of identity as well as social relationships. Therefore, finding out what options and opportunities older people have to exercise choice in various aspects of relocation is equally important.

## **2.5 Discussion**

Empirical work on domestic settings has brought out the significance of place in preserving, and maintaining the sense of self, the significance of emotional connection to places, and the role of the physical environment in constraining and (or) enabling access to services and resources in the

lives of older people. However, current conceptualisations while emphasising place attachment and (or) material significance of place ignore other aspects of person-place relationships thereby presenting a bounded and stable notion of place for a homogenous group of older people. Some empirical research attends to the dynamic nature of older peoples' experiences. But, attention to the temporal aspect of older person-place relationships vis a vis: older peoples' experiences of change, diversity in socio-economic contexts, changing nature of some places (neighbourhoods), and interrelatedness of places at different scales has largely been overlooked.

While the literature review reports various factors, both individual and contextual in shaping relocation, it is not clear why and how relocation trajectories into particular settings are shaped. Lack of attention to situated understandings of the processes and pathways that shape relocation may explain why despite broadly similar factors contributing to relocation to different settings, relocation trajectories are different for different people.

The combined role of contexts, past experiences, and other aspects of change (such as, age and health related changes) in shaping adjustment to the supported setting (residential care settings) are seldom considered. Settings from and to where older people relocate are understood as discreet bounded entities, and, relocation and adjustment to the new place of residence are also conceptualized as discreet events. Accounts of successful adjustment as Golant (2003) aptly notes are presented as 'static snapshots' from a movie rather than 'frames of an on-going movie'.

There is hardly any literature that systematically captures changes associated with moving from one setting to another. Most current literature presents a view that older people suffer losses in all aspects of life and living upon relocating to residential care settings and yet, there is evidence that some people do have positive experiences. Relocation and adjustment experiences of older people moving from domestic to domestic or domestic to sheltered setting are far and few.

Notwithstanding the privileged role of the 'home' place, there is a preoccupation in literature with making supported settings home like. Hence, a lot of the academic literature is devoted to understanding how supported settings can be made home like, regardless of the fact that the word 'home' may not connote the similar (or positive) experience /meaning to everybody. There is also a limited engagement with how place attachment interacts and intersects with unique circumstances, relocation decisions, and the process of relocation. Because moving and adjustment are seen as separate events, attention to making the unfamiliar familiar (place attachment) in promoting adjustment and adaptation is a post relocation concern. Whether processes and pathways of relocation may be implicated in positively or negatively influencing experiences of living in supported settings is overlooked.

Discourses surrounding the desirability of 'ageing in place' at home also work towards homogenising older people and hence may be detrimental in two ways: 1) by reducing opportunities that older people might actually have in relation to different settings that may be more suitable and appropriate; and, 2) by internalising and upholding the rhetoric of ageing in place at home that might not match the reality of older peoples' diverse circumstances. Hence, there is also a need for a space and language in literature on older people that allows shifting the focus away

from binaries of independence and dependence, continuity and discontinuity and autonomy/loss of control that simultaneously tend to homogenize and stigmatize.

## 2.6 Chapter summary

This chapter reviewed contemporary understandings of place in relation to everyday living environments of older people. The discussion was organized around the different kinds of everyday living environments, i.e., both domestic and supported (sheltered, very sheltered and residential care homes) paying specific attention to the significance and the assumptions underlying ideas about place. The chapter drew upon diverse bodies of literature from a range of disciplinary perspectives: gerontology (environmental, social and geographical), environmental psychology, nursing, and housing.

Review of place literature informed as well as highlighted gaps in knowledge. The reviewed literature provided an understanding of why places are important for older people. But the identified gaps as discussed in detail in the previous section suggest that we do not know enough about the processes by which places differentially enable and (or) constrain older peoples' lives within the context of diverse and changing circumstances, material and social realities. Paralleling the huge body of literature on place is literature on the wellbeing of older people. The next chapter attends to this body of literature that explicitly focuses on the wellbeing of older people.

## Chapter 3 : WELLBEING AND OLDER PEOPLE

### 3.1 Introduction

The previous chapter reviewed contemporary understandings of place through an examination of place experiences of older people across domestic and supported settings (sheltered and residential care homes). The review identified the significance of the (home) place for preserving, maintaining and moderating independence and sense of self for better or worse, as well as, highlighted the emotional connections that an older person might have to his/her (home) place. The review also noted that against the notion of 'home as the ideal', metaphors of home have been used to explore experiences of those living in supported settings. The relationship between people and place was largely predicated upon stable notions of place attachment, on the adaptation of the microenvironment of the home to accommodate age and health related changes, and on making supported settings homelike.

It therefore becomes imperative to first develop a detailed understanding of how wellbeing is understood in relation to older people. There is a need to pay close attention to the various conceptualisations of wellbeing before exploring the links between place and wellbeing. This chapter attends to these concerns and is organized as follows. Section 3.2 provides a broad overview of wellbeing and briefly explores the shifts in the understandings of wellbeing in policy and research. Section 3.3 describes and reviews in detail the various approaches that frame understandings of wellbeing of older people. In section 3.4, I discuss and highlight the gaps in wellbeing research. Section 3.5 brings together gaps in literature on place and wellbeing (from chapter 2 on place and chapter 3 on wellbeing). It critically



reviews the nature of the relationship of place and wellbeing, highlights what is included as well as excluded in these interrelations and is followed by a concluding chapter summary.

### **3.2 Background**

Rather than denoting a particular conception, 'wellbeing' is widely understood as an umbrella term (Gough, McGregor and Camfield 2006). The term 'wellbeing' accommodates a range of interpretations and competing conceptualisations about what 'wellbeing' means and is actualized through a range of related concepts, for example, health related quality of life or psychological wellbeing to name a few. Emerging from different disciplinary backgrounds, underpinned variously by normative conceptions that range from hedonic to eudaimonic, what broadly distinguish these concepts from each other is their focus, emphasis, and the types of measures used.

Broadly, hedonic conceptions of wellbeing focus on positive and negative affect (Bradburn 1969), happiness and life satisfaction as the ends of living well (Diener 1984; Kahneman, Diener, & Schwarz 1999) and eudaimonic conceptions variously emphasize human development and flourishing including capabilities (Nussbaum 2000; Sen 2009), personal growth (Rogers 1961) and positive psychological functioning (Ryff 1989). Eudaimonic conceptions are however broader in scope than hedonic conceptions of wellbeing. Eudaimonic conceptions acknowledge that happiness might be a valuable component of wellbeing, however, unlike the hedonic conceptions, do not see happiness or pleasure as the sole or primary basis for wellbeing.

Some use the terms 'wellbeing' and 'quality of life' interchangeably (Felce and Perry 1995; Nordbakke and Schwanen 2014), others see wellbeing

as a component of the quality of life (Vitterso 2004) and still others understand quality of life as a component of wellbeing (Dodge et al 2012). Nevertheless there is an agreement that both 'wellbeing' and 'quality of life' are best understood as multidimensional constructs. Underpinned by the recognition of the multidimensional complexity of human life, it is further acknowledged that both terms comprise of personal characteristics and socio-environmental dimensions. It is however, important to note, that although, multidimensionality is recognized and understood, it does not necessarily follow that all studies uniformly capture both personal and contextual aspects. Such difference partly arises from plural notions about what aspects of life are considered important, and, some of which are research and discipline led.

Broadly, a number of considerations have shaped the shift to multi-dimensional understandings of wellbeing and (or) quality of life. There is a widespread recognition that economic growth and standard of living do not equate to wellbeing or quality of life and as is evidenced from the launch of National Wellbeing program in UK (2010). Persistent and worsening inequalities in health globally and in the UK have highlighted the need for addressing the social determinants of health (Marmot 2010). In the post-industrial context, a rapidly ageing society too has contributed to shaping of multidimensional understandings of wellbeing in different ways. Arguing the need for broader conceptualisations of quality of life, many have highlighted that not only are older people enjoying healthier and longer lives (in Western context) but also that quality of life of older people cannot be restricted to disease specific measures (Higgs et al 2003) and/or equated with longevity (Birren and Dieckman 1991; Bowling 1997).

Within the field of health economics, the focus is on developing outcomes measures that capture more than health related quality of life (Al-Janabi, Flynn and Coast 2012; Milte et al 2014). As Makai et al (2014) note, in decisions relating to allocation of resources for health and social care interventions for older people, "...a focus on health dimensions of quality of life may be less appropriate if health improvement is not the only or even the main goal of the services provided" (pg. 83). At the same time, discourses of active ageing aimed specifically at promoting healthy ageing through participation and engagement in social and leisure activities have also gained currency (ODPM 2005; Scottish Government 2007a). As many have noted, these discourses are to a large extent driven by concerns around rising costs of health and social care due to population ageing (Biggs 2001; Scherger, Nazroo and Higgs 2011)

Finally as White (2010) and others note, the term 'wellbeing' has become popular both in policy and academic circles because of its positive, multi-disciplinary, holistic, and, person-centred focus. From a policy perspective, the holistic focus of wellbeing permits consideration of an integrated and joined up approach to policy-making and implementation. White (2010) further adds that a focus on wellbeing may well encourage one to resist defining people only in terms of their needs or as Higgs et al (2003) note avoid conflating, "...diseases associated with older age with the experience of older age..." (p.242). This review will stick to the term 'wellbeing' unless making reference to specific concepts. The next section discusses key conceptions of wellbeing that underpin literature pertaining to older people.

### **3.3 Various conceptions of wellbeing**

Recognition of the multifaceted and complex nature of human life has directed attention towards approaches that strive to acknowledge,

capture, and contribute to an understanding of the multidimensional nature of wellbeing. In line with this, wellbeing of older people has been variously defined and captured across both domestic and supported settings. This section reviews literature that explicitly describes and explores different conceptions of wellbeing in relation to older people and includes: conceptions of wellbeing in terms of health related quality of life, quality of life, capabilities, lay perspectives, subjective wellbeing approach, and ecological/place-based perspectives.

Though health related quality of life is understood as being distinct from broader quality of life concept (Bowling 1997; Smith et al 2004), the concept is nevertheless multidimensional. It is underpinned by the framework of World Health Organization's definition of health drafted in the preamble of its constitution: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1946:1). Health related quality of life has been understood as the effect of disease or illness and treatment on daily life and incorporates physical, social and psychological dimensions of health (Stewart and King 1991).

There are, however, variations within the conceptualisation of health related quality of life. Some understand it more as a psychological construct (Raphael 1996) that is concerned with individual's judgement and experience of impact of illness and treatment on daily life in terms of overall life satisfaction, self-esteem and self-rated health perceptions. Others conceptualize health related quality of life primarily in terms of 'functional effects on patients of an illness and its consequent therapy' (Rejeski and Mihalko 2001). As such, generic measures of health status such as, Short Form Health Survey (SF-36) that includes physical and mental health dimensions as well as disease specific measures for

specific populations who have cancer, arthritis, stroke, heart failure etc., have been utilised (Hambelton, Keeling and Mckenzie 2008).

In defining quality of life, some have focussed on the attributes of quality of life that are distinct from influences (proxies) upon quality of life and have been derived both theoretically and empirically (Higgs et al 2003; Grewal et al 2006). In defining and exploring quality of life both studies have explicitly moved beyond the 'what' (influences) to explore 'why' (attributes) of what gives or makes life worthwhile. For example, health, relationships and/or money are seen as influences that are variously associated with attributes such as, freedom to do and be, to express and reciprocate love and friendships, for enjoyment, and in enabling a sense of security etc. Higgs and colleagues draw upon Maslow's (1962) 'theory of human needs' (Doyal and Gough 1991) and Peter Laslett's (1989) conception of 'third age' to define that quality of life is about meeting human needs and, "...QoL should be assessed as the degree that human needs are satisfied" (Higgs et al 2003:243). Four domains of need have been identified and built into a scale referred to as CASP-19: control, autonomy, pleasure and self-realisation.

Grewal and colleagues (2006) too focusing on empirical accounts of attributes of quality of life of older people interpreted their findings drawing upon the capability approach (Sen 2009), another way of conceptualising wellbeing. The capability approach (Nussbaum 2000; Sen 2009) sees capabilities as the essence of wellbeing, i.e., the freedom to pursue and achieve various valued functionings (and to which I return again later in detail in chapter 4). They found clear parallels between their work and the notion of 'functionings' and 'capabilities' outlined in the capability approach. The attributes of quality of life identified from their empirical work such as, security, attachment, enjoyment, role etc.

were 'functionings' (what a person may do or be, for instance, feeling (in)secure, being healthy). But, it was 'capabilities' (what a person is able to do and be) to achieve various functionings (of being secure or healthy) that emerged as being significant from their work.

Others have drawn upon lay perspectives grounded in older peoples' accounts (Bryant et al 2001; Bowling and Gabriel 2007). Wellbeing from lay perspectives is defined, '... through the eyes of the people who experience it themselves (Nordbakke and Schwanen 2014: 115) but further seeks to understand what aspects constitute wellbeing and in what way. Still others have defined wellbeing in terms of pleasure, satisfaction, happiness, and affect (mood) either in relation to one's life as a whole or satisfaction in relation to particular domains (Diener 2009, Wilkinson et al 2012; de Quandros-wander et al 2014) as per the subjective wellbeing approach within Psychology. Global measures (e.g. life satisfaction scale) for assessing satisfaction, affect etc., have been developed and are widely used across various disciplines though more prominently in health and psychology disciplines. Ease of use of such scales is one reason contributing to their wide usage (Nordbakke and Schwanen 2014).

A substantial amount of literature on older people is defined by how it is measured or operationalized (Netuveli and Blane 2008). Hence, a lot of work defines wellbeing by a particular domain or a number of domains such as, health, social relationships, autonomy, physical environment, activities etc., empirically derived (Ball et al 2000; Hambleton, Keeling and McKenzie 2008) or externally determined (Mitchell and Kemp 2000; Hall et al 2011). The domain of health itself is multifaceted and variously understood in terms of both physical and mental health or functioning, one or the other, or in terms of social functioning. In exploring and(or)

assessing domains that contribute to wellbeing, this literature offers a rich coverage of the kind of things that matter to older people in different contexts (e.g., living in different types of settings, socio-economic context) and circumstances (e.g., older people receiving high or low level of support services, older people with chronic illnesses).

Environmental gerontologists and geographers have highlighted the central role of human-environment interactions in wellbeing (Lawton 1991; Atkinson, Painter and Fuller 2012). In giving a central role to the environment, Lawton (1991) conceptualized quality of life as, “the multidimensional evaluation, by both intrapersonal and social-normative criteria, of the person–environment system of an individual in time past, current and anticipated” (p.6). He specified four overlapping dimensions of behavioural competence (understood as biological health, sensation, perception, motor behaviour and cognition), perceived quality of life (as satisfaction with major life domains), psychological wellbeing (as positive and negative affect) and the external environment (physical, social and cultural). However, as Netuveli and Blane (2008) and others note, quality of life in Lawton’s conceptualisation is understood primarily as psychological construct defined in terms of global measures of satisfaction and affect.

Concepts of place and space are central to wellbeing in human and health geography. Place is emergent, relational and understood as a process (Massey 1994; Duff 2011) and to which I return later in chapter 4. Hall (2010) notes that wellbeing is, ‘is an ‘individually judged, yet socially experienced, state of happiness, freedom, safety and capability, shaped by interrelations with social, cultural (and natural) environments’ (p. 277). Place based approaches tend towards contextualised understandings of wellbeing.

Others have also highlighted the importance of contextualised accounts of wellbeing. Findings suggest that older peoples' interpretations of the same aspect, for instance, health, safety & security, etc., are highly contextual (Gooberman-Hill, Ayis and Ebrahim, 2003). Milte et al (2014) in exploring why safety and security was ranked as being important highlighted how safety and security for some was grounded in the context of their home and neighbourhood, for some others in context of driving, and, still others interpreted safety and security in the context of their physical health. Contextualised interpretations in addition also reveal the differential emphasis that people place on broadly similar things that matter to them. Hendry and McVittie (2004) and others further note that quantitative accounts using global assessment measures, such as, life satisfaction scales run the risk of ignoring the breadth of contextual influences within which older people describe their experiences of wellbeing.

More broadly, however, research engagement with multidimensional notions of wellbeing confirms that individual notions of wellbeing are plural and that older people might value many things in their lives. Wellbeing research also sensitizes the researcher to a wide range of domains that might matter for wellbeing (including amongst others though not limited to): social relationships, health (physical and mental), participation in meaningful leisure and social activities, safety& security, autonomy, independence and control over environment, personal outlook and attitudes towards life, material and financial resources, physical and social environment, religion/spirituality, demographic factors (age, gender, marital status), dignity and caring practices (formal and informal).



Underpinned by the above mentioned and different conceptualisations of wellbeing, a large body of literature on wellbeing of older people is concerned with understanding the impact, influence and (or) contribution of particular domains on wellbeing. The next few sections review and discuss such literature under the following broad headings of health related quality of life, psychological perspectives, social perspectives, ecological perspectives and person-centred perspectives. I do not see these perspectives as mutually exclusive, rather, the intent is to understand and highlight the differential emphasis that each perspective brings to researching wellbeing.

### **3.3.1 Health related quality of life**

Contemporary health related quality of life research has variously attended to impact of: (1) psychological wellbeing (defined as 'vitality') on self-rated health (Burns et al 2014); (2) stroke on morale (Niklasson, Loveheim and Gustafson 2014); (3) vision and hearing impairment on vision specific quality of life, physical health, and mental distress (Lamoureux et al 2009; Li et al 2011); (4) multiple chronic diseases on health related quality of life and psychological distress (Walker 2007); (5) chronic pain on health related quality of life (measures of physical and mental health) (Willman et al 2013); (6) physical activity on health status of older people with chronic conditions (Sawatzky et al 2007); (7) physical ability on mental wellbeing (Cooper et al 2014); and, (8) the role of physical activity and exercise in improving the psychological wellbeing (self-reported physical and mental health) amongst residents of residential care homes (Cairano, Luibicich and Rabaglietti 2010).

The review of health related quality of life of older people undertaken here is by no means exhaustive. However, what is evident is that wellbeing is primarily understood as a physical and/or psychological

construct, measured using single and multiple item scales and is grounded within the context of medical conditions and health status.

Health related quality of life studies confirm that for older people, single, multiple, chronic health conditions, and pain are associated with reduced physical capacity, poor psychological wellbeing, and, depression. This view of wellbeing defined in terms of functional impacts of illness and its management is however provided at specific older population level. Key criticisms therefore include questions about: the limited view of wellbeing (Flick et al 2003; Stanley and Cheek 2003; Prahruiger 2010); a universalist stance where the role of the social, material or wider contexts and its influence if any on the experience of living with or managing health conditions across individual lives is ignored (Smith and King 2009); and, linked to this is the difficulty of generalising from global self assessment measures (e.g., mental wellbeing scale, morale scale) that offer a collated response to individual judgments of experiences.

Use of clinical measures, diagnostic and standardized terms to measure wellbeing (for example, tug speed, grip strength etc. to denote physical ability or distance vision acuity, near vision acuity or contrast sensitivity for visual impairment) do not offer an understanding of how what is measured maps on to a person's experiences. They also do no support consideration of consequences and implications of how these differentially affect peoples' lives.

There are however exceptions. Stevenson et al (2004) in a study of the impact of visual impairment (brought on by onset of age related macular degeneration) on older peoples' ability to care for self and/or as a carer questioned the use of clinical measures of vision both as biomedical markers of visual disability and as the primary indicator for receipt of

statutory support services. They found that self-reported measures of physical health and visual functioning were better at distinguishing between, older people who could care for themselves and for others, from those, who could not care for self, or, could only care for self, than, clinical measures of vision.

Though at a population level, Courtney et al (2003) importantly draw attention to the heterogeneity amongst older populations vis-a-vis the use of health related quality of life measures. They along with others note that health related quality of life measures with a strong focus on illness and physical functioning may not be suitable for capturing the wellbeing of older people living in care settings as physical and mental health issues are central to this groups' requirement for care in the first instance.

### **3.3.2 Psychological perspectives**

Within this body of literature the emphasis is on psychological aspects such as, control, acceptance, mastery. These works also utilize a variety of terms and measures in conceptualising and operationalising wellbeing. Some have investigated: the influence of perceived control (de Quandros-wander et al 2014), psychological acceptance (Butler and Ciarrochi 2007), and the mediating role of psychological resources (Windle and Woods 2004; Jonker et al 2009) on life satisfaction and quality of life.

Interest and emphasis in psychological aspects such as perceived control, mastery, self-efficacy and self-esteem in influencing wellbeing have arisen from findings that indicate high levels of wellbeing of older people despite declining health and decreasing social networks (Netuveli and Blane 2008). Within this context, psychological resources are understood

as promoting adaptation to adversities of life and acceptance of what cannot be changed. Adaptation has been variously described in terms of Baltes' (1993) 'theory of selective optimisation with compensation' to explain how older people deal with more losses and fewer gains; and, in terms of assimilative and accommodative strategies (Brandsta'dter and Greve 1994) that older people employ in coping with losses, whereby, they change their values or ideas about wellbeing. Cummins and Nistico's (2002) 'homeostatic theory' highlights the role of buffering mechanisms such as perceived control, positive self-concept and positive outlook in maintaining wellbeing.

Some have highlighted the significance of perceived control for life satisfaction amongst older people and in particular, the role of acceptance (secondary control) of what cannot be changed in the domains of health and productivity (understood as participation in activities) (Butler and Ciarrochi 2007). Windle and Woods (2004) note that older people with a high sense of mastery reported higher levels of life satisfaction despite health and housing problems. Jonker et al (2009) in a longitudinal study examined the role of availability of coping resources (self efficacy, mastery and self esteem) in explaining the association between persistent health decline and life satisfaction. Their findings suggest that coping resources are not inexhaustible and people who experience persistent health decline over time also experience a decrease in coping resources.

Not underestimating the importance of psychological resources in promoting adaptation and acceptance to health problems, none of the above studies however, locate the individual as well as their claim to psychological resources within their material and social context. It is not difficult to imagine that the coping resources of an older person who for

instance, has health problems and(or) impairments as well as less material and social resources will be very different from another older person who too has physical health problems and(or) impairments, but, at the same time, has sufficient material and social resources.

### **3.3.3 Social perspectives**

Another body of literature underscores the importance of social relationships, networks, social support, participation, and engagement in contributing to the wellbeing of older people. Wellbeing is assessed in terms of loneliness, depression, morale, positive and negative affect (Litwin 2001; Almedom 2005) and physical health and functioning (Holt-Lunstad et al 2010). Research evidence reveals that relationship with family and friends is an important and valued domain in quality of life studies on older people with profound implications for both physical and mental health.

Merz and Huxhold (2010) highlight the role of social relationships (family, friends and neighbours) in providing emotional and instrumental support to older people. They however importantly note that social relationship characteristics and in particular the quality of relationship mediates the association between support and wellbeing. Forsman et al (2013) in a study with older people living in domestic and supported settings explore the mechanisms through which social capital (defined as social networks, social participation and trust) influences the mental wellbeing of older people. The authors confirm that family and life-long friends were cited as the most valued relationships. These relationships were important for the security, love, support and trust that was shared within them as well as provided the social context. Participation in meaningful social activities emerged as being significant

for imparting a sense of purpose, maintenance of social skills and creating a sense of belonging.

Duner and Nordstrom (2007) explore the role of informal support networks (defined in terms of size and structure, function and interactions) in providing practical, emotional and instrumental support for older people who also receive formal care. Their findings note that older people who had a fairly reliable informal support network (comprising of family, friends and/or neighbours) felt they had more control and choices, felt more secure vis a vis those who were totally reliant on formal care. Availability of formal care did not decrease informal support giving but where older people and their families did not enjoy a good relationship, support receiving, giving, and wellbeing were negatively affected.

Research also draws attention to the role of geographic proximity between older people and their children in facilitating contact, interaction, mutual support, and reciprocity (Mulder and Van der Meer 2009). It has however been pointed out that for some types of support geographic proximity is important, for instance, looking after grandchildren, support with household chores but, for emotional, legal and financial support, geographic proximity is not an essential precondition.

The evidence on whether supported settings being communal in nature are conducive to formation and development of new relationships is contested (Percival 2001). Park et al (2012) draw attention to challenges of building new relationships in assisted living facilities. Their findings reveal that while maintenance of family and friend relationships was not difficult building new relationships with other residents was not so easy,

although, residents developed positive relationships with staff. Individual and contextual factors were at play. Reciprocity, expected losses of newly built relationships through death or discharge put residents off from investing in these relationships. Inability of many to communicate as well as the social environment of the facility influenced social interaction and formation of new relationships.

Percival (2001) in a study of social interaction in sheltered housing focusing on the self-concept notes that while some residents find the communal experience conducive to developing new relationships, others do not. Motivation for social interaction and formation of relationships was related to self-esteem. For some, interacting with others was meaningful and important to their sense of self, such as supporting a sociable identity, reducing loneliness, have someone to speak to and reminisce about things. For others, living with older people with whom they had nothing to share, maintaining a physical and social distance from frail and disabled older people to maintain a positive self-image, affected, the motivation to interact and communicate.

Older people are vulnerable to social isolation and loneliness. Functional limitations, loss of social relationships, and low self-esteem has been found to be negatively and independently associated with loneliness and social isolation (Van Belijouw et al 2014; Dahlberg and McKee 2014). Loneliness and social isolation is also associated with depression and poor physical health (Golden et al 2009). Separate studies note that where mediators and resources such as social networks, support or other resources (e.g., poor social skills, material resources, adequate transport and knowledge about support networks) are not available, ability to maintain or form new contacts is constrained.

Loneliness and social isolation in turn negatively impact physical and mental health (Hawton et al 2011).

The association between gender and loneliness is not clear, with some suggesting that older women experience higher levels of loneliness than older men (Cohen-Mansfield, Shmotkin, and Goldberg 2009). However, as Stone, Evandrou and Falkingham (2013) note that living alone for women may not in all instances translate into loneliness or depression. They highlight the need to take into consideration quality of social relationships preceding the status to living alone.

Some have also explored how building social identification can contribute to wellbeing and a stronger sense of self. Within the context of care settings, Gleibs et al (2011) have considered the social isolation of older men in care settings and demonstrated that group based interventions drawing upon a social identity approach in the form of a men's club could contribute to psychological wellbeing. They note that older men in care settings are particularly disadvantaged. There are fewer men in care settings, as well as older men find it relatively difficult to draw support and develop relationships than women. At the same time, some may experience a conflict between the ageing and male stereotype identity and which together could contribute to social isolation.

Tackling both social isolation and loneliness is squarely a public health concern and firmly on the policy (Scottish Government 2011) and practice (Age UK 2010) agenda with a shift towards prevention. Aligned with this is the discourse of active and positive ageing. Underpinning the policy initiatives are the recurrent themes of 'ageing as an opportunity', older people as 'assets', and 'empowered and active participants of societies and labour markets', as evidenced from the various Scottish



government documents (Scottish Government 2003, 2006, 2007a, 2011; JIT 2014).

Ranges of initiatives to tackle social isolation, loneliness and to encourage health promotion have been implemented (Collins 2014). These include one to one interventions such as befriending services or social group interventions such as lunch clubs, art activities, physical exercise etc. Studies have variously explored and highlighted the role of participation in group activities in promoting psychological and social wellbeing (Creech et al 2013; Habron et al 2013); and, the mediating role of leisure in reducing isolation and improving social connectedness (Toepel 2013). Sense of control, purpose, autonomy, increased opportunity for identity making, and social affiliation was related with participation in music making.

The role of meaningful occupation in promoting wellbeing particularly in supported settings has repeatedly been highlighted by various studies. Toepel (2013) examined how social connectedness of older people could be increased via their participation in leisure activities. Their findings indicate that close social relationships (partners, children, siblings, and friends) by way of encouragement as well as taking the initiative to arrange social and leisure pursuits could stimulate older people to participate.

Tetley et al (2007) however highlight that there could be a range of barriers to participation. Their study explored activity participation amongst residents of sheltered housing and found that loss of confidence, lack of knowledge about accessing various activities, and resources together with issues of transportation acted as barriers to participation. Their study emphasized the need for provision of more in

house activities. While on one hand, a variety of policy initiatives to tackle social isolation and promote health promotion are being produced, on the other hand as Gilroy (2012) observes, the rationing of services has led to closure of collective public spaces such as lunch clubs, and day centres as well as loss of warden services in sheltered settings that are much valued by older people.

Fenge et al (2012) similarly highlight that in the context of economic recession financial constraints reduce older peoples' opportunities to engage in ways of life and activities that matter to them with negative implications for physical, social, and psychological wellbeing. For example, many older people in their study spoke about stopping attendance at luncheon clubs or reducing the number of 'meals on wheels' they receive due to the issue of cost rather than preference.

The links between mobility and wellbeing are well established and some (Schwanen and Ziegler 2011) point out that mobility to older people means more than getting from A to B. The free bus travel policy in UK has as Green, Jones and Roberts (2014) note in a study of older people in London not only provided affordable and accessible means of getting from one place to another but at the same older people described the benefits it offered in terms of opportunity for social interaction, visibility in the public sphere, as a strategy to reducing loneliness and encouraging participation in the life of the city. However, Age Scotland's 'Still Waiting to End Transport Isolation' campaign (launched in Feb 2013) draws attention to the heterogeneity amongst older people and their circumstances in arguing for more diversity in the provision of transport. They note that for many older people in Scotland the free bus pass does not mean much as some live in areas that are poorly serviced by buses or cannot use the bus due to poor health and impairment.

There is therefore a need to take into account individual differences, contexts, motivations, and preferences in relation to social participation. Park et al (2012) note that amongst those living in assisted facilities, some chose not to participate in social activities, and some others expressed preference for social engagement outside the facility. Others (Cattan et al 2005, 2011) point out that some may not be able to participate in-group activities due to various functional limitations and as such may prefer one- to- one activity.

Evans and Vallely (2007) examined social wellbeing in extra care housing schemes and noted the need for a creative range of activity types to cater to diverse interests and functional abilities of older people. Croucher, Hicks and Jackson (2006) highlight that while the benefits of user led or tenant led approaches to organising social activities has obvious benefits of increased participation in line with preferences of the older people themselves, this may be context dependent. Some older people (who were older and less active) in their study expected, as well as, expressed a desire for social activities being organized for them and bring into focus the role of wardens in sheltered settings.

Notwithstanding active ageing discourses, Nilsson, Lundgren and Liliequist (2012) undertook a qualitative study of engagement and wellbeing of older people aged 90 years and above living in domestic settings from an occupational perspective. Their findings indicated that occupational engagement included: a mix of active interaction and engagement with others; participation in valued activities (including activities such as, being able to care for self, being neat and clean, properly attired); as well as the more passive, less obvious meditative contemplation such as thinking about the life lived and planning for

future. Some resisted the activity-dominated discourse while others pointed out that whilst their engagement had declined, the value they placed on doing things too had changed, become less important. A situated understanding of ideas about meaningful activities and participation in light of personal values, changing circumstances and contextual influences is hence called for.

### **3.3.4 Environmental perspectives**

A common underlying theme within environmental perspectives relates to expanding the understanding of older person-place relationship and particularly, how where people live affects their wellbeing (Andrews et al 2007; Duff 2011). As such research has variously engaged with neighbourhoods, homes, housing, and supported settings, focused either on a specific place dimension or a combination of dimensions of place, i.e., physical, social, symbolic and/or cultural, to examine and explore the role of place in producing wellbeing. Wellbeing itself has been framed and conceptualized in particular and diverse ways. However, Gilroy (2008) emphasizes the need to deepen our understanding of older people-place relationships - as negative influences on wellbeing may originate in the places where older people live and may not in all instances arise from age or health related issues.

One body of research has sought to explore the relationship between neighbourhoods and wellbeing of older people and within this area of inquiry two strands of literature have emerged. The first strand relates to the role of place (neighbourhoods) in influencing health inequalities or promoting health at the area level and the second though similarly focused on the scale of the neighbourhood examines relationships specifically between the built environment and health. Within the first strand, where earlier work (for example, Balfour and Kaplan 2002; Glass

and Balfour 2003) has focussed on dimensions of neighbourhoods that potentially might influence wellbeing, later and more recent work has added experiential and cultural dimensions of place (e.g., concepts of place attachment, place identity) to examine the influence of neighbourhoods on older peoples' health and wellbeing (for example, Gilleard, Hyde and Higgs 2007; Walker and Hiller 2007).

Neighbourhoods are typically assumed to hold an important place in the lives of older people. Neighbourhoods might be important because older people may have lived in a particular neighbourhood for a long time, and also, because health decline may be reflected in contracting spatial environment. Social capital as mediating the pathway between where older people live and their health (physical or mental) has been used to understand how places influence health (Walker and Hillier 2007; Gale et al 2011). One set of findings suggest that material and social features of the area influence social functioning and those living in less affluent areas were less likely to participate in social activities (Bowling and Stafford 2007).

Others have investigated the influence of neighbourhood cohesion (individual attachment to the neighbourhood including social interaction) on mental wellbeing (quantified using the mental wellbeing scale) in deprived neighbourhoods (Gale et al 2011). They found that the perception of neighbourhood cohesion was strongly associated with high levels of mental wellbeing than with neighbourhood deprivation. Their study suggests the need to incorporate individual attributes and the experiential dimensions of place in future research.

Another set of studies investigating associations between the neighbourhood and older people have been framed with the ecological

model of ageing (Oswald, Hieber, Wahl & Mollenkopf 2005; Yen et al 2012). Within this model, the relationship between place and older people is described functionally in terms of fit, competence and adaptation between the person and their environment. Oswald and colleagues (2005) note that fit between one's perceived housing needs and housing condition explains attachment to neighbourhood, however their conception of the neighbourhood does not go beyond the immediate environment outside the residence.

Gilleard, Hyde and Higgs (2007) however, provide evidence to suggest that while older people express attachment to place it does not necessarily contribute to wellbeing. It must also be taken into account that Oswald and colleagues (2005) use 'place attachment' as an indicator of quality of life while Gilleard and colleagues (2007) define wellbeing in terms of ability to enhance opportunities for control, autonomy, pleasure and self-realisation. Place attachment in itself therefore may not be sufficient to explain quality of life. A review of the above literature also highlights the different operational definitions of neighbourhood, different conceptions and methods of measuring health and (or) wellbeing (physical functioning, social functioning, mental wellbeing, place attachment, quality of life) and variations in the inclusion of contextual and/or compositional factors. This in turn means that findings from various studies have to be interpreted with caution.

Although there is a broader shift in the understanding of person-place relationships that acknowledges the role of both contextual (area related factors) and compositional factors (individual attributes) in shaping wellbeing (Macintyre and Ellaway 2003; Bernard et al 2007) exactly how these interactions occur is still unclear. Criticisms of the role of place in influencing wellbeing have been levelled at the often reductionist view of

place as space and a passive backdrop, thereby ignoring the complex meanings and processes associated with places (Cutchin 2003; Cummins et al 2007); some have reflected on the complexity of person-place interactions in whether place effects on individual health can be readily disentangled at (neighbourhood) geographical scale (Ohlsson and Merlo 2011).

Some measures of social capital are also problematic and not clearly defined. Whilst (Bowling and Stafford 2007) examine social contacts which ask questions about family and friends, these are then mapped on to the geographical scale of the neighbourhood in which the older person lives. There is an assumption here that family and friends live within the same geographical boundary or that neighbours are friends, which may or may not be applicable to all. Smith et al (2004) note that whilst environmental factors influence wellbeing, it may well be indirect as well as individually judged and experienced within situated contexts. There is hence an argument for more relational and situated conceptions of place (Cummins et al 2007), "...to move away from empirical research designed to distinguish between contextual and compositional effects and instead concentrate on the processes and interactions occurring between people and places and over time which may be important for health" (p.1828). Studies utilising perspectives (implicitly or explicitly) that move away from dualistic interpretations of people and place to seeing both as integral to understanding of either or both are few.

Yen et al (2012), drawing on Wahl and Oswald (2010), extend the 'ecological model of ageing' to understand the relationship between the neighbourhood and health. By envisaging the nature of people-place relationships as dynamic, they explored the notion of place attachment qualitatively through the lens of activity in ethnically diverse

neighbourhoods. They noted diversity in neighbourhood relationships from distant to very close. Factors such as age, ethnicity, changing composition of neighbourhood contributed to feelings of attachment or physical and social distancing as well as whether neighbours are seen as a resource or as a constraint. Mobility, social connectedness, and being active mattered to their research sample and was related to places beyond the neighbourhood, thereby bringing into focus the issue of scale and problems of administratively defined neighbourhood units. Their research however drew upon a sample with relatively good self-reported health status as well as excluded older people living in deprived neighbourhoods.

Walker and Hillier (2007) in a qualitative study explored neighbourhood experiences (affluent and less affluent areas) of older women living alone and its relationship to health drawing upon notions of social capital and experiential dimension of place (in health geography). Their research highlights that neighbourhood relationships were potentially diverse ranging from low- level contact (such as taking mail etc.) to socialising, or, no contact, but neighbours played an important role in promoting a sense of security regardless of socioeconomic status of the area. Neighbourhood experiences comprised of inter-related dimensions of the physical, social and symbolic aspects of the neighbourhood. No contact with neighbours was for some voluntary and for others restricted by their mobility as well as high turnover of residents in the neighbourhood.

Ziegler (2012) undertook an intersectional life course analysis using in-depth case studies of two older women living in deprived neighbourhoods to understand how the social and physical environment impacts upon social participation in later life. She draws upon relational



notions of place (see Massey 1994; Pile and Thrift 1995 and to which I return in chapter 4) that collapse the dualism between binaries of structure and agency, focusing attention on the processes that shape social participation over time and space. The study findings highlight that for these women, social interaction and participation was not practiced in the informal everyday spaces of the neighbourhood they lived in, but in age exclusive social clubs. The author points out that broader contextual changes (more cars, changing composition of neighbourhoods, intergenerational distance) interact with situated contexts of age, class and gender to shape opportunities for social interaction and in turn produce spatially segregated places for social participation and that are valued.

The second strand of research within the neighbourhood –older person relationship is framed within broader urban development frameworks which brings together ideas about place making such as notion of ‘healthy cities’, ‘lifetime neighbourhoods’ (DCLG 2007) underpinned by themes of accessibility, sustainability and universal design. The impetus to understanding specific challenges of older people in relation to their environment has however emerged from the WHO’s (2007) adoption of the concept of ‘age-friendly cities’ with older people as a particular priority in supporting active ageing as well addressing the challenges of population ageing.

In supporting ageing in place, the concept of age-friendly environments has become prominent (Emlet and Mocerri 2012) and has been adopted by many cities around the world. A number of domains too have been identified by WHO (2007) including outdoor environment, transport, housing, social participation, respect and social exclusion, civic participation and employment, communication and information and

community support and health services. Within this broader context, research has focused variously on housing related issues (Howden-Chapman, Chandola, Stafford and Marmot 2011), outdoor environments (Day 2008; King et al 2011), transport and mobility (Schwanen and Zielger, 2011; Clarke and Gallagher 2013), as well as, design aspects of neighbourhoods and supported settings in relation to safety and security (De Donder et al 2013).

The links between housing and health are well established (Harrison and Heywood 2000). There is evidence that housing related problems affect both physical and mental health (Mitchell, Blane, and Bartley 2002). House ownership is usually associated both with personal, social and material advantages. Howden-Chapman et al (2011) in a longitudinal quantitative study of older house owners however, note that poor mental health could be an outcome of poor housing quality interacting with differential financial abilities of older people to deal with housing problems. Hence, housing maintenance and ownership might constitute a burden rather than a resource for some.

Means (2007) on the other hand, cites the case of older tenants in the private rented sector. He argues that despite a range of legal frameworks to safeguard them, older tenants in private rented sector may be vulnerable to financial abuse, harassment, eviction and live in poor housing conditions due to failure to repair properties by landlords. He notes that although specialist advice to support such older tenants through various legal processes is available, it is however limited. There is however a recognition of housing quality issues for older people and a range of policies such as, Care and Repair, Fuel poverty, Central heating programs have been put in place to support older people (Department of Health 2005; Scottish Government 2007b).

The role of outdoor environments has received considerable attention in providing a supportive and barrier free environment for older people. Barriers posed by built environment have been understood in terms of reduced opportunities for walking and physical activity (King et al 2011) lack of availability of services and amenities (Vine, Buys and Aird 2012), and fear of going outdoors because of poor built quality of the outdoor environment together with the fear of falling (Nyman et al 2013). Barriers studied include lack of resting places, noisy traffic, dangerous crossroads, hilly terrain and poor street conditions (Rantakokko et al 2010) and whether neighbourhood designs were walking friendly or not (King et al 2011). While many have focused on older people who are ambulatory some have also looked at those with functional impairments. Clarke and Gallagher (2013) noted variations in outdoor mobility of frail older people with various functional limitations living in disadvantaged neighbourhoods. Their findings suggest that functional impairments together with barriers to access to outside (lifts that don't work, steep steps, unsafe flooring) make some older people housebound.

Some studies suggest that links between availability of neighbourhood amenities and its use by older people are complex (Vine, Buys and Aird 2012). A range of factors such as the availability of good public transport, convenience of using the bus, distance from nearest bus stop, local topography that discouraged walking, and issues of affordability in relation to grocery shopping all contributed to going out beyond the neighbourhood for everyday activities. However, most studies do not clarify what neighbourhood facilities are available and what if any of these facilities (except grocery shopping) are being accessed outside the neighbourhood.

Out of home mobility is positively correlated to wellbeing (Schwanen and Zielger 2011). Findings also indicate the inherent value placed on car as it allows freedom and ease of movement to pursue a range of activities, fulfil social roles, and promote social participation. The impact of driving cessation however, not only has wide ranging implications for ways of life and living but, for some, it also has negative implications for their the sense of self. Schwanen and Ziegler (2011) focusing on contextualised notions of mobility further note that though reduced mobility in terms of getting from A to B may result in lower levels of wellbeing, however, this may not be a generic outcome. Motivation, availability of resources, physical and social environment, and personal meanings associated with mobility can modify the links between wellbeing and mobility.

Nordbakke (2013) drawing upon the Amartya Sen's capability approach explored the capability for mobility in relation to out of home activities amongst older women in urban areas in Norway. Capability for mobility was understood as comprising of individual resources, strategies, and contextual conditions that enhance opportunities to be mobile and participate in activities as and when one wishes to. Her study noted that capability for mobility was variably shaped by interaction between individual resources (having a car, skill of driving, knowledge and competence in relation to travelling by public transport) and contextual factors (availability of public transport facilities, the type of activity being pursued, its spatial and temporal characteristics).

There is some evidence that perceived physical aspects of the neighbourhood can contribute to feeling (in) secure and (un)safe (De Donder et al 2013). The authors suggest some role for physical aspects but not independently of the social aspects of the neighbourhood. Others

have argued that the links between built environment, neighbourhood crime, perceptions of safety, and, going outdoors are not so straightforward (Foster and Giles-Corti 2008). In reviewing literature on these associations, they highlight that while individual characteristics, socio-environmental factors, and design aspects are seen as potential influences, however the evidence is inconclusive. Inconsistencies were noted in terms of not making explicit what makes people feel unsafe, such as, physical vulnerability, crime, traffic, dogs etc., and thereby ignoring what dimensions of safety or security need to be addressed. Additionally, they found a lack of clarity regarding whether concerns of safety are being discussed in relation to and limited to the neighbourhood or places beyond the neighbourhood.

Others have (Sugiyama and Thompson 2007; Clarke and Nieuwenhuijsen 2009) argued that the focus more than often is on characteristics of environment. Characteristics of individuals in terms of activities that are important to them, personal characteristics, social and material contexts are often ignored as is the fact that some may not have the confidence to do things or activities on their own.

A number of studies have also focused on the scale of setting (domestic and supported) to understanding the role of physical space and home environment in contributing to continuity, identity, control (Percival 2002; Sixsmith et al 2014) and capabilities (Gilroy 2005). The importance of space to older people's identity, mobility, and, social relationships in both mainstream and supported settings has been highlighted. Percival (2002) notes how space was variably important to: entertain guests; to accommodate family who did not live close by; to support free movement particularly for those on wheelchairs; to keep up routines despite relocating, such as, continuing to eat at the table, to

showcase personal possessions, engaging in leisure activities, and for undertaking housework. For those who valued homemaking and saw themselves as homemakers, limited housing space was preferred, while, for people who were functionally impaired, valued entertaining, needed extra room for their family or could not continue to engage in routines, lack of or limited space was an issue.

Gilroy (2005) draws attention to the UK housing space standards, particularly, in sheltered and care home settings. Her study captures and demonstrates how poor housing space standards contribute to negatively influencing a number of capabilities such as, capability for affiliation, control, emotions and play (drawing upon Nussbaum 2000). Both the above studies highlight diversity in uses and meanings attached to domestic spaces in accordance with valued priorities and identities. Not being able to personalize space, have adequate amount of space or difficulty in accessing space can be detrimental for both control over the use of space and the older person's sense of self.

Sixsmith et al (2014) examined the role of the home environment in supporting healthy ageing. Healthy or active ageing has been referred to by some as a 'process' of maintaining health (broadly understood) so as to contribute to quality of life (Bryant, Corbett and Kutner 2001; Malderen et al 2013). Their findings suggest that healthy ageing held diverse meanings and included physical, social, functional, and psychological dimensions. Personal interpretations and experiences of healthy ageing were at once varied and complex and the home environment did not connote the same and positive meaning to all participants. Such research reminds us that homes however desirable can also contribute to isolation and loneliness for some.

Issues of choice, control, identity, feelings of loneliness, meaningful activities as well as maintenance of social relationships are not limited to older people in domestic settings. Quality of life studies and role of active ageing in contributing to quality of life in supported settings too have highlighted the role of social and physical environment of the facility in contributing to matters of choice, control and identity (Ball et al 2000; Cooney 2012) as well as promoting opportunities for maintenance and development of social relationships and reducing feelings of loneliness (Prieto-Flores et al 2011). The importance of paying attention to older peoples' identities, life histories and preferences in contributing to wellbeing has been repeatedly highlighted by this research.

The value attached to physical space even though scaled down to that of a room does not diminish in residential care settings and is seen as an important and valued expression of personal identity. Rules and regulations of the facility at times may work to reduce residents' choices as well as sense of control in relation to eating, choosing what to wear, when to get up or how to spend time. Whilst the communal nature of the facility is seen as offering opportunities for interaction, the need to take note of individual preferences and varying abilities in relation to activities has also been pointed out. Some have noted that participation in meaningful activities by influencing enjoyment and one's personal identity can produce wellbeing (Cutchin 2003).

Not denying that the home or supported setting might be the locus of activities for some, research on neighbourhood and other studies on home (Ewart and Luck 2013; Sixsmith et al 2014) and supported settings (Park et al 2012) also point to the increasing role of outdoors. A study of older people living in sheltered housing in a deprived estate in England noted that while some had a preference for social activities to be

provided in-house, others expressed a preference for going out for various social activities (Gilroy 2009). Park et al (2012) and Evans and Vallely (2007) similarly note that some older residents in supported settings expressed a desire for social engagement outside the facility.

Attention has also been directed towards the design of supported care settings including residential care settings (Parker et al 2004; Burton and Sheehan 2010), extra care housing schemes (Evans and Vallely 2007) and outdoor spaces (Dahikvist et al 2014) within, with a view to understand and explore how design can influence and promote wellbeing. This literature in viewing design features through a user centred and a wellbeing perspective provides nuanced insights into how design features (e.g., indoor streets with a range of facilities, accessibility to outdoor garden areas, wide circulation spaces) can directly offer opportunities for social interaction and activities, ease of access and way finding, and, indirectly, contribute to (or not) to the older person's sense of control over the immediate environment. But equally, what this research also brings to fore is the complexity and challenge in making design interventions that have to cater to a broad range of older people with different types and levels of impairments.

Parker et al (2004) in a study of various types of residential care settings in England pointed out that building standards were geared towards physical needs rather than wellbeing. Their study highlighted the role of building design features, both indoor and outdoor, as well as, the siting of care homes in contributing to privacy, personalisation, choice and control, comfort, supporting social relationships and interactions, safety, as well as, a non-institutional feel. The authors however also point out: 1) the challenges to inclusive design provision in relation to the diverse nature of residents with varying abilities; and, 2) the requirement to



balance security and safety concerns with free movement and which may impact those who are physically but not cognitively impaired.

The role of building design features in contributing to wellbeing is increasingly being recognized. Evans and Vallely (2007) in reviewing social wellbeing in new build extra care housing schemes in England highlight how the incorporation of design features such as, 'indoor streets' offering a range of on site facilities was a social meeting point. The authors also emphasize the importance of siting of extra care housing in relation to accessibility to good public transport in promoting mobility and maintaining engagement with wider community. Building design features have also become an important policy issue from the perspective of difficult to let sheltered housing schemes, as well as, in light of the projected growing demand for supported schemes (Scottish Government 2010).

Person centred perspectives have their origin in policy with the purpose of improving the experience, quality, and delivery of health and social care services (Dowling, Manthrope and Cowley 2006). Wellbeing is therefore also tied to service provision and delivery of health and social care. This perspective has been discussed and elaborated upon in the following section.

### **3.3.5 Person centred perspectives**

Broadly, the guiding principle underpinning person-centred approaches is a holistic focus on the person (McCormack 2003) and not losing sight that behind and beyond the stereotype label of 'patient', 'older person', 'frail and disabled' there is a person (Clarke, Hanson and Ross 2003; Entwistle and Watt 2013). Person centred approaches feature centrally in UK Government policy and encompass both (health) care practices as

well as the provision of (social and health care) services (Mezzich et al 2009).

Within health and social care services, person-centred care and practice has emerged to redress the narrow disease focus that ignores patients' needs, values and interests that are not necessarily limited to illness (Epstein et al 2010). The notion of person-centeredness and personalized services (Ferguson 2007) has multiple meanings: enabling service users to influence how services they receive are designed and delivered; encouraging involvement of family members; paying attention to the person's values and interests rather than a narrow focus on needs as well as, supporting self-management of long term health conditions (Cutler, Waine and Brehony 2007).

The idea of person-centeredness endorses independence, choice, autonomy, inclusion, respect and empowerment as key to making a positive difference to peoples' lives. Quality of life research with older people has highlighted the value placed on these aspects both by older people and providers, although meanings and interpretations are contested.

Within the context of person-centred approaches, literature on older people has focused on: (1) exploring meanings associated with terms 'autonomy' (Boyle 2004; Perkins et al 2012), 'independence' (Hillcoat-Nalletamby 2014) and 'dignity' (Gallagher et al 2006; Hall, Dodd and Higginson 2014) across domestic and supported settings; (2) ways of promoting participation, empowerment and autonomy (Knight, Haslam and Haslam 2010; Bauer and Abma 2012) in supported settings; (3) exploring whether the stated quality of care outcomes capture the quality of life as described by residents in supported settings (Netten et

al 2012); (4) service users perspectives on the quality of care and care experiences (Francis and Netten 2004; Hasson and Arnetz 2011); (5) approaches and models of residential care that promote independence and autonomy (Bland 1999; Peace and Holland 2001), and; (6) the role of interpersonal relationships and communication between care givers and residents in promoting dignity and positive experiences of care (Wilson and Davies 2009; Marsden and Holmes 2014).

Separate studies on meanings of independence, autonomy, and dignity highlight the interlinked nature as well as the differential interpretations of these concepts. These studies also highlight that translating the notion of person centred care into practice might be complex. Hall et al (2014) in exploring views of residents and staff of in care settings note that independence, autonomy, control and choice, privacy, respect, comfort and care, communication, and seeing the person emerged as themes when discussing dignity. The authors observe that staff was aware of the value of fostering dignity in relation to care practices yet, resident views highlighted that it may well be rhetoric rather than reality.

In the context of community care reforms, Boyle (2004) investigated whether older people living at home enjoy more (decisional) autonomy in daily life than those living in supported settings. The author reveals that although staff, formal, and informal carers variously constrained decisional autonomy, people in care settings perceived having more decisional autonomy in daily decisions than those living at home. For those living at home, community care was found to be concentrated on the tasks of personal care. Her study indicated that receiving care at home had not translated into facilitating choice and control in everyday life and the inherent assumption about community care being better than institutional care did not add up.

The role of personnel, regulations, staffing shortages, and the working environment of the care homes in denying older people choice and control over everyday activities and hence, contributing to loss of autonomy, independence and dignity has repeatedly been pointed out. However, what is not sufficiently contextualised is the experience of those older people who do enjoy control and choice. For instance, it is not clear what facilitates it: the physical health of the older person, the ethos and standard of care, personnel, other individual attributes or a combination of factors. Also, while the importance of choice and control cannot and should not be ignored, there is a lack of clarity in whether older people wish to exert choice and control in all spheres of everyday life or some spheres are valued more than others.

Hillcoat-Nalletamby (2014) examines meanings and interpretations of independence across domestic and supported settings and concludes that independence relates to notions of autonomy. The author argues for a nuanced and contextualised understanding of independence rather than simple dichotomies of independence and dependence, a point echoed by others (Fine and Glendinning 2005). She further notes that loss of independence can occur in any context and is not an outcome associated only with communal living although communal settings may provide more opportunities to offset such losses. Perkins et al (2012) in exploring autonomy in assisted living facilities argue for more relational conceptions of autonomy to include dependence, interdependence and relationships. Their findings too suggest that autonomy is experienced and interpreted differentially within a situated material and social context.

Though the idea of person centred care practices is a genuine one, notions of autonomy and independence, however, are not unproblematic. While policy and practice espouse notions of person-centeredness, many, have expressed doubts about the implicit conception of the person that it entails. Service users are assumed to be autonomous, responsible agents, capable of making rational informed choices, thereby, ignoring that people may not be able to or may not desire to do so (Sherwin and Winsby 2011).

In the context of community care schemes promoting individual budgets for older people in managing their care, Moran et al (2013) make three observations: first, that budgets were discriminatory in that amount allocated to older people was much less than what is usually allocated to younger disabled groups; second, that choice and control over how to spend the budgets did not exist as the amounts were only sufficient to cover the cost of personal care leaving nothing for social and leisure activities, reflecting the narrow focus on needs ; and third, that many service users expressed the requirement for support to learn about managing their budgets, some who managed budgets did so with support from family , as well as, others refused to change over to direct payment system as they did not want to take on the added responsibility.

Some have focused on notions of empowerment. They point out that choice and control in matters of everyday life is not enough and residents of supported settings should be empowered to participate in and have a voice in the organisational affairs that affect them directly. Abbott, Fisk and Forward (2000) reflect that residents of various supported settings had: limited opportunities to being informed about various things happenings in the care settings; redress and complaints were usually not encouraged and if a system existed these were not

attended to; and, residents were not represented or consulted in organisation of matters that affected them directly.

That in supported settings resources of time and personnel may be required in promoting empowerment is brought to fore by Knight and colleagues (2010) and Bauer and Abma (2012). Conducting participatory action research with residents and staff of supported settings they draw attention to the role of collective participation in empowerment, identity making and social engagement.

Francis and Netten (2004) and others have highlighted that quality of care outcomes in residential homes have focused largely on personal needs and require incorporation of wider understandings of quality of life in defining care quality outcomes. The focus on quality of life as opposed to a narrow focus on health related quality of life or quality of care is now being recognized within health and social care. On-going work in the field of health economics concerned with developing outcomes that are closely aligned to the quality of life provides evidence of progress in this area.

Woodhead et al (2006) and Wilson and Davies (2009) usefully draw attention to the role of interpersonal relationships and, in particular, communication between staff and residents in care settings to - cultivate and promote mutual respect, self-worth, and autonomy. These studies variously note that different approaches to care delivery such as task oriented, person oriented, and relationship oriented not only make a difference between positive and negative experiences of care but also support or undermine the cultivation and development of friendships. Continuity of care relationships in domestic setting too has been identified as something, which older people value. The work of Marsden

and Holmes (2014) reminds us that although interactions between caregivers and residents are complex these need to be interpreted in a nuanced and situated way - by paying attention to relational and co-constructed aspects of the interactions in addition to issues of power and control.

### **3.4 Summarising wellbeing literature**

The reviewed literature shows that understandings of wellbeing are diverse and insightful. A focus on wellbeing shifts attention away from the biomedical health to peoples' lives and ways of living that matter, as well as, to the wider contexts within which they are embedded. Considered together, the different perspectives employed to understand wellbeing, emphasize, the complexity and multidimensionality of wellbeing. Wellbeing is concerned with personal attributes (e.g. identity, self-esteem, confidence, sense of control and security), social relations (availability of support and social networks, provision of care and other services, societal attitudes and social positions), amount of resources including income that one commands, and the spatial contexts within which ways of life and living are practiced and differentially experienced.

Different disciplinary perspectives though relevant however, contribute to partial understandings of wellbeing. Within psychological perspectives, the focus is on individual attributes such as perceived control, self-efficacy, motivations, and positive attitude towards life that are used to explain how older people adapt to and accept change in their lives. Not denying the importance of psychological resources to living well, these perspectives do not incorporate the social and material contexts of age and health related circumstances in explaining why some have more psychological resources than others or in other words, the source of these psychological resources. It may well be that for some,

their psychological resources are already negatively impacted due to their social-spatial locations, and, age as well as health related issues erode it further. Privileging the individual at the expense of the environment is problematic as the ability to improve life and experience wellbeing resides solely within the person.

Person centred perspectives too emphasize the 'person' and importance of exercising and experiencing autonomy, independence, dignity and respect in context of delivery of care and services. Emphasis on the person is also about personal identity (ies) that people value and not the stereotype identity of a patient, disabled or a frail person.

Notions of autonomy and independence as they relate to older people are complex and in policy and practice many a times are narrowly conceived. Ironically, person centeredness advocates a holistic focus on each person, yet, notions of autonomy are often atomistic. Differences among older people in terms of their personal characteristics, different degrees and types of impairment, and, the fact that decisions and choices are being made from diverse social realities and which may in turn place limits on their choices is often ignored. Reliance on others, or rather dependency is viewed negatively, might be internalized, becomes socially entrenched and is synonymous with particular places such as residential care settings. Instead of enhancing wellbeing, individualized conceptions of self may work towards marginalising and stigmatising some older people.

Environmental perspectives give a central role to person-place relationships in considerations of wellbeing. Separate literatures indicate that material (features of the built environment including housing quality, access to amenities and services, infrastructure), social



(social capital and relationships) and symbolic (belonging, attachment) dimensions of place potentially constrain or facilitate wellbeing.

With the exception of a few, however, focus of much research on wellbeing in relation to older people has been on identifying the influence of context (neighbourhoods) on physical and mental health. In the process, place itself has been defined in reductionist terms (as a statistical unit). Places are often seen as devoid of any personal meaning, and, unchanging in character. In utilising particular spatial units for analysis, interrelatedness of places is often ignored, as is the fact that different spatial scales may impinge, influence, and simultaneously shape experience of living and wellbeing in diverse ways for different people.

There is a growing recognition that in understanding wellbeing people and places have to be considered together and not external to each other (Ziegler 2012) or as exclusively influencing wellbeing (Cummins et al 2007; Sugiyama and Thompson 2007). Different qualitative studies seemingly point towards considerable diversity in older peoples' values, preferences for particular forms of social interaction and (or) the importance of out of home mobility. A few have noted that personal characteristics, material and social contexts may differentially interact with features of places where people live to facilitate or constrain wellbeing in diverse ways. While, some have employed relatively situated notions of wellbeing to examine people-place relationships of those living in domestic settings, such perspectives are noticeably absent (exception of Perkins et al 2012) in supported settings.

Measuring wellbeing using global measures against a checklist of domains is also problematic as individual experiences become fragmented and are quantified into a single value. Contextual and

relational influences on wellbeing are therefore difficult to unpick. Further, within, health, social care, and gerontological literature activities of daily living are utilized as proxy measures for health. Johansson and colleagues (2009) and Grenier (2005) separately note that framing older people in terms of their functional limitations diverts attention from how these limitations enable (or constrain) choices and opportunities related to broader aspects of life and living. Higgs et al (2003) are critical of how scales measuring functional limitations, support biomedical conceptions of an undifferentiated notion of good health as the absence of functional limitation. Additionally, the researcher notes that it is hardly ever considered that some of these activities such as walking, cooking or shopping might be of personal significance or value to the person. Not being physically able to do certain activities is not just a functional loss but may be experienced as a loss to the sense of self.

A noticeable gap in literature on wellbeing of older people relates to addressing how age and health related impairments intersect and interact with socio-spatial environments to shape wellbeing. Schwanen, Hardill and Lucas (2012) and Gilroy (2012) observe that despite active ageing discourses, there is a need to acknowledge that some older people are likely to experience ill health, and, that the notion of later life needs to acknowledge this. Schwanen and colleagues note that, “alliances between the biological/physiological and the social/cultural aspects of embodiment are also critically important for understanding the emplacement and relational nature of ageing” (p.1293). Along similar lines, Wiles and Allen (2010) have argued for the inclusion of the body (including its pain and impairment) and for the experience of ageing to be understood within and in relation to socio-spatial environments, but, without equating it with biomedical conceptions.

Although the reviewed research has included older people living in a range of settings, receiving formal and informal care, however, in line with social models of health, a focus on age and health related impairments is missing. Though research based upon the ecological model of ageing talks about function, this is, as in health related quality of life research not related to consequences of particular impairments for living well. Excluding the dimension of impairment as it interacts with socio-spatial environments runs the risk of assuming that all experiences of older people who have some form of chronic illness or impairment are the same.

The consequences of different types and degrees of impairment for broader ways of living might be variable for different older people. It is only by paying attention to how chronic illness and impairments variably constrain peoples' interaction with their unique socio-spatial environments that a deeper understanding of how the socio-spatial environment can modify (or not) these constraints can be derived in a situated way. Moreover, as Schwanen and Ziegler (2010) point out that consequences of impairments for some can bring a profound loss of sense of self (e.g. driving cessation) and which may have nothing to do with social-spatial factors.

Wellbeing also needs to be understood as a dynamic process. Although conceptions of wellbeing are assumed and implicitly placed in the context of individual changes brought upon by ageing, wellbeing is rarely conceptualized as on-going process encompassing both change and continuity. Wellbeing often comes across as being a static concept according to which: priorities and values do not change; circumstances and resources remain constant; self evaluation and reflection of what is

more or less important to living well in the material and social context of an individual's life does not happen.

Various authors acknowledge the limitations of cross-sectional studies in understanding the relationship between wellbeing and place over time. A few have however employed longitudinal (Mroczeck and Spiro 2005; Webb et al 2011) and (or) biographical or relational perspectives (Clarke and Warren 2007; Ziegler, 2012). The temporal dimension of change in neighbourhoods and change in individual circumstances over time, and, the implication that interaction between the two has, for issues of place and wellbeing is rather limited. That places can change over time as well as the fact that older person's conception of wellbeing and opportunities may be temporally and spatially embedded and shaped is largely ignored in wellbeing literature.

The next section draws together strands from the individual chapters 2 (on place) and 3 (current chapter on wellbeing) to highlight the gaps and discuss current conceptions of the links between place and wellbeing.

### **3.5 Discussion: Interrelations between place and wellbeing**

As the review on place and older people indicates, a substantial bulk of research has emphasized two aspects of place: 1) the importance of the physical built environment of the 'home' place which can be modified and adapted to a large extent to accommodate various functional limitations; and, 2) the significance of the emotional connections to place(s) where older people live for their sense of self. Wellbeing literature highlights the importance of both the physical environment and the sense of self for older people. But, conceptions of place drawing upon the concept of place attachment and a functionalist perspective on place are narrowly defined and make universalist assumptions about

older people. Within both these conceptions, socio-economic contexts are ignored, older people are seen either in terms of their functional limitations, or, as a homogeneous group with the shared attribute of attachment to place.

Place attachment is accorded a positive status in older peoples' lives. Stable notions of place attachment are advanced thereby disregarding how meanings and values attached to places where people live, may change, conflict and (or) differ for different people depending upon their context. Not to mention how policy by legitimising certain spaces, such as the 'home' place makes visible these spaces and in the process discriminates other spaces (care settings). It is not only that certain spaces are legitimized but also some meanings are privileged over others. As such, the limited notion of independence (as lack of dependency) oriented towards the interests of policy and practice too has been tagged on to older people by linking independence with the 'home' place.

Despite the availability of a wide range of community care services to support ageing in place at home, however, as research suggests, some older people do relocate variously to domestic and supported settings. Relocation research highlights a range of individual and contextual factors (determinants) that contribute to it, but we still do not know why where people live ceases to enable ageing in place. There is a lack of attention to the situated understandings of the processes and pathways that shape relocation. The review however, also indicates that various individual and contextual factors are not different for domestic-to-domestic or domestic to supporting settings. If so, then it is not clear how and why relocation trajectories into different settings are shaped. With the exception of some (Nygren and Iwarsson 2009; Peace, Holland and

Kellaher 2011), missing within this perspective is also how tensions vis-a-vis place attachment in situated experiences of relocation are engaged with by different older people.

There is a gap in our understanding of experiences of those who relocate to domestic and/or sheltered settings as engagement with post relocation experiences has largely focused on residential care settings. Because relocation and adjustment post relocation are seen as independent events, attention to situated understanding and status of individual agency and unique socio-spatial contexts of different older people that shape relocation is mostly absent in research. In addition, by extending the metaphor of the home to engage with experiences of living in supported settings, universal and positive assumptions about importance and significance of places where people have moved from are made.

How a sense of place could be created in supported settings has received attention but it not clear whether this has to be attended to only after one has relocated. For example, research on supported settings repeatedly emphasizes that being able to personalize space and stamp it with one's identity is significant for sense of self and for developing a sense of place. Yet, research also reports how in many instances this does not happen but without clear explanations as to why. We do not know whether, if, and, how processes of relocation are tied to the creation of sense of place and, by extension, whether attention to supporting creation of a sense of place needs to begin much before people move into particular settings.

What is not being contested is that places matter for wellbeing, but the above gaps raise two important questions. One, relates to what is

important for the wellbeing of older people, who defines it, how is it related to the places where people live and influenced by change over time. Two, in questioning whether places matter in the same way to older people what is also being contested are the definitions and conceptions of place and that have implications for how the nature of relationship of place and wellbeing is understood.

Wellbeing research on older people demonstrates the multidimensionality of wellbeing. The importance of material, social, psychological, and environmental determinants of wellbeing is well established and documented. What is however contested in the literature are the competing and diverse conceptualisations of wellbeing as: health, satisfaction, happiness, purpose, growth and (or) opportunities for living well, as well as, who defines wellbeing. Some have also highlighted the considerable diversity in not only what matters for wellbeing but also how interpretations and meanings of wellbeing are contextual and situated across different older people.

Wellbeing of older people has been approached from particular perspectives and in response to critiques of biomedical conception of wellbeing. Particular conceptions of the 'individual' and the nature of the relationship of individual and context are brought to bear upon these understandings of wellbeing, some of which are problematic. Psychological perspectives on wellbeing privilege the individual over the context and hence the context has limited or no role to play in wellbeing. Narrow conceptions of person-centred perspectives too at times see the person as 'free from all constraints' rather than as embedded within particular 'contexts'. Social perspectives while taking note of diversity and heterogeneity amongst older people and their social relationships

are focused on social domains and do not take into account the environmental contexts.

Environmental perspectives fall within two strands. One strand draws upon ecological models of ageing and understands the environment (place) as a backdrop to human life, and does not sufficiently take note of the social contexts within which people are embedded. As such, although, the individual and context is important, the relationship is however seen in dualistic terms and not integral to conceptions of wellbeing. The second strand within environmental perspectives favours relational thinking drawing upon the works of human and health geographers. Wellbeing is conceptualized as situated as well as embedded within unique socio-spatial contexts. However, within wellbeing research on older people, only a handful have employed such perspectives to examine interrelations of wellbeing and place of older people living in domestic settings and even fewer in supported settings.

An aspect that has not received sufficient attention in explorations of wellbeing or the role of place as concerns older people is consideration of dynamic nature of older people-place relationships in shaping wellbeing. The dimension of time is significant in respect of age and health related changes, changes in the places where people live, as well as, in shaping values and priorities over time.

What is, also overlooked in the literature on place and wellbeing, is, the role of age and/or health related impairments in shaping people-place interactions and wellbeing. Societal attitudes and discriminatory practices that view older people in a negative light and pose barriers to their wellbeing have received sufficient attention. However, there has been less focus within literature on understanding: 1) how different



degrees and types of impairments variably influence experiences of wellbeing; and, 2) how impairments are differentially modified by socio-spatial contexts to overcome limitations.

The review in highlighting gaps suggests that developing an in-depth understanding of the relationships between place and wellbeing depends upon how notions of place and wellbeing are conceptualized. Current conceptions of place and wellbeing, as the gaps indicate, offer: 1) limited insights into the processes shaping experiences of place and wellbeing and, 2) limited ways to think about the relationship between place and wellbeing, particularly as older people age and experience change over time.

### **3.6 Chapter summary**

This chapter reviewed and developed an understanding of the various conceptions of wellbeing in relation to older people in literature. The review revealed different approaches and perspectives to the study of wellbeing of older people informed by particular disciplinary traditions. A number of gaps from the two individual literature chapters on place and wellbeing highlighted issues (as discussed in the previous section) that are important to consider in conceptualising place and wellbeing. The next chapter sets out my approach to conceptualising wellbeing and place paying specific attention to these gaps.

## Chapter 4 : Conceptualising Wellbeing and Place

### 4.1 Introduction

The central purpose of this chapter is to outline my approach to conceptualising wellbeing and place. The conceptual gaps identified in literature highlighted issues in respect of the various conceptions of wellbeing and place and the lack of sufficient attention to the processes that shape interrelationships of place and wellbeing over time for older people. Conceptualising wellbeing and place in ways that can promote a situated and nuanced engagement with processes shaping older peoples' experiences of place and wellbeing becomes important. The importance lies not only in the context of a rapidly ageing post-industrial society but also in the implications that interrelationships of wellbeing and place have for contemporary geographies of growing old and consequently, for the wellbeing of older people.

The chapter is organized as follows. I draw upon the capability approach (Sen 2009) to conceptualize wellbeing. The following section (4.2) provides a brief and general introduction to the capability approach. Section 4.3 describes in detail the key features and components of Amartya Sen's capability approach. In sections 4.4 and 4.5, I set out my rationale for using Sen's capability approach and discuss the challenges to operationalising the capability approach. Following which by drawing primarily upon the work of human and health geographers, I set out my conceptualisation of place (section 4.6). The relational perspective adopted in this study is then described (section 4.7). A visual representation (section 4.8) brings together an assemblage of key components (from my conceptions of wellbeing and place) that I think are important to exploring and interpreting the processes shaping older

people's experiences. The framework illustrates linkages between these key components. I conclude with a chapter summary.

## 4.2 The Capability Approach

With philosophical underpinnings dating back to Aristotle, the capability approach derives from the works of Amartya Sen and Martha Nussbaum. Although both authors (Nussbaum 2000; Sen 2009) endorse different versions of the approach, more broadly, the capability approach is squarely and directly concerned with developing an understanding of the quality of human lives. As Robeyns (2005) notes, "The capability approach is a broad normative framework for the evaluation and assessment of individual well-being and social arrangements, the design of policies, and proposals about social change in society" (p.94).

Both versions of the approach have been built upon to variously: (1) address issues of human development (Fukuda-Parr 2003); (2) make wellbeing and poverty assessments in developing (Klasen 2000; Qiziblash 2002) and developed contexts (Chiappero-Martinetti 2000; Wolff and De-Shalit 2007); (3) assess gender inequalities (Robeyns 2006); (4) to evaluate specific projects and social policies (Alkire 2002) including those focused on specific groups, such as disabled (Kuklys 2005; Zaidi and Buchardt 2005) or specific capabilities such as, education, health, mobility (Unterhalter 2005; Nordbakke 2013)

While it is not within the scope of this work to delve into the differences between Sen and Nussbaum's versions of the approach, a key distinction and that is of relevance to my work is the specification of capabilities. Nussbaum proposes a concrete list of capabilities that can be modified according to the context under consideration. Sen refuses to endorse a predetermined list of capabilities and argues that these need to be

contextually grounded as different sets of capabilities might be relevant for different groups in different contexts. Both Nussbaum and Sen have been criticized in different ways. Nussbaum's list has raised concerns about the democratic legitimacy and role of agency in her list (Robeyns 2003). Sen's refusal to specify a list presents methodological challenges for operationalising the capability approach (Alkire 2002; Robeyns 2006) and to which I return later in the chapter.

### 4.3 Sen's Capability Approach: key features

In my research, I draw upon Amartya Sen's capability approach to conceptualize wellbeing. This is because I am interested in developing an understanding of wellbeing that is attentive to older peoples' own accounts of what matters to them within their particular contexts.

The key idea underlying the capability approach is that understanding wellbeing requires focussing on 'capabilities' that people have for various valued 'functionings'. Capabilities refer to the freedom and/or opportunity that a person has to achieve various functionings. Functionings are defined as various things a person may do or be. These could include ways of *being*: being healthy, being literate, being happy and content, and, *doing*: going to the market, writing a book, or enjoying a family get together. So, for example, living in a safe neighbourhood is a functioning and the genuine opportunity that a person has to live in a safe neighbourhood is the capability for that particular functioning. In analysing how well peoples' lives go a focus on the capabilities that people have for various functionings can potentially highlight the gap, "between doing something and being free to do that thing" (Sen 2009: 237).

Within the capability approach, wellbeing lies in the ‘capabilities’ or the ‘genuine opportunities’ that people have to choose and to lead their lives in ways that matter to them. An expansion in capabilities means an enhancement in wellbeing. Such emphasis on ‘value’ recognizes, one, that a person may simultaneously value many different things in his/her life, including, capabilities for holding or developing particularly valued identities, i.e., capability to be who I am and/or the capability to be who I want to be. And second, that plural notions about what matters and the relative importance of what is important in living well might vary from person to person, although, some capabilities are generally widely valued. In conceptualising wellbeing, the core focus of this research will be on older peoples’ capabilities for valued plural functionings.

The capability approach also signals the need for an information rich understanding about the person and their context to identify underlying factors that enable and (or) constrain capabilities. Not only so, it argues for developing an account of a person’s capabilities situated as he or she is within their personal, social and environmental context and is underpinned by a relational ontology (Smith and Seward 2009). A relational conception means privileging neither the person nor the context but focusing attention on the interactions between the person and context.

The socially shaped nature of capabilities implies that depending upon the personal characteristics and the person’s context, capabilities for particular functionings may be differentially shaped, valued, realized, and interpreted and (or) that different situations may variably impact upon people’s capabilities. The situated nature of capabilities draws attention to the specificity of situation and the dynamic aspect of capabilities and is consistent with a relational perspective.

While the core focus of the conceptual framework (as set out in section 4.8) will be on the capabilities for valued plural functionings, I will now draw upon the other aspects of the Capability Approach (which I refer to as key 'components') to inform the conceptual framework. These components include: individual and socio-spatial factors shaping capabilities and the plural nature of freedoms.

#### **4.3.1 Component 1: Individual and socio-spatial factors shaping capabilities**

The capability approach gives central importance to the person and his/her life. Implicit within such a focus is the notion of 'diversity'. The novelty of the approach lies not in acknowledging the existence of human diversity but in incorporating this aspect in developing an understanding of wellbeing. Expanding on diversity Sen (2009), lists at least five sources of diversity ranging from individual to contextual factors. These extend from heterogeneity in, for instance, age, gender, disability or illness, material resources amongst others to include variations in policies, the physical environment that one inhabits, social relationships, cultural norms and beliefs which may potentially affect, influence and/or shape a person's capability.

A closely related concept proposed by the approach is about 'conversion factors'. Conversion factors can be aspects of person or context that influence how particular resources (personal, material or social) can (or cannot) be converted into capabilities. When thinking about capabilities for particular functionings, conversion factors do two things: first, alert us to the possibility of gradations and variations in personal and/or contextual characteristics of different people and two, by extension, advocate a nuanced understanding by not leaping to assumptions about the capabilities that different people may have in some instances even

for the same functioning. For example, the availability of good and free public transport services in the neighbourhood may not automatically translate into the capability to use the bus or capability for mobility for older people living within that neighbourhood. Some older people because of their particular health conditions may be lacking in conversion factors such as, the physical energy or other support in the form of someone accompanying them to the bus stop or being mobile using the bus.

Individual and socio-spatial factors become a key input (i.e. Component 1) for building the conceptual framework to capture the different sources of diversity and heterogeneity that shape capabilities of older persons in particular places and at particular points in time.

#### **4.3.2 Component 2: Plural nature of freedoms**

The notion of 'freedom' lies at the heart of the capability approach and is the second component of the conceptual framework. 'Freedom' as proposed by Sen (2009) comprises of plural aspects that are context-dependent. Plural aspects relate to opportunity, process, direct control and indirect control. The opportunity aspect of 'freedom' is concerned with one's capability to achieve a particular functioning. Using the example of capability for mobility described above, this would include, options and opportunities that older people have and are open to them such as, driving a car or getting a lift from family or friends in addition to using the bus to go out from the home.

The process aspect draws attention to one's capability to choose, "...being free to determine what we want, what we value and ultimately what we decide to choose" (Sen 2009:232). It helps us to think about the extent to which people are free to choose how a particular functioning is

achieved, by drawing attention to their own participation, the role of others and circumstances in processes shaping capabilities for particular functionings. For instance, in a process perspective, the capability for mobility leaves open the space to acknowledge and recognize that some may place a higher value on driving over using the bus and may be free to choose not to use the bus or ask friends for a lift. Choosing one way of being or doing over another signals the role of value and the relative importance (or not) attached to a particular option or opportunity. Capability for mobility may also incorporate for instance, consideration of choosing freely to go out from the home as and when one wishes to.

The opportunity and process aspects of freedom draw attention to the agency of the person and his/her values. Other aspects of freedom, such as, direct and indirect control, highlight that capability to choose depending upon context and person may or may not be similarly prioritized and/or valued by the same person or different people. In some instances and for some people, capability for a particular functioning may be conditional upon being able to freely choose and act by oneself in bringing about that particular functioning. But in some other instances, capability may also be achieved by securing the help of others, and where capability to achieve may be more important than capability to do it by oneself. And sometimes, one may not necessarily attach a high value to doing things independently in various spheres of one's life. The plural notion of freedom is particularly valuable when thinking about debates around autonomy and independence that feature centrally in literature analysing the wellbeing of older people.

An emphasis on freedoms also captures the importance of focusing on the capability rather than on functioning. Focus on capability can extend the informational space of the analysis beyond taking note of the



conversion factors. This would include the availability of opportunities, the relative importance some may attach to available opportunities, being able to choose, decide and act freely either independently or in concert with others.

#### **4.4 Rationale for using Sen's Capability Approach**

As the review of literature on wellbeing of older people has highlighted, wellbeing is multidimensional. Particularly, qualitative work (Gabriel and Bowling 2004; Grewal et al 2006; Milte et al 2014) on exploring the quality of life of older people both in domestic and supported settings has emphasized giving voice to older peoples' own conceptions rather than starting from a priori assumptions about what contributes to wellbeing. Their works point out that understandings of wellbeing are socially constructed. The capability approach in highlighting that people might value capabilities for a number of functionings is sensitive to capturing the multidimensionality of wellbeing. In emphasising the socially shaped and situated nature of capabilities for various functionings the capability approach also attends to the socially constructed nature of wellbeing.

Wellbeing literature has usefully highlighted that individual and socio-environmental factors influence wellbeing including peoples' identities. However, instead of understanding wellbeing from particular perspectives (e.g. psychological, social or environmental) the capability approach re-situates the various individual and socio-environmental factors as constituting and representing the diversity of human life. Diversity amongst people might relate to their personal characteristics (and attributes), and their socio-environmental contexts. Emphasis on the socially situated and shaped nature of capabilities favours the

interaction between the person and the context and hence permits a relational perspective on wellbeing.

By making explicit the sources of heterogeneity, the capability approach incorporates diversity into an analysis of wellbeing. The diversity not only relates to what people might value, but also to their personal characteristics (e.g., age, gender, health), attributes (skills, outlook on life, confidence, identity) and their socio-environmental contexts (social relationships, geographic locations, public policies, availability of services). Such variations raise the possibility that depending upon the person and their situation, some individual and socio-environmental contexts might be more significant than others in shaping wellbeing. At the same time by introducing the concept of conversion factors, the approach is sensitive to interpersonal variations in characteristics and contexts. Therefore, it can also support identification of the differential implications and consequences of age and health related impairments in shaping valued capabilities. This as identified in the previous chapter is largely overlooked in place and wellbeing research on older people.

The capability approach sees human beings and their wellbeing as ends in themselves. In emphasising capabilities, it gives due recognition to human agency, i.e. the opportunity to achieve and the ability to pursue what each person values. While emphasising that each person matters, the capability approach does not however support ontological or methodological individualism (Robeyns 2008). This brings to fore another closely related issue originating from wellbeing literature, i.e., the conception of the person. Seeing people not as patients but as persons has been vigorously adopted by policy and is apparent in the emphasis on person centred and personalized approaches to health and social care. Various authors (Sointu 2005; Entwistle and Watt 2013)

however, warn us about the narrow translations in practice of 'person' who is equated to: an active agent, self-governing individual, responsible for self, often characterised by a narrow focus on autonomous choices and stable preferences.

As seen in previous chapters, older people are framed variously in terms of their needs or functional limitations that additionally has consequences for peoples' identities. Understanding wellbeing then also means attending to how identity and (or) the expression of it is affected. Sen (1985, 1990) in his various writings acknowledges that people could potentially have multiple identities (social and personal) although some may be emphasized or valued more than others in specific situations and contexts. The notion of what one values in the capability approach is also tied to who one is (Teschl and Derobert 2008). The idea that people might hold multiple and specific identities as well as the fact that identities are fluid requires consideration. Such consideration of identity (ies) becomes significant precisely because of its potential for being harmed, maintained, moderated, and cultivated in specific situations and contexts.

I believe that the capability approach is relevant to exploring the wellbeing of older people relationally and responsively. The approach also conceptually permits rejecting binary conceptions of older people by giving due recognition to heterogeneity and diversity in people, contexts, and interaction between the two. And, in doing so, steer clear of assigning them a particular identity that smothers out other simultaneously held and valued identities.

#### 4.5 Operationalising the Capability approach

Sen's capability approach (2009) argues for an account of human wellbeing in the space of capabilities (what people are actually able to do and be) and functionings (what they actually do and be). An emphasis on and respect for plural conceptions of what matters to different people or what different people 'value' however underpins as well as is a distinguishing feature of the Sen's approach. The deliberate under specification in terms of what 'capabilities' to focus upon that people may 'value or have reason to value' as many authors (Alkire 2002; Robeyns 2006) have variously noted denotes the conceptual strength of the approach as well as presents a methodological challenge for empirical research.

Questions for empirical work therefore are related though not limited to: whether to focus on capabilities or functionings or both; which capabilities to measure or investigate in detail; how to prioritise between different capabilities as well as whose version of prioritisation between different capabilities should be adopted (Robeyns 2006). Several empirical applications have been operationalized using both quantitative and qualitative perspectives (see Robeyns 2006; Chiappero-Martinetti and Roche 2009 for details).

Various empirical applications have also been specifically oriented towards eliciting various relevant capabilities that matter to groups and/or individuals include: capability expansion for women beneficiaries in poverty alleviation projects in the developing world (Alkire 2002); identifying capabilities for evaluating gender inequality in the Western context (Robeyns 2003); identifying relevant capabilities for making assessments of children's wellbeing (11-17 year olds) across developing and developed contexts (Biggeri et al 2006); and, developing a capability

list to monitor equality and human rights aspects of individuals and groups in England, Scotland and Wales (Vizard and Buchardt 2007). But the focus varies depending upon the different purposes of the research: to develop and use quantifiable indicators; and (or), to qualitatively, understand what capabilities matter to people, what these are, and how these are shaped.

A common feature of these empirical applications is their emphasis on the selection of capabilities that are context sensitive and specific. Hence, selection of capabilities has been done through: participatory methods (Alkire 2007); through democratic deliberation and debate (Vizard and Burchardt 2007); and/or, through the basic criterion of ensuring that selected capabilities are 'explicit, discussed and defended', open to revision and development (Robeyns 2003). Robeyns (2003) has proposed a four step methodology to selection of relevant capabilities starting with, a) collating a draft list of capabilities through brainstorming, b) contextualising the list in relevant literature and discourses as a way of justification, c) comparing the relevance of the proposed list in relation to other lists, and, finally, d) debating the list with other people. Biggeri et al (2006) and build upon Robeyns (2003) in starting from a capability list from relevant literature but combine it with participatory approaches to arrive at a relevant list of capabilities applicable to children across different cultural contexts.

Alkire's (2002) approach differs slightly from the above that she does not identify a list of capabilities but a fairly conceptual range of basic human dimensions drawing upon Finnis (1980). She utilises these as the basis for eliciting through participatory methods the capability changes that occurred in the lives of women beneficiaries of a poverty alleviation project. Alkire (2002) draws upon Finnis's (1980) approach that is based

on 'practical reason'. 'Practical reason' means, "reasons for acting" (Grieze et al 1987: Alkire 2002:103). Finnis (1980) has outlined seven basic human dimensions that according to him are simplest and most basic reasons for which people act in pursuit of their wellbeing, regardless of culture or context, but at the same are fairly abstract. In Alkire's work these dimensions have been used to examine capability changes in lives of women beneficiaries of three poverty alleviation projects.

## **4.6 Conceptualising place**

Building primarily upon the work of human and health geographers I explain my interest in drawing upon relational notions of place and, present two more components that will support the building of my conceptual framework.

### **4.6.1 Component 3: Inter-relatedness of places**

"That place ought to be regarded as a relational achievement has become something of a mainstay in contemporary studies of human geography, society and culture" (Duff 2011:152).

In moving away from narrow conceptualisations that understand place primarily as material, bounded, and static backdrops or containers, I draw upon Massey's (1994) conception of place(s) as being unbounded, extended and interrelated and where the material is but a part of place. She encourages us to think about place(s) as, 'a meeting place' [...] as "articulated moments in networks of social relations and understandings, but where a larger proportion of those relations, experiences and understandings are constructed on a far larger scale than what we happen to define for that moment as the place itself,

whether that be a street, or a region or even a continent”(p.7). And people occupy different (social) positions within the complex web of social relations that define particular places.

Within such a conception then, places (e.g., domestic homes or supported settings) are seen as points of confluence of social relations, both immediate and wider. As such place is understood through and by the relational linkages and interrelatedness between people and place and to the other places at different geographical scales. Hence, places are not distinct and neatly categorised bounded entities which people inhabit.

Massey (1994) also calls for a conception of place as a process since person-place interactions are underpinned by continually changing social relations that come together in ‘place’. This conceptualisation then also permits a nuanced engagement with dynamics of residential relocation as an on-going, complex and contextualised process of person-place interaction rather than seeing some forms of relocation as a disruption and de-stabilisation to continuity of place, person and identity.

While Massey (1994) and others have brought the social into place, health geography by drawing upon the work of humanist geographers has added the dimension of individual meaning and values to the social in extending understandings of how places are created (Relph 1976; Eyles 1985; Kearns and Gesler 1998). Within health geography, places are understood as socially constructed, experienced, imbued with meaning and do not merely exist as a physical location within which every day life occurs. So while places and social relations constituting place influence and shape who we are and what we do, equally,

individual experiences actively influence and shape the places we inhabit. Meanings attached to places may be individual and (or) shared.

#### 4.6.2 Component 4: Sense of place

Reviewed literature on place usefully informs about the meanings older people attribute to their homes as well as the diverse experiences of different places, be it the domestic or care home. Understanding older peoples' relationship to place therefore requires unravelling the significance of place in terms of meanings ascribed to place. To develop an appreciation of the significance of place to older people I draw upon the concept of 'sense of place'. Rose (1995) defines sense of place as referring to, 'the significance of particular places for people' (Massey and Jess 1995:88). People do not only ascribe meanings to places, but sense of place can importantly contribute to their identity.

In addition to emphasising the role of social relations in shaping meanings and experiences of place as in health geography, concepts such as, place attachment, place identity, and place dependence have variously been utilised in examining how people feel and think about places paying special attention to the nature of person-place bonds (Jorgensen and Steadman 2006). Place attachment signifies the emotional and affective aspects of bonding (Altman and Low 1992; Riley 1992; Moore and Graefe 1994). Place identity could be an alternative identity in the array of plural identities that a person has where the self is defined or situated in relation to some aspects of the physical place (Proshansky, Fabian and Kaminoff 1983). And, place dependence indicates a person's appraisal of how far a setting is congruent with his or her goals and beliefs that are important (Stokols and Shumaker 1981, 1998).



Jorgensen and Steadman (2006) argue that combining various concepts outlined above under 'sense of place' would permit attending to the multidimensional, varied and changing nature of place experiences. They further note that while attachment, identity and dependence may be related this need not always be the case. Sense of place is therefore not contingent upon one or the other: attachment, identity or dependence. Each of these may be individually significant, in combination or marked by absence of one or other. Some others observe that in understanding how a sense of place is created requires situating processes that tie moving away from and moving to particular places in context of peoples' lives (Cuba and Hummon, 1993; Luborsky et al 2011; Johansson et al 2013).

By drawing upon the concept of sense of place in the broadest sense, this study will favour a focus on developing an understanding of how a sense of place is shaped. In the context of relocation, rather than aiming to understand what makes 'supported settings' homelike this research will focus on how older people make and create a sense of place.

Following from above as well as from the review of literature on place, it becomes apparent that experience of place(s) brings together the interplay of material, social and symbolic aspects of place (Wiles 2005; Cattell et al 2008; Duff 2011). The interacting material, social and/or symbolic aspects of place therefore, may inform processes that contingently shape peoples' experience (enabling and constraining) and, might influence sense of place, sense of self, future encounters with and expectations of place.

#### 4.7 A relational perspective

Conceptualising wellbeing in the space of capabilities and drawing upon the notion of place outlined above together offer a relational perspective: (1) to exploring and developing a nuanced and situated understanding of the processes that shape older peoples' experiences of place and wellbeing over time (2) to gain insights into the interrelationships of place and wellbeing; and (3), to inform collection and analysis of empirical data.

A relational perspective in this study means:

- a) Focussing not on older people and (or) places as isolated discrete entities but attending to the processes involving interactions between the two;
- b) Acknowledging that older peoples' lives are socially situated which might potentially enable and (or) constrain a person's valued capabilities as well as influence how capabilities are shaped;
- c) Capabilities are dynamically shaped and meanings ascribed to place might be fluid and change over time as older people experience change;
- d) Place is open-ended, being actively constructed, reproduced, and scaled in relation to and through interaction between people, their values, place, and context and simultaneously material, social, and symbolic;

A visual representation (see Figure 4.1) assembles the key components from my conceptualisations of wellbeing and place and illustrates linkages between these in the conceptual framework outlined below.

## 4.8 Conceptual framework

The conceptual framework offers a starting point to exploring and interpreting older peoples' experiences of living in different kinds of settings. The different parts of the framework are described followed by a discussion of how the framework is to be understood.

The conceptual framework (Figure 4.1) reads from left to right with time along the horizontal framework flowing from left to right. To illustrate processes, I show two possible interlinked scenarios; one which shows a person's current and inter-linked valued capabilities (shown in circles as C1, C2...) at current place of residence (shown in extreme left as Place A), and, two, the same person's valued capabilities at a future point in time, which may or may not be the same place of residence (shown in extreme right as Place A/B). It is also to be noted that Place A/B refers both to a location and a set of social relations (shown as an overlap of a number of place-related dimensions).

In capturing the dynamic processes that shape older peoples' experiences, I use four distinct yet inter-related components (shown in black triangles, numbered): component 1 – individual and socio-spatial factors shaping capabilities (from Section 4.3.1); component 2 – plural nature of freedoms (from Section 4.3.2); component 3 – inter-relatedness of places (from Section 4.6.1), and component 4 – sense of place (from Section 4.6.2).

Now I discuss the conceptual framework. In doing so, I modify and expand upon Robeyns (2005) framework. The conceptual framework places the human being at the centre of the analysis by focusing on their capabilities (for various plural functionings). Capabilities are emplaced and situated in the web of continually changing social relations that

constitute and are constituted in place (represented by Place A or B in the figure) and within which individuals are located in multiple and complex ways. Relational notions of place in contributing to developing rich and nuanced understandings of place can elucidate and complement the capability perspective.

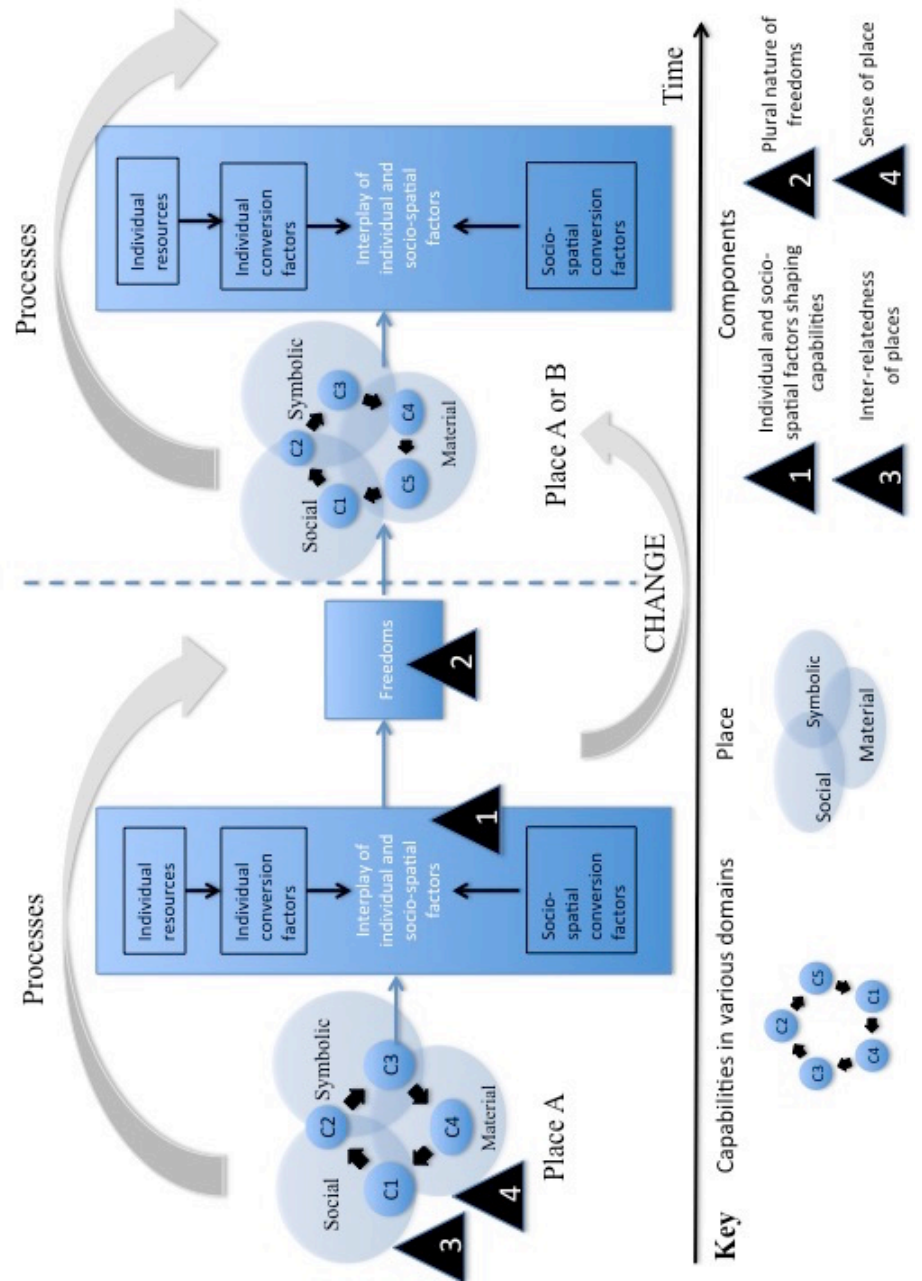
A person's wellbeing, therefore, is understood as being constituted in specific socio-spatial contexts. Further, I envisage that an older person's life world is comprised of interrelated places at different scales of the room, neighbourhood, city etc., (component 3 in the framework). The interrelated material, social, and symbolic dimensions of place, in interacting with the person, structure as well as offer the resources, opportunities and constraints in generating conditions for shaping capabilities for valued functionings. The vertical axis represents the interplay of individual and socio-spatial factors. I presume that individual and socio-spatial factors might not only vary from one person to the next but some are dynamic and change over time for the same person. For instance, these might include age and potentially, for some, health related changes or neighbourhoods where people live can change in terms of residential mix or the services that are offered. These dynamic factors might directly and indirectly influence valued capabilities.

The interplay of individual and socio-spatial not only dynamically shapes capabilities but, in some instances, might hold implications for place of residence (and involve moving from place A to place A/B as in the figure). Moving from place A to place A/B would bring into play a different socio-spatial context that in interacting with individual (values, characteristics or circumstances) would influence and contribute to

shaping of capabilities with varying implications for one's sense of place (component 4 in the framework).

The plural nature of freedoms (component 2 in the figure) permits taking note of the processes of choice involved in shaping capabilities, including: 1) considerations of whether a person has a capability; 2) whether the processes shaping the capability are in accordance with the person's values; and, 3) identifying what constrains or enables the freedom to choose. The conceptual framework allows me to map and explore the dynamics that might shape interrelations of place and wellbeing.

Figure 4.1: Conceptual Framework



## 4.9 Chapter summary

In this chapter, I have developed and described the broad conceptions of the two key concepts of 'wellbeing' and 'place' that underpin this research. In doing so, I have explained my interest for employing a relational perspective and have brought together strands from my conceptualisations of wellbeing and place to build a conceptual framework to explore and interpret older peoples' experiences. I have also explained that it is within relational understandings of capabilities and place that engaging with processes that dynamically shape and support capabilities for various functionings with implications for one's wellbeing and sense of place can be understood both spatially and temporally. The next chapter in summarising the gaps identified in literature and drawing upon conceptual framework developed in this chapter sets out the research questions and the methodology.

## Chapter 5 : Research methodology

### 5.1 Introduction

This chapter sets out to describe the purpose, design, and implementation of my research. I present the research questions drawing upon the gaps highlighted in literature and the conceptual framework developed in the previous chapter. I discuss the philosophical considerations underpinning my choice of methodology and the specific methods used for gathering data, recruiting participants, and analysing data. I choose to describe these in a first person account where I weave in my reflections into the narrative and attend simultaneously to ethics and issues of reflexivity, that are important to establishing the quality of my research.

### 5.2 The story until now

The rich body of literature on place and wellbeing of older people sensitised me to the multiple determinants of wellbeing and how place was a crucial part of that. But I found that with a few exceptions, there was considerably less research that employed well-nuanced and situated conceptions of place and (or) wellbeing. I noted that while the importance of place to wellbeing in literature was implicitly or explicitly set out, the dynamic nature of people-place relationships in shaping wellbeing was not captured despite the fact that change is an on-going feature of older peoples' lives.

Although the literature was replete with the determinants of relocation, it was not clear why for some people the places where they lived ceased to enable ageing in place or how relocation trajectories into different



settings were shaped. And while I found a sizeable body of literature on relocation to residential care settings, there was hardly any on relocation to other domestic or sheltered settings. This I felt reflected and mirrored the dominant policy discourse relating to the perception of relocating to some places as being more significant and damaging than others.

I found that these gaps related to the different perspectives on place and wellbeing in literature that not only influenced how the interrelations of wellbeing and place were understood but also carried within them particular assumptions about older people. The metaphor of home was operationalised to engage with older peoples' experiences of domestic settings. In the process, place was characterised as a bounded, stable and a static entity with neatly delineated boundaries of home, neighbourhood or city connoting positive attachments.

Empirical work on wellbeing of older people too had fixed attention on either the place of residence or the neighbourhood as the spatial unit of analysis. For instance, neighbourhood studies on wellbeing variously conceptualised wellbeing in terms of physical and/or mental health or social capital but the notion of place drew upon statistically defined neighbourhood boundaries. Such conceptions then did not permit considerations of: the interrelatedness between places; the breadth of peoples' experiences that were not necessarily bounded to the neighbourhood or the place of residence; and, change in the individual or the place with implications for meanings and values attached to particular places and experiences.

By employing the metaphor of home in engaging with supported settings universal and positive assumptions about the importance and significance of the home place to older people was extended to

supported settings. This then framed understandings of the wellbeing of older people in supported settings in two ways: firstly, understanding supported settings and in particular residential care settings by not what they are but what they are not, i.e., the domestic home. Starting from such a focus therefore obscured attention to other sources of diversity in peoples' lives, such as, variations in health status and resources as well as the status of peoples' lives prior to relocation. Secondly, relocation and adjustment post relocation were understood as two separate events. Hence, not only were the processes that influenced and shaped particular relocation trajectories ignored but changes in peoples' ways of life and living as influenced by relocation too were not captured.

Wellbeing literature contributed to an understanding that multiple individual and contextual factors might shape wellbeing. At the same time, it highlighted the partial nature of understandings of wellbeing underpinned by disciplinary perspectives that raised questions about the nature of relationship of the individual and the context. In developing a relational perspective as set out in the previous chapter I have broadened the conceptualisations of wellbeing and place. Through a series of interlinked research questions set out below, I intend to address gaps identified from literature based upon older peoples' own experiences and understandings of living in different settings.

### **5.3 Research questions**

Two research questions were set out as below to address the overall aim of the research – to *explore what matters for the wellbeing of older people and how this might shape and be shaped by interrelationships of place and wellbeing.*

*What opportunities and constraints do different place settings offer in shaping the valued capabilities of older people?*

*How are relocation trajectories into different settings shaped for those who move? What are the implications for older peoples' valued capabilities?*

#### **5.4 Philosophical considerations**

I was interested in exploring what mattered most to older people and why. In doing so, I was seeking to examine whether they had the opportunities to do and be what mattered to them and the role of place in shaping these opportunities. Therefore studying and understanding things 'in context' was important to me – "realities are wholes that cannot be understood in isolation from their contexts" (Lincoln and Guba 1985:39).

I was sufficiently sensitised through a review of literature that older people might mention aspects like social relationships or health amongst other things as being important to them. I anticipated that, but I also believed that the understanding, meaning, and interpretation of these aspects might not be the same for all - that meaning making and interpretations would be grounded in material and social realities of the participants' lives, i.e. be socially situated and context dependent.

I found that my epistemological stance aligned with constructionism. Constructionism as Crotty makes clear,

"is the view that all knowledge and therefore all meaningful reality as such, is contingent upon human practice being constructed in and out of interaction between human beings and

their world, and developed and transmitted within an essentially social context" (1998:42).

He further notes that, while multiple interpretations exist and can be, "useful," "liberating," "fulfilling", "rewarding" (p.48), there are no true or valid interpretations. Meanings emerge and are constructed in interaction with specific material and social worlds we inhabit and relate to that. And therefore, "meanings are at once subjective and objective" (Crotty 1998:48) thereby emphasising the context specific, context sensitive and emergent nature of meaning making but at the same time reminding that "we are born into world of meaning" (Crotty 1998:54).

Crotty highlights the complementary nature of the terms epistemology and ontology, "to talk of the construction of meaning [epistemology] is to talk of the construction of meaningful reality [ontology]" (1998:10). For instance, a particular capability, such as, being able to own a property (house) might be an important capability for some but may not be an important capability for some others. Owning (or not owning) a property might mean different things to different people as well as be shaped and vary depending upon the values and nature of the particular society in which they live. Property ownership might be an important capability at one point of time in a person's life and not at another point of time.

But this meaning making, valuation of what or how something is important, whether a particular capability exists, how it is shaped (enabled or constrained) is not possible to grasp without paying attention to a range of underlying factors (economic, social, spatial, biological, and psychological). Here, I am influenced by the work of Smith and Seward (2009) who emphasise that,

“a particular capability is the outcome of the interaction of an individual’s capacities and the individual’s position relative to others in society’ (pg.214). They further note that, ‘...one way to understand the interaction of these components is through the [ontological] conception of a relational society...” (p.231).

In arguing for a relational conception of society they advance the notion of ‘contextual causality’ to explain the ontological status of the individual and society and the relationship between the two. Individual (e.g., reasons, beliefs, desires, personal and social identity, personal characteristics etc.,) and social structures (social norms, institutions, governments, class, culture etc.,) are understood as two ontologically distinct causal components that interact through time and where, one is not reducible to the other, and yet, at the same time, are interdependent.

Contextual causality implies that the relationship between the individual and social components is not static, fixed, or given but is contingent upon the context within which these components interact. Causality is not determinate, rather, it implies possibilities for individual action that can be modified, constrained or enabled by the individual and (or) social components. Hence, it is important to situate the individual in relation to the context in which he/she is embedded: a) to develop an understanding of how the interaction between the two unfolds over time in diverse ways for different people; and, b) what configurations of interactions differentially enable or constrain meaning making and capabilities. To summarise, the ontological assumption of a relational conception of society supports the constructionist epistemology that I have adopted for my research.

Epistemology is, however, also concerned with “the nature of relationship between the knower or would-be knower and what can be known” (Guba and Lincoln 1998:201) or “how we know what we know”

(Crotty 1998:8). Generating knowledge about manifold accounts of wellbeing and place from participants necessitated some form of direct interaction with them. I was the sole investigator who directly interacted with the participants and I was aware that making sense of multiple realities of the participants' would be an interpretive act.

As many have highlighted, within a constructionist epistemological stance the subjectivity of the researcher is a given (Lincoln and Guba 1985; Charmaz 2000; Ritchie and Lewis 2003). Maxwell (1992) points out that, "as observers and interpreters of the world, we are inextricably part of it; we cannot step outside our own experience to obtain some observer-independent account of what we experience" (p283).

In emphasising the value-laden nature of research, these authors call for reflexivity. This means taking account of how the researcher's background, and assumptions might impact the research process. Alvesson and Skoldberg (2009) highlight that reflexivity needs to be practised both at the level of data collection, as well as, when interpreting, analysing and presenting the collected data. For instance, practising reflexivity would mean being aware of how issues of perception of power between interviewer and the interviewee and/or issue of age, gender, ethnicity etc. may influence the interview dynamics (Alex and Hammarstrom, 2008).

I was conscious before entering the field that in interacting with an all white older sample, my age and ethnicity (non-white) might influence the interview dynamics, but as I discuss later in the chapter, other aspects too played a major role in shaping the interview dynamics. I made notes that were reflections of: my experiences of interview, the observations I had made of the different settings that the interviews

were held at, and, things, which were discussed before and after the interviews. I not only weave these reflections into the narrative to present a transparent account, but, in choosing to write this chapter as a first person account, I also revisit and reflect upon the processes by which I collected data, analysed and presented it.

## 5.5 Qualitative research design

I adopted an exploratory qualitative cross-sectional research design. Underpinned by a constructionist epistemology, it was not a surprise that I chose to adopt a qualitative research design, but there was more to the design selection. Qualitative approaches can offer insights into the inner world of the participants, i.e. meanings, motivations, values and identities. But they can also reveal the immediate and wider material and social contexts within and in relation to which meanings and values are situated, interpreted and acted (or not acted) upon (Ritchie and Lewis 2003; Mason 2002).

For me it was important to understand what mattered to older people from their own individual perspectives, in their own words. I believed that gathering insights into participants' experiences of living in different settings from their perspectives would enable me: to get close to understanding the complexity of their experiences and in detail; attend to their values, meanings and identities; situate these within their particular socio-spatial and cultural contexts to understand why and how some values, meanings and identities were more important than others.

My qualitative approach was also aligned with the capability approach. Agency concerns are central to the capability approach. One such concern emphasises that wellbeing be understood in terms of what

people value. By listening to and hearing older peoples' experiences, and exploring directly with them what they valued, I respected the older person as an agent capable of actively voicing out his/her values, concerns and priorities rather than treating them just as an analytical unit. By gathering detailed information that a qualitative approach permits, I was not only able to gather insights into what mattered to them but also ground it within the material and social realities of their lives.

In addition to finding out which capabilities mattered to the participants, I was interested in exploring the interplay between capabilities and places where people lived. What significance did people attach to the places where they lived (sense of place)? How did changes in individual context and/or the changing nature their living environments influence their sense of place and capabilities?

To gather insights into the interrelations of wellbeing and place, focussing on the interplay between the individual characteristics and socio-spatial contexts was key to understanding the processes by which capabilities (for variously valued functionings) were shaped. Capturing the complexity of processes was in turn important to understand why some older people relocated. Within this I was keen to explore the contexts, conditions, and the processes by which participants made decisions, for instance, about relocation. What did moving mean for their sense of place? And, how did moving to a new setting impact upon other capabilities? What supported the construction of a sense of place in the new setting?

I realised that I wanted to gather processual rather than static accounts of participants' experiences to capture the dynamic interplay of people-



place relationships. This as I set out in the next section informed the research methods.

### 5.5.1 Research methods

I chose in-depth interviews with a biographical perspective so that I could explore and capture the dynamic interplay of people-place relationships over time. Given the time bound nature of the research, I could only do so retrospectively. Biographical approaches as Merrill and West (2009) note,

“offer rich insights into the dynamic interplay of individuals and history, inner and outer worlds, self and other. We use the word ‘dynamic’ to convey the idea of human beings as active agents in making their lives rather than being simply determined by historical and social forces” (p.1).

Incorporating a biographical perspective therefore provides the opportunity to understand and “appreciate the relationship between structure and agency” (Burke 2011:10) or, as in this case, was useful in exploring the relational nature of people-place relationships.

Biographical research can be carried out in many ways, such as, through the use of diaries, photography, other visual memorabilia, but I chose to do so through the biographical interview. Biographical approaches are increasingly being used not only for purposes of research (Wengraf et al 2002) but also to inform professional practice in health and care settings by focussing on the ‘whole person’ (Gearing and Dant 1990; Clarke, Hanson and Ross 2003). Research has also shown that such approaches have therapeutic value for older people (Nolan, Davies and Grant 2001; McKee et al 2002). Gearing and Dant (1990) further highlight that a

biographical perspective by focussing on an individual's reconstruction and interpretation of their past life, throws light on the participants' conception of self or in other words their valued identity(ies).

The very strength of a biographical perspective, reinterpreting the past through telling one's story however can also be its weakness, particularly in relation to research on older people. As Wengraf et al (2002) note, narrativity in gerontology views:

“storytelling as one of the most enduring themes of late old age. This very social function of the narrative act is also detected in studies of narration among elderly population living in residential care, where the life story, as told, may be a product of the social context in which someone lives, a version of a life made ready for public consumption in a situation where identity is at risk from the negative stereotypes of frailty and the processes and procedures of caring” (p.254).

While reviewing literature on older people, I became aware of how the told or the narrated life could be problematic. Though past experiences have been identified, as being significant in understanding current experiences of place, the status of peoples' identities, degree of control and independence they could exercise in their lives prior to entering supported settings (particularly residential care) was not clear from the reviewed literature. As noted in chapter 2, I realised that the problem partly might lie in the way people talk about themselves and partly with what the researcher focused upon. Narrative identity allows people to portray those aspects of self that are important and valued and in the narration of which the time dimension is dissolved. So, in giving voice to their lives prior to relocation while revealing valued aspects of sense of

self that derive from their occupation or role identities, does not necessarily mean that it presents an accurate picture of their lives or identities just prior to relocation.

I was therefore concerned with both the 'lived life' and the 'told life' (Wengraf 2001; Rosenthal 2004). Verd and Lopez (2011:10) point out that the 'lived life' is about "the sequence of events and actions experienced by the interviewee which constitute the material basis of the story" and the 'told life' is about "the way in which the events experienced are narrated". Gaining insights into the participants' conceptions of self as it related to their identities, exploring shifts in meaning that they attached to their experiences, as well as obtaining information about their material, social-spatial contexts and circumstances was thus important.

Apart from the biographical consideration, I anticipated that face-to-face in-depth interviews would allow me to explore and probe interesting and relevant areas in greater detail in a flexible and sensitive fashion; allow personal observation, where possible, of the settings in which participants lived or socialised; and make note of the non-verbal communication i.e., gestures, pauses, emphasis, and emotions.

Adoption of a qualitative design and in-depth interviewing allowed me to engage with the capability approach's concern regarding the imposition of value judgements as set out in the next section.

## 5.5.2 Capability approach: conceptual and methodological

### considerations

One component of my study was about finding out what mattered to older people paying specific attention to their contexts. This meant identifying a range of capabilities rather than working from a pre-determined list. Additionally, I was interested in identifying capability changes (if any) for those older people who had relocated to different settings: both in respect of what capabilities they valued and what capabilities they had.

Conceptually, I drew upon the qualitative approach conceptualised by Alkire (2002) and Robeyns (2003) to explore capabilities (for functionings) that mattered to older people. Alkire (2002) adopted a generic multidimensional set of broad and basic domains rooted in 'practical reason' and not in prescription of what a good life is drawing upon Finnis (1980). The basic domains outlined by Finnis (1980) are conceptually compatible with Sen's capability approach.

I drew upon the same set of domains as identified by Finnis: life/health/security, friendships, work and play, self-expression and integration, religion/spirituality, and knowledge. However, as per Robeyns (2003), I assessed the relevance of and synergies if any between six basic domains as outlined by Finnis and emergent themes/domains of wellbeing specific to older people. And for doing so, I engaged with literature (though not exhaustively) that identifies themes and domains that older people have mentioned as contributing to their wellbeing (as illustrated in table 5.1).

Date	Wellbeing themes and domains	Setting	Authors
2000	Psychological well-being Independence and autonomy Social relationships Meaningful activities Care from facility	Sheltered setting	Ball et al
2003	Family /friends/companionship Hobbies/ interests/social life Health Home Independence - freedom of choice, Mobility	Domestic, sheltered and residential care settings	Beaumont and Knealy
2004	Having good social relationships and social roles/help and support; Home and neighbourhood (safe with access to local facilities and services); Social and leisure activities Positive psychological outlook and acceptance; Health and mobility; Having sufficient finances; Independence and control over life	Domestic settings	Gabriel and Bowling
2005	Activities/doing something; Family and other relationships; Home and surroundings; Health; Standard of living/wealth; Faith/religion/spirituality	Domestic settings	Grewal et al
2007	Care environment and ethos of care (autonomy, independence and choice) Personal identity; Connectedness to community and family; Activities and therapies	Residential care settings	Murphy et al
2011	Leisure activities /social life; Family/Relationships with others; Independence; Peace and contentment; Health (feeling good, good health); Living conditions (security, warmth, caring environment); Religion/spiritual life Getting out and about	Residential care settings	Hall et al
2014	Good health; Psychological and emotional wellbeing; Safety; Dignity; Independence/Control over life /Freedom	Domestic settings	Milte et al

**Table 5.1: Wellbeing themes and domains drawn from qualitative research in the Western Context**

The following key observations confirmed that the fairly abstract domains specified by Finnis were relevant to exploring capabilities (for valued functionings) amongst older people:

- *Life/Health/Safety*: There were visible parallels between some of the themes/domains in the aforementioned table and Finnis's domains. For instance, *life/ health/ safety* in Finnis's account parallels health, mobility, and security in wellbeing literature on older people, while, themes such as adequate income, material resources, accessible services, and living in a safe neighbourhood are instrumental to maintaining and sustaining life, health and safety;
- *Friendship* found parallels in almost all themes as social relationships with friends, neighbours, family, attachment and relationships with others in the care settings;
- *Work and play* paralleled engaging in meaningful activities (group and solo), hobbies, and something worthwhile and desirable to do;
- *Self-expression and self-integration* had identifiable parallels in independence and control over one's life, maintaining a sense of self, personal identity, autonomy, ability to have a say and ability to exercise agency and having roles, psychological wellbeing;
- *Religion/Spirituality* as relationship of self to wider than human sources of value found parallel in religion/faith/spirituality in a few studies;
- *Knowledge* found parallels with access to good relevant information (Raynes, Clark and Beecham, 2006); another study highlighted how learning (through formal learning activities, such as, attending courses etc., and informal activities, such as, radio and television programmes, reading) was important to older people as it offered

intellectual stimulation as well as being a source of pleasure and enjoyment (Withnall, 2000).

A theme widely echoed in wellbeing studies is the home, neighbourhood, and physical environment. The theme was understood as contributing to self-expression, security, comfort, and mental wellbeing. Since for my research place was a key concept in understanding how capabilities were shaped, I made a pragmatic decision in order to avoid circularity to not to include it as a wellbeing domain.

## **5.6 Establishing quality of the research**

Unlike in positivist research, evaluation criteria, such as, internal validity, reliability, generalisability and objectivity do not carry the same meaning when applied to qualitative social research (Angen 2000). Particularly, framed within a constructionist epistemological stance, there is no single reality that exists independently as objective facts and that can be discovered using methodological techniques as in positivist paradigm. Further, the relationship between the researcher and the researched is not one of distance, bias free, and neutral but value laden and where, “investigator and the object of investigation are [...] interactively linked so that the ‘findings’ are literally created as the investigation proceeds” (Lincoln and Guba 1985:207). In relation to my research, therefore, a straightforward adoption of such criteria was not the way forward to ensure that I had attended to issues of quality and rigor.

Broadly, two sets of approaches have emerged within qualitative research community to evaluate the goodness of qualitative research (Angen 2000). One set of approaches has attempted to draw up a range of parallel criteria and terms not un-similar to those developed in positivist research. For instance, some (Lincoln and Guba 1985) have

come up with a set of trustworthiness criteria that include 'credibility', 'dependability', 'confirmability', and 'transferability' and later, 'authenticity' (Guba and Lincoln 1989). Others have suggested that researchers consider 'plausibility', 'relevance' and 'validity' (redefined as confidence) (Hammersley 1995). And some others have stressed 'resonance' and 'usefulness' (Charmaz 2006).

These criteria have been the subject of on-going debate, contestations and criticisms. For example, returning to the participants after data analysis (member checking) to establish credibility (Guba and Lincoln 1989) has been criticised as contradicting the assumptions that underpin the notion of reality (as multiple and constructed) in qualitative research (Sandelowski 1993). Contradictory and at times competing philosophical stances have been borrowed from in attempting to draw up criteria to assess qualitative research (Seale 1999).

The other set of approaches emphasise that evaluating the merit of research is a continuous process (Schwandt 1997; Angen 2000). Within this, "knowledge claims and truth" are seen "as negotiable features" (Angen 2000:386) and trustworthiness of research, "a continuous process occurring within a community of researchers" (Angen 2000:387). With a focus on the process of research inquiry, Angen (2000) employs the term 'validation' as opposed to 'validity' when thinking about quality. Validation according to her is, "a judgment of the trustworthiness or goodness of a piece of research" (p. 387). In emphasising 'validation' she notes that,

"In interpretive inquiry, there is no choice but to be responsible for choosing, and much of the craft of the inquiry process lies on



the shoulders of the person conducting the investigation” (Angen 2000:392).

The ethical aspects relate to: examining the moral assumptions that guide the research agenda; whether the work is responsive to issues of difference and diversity; developing new generative understandings of the topic at hand; and, being transformative. The substantive aspects include: being reflexive of one’s own position; values and assumptions as a researcher and to incorporate these as part of the research process from inception to completion; and, providing a written account that is comprehensible, coherent and convincing. Hence,

“validity does not need to be about attaining positivist objective truth, it lies more in a subjective, human estimation of what it means to have done something well, having made an effort that is worthy of trust and written up convincingly” (Angen, 2000:392).

Hammersley (2008) suggests treating the plethora of evaluative criteria (e.g., thick descriptions, peer review, member checking, purposive sampling, prolonged engagement, reflexive diary) that have emerged in qualitative research as a set of ‘guiding principles’ rather than as a universal list. Incorporating these guiding principles into the my research and combining it with Angen’s notion of validation that emphasises a process and reflexive view of the research inquiry, I attended to ensuring the trustworthiness of my research as set out in the following sections. Formal ethical approval was sought from the University of Dundee Research Ethics Committee (attached as an Appendix 1).

## 5.7 Preparing for fieldwork

The next few sections set out the sampling strategy that was adopted in the study, the process of recruiting participants, the topic guide and details of the practice and pilot interviews that were carried out prior to the entering the field.

### 5.7.1 Sampling strategy

Several factors shaped the sampling strategy including the qualitative nature of the research, the particular research questions, and pragmatic considerations of time and resources. I was seeking a sampling strategy that would permit a thorough exploration of experiences of older people living in different settings and how these contributed to their wellbeing. I therefore, adopted a purposive sampling strategy. Purposive sampling is a particular sampling technique by which, “ sample units are chosen because they have particular features or characteristics which will enable detailed exploration and understanding of the central themes and puzzles which the research wishes to study” (Ritchie, Lewis and Elam 2003:79).

A key dimension of the purposive sampling strategy in line with my research questions was related to the living environments of older people. In selecting the sample, I clearly wanted to pick environments that could give me a rich, diverse, information base as well as illuminate and inform. Within the UK, the living environments of older people include domestic settings (mainstream housing either owned or rented) and supported settings such as sheltered, very sheltered, and residential care homes that combine different and varying levels of support and care.

I chose to select the settings from the local authority area of Dundee City Council in Scotland and from neighbourhood areas that vary in terms of affluence. Two factors influenced the choice of Dundee as the study area. Firstly, I knew that a reasonably robust sample could be drawn from across the residential, sheltered, very sheltered settings and domestic homes that were located within the city. Secondly, pragmatic considerations of time and resources influenced the choice. Having lived in Dundee for more than 6 years now, I had local knowledge of the city and I anticipated that I could draw upon the resources of my colleagues and supervisors to gain access and links to useful organisations.

However, choosing to study older people in supported settings meant that some eligibility criteria would apply, particularly in relation to age. Age as an eligibility criterion was thus shaped by pragmatic considerations. Bytheway (1990) has argued that chronological age is, "...widely used as a means of social regulation throughout ordinary life..." (p.18). This is true in UK as well with regard to policies for receiving formal support services at home or gaining access to supported settings where a cut off age of 60 or above is specified. As I was not interested in investigating ageing and ageing processes per se, a homogeneous group was not deemed necessary. Rather diversity of age was welcomed and moreover, the purpose was not to draw comparisons based on chronological age.

Delineating a segment of older people based on chronological age however required reflection on how age was understood and constructed within the study. The use of 'chronological' age and question of defining who is old is fraught with dilemmas because age is conceptualised in many ways - chronologically in number of years, in generational terms, and as a social construction (Degnen 2007). In this

regard, Grenier (2007) points out that, "It is not where the divisions are drawn that is important, but how individuals and societies interpret the boundaries and how these divisions may shape the processes and outcomes" (p.715). She therefore stresses the need for the researcher to reflect on the construction of age in their study as it has implications both for the research process (interview) and outcomes.

While my research used a cut off age because it is institutionalised in practice and could possibly be a marker of richer and thicker experiences, I was at the same time mindful that older people may or may not contextualise their experiences within a framework of chronological age and/or could draw upon a combination of frameworks of chronological age as well as socially constructed ones (Gubrium and Holstein 2000; Grenier 2007). As it happened, chronological age did play a role in the interview process but not in the way I had anticipated as I discuss in a later section (5.9.3) on interviews.

Eliciting information about older peoples' valued functionings, how capabilities for valued functionings were impacted and shaped by their living environments from their own perspective and in their own words necessitated another eligibility criterion, i.e., selecting older people with sufficient conversational and cognitive capacities. Apart from the eligibility criteria of age, older people with conversational and cognitive capacities, an important aspect of understanding the interrelations of wellbeing and place also related to the material and social contexts of the participants' lives. I was therefore interested in selecting a sample that would include some diversity in relation to socio-economic backgrounds.

While the primary interest was in the settings themselves, specific geographical locales within Dundee City were chosen to include diversity

along the socio-economic spectrum. Within Dundee City, Lochee and Broughty Ferry wards not only represent the two ends of the spectrum, [for instance, Lochee has the highest number of deprived data zones and Broughty Ferry the highest number of least deprived data zones as per Scottish Multiple Index of Deprivation (2012)], but, they also have particularly distinct identities and histories. As Tunstall, Shaw and Dorling (2004) note, places too have “life course’, ‘[...] homes, public buildings, and roads are the embodiment of past capital accumulation and the bodies of its peoples and communities reflect the collective benefits of material wealth accrued over time variously in each place (place histories)” (p.7).

Historically, Lochee and Broughty Ferry were separate burghs that were later annexed into Dundee in the 20th century (Dundee City council, 2014a, 2014b). The setting up of the largest jute mills in Lochee by the Cox family in the 19<sup>th</sup> century enabled the growth of a prosperous community, “centre of weaving, a town of double incomes” with a town centre that was “prosperous, with good quality shops” (McKean, Whatley and Baxter 2008:120). The jute mills also attracted a huge Irish immigrant population and Lochee is still regarded, “as a largely Catholic area with its roots steeped in Irish tradition” (BBC 2014). Since the decline of the jute industry, Lochee has however, had mixed fortunes and is currently the focus a major regeneration project (Dundee City Council 2014a). Broughty Ferry, on the other hand, benefited from the setting up of a railway line between Dundee and Arbroath in the 19<sup>th</sup> century. It became home to the jute barons of Dundee and to those wanting to escape the smoke pollution in Dundee as well as a seaside resort for visitors. Broughty Ferry remains to date an upmarket residential suburb of Dundee City.

I chose to identify residential care facilities, sheltered and very sheltered schemes, day care centres, lunch clubs, and local churches within Lochee, and Broughty Ferry to maximise the chances of recruiting a diverse and balanced sample comprising of men and women.

### **5.7.2 Recruiting participants**

I needed to recruit participants from diverse settings: domestic settings, sheltered, very sheltered, and residential care homes. As set out in an earlier section to maximise the chances of recruiting a diverse and balanced sample I concentrated my efforts on identifying registered residential care homes, sheltered, and very sheltered schemes primarily within Lochee and Broughty Ferry. I had anticipated that it would be easier to access participants in supported settings (sheltered and residential care homes) than those living in domestic settings. For accessing participants living in domestic settings I decided to identify a number of day care centres, lunch clubs, local churches and places such as the Dundee Carer Centre in and around Lochee and Broughty Ferry as potential venues.

I identified care homes, sheltered settings and potential social venues through web searches and further through my supervisor's contacts over a number of months. I made contact with the managers, wardens and heads of the local churches of various settings (via email and face-to-face) who could put me in touch potential participants. I gave them an outline of my research (including a copy of my formal ethical approval) and asked them if they could pass the participant information leaflets (Appendix 2) to their residents and members variously. One of the organisations were keen that their role in securing access to participants be duly acknowledged in the thesis and any other reports/papers that were likely to be published thereafter before proceeding any further.

I anticipated that identifying potential participants (initial selection of participants by service provider or self-selection) would have to be agreed upon with the service provider. The participants I recruited included both self-selected as well as participants initially identified by the service providers. In some venues, I was allowed to speak about my research to a small gathering to invite participation and at other times, the managers directly or by putting me in touch with another front line practitioner picked out likely participants and with whom I met individually to discuss and invite participation. Accessing male participants proved more difficult.

While I was conscious about my positionality vis-a-vis the participants, I had not given much thought to my positionality as a researcher vis-a-vis the gatekeepers. However, on two separate occasions, and both in relation to care homes, during the conversation it came to light that the managers had initially presumed that I was a student of medicine or nursing wanting to conduct research in care homes. As one of the care home managers casually mentioned they frequently received requests from the medical and/or nursing students to conduct studies. It seemed that at least that within those care homes, I might have been the first person to conduct social research.

### **5.7.3 Topic guide**

For carrying out the interviews, I had drafted a topic guide (attached as Appendix 4) that would help me in the field to explore areas of interest to my research and at the same time ensure that I had covered key themes consistently in all interviews. Through the interviews I was wanting to explore what kind of things mattered to the participants in

different spheres of their life and how where they lived (place of residence) made a difference to what they could do and be (or not).

In particular, I drew upon Alkire (2002) to encourage responses across a range of dimensions of human flourishing (set out in an earlier section) rather than rely purely on open-ended questioning. These dimensions included, life/health/security, friendships, work and play, self-expression, knowledge and spirituality/religion. Following on from Alkire (2002) each of these dimensions was converted into prompts, for example, if exploring the dimension of work and play, the following prompt was prepared:

What about engaging in activities or hobbies that are meaningful to you or make you feel good/relaxed/satisfied or creates value for you or for others? It could be something you do on your own or with other people, it could anything like solving puzzles to gardening or going to the local pub or helping out with charitable work - it may have nothing to do with earning more respect, or showing off or income- something you enjoy doing for its own sake, to advance your skills.

Of course, the entire prompt was not intended to be read out at once, but to be used as a conversational trigger. This would then be followed by carefully asking participants, how where they lived made a difference to what they could do and be. And, for those who had relocated, to explore, how what mattered to them had been impacted. While such an approach too is not without its bias and may be seen as fishing for answers, previous work using this methodology by Alkire (2002) highlights that bias may not emerge. She reiterates that if people do not find that a particular aspect makes a difference in their lives they will say so.



#### 5.7.4 Practice and pilot interviews

Before carrying out the main interviews I decided I would carry out a practice interview followed by a pilot interview. The practice interview was carried out with my supervisors. The pilot interview was carried out with an older person. The older person happened to be the mother of an acquaintance who had kindly agreed to be interviewed and comment afterwards on the experience of how I might improve the interview. The idea behind the practice interview with my supervisors was to ensure: a smooth flow of the conversation with the participants; that the way I introduced the topics would encourage participants to open up, to take the lead in the conversation and did not have them struggling; the wording and the phrases used were not too abstract and something people could readily associated with. While one supervisor acted as the interviewee, the other supervisor took down notes and we reviewed these as we went along and at the end of the interview. Subsequently, changes were made to the topic guide.

It was agreed that after starting with the opening question of asking participants about their lives, I would first encourage conversation about the places where they lived rather than jump straight into questions about wellbeing. We all agreed that because a part of the life story would make reference to place, it would be appropriate to continue with that before moving onto to wellbeing related questions. Another purpose of the practice interview was about me as the person and the researcher. I was going to conduct research in a different culture from my own. I knew that I would be able to converse in fluent English, that I would be polite, respectful and listen and that was not a concern. What concerned me was etiquettes, such as, how to respond if the interviewees offered me tea and biscuits, what was the appropriate thing to do?

I was invited to conduct the pilot interview at the participant's house in a sheltered setting. The pilot interview was a kind of a trial run and to gather feedback from the participant about how the interview experience was, what worked and what did not work. I conducted the pilot interview following the interview protocol, i.e., talked the interviewee through the interview process, about consent, anonymity and confidentiality, tape recording the conversations, about how I would store and use the information collected.

I obtained a written consent (Appendix 3) before the pilot interview commenced to make sure that she would be happy for me to include her in as a sample. The interview itself lasted for about two hours with a tea break in between (which I graciously accepted). I took notes as the conversation went along. The feedback from the interviewee was positive, she had enjoyed the conversation and she did not find herself struggling for answers. I later transcribed the interview and added notes about things such as my impressions of the interview and observations I had made about the place of residence. The transcriptions and my impressions of the interview were shared and discussed with my supervisors.

As indicated in an earlier section, I had anticipated that my age and ethnicity might play a role in the interview dynamics. However, in this interview, whether because as it emerged in the interview, faith was an important part of the participant's life, the interviewee was curious about my religious affiliations and practices, and, information about which I duly shared with her. My supervisors noted that reciprocity of information might be expected in conversational interviews as I was asking people to talk to me about their lives in great detail.

It was not difficult to corroborate some information that was advanced because it was so obvious. The biographical approach was useful. Conducting the interview in a naturalistic setting (her home) too helped. The manner in which the interviewee spoke about the importance of faith in her life right from the beginning then did not present a surprise when she spoke about faith as an important dimension of wellbeing, a valuable identity, although I had to steer the conversation away from that topic a number of times to focus on other things.

She used visual memorabilia a lot to express what something meant to her. For instance, she loved to knit and actually showed me her knitting machine that she did not use now but meant a lot to her or the knitted gifts that her friends had presented her with. I noticed she was also keen to present a particular identity to me and mentioned during the conversation how nobody wants to hear people moaning about their health. I had to prise information about her health status from her and towards the end of the interview and that was more like a question and answer session. The pilot interview also made me reflect and be conscious that people might be expansive with information about some spheres of their life than others and using a topic guide would indeed be helpful to stay the course.

## **5.8 The sample size**

Justifying that an appropriate sample size has been attained is an issue in qualitative research and operationalising the concept of data saturation is a difficult one in practice (Francis et al 2010). I anticipated that I needed a sample that was sufficiently small so that I could manage the in-depth interviews, transcriptions, and have sufficient time to carefully analyse the data but at the same time large enough to allow me to

meaningfully build robust findings from the data. In formulating the sample size based on a purposive sampling strategy, I had envisaged the likelihood of a sample size of 24-30 participants to ensure that the sample would be diverse.

While I did not attempt to check my sample for data saturation, I monitored the sample as the interviews went along to ensure that I had captured the experiences of older people by different settings and socio-economic locations. I actively pursued gatekeepers to introduce me to male participants, as they were more difficult to come by. I politely refused willing participants when, for instance, I already had a number of women participants living alone in sheltered settings in my sample.

My final sample size comprised of a total of 16 women and 10 men between the ages of 65- 96 (at the time of interviews in 2012 and set out in Chapter 6). Two participants in two different care homes who had initially agreed to participate later decided not to go ahead. Upon asking why there were no longer willing to go ahead they responded saying that they no longer felt like it. One interview had to be dropped, as at the time of the interview the support staff observed that the person lacked sufficient conversational and cognitive capacity.

## **5.9 The interviews**

The interview process as a whole took place over a series of meetings. All interviews were digitally recorded. Initially, I met with prospective participants, chatted with them informally about who I was, what I was intending to do and how I envisaged their participation in the research. I gave them details about my research, answered any queries they had and gave them some time to think about whether they were willing to

participate. People either got back to me via telephone or post and in other cases, as agreed, I called upon the prospective participants after a week or so to find out what they had decided.

### 5.9.1 The interview setting

I then called them up to decide upon the place of the interview and which I left to them, though in relation to care homes, it was the time and the date that was discussed rather than the place. As a result, I ended up meeting with participants in a number of places, such as, their place of residence, the day clubs they frequented and one interview took place in the University. Some did not volunteer to have the interview in their place of residence, rather they were keen to fit me in within their schedules of the day club or other social events that in relation to the University interview was conveniently close for the participant. I interviewed participants in settings they were comfortable and which included their place of residence or the day club they visited. Because I volunteered to fetch a few participants across or drop them back home, I got a glimpse of the places where they lived. But this was not possible for a couple of interviews.

Knowing and meeting people in their naturalistic settings was helpful during the interviews to place what people talked about in the context of their current living conditions, such as, when references were made to gardening, walking, adaptations, how close or far the bus stop was from their residence and (the use of visual memorabilia) when participants talked about their family. But I also knew this was not something I could impose upon the participants and assume that everybody was comfortable with. I however, also started to notice the lack of visual memorabilia within some settings particularly in the care homes and

some sheltered settings. When these participants agreed to a verbal audio recorded consent rather than a written one, I reflected upon the possible reasons for the lack of visual memorabilia. It brought to life the various concepts I was using in my research in relation to personal heterogeneities, interpersonal variations and conversion factors.

The face-to-face interview allowed me to capture as well as corroborate things. When people mentioned some things as being important to them, it often became visible during the interviews as well. For one participant, his daughter in law was very important and it became obvious when he invited her to join in on the interview as his speech was partially impaired. When another participant mentioned that she liked working at a table, I could place it in context because she took me to a meeting room in the care home where we sat at a table for the interview. Her room did not have a table. Many participants found it easy to answer why religion was important or not, but found it difficult to qualify in words why family was important. But showing me a piece of jewellery, the big television screen that the son had bought for the mother, or photos of grandchildren who were doing well in their studies and professionally helped understand the significance of these relationships in their lives.

Where the interview was carried out too influenced the interview dynamics. While most interviews within care homes and sheltered settings were carried out in the participants' rooms or in the quiet spaces within these settings such as the library, or small meeting halls, one interview took place in the dining room of the care home. Although the dining room was generally quiet, there were constant interruptions in the way of staff or residents passing through which then distracted the researcher, the researched as well as the content of the conversation. In the process, conversation threads were lost.

### 5.9.2 Positionality of the researcher

I had anticipated that each interview would be different because people and their contexts would be different. But what I had not anticipated was how different each interview encounter would be. I could not understand why some accounts were more full than others? Why did some need little prompting while with others I had to adopt a more questioning tone? Was it about the topic guide, which worked well in some instances and not others? Was it my style of interviewing? Why did some people take a lot of time to answer questions that others responded to more quickly? In reflecting and pondering upon this back then, and, now again as I write this account in first person, I find myself wondering whether it was a bit about me as the researcher, a bit about the person whom I was researching and how this relationship was reflected in the responses.

I distinctly remember and was simultaneously pleased and surprised to know that one participant (living in a care home) had made notes about what mattered to her lest she forgot mentioning something during the interview. She also had a set of questions for me about India, about where and with whom older people lived, for after the interview. She had then subtly set the tone of the interview and, our relationship as one based upon reciprocity and exchange of information that we were both interested in for may be different reasons. It however also raised the question of what she had chosen to exclude from her story.

I had left information leaflets with participants beforehand that gave them some inkling about what I wanted to know. Perhaps, others too had reflected about what they would say at the interview but did not make it apparent in so many words. At other times, when questions were posed

to some participants, such as, what they liked about where they lived or why something was important to them, I could literally see them thinking about it. It seemed as if they had never thought about this before. I was then reminded about what I had read in literature that, “investigator and the object of the investigation are [...] interactively linked so that the ‘findings’ are literally created as the investigation proceeds” (Lincoln and Guba 1985:207). By asking people questions, I was co-constructing their ‘realities’ and in some instances, for the first time.

Some participants’ valued particular identities and as a consequence of that perhaps, how they saw me, influenced the interview dynamics. Vice-versa, how some positioned me influenced their responses. Some participants told me that they were sociable and loved to meet new and different people. As such, I was also seen as one of those new and different people and the conversation flowed easily. In some other instances, when asking about whether spirituality or religion was important to them, a participant, while confirming that it was not, qualified it with a statement:

There was a very good programme on overseas service, ‘a matter of faith’ and [...] there was this old senior Hindu going on about the caste system and he said, ‘ I am not saying it is good but we have nothing to replace it with (we both laughed).

I sensed that a question about wellbeing that was to me seemingly straightforward however had been interpreted in light of my background as a Hindu.



I was not only positioned with respect to religious affiliations, but towards the end of another interview it appeared that being a woman too might have played a role in the interview conversation with a male participant. This was an interview where I felt I had to adopt a questioning tone as responses were not easily forthcoming. When asking the participant about whether he had made any new friends at the day centre, he responded saying:

‘There are far more ladies than men [...] I find it difficult to talk to ladies (laughs shyly)’.

In the light of that information, I was then glad that he had given me the opportunity to interview him.

Much has been written about the power relationships in interviews and how this is usually skewed in favour of the researchers (Sultana, 2007). However, as I noticed in some instances, during the course of interview, this was not necessarily true. Some participants rushed the interview, responded to my questions saying they were irrelevant, kept looking at their watches and emphasising how they did not want to miss the goings on in the day centre where we were meeting. This was despite the fact that the meeting had been arranged with their prior consent.

At the time of the interviews, I was also in the family way. I was positioned as a would be parent too. Some participants, advised me to take time out to bring up the baby, that parents nowadays did not do that, do not cook for them and rather buy stuff off the shelf. I felt somehow that positions had reversed at that moment. Vis-a-vis the ways others constructed my identity, I felt that I was positioned in multiple ways.

While I was positioned in multiple ways, age was not something that the participants had used to frame our relationship. But I stumbled upon the fact that I unconsciously had some notion of chronological age lurking in my mind. While some interviews typically started off in a chronological fashion, many however did not begin or end with any mention of how old they were. Towards the end of the interview, I had to ask participants about their age or age band as a part of the data. It was when participants revealed how old they were chronologically that I realised that I had been building a stereotype about my participants and these stereotypes crashed instantly. Where I had unconsciously played the number game and imagined some one to be in their late 70s it turned out they were in their late 80s and vice-versa.

### **5.9.3 Ethical issues in fieldwork**

I realised during the interviews, that asking participants about their lives and where they lived brought back painful memories, visible distress, and emotional outbursts for some. I had anticipated that in the sample, I was likely to encounter people who had lost loved ones and had at the start of the interview told the participants that I would not probe areas of their life they were not comfortable to speak about. I felt very bad about it at the time, apologised to these participants and after they had composed themselves, checked if they were willing to continue, steered the conversation to other topics, or introduced a break in the interview process where feasible (for instance, where one of the interviews was held in the University premises and that gave me the opportunity to offer the participant some refreshments and time to compose herself)

The University ethical approval application process and wider reading around ethics in fieldwork with older people had sensitised me to the basic ethical principles including the principle of 'do no harm'. Yet reflecting upon experiences in the field brought to fore some ethical dilemmas. As a researcher entering the field I was conscious about and not intentionally seeking to harm participants in any way and yet choosing to carry out in-depth interviews was an intentional act and where my research interests were guiding the process. I was aware that asking participants about their life stories might produce emotional discomfort for some. On one hand, in-depth interviews as a methodological choice respect participant agency and control over the interview process, a key aspect of significance for this research, and, yet, the process also contains within it the potential for, in this instance, emotional distress.

Reflecting back, at the start of the interviews I had spoken to the participants about respecting their wishes if they were uncomfortable discussing some aspects of their lives. Perhaps, engaging with the above mentioned ethical issue in an anticipatory manner might also have involved discussing with participants early on that narration and retelling of some experiences might be emotionally difficult and discomforting for them. Fieldwork however also indicated the unpredictability of if and how ethical dilemmas might present themselves and making presumptions about harm during interviews. While past experiences for some brought back painful memories, another participant at the end of the interview remarked how much she had enjoyed the interview and particularly, reminiscing about the past.

### 5.10 Data handling and analysis

All interviews were digitally recorded, transcribed verbatim and paper copies were made. The voice files were stored separately so that I could return and listen to these any point. I transcribed most of the interviews myself but some were also sent to a transcription company (TP Transcription Services based in Wales; <http://www.uk-transcription.co.uk/about.htm>) to speed up and begin the process of familiarising with and immersing myself in the gathered accounts. By listening to the recorded conversations, I was able to check the accuracy of the transcriptions produced by the company, re-engage with and remind myself of the conversation, and add, any notes or observations that I had made against the particular interview.

I used the Framework approach (Ritchie and Lewis, 2003) to organise data by themes and cases to facilitate further interpretation and making sense of data. Framework uses a systematic, rigorous and transparent thematic approach to make data accessible. Thematic charts and matrices are used to organise data, with columns describing the key topics, and, rows representing individual interviewees. This allows for exploring experiences within cases and across cases. I worked with printed transcripts and pen to work my way through the data, jotting down notes and making connections. Microsoft Excel and Publisher was used to for preparing thematic charts.

Thematic charting permitted familiarising, summarising, coding, theme building, marking out quotes, exploring interconnections within and patterns across cases. It also meant reading and returning to the transcripts many times. I started off with preparing three sets of thematic charts focusing broadly on three different things (illustrations shown below in Tables 5.2 to 5.4). The first set of charts (Table 5.2

below) looked at what kind of things participants' had said were important to them by different settings. Using research questions and preliminary conceptual framework as a starting point, I developed a series of low level descriptive codes that were close to the participants' accounts, such as, 'what matters' (for wellbeing), 'able to do', 'not able to do', 'what contributes to ability' and 'what constrains ability'. Not wanting to discount or overlook data, I sorted and categorised data under broad wellbeing domain themes that had also supported data collection, such as, 'life', 'relationships', 'religion', and 'activities' amongst others.

The second set of charts again organised by participants living in different settings focused on situating what people valued in the context of places where they lived. For instance, as in Tom's example (illustrated in Table 5.3 below) putting, 'place and relationships' and 'place and activities' side-by-side revealed interconnections and interrelationships between different domains, between past and present, and the significant role of interpersonal relationships.

Table 5.2: Thematic chart 1: What matters for wellbeing by specific domains

Care homes : Thematic charting - Life Respondent		What matters	Able to do	Not able to do /may not be able to contribute to what constrains ability to do in future	Not able to do /may not be able to contribute to what constrains ability to do in future	Comments/ Reflections
<b>JIM, 82, WIDOWER, BERRY CARE HOME FOR PAST 3 YEARS, MOVED FROM A PRIVATELY OWNED HOUSE IN BERRY, WORKED AS A SEA ENGINEER</b>	HEALTH; [...] I liked cooking, I am a good cook and [...] And this osteoarthritis set in and oh! so much effort to cook, you know. They got me a chair so that I could half stand and half sit in the kitchen, but even with that...I had sort of eased up on the eating (59-62:2) B) And arthritis at that time was really crippling me and my house was not adapted. I couldn't look after the garden, I started hating it because I used to love the garden (71-73:2) C) The accommodation (HOME) was alright but it was getting out. I just couldn't get out into the garden, just a few steps to get out, couldn't use a chair or anything (275-77:7) D) [...] they had an operation which was a failure and blinded my right eye. My sense of balance is poor (363-64:8) E) JIM WOULD LIKE TO Get rid of is this pain and arthritis (426:10) F) About this time last year I could go around the garden three or four times but now I can't and that is just a sample (782-83:18) G) but staff are excellent. They do look after me (150:4) I get a shower every morning has to be attended in case I pass out in the shower. My food is brought up here. (763-64:17)	A) ABLE TO WALK IN THE CARE HOME STICK B) ABLE TO SECURE GOOD CARE	A) NOT ABLE TO GET RID OF HIS PAIN B) NOT ABLE TO COOK AND DO GARDENING C) I can't look after myself, in the house can't live on my own(154:4) D) We'll I'll need a specially adapted house for the way my legs are going and worse I am heading for a wheelchair (154-55:4) E) I was getting around alright with a stick but now if I want to go any distances I need a wheelchair (161-62:4) F) NOT ABLE TO SHOWER ON HIS OWN (372-73:9)	A) ARTHRITIS B) PARTIAL BLINDNESS	Osteoarthritis started when Jim was working and since then has got worse. Also had a heart attack and is prone to blackouts	
<b>Tina, 85, WIDOW, BERRY CARE HOME FOR PAST FEW MONTHS, MOVED FROM PRIVATELY OWNED HOUSE IN BERRY, HOUSEWIFE</b>	A)HEALTH. I am so happy here [...] if you are not feeling well, you know, once I was in my bed for a couple of days and some of the girls are true nurses so it's a perfect place to be (251-53:7) AT HOME, it's just that I wasn't going out, I was keeping well enough but I just didn't want to go out, I was in the house most of the time (49-50:2) I don't know, I just couldn't be bothered I used to think what's the point, I get everything delivered (57-8:2) I wasn't happy at home, it was too lonely (481-82:14) B) Getting looked after: I know I'll end my life here and I'm quite happy about it because you're well looked after (359-60:10) i'm more, well (IN CARE HOME) I wasn't coping at home that's the reason I'm in here and I mean I worried my family to death because I wasn't going out, I had home help coming in (400-2:12)	A) ABLE TO BE LOOKED AFTER WHEN UNWELL B) ABLE TO MAKE FRIENDS AND NOT BE LONELY	TINA BELIEVES MOVING INTO A CARE HOME HAS BEEN GOOD FOR HER but I was glad to come here, I'm back to my old self because I was never going out I couldn't be bothered (77-78:3)	AT HOME TINA WAS ON HER OWN I'd been on my own I don't know what the hell happened, I think it was just old age, I missed my husband and then my family going out I couldn't (433-34:13)		

**Table 5.3: Thematic chart – Place and wellbeing**

Respondent	Place and life	Place and relationships	Place and activities	Place and self direction	Place and religion	Place and knowledge
<b>TOM, 88, BACHELOR, LIVING ALONE IN A 2 BED UPSTAIRS PRIVATELY OWNED FLAT IN BERRY FOR PAST 17 YEARS</b>	A) LIVES IN AN UPSTAIRS FLAT WHICH DOWN STRENUOUS BUT MANAGES TO DO IT (105-6.4) B) TOM'S NEPHEW WHO LIVES CLOSE BY PROVIDES PRACTICAL SUPPORT WITH SHOPPING, LAUNDRY AND HOUSECLEANING AND GIVES HIM A LIFT TO AND FRO WHEN GOING OUT (44-45:2) C) Good thing (ABOUT CARERS) is that there is help with things i could not do myself (316:10) D) HAVING CARERS HELP HIM IN MORNING AND EVENING WAKES TOM FEEL SAFE THAT HE WILL NOT FALL	A) TOM'S NEPHEW WHO LIVES CLOSE BY PROVIDES PRACTICAL SUPPORT WITH SHOPPING, LAUNDRY AND HOUSECLEANING AND GIVES HIM A LIFT TO AND FRO WHEN GOING OUT (44-45:2) B) Very good neighbours. This lady who bought flat next to where i stay across the road she is awfully nice and she comes in quite a lot (129-30:5) C) Some memories going back over the years and when my sister was alive, well, we used to socialise with some neighbours further up the street, but, well since she died everything is different (199-200:7) D) TOM FEELS THAT DUE TO THIS SISTER'S DEATH, IT CAN BECOME LONELY ON HIS OWN IN THE HOUSE (201-3:7) E) TOM FEELS THAT IF HIS NEPHEW HAD NOT BEEN THERE, I don't know what i would have done (268-69:9) F) HAVING CARERS COMING HOME ..in the beginning you felt truly bad but, when they came in they are quite so friendly, i forgot all about it (321-22:10) G) TOM HAS LEFT THE FLAT TO HIS NEPHEW (344:11) H) [...] of course, lots of friends i knew in the area have died, it is quite a change (356-57:11) I) GOING TO COMMUNITY CENTRE... Friendliness, everyone is so friendly, even the girls and the manager (366:12)	A) TOM GOES OUT TO THE PUB FOUR TIMES A WEEK AND TO THE COMMUNITY CENTRE EVERY WEDNESDAY. HIS NEPHEW DROPS HIM OFF AND PICKS HIM UP B) TOM REMINISCES ABOUT PAST ACTIVITIES THAT HE ENJOYED DOING IN BARNHILL BEFORE HIS MOBILITY BECAME WORSE (108-9:4) C) TOM FEELS LIVING IN BARNHILL HE HAS TO RELY ON HIS NEPHEW FOR TRANSPORT WHEN HE WANTS TO GO SOCIALISING IN THE FERRY (152-53:5) D) TOM LIKES SOCIALISING/ GOING OUT BECAUSE THE HOUSE CAN BE A BIT QUIET (273-74:9)	A) I don't want to move [pause] you know when you have been in a flat for 17 years you don't want to leave it, don't want to leave the place (72-74:3) B) GETTING SUPPORT FROM CARERS AT HOME ..you feel more at ease; you feel you are not so helpless as you would be otherwise(326:11)	A) When i joined the church, that long time in a things you are happy and you like you will take part in public worship (453:13) B) You see, the next door is a bright lady and reads lots [...] and has plenty of interesting comments and opinions and even if i don't agree, i like salty people (355-58:10)	
<b>KATE 80, WIDOW LIVING ALONE IN A 3 BED PRIVATELY OWNED HOUSE IN BROUGHTY FERRY FOR PAST 40 YEARS, WORKED AS A PHYSIOTHERAPIST</b>	A) I have had to give up my car because of ARMD in eye so this is a very good house because it has good public transport B) BIG HOUSE AND GARDEN BUT ABLE TO MAINTAIN (32-33:1) C) CHANGED GARDEN LAYOUT TO MAKE IT MANAGEABLE (47-51:2) D) FAMILY IS VERY IMPORTANT BUT THEY ARE IN GLASGOW AND I DON'T SEE THEM OFTEN (250-51:7) E) Friend with whom i socialise here have been here for 40 years (304-5:9) [...] but people i have shared a life with are really not here (297-98:9) F) You know there is usually not a day when i don't see somebody [FRIENDS] (313-14:9) G) You have to make an effort to keep in touch with people who are faraway [...] do it mostly by phone (346:49:10) H) When you are young and have a you are meeting other young mothers at school, it is easy to kind of build up a circle of friends but not so easy when you are older (523-25:15)	A) And i have very nice neighbours and [...] I have had the same HELPFUL NEIGHBOURS WHO ARE ALSO FRIENDS (107-8:3) B) It is hard to do the big shop without the car(57:2) C) IF KATE NEEDS TO MOVE, SHE WILL MOVE CLOSER TO HER SON AND HIS FAMILY IN GLASGOW (134-38:4) D) Family is very important but they are in Glasgow and i don't see them often (250-51:7) E) Friend with whom i socialise here have been here for 40 years (304-5:9) [...] but people i have shared a life with are really not here (297-98:9) F) You know there is usually not a day when i don't see somebody [FRIENDS] (313-14:9) G) You have to make an effort to keep in touch with people who are faraway [...] do it mostly by phone (346:49:10) H) When you are young and have a you are meeting other young mothers at school, it is easy to kind of build up a circle of friends but not so easy when you are older (523-25:15)	A) I have had to give up my car because of ARMD in eye so this is a very good house because it has good public transport (33-5:1) It is hard to do the big shop without the car(57:2) [...] so if i have anything heavy i do ask a friend for a lift (67-8:2) C) IF KATE NEEDS TO MOVE, SHE WILL MOVE CLOSER TO HER SON AND HIS FAMILY IN GLASGOW (134-38:4) D) Family is very important but they are in Glasgow and i don't see them often (250-51:7) E) Friend with whom i socialise here have been here for 40 years (304-5:9) [...] but people i have shared a life with are really not here (297-98:9) F) You know there is usually not a day when i don't see somebody [FRIENDS] (313-14:9) G) You have to make an effort to keep in touch with people who are faraway [...] do it mostly by phone (346:49:10) H) When you are young and have a you are meeting other young mothers at school, it is easy to kind of build up a circle of friends but not so easy when you are older (523-25:15)	A) For as long as i can manage i will be here (145:4) B) By the time you get into a care home you are beyond coping with autonomy (370-71:10) C) Well if i become dependent on outside help then i will have to think [...] where i live [...] (490-92:14)	A) I have learnt that if you stay a long time in a things you are happy and you like you will take part in public worship (453:13) B) You see, the next door is a bright lady and reads lots [...] and has plenty of interesting comments and opinions and even if i don't agree, i like salty people (355-58:10)	

A final set of charts focused on specifically on how places at different scales and across what dimensions (material, social and symbolic) were connected to different valued aspects of multiple participants' lives (illustrated in Table 5.4 below).

Table 5.4: Thematic chart – Characteristics of place

Participant	Characteristics of Place			Perceptions about place	Quotes
Scale	Material dimensions	Social dimensions	Identification with place		
JACK & JILL	Neighbourhood Transport facilities available	Friendly and helpful neighbours but do not socialise any more	Identity with wider locality (Berry) as a contributing to a good social life and as offering good educational opportunities for children and grandchildren; Communal activities available in Church; Going to the harbour, café, ice-cream shop almost every day;	Jack is concerned about security from intruders when wife is not at home although they believe they live in a good area	JILL: we've got very pleasant neighbours, we don't run out and in or socialise. I mean, I used to go quite a lot to next door, but my neighbour is not very well now and my husband needs my attention so, but we're perfectly friendly with our neighbours, they're all nice and if you need a help, they're there and they're really nice. JILL: I mean, there two bedrooms up the stair, which are not bedrooms, well one is the office and this is a bedroom as well, because husband was having bother with the stairs JACK: I don't think I would be as well as I am if it wasn't for my wife[...] I think I would be in a home if she wasn't here. JILL: when I was going out, I furnished my husband with the door open, though this is a quiet street and a quiet house and you would really never bother at all, but then there is the off chance [...] INSTALLED A chubb lock, which has a key inside it. I have phoned the alarm people and they have the key, they have the number of the key pad JACK: It's the nicest place that we've ever lived. It's the nicest place I think we've ever been socially. And our involvement with the church has been, perhaps, the nicest we've ever had here. And from the point of view of the children and grandchildren, they've all done very very well here, from an education point of view. And I can't think of anything that we could or would say against Broughty Ferry. JILL: we'd hate to live anywhere else. JACK: son in law and daughter and their two older boys are all drivers now, so we're never stuck. My wife's daughter takes her shopping, once or twice a week [...] JACK: I don't know if I can still do it because it's been closed for the summer, is indoor bowls in the church. I'm waiting for that to start to see if I can do that JILL: we're out every day for a wee while, we go down to the ferry and we have a wander down to the harbour and we have a coffee and we get a taxi down and a taxi back, JILL: Yeah. We get picked up in the morning [CHURCH FRIENDS] and I go to the guild and my husband got the carpet bowling and, yeah. And there's Saturday morning coffee at the Kirk as well. There's, between 10 and 12, there's a coffee morning and it's nice as well. You just meet everybody and have a wee chat, it's really pleasant. we're exceedingly lucky, because my daughter just lives five miles along the road, so we've been well involved with the boys and she's a manellous support to us, now that my husband is really quite frail and [sighs] she's a really good help.
	House as a site for care Bedroom on a ground floor enables JACK to sleep downstairs as physical mobility is impaired Security lock installed on front door operated from outside	Jack is cared for by his wife at home	Enjoy good Social life; church membership enables participation in communal church activities; Church friends take them to Guild, for carpet bowling and coffee morning at Church		
	Wider locality and Church				
	Wider locality	Daughter and her family provides practical support and emotional support; participation in family life			
Church		Get a lift from friends for going to church	Religious affiliation		JACK: we have to get a lift for church. JILL: my husband isn't able to get on the bus and we have the four wheel rollator there, but it's inconvenient to take on a bus
Wider locality	Going to the hotel once every month	JILL meets up with her contacts from work			JILL: I still have my nurse contacts, nurses are like that, staff nurses, we have coffee in the post office bar the first Thursday of the month.
Carer Centre (City)	Centre which provides services and support for carers;	Has access to carer network			JILL: the carers had a thing and there's a stress management course[AT CARER CENTRE] and I'm going to it, because I'm stressed.
City	Bridge club; JACK GOES TO BRIDGE CLUB TWICE A WEEK; JACK GOES SWIMMING EVERY DAY)	JACK'S bridges partner takes him to club and brings him back			JACK: I play bridge twice a week and my partner gives me a lift. JILL: He goes to the [...] centre with a friend. He taught her bridge, now she is helping him greatly. She's really nice and she collects him on a Wednesday at half past twelve, twenty to one and then brings him back fourish. And then on a Thursday night [...] JACK: With the bridge, I'm almost certainly going to have to give up the bridge, because I'm not coping with it and I used to be a very good bridge player. JILL: I swim in Dundee itself in [...] a daily thing (with emphasis) Well, it's my time actually. And I don't play golf and I don't play bridge, I swim.

Preparing the thematic charts and fracturing data was useful to identify themes. Looking within and across cases highlighted some common dominant themes around issues of health, such as, 'mobility', 'security',



and 'identities', the role of personal relationships in participants' lives, the things participant's valued doing, the interlinked nature of these aspects, and how, these were tied to places where they lived. But fracturing data also runs the risk of losing sight of the whole of the individual stories. Alongside preparing the thematic charts I re-read the transcripts to maintain familiarity with the whole individual stories.

The thematic charts however also highlighted nuances. At generic level participants broadly valued similar things, such as, driving a car or getting out and about. But, looking at specifics they valued very different aspects relating to driving a car or even for the same person getting out and about was specified at different levels such as going to town or going to do shopping. Pursuing these lines of inquiry further then revealed different but contextualised experiences of living in different places across participants and even for the same participant: tied to 'different dimensions and scales of place', 'valued capabilities', 'personal characteristics', 'change', and 'particular situated contexts'. With these broad key themes in mind, I read and re-read the transcripts and looked at the charts again with the purpose of exploring connections and relationships between them - for instance, what kind of changes participants referred to, what valued aspect of their lives did it impact and how did it relate to the different themes.

The data in the three analyses chapters that follow includes a mixture of short quotes, some longer passages, and a case example. Accounts have been used that are clearly illustrative of the key themes and aptly highlight particular discussion points.

### 5.11 Chapter summary

This chapter set out the research methodology, design, and methods to describe how research with older people living in different settings, i.e., domestic, sheltered, very sheltered, and residential care settings was carried out. I have attempted to present a clear, reflexive and transparent account as I see reflexivity and transparency as contributing to the quality of the research carried out. I now move to the empirical section of the thesis comprising of three analyses chapters (6, 7, and 8). Chapter 6 sets the scene for the subsequent chapters 7 and 8: firstly, mapping out the kind of things older people said mattered to them and secondly, discussing the significant role of health in participants' account and its impact on many valued spheres of their lives.

## **Chapter 6 : ANALYSIS –CAPABILITIES THAT MATTER**

The analysis is organised around three chapters. Together the three chapters capture, highlight and describe the fluctuations, continuities, and changes in older peoples' lives that structured and were in turn structured by the dynamic interplay between individual and socio-spatial factors. The interplay of these factors shaped capabilities in diverse ways and with varying implications for place of residence for some. The first chapter looks primarily at functionings that mattered to participants and the role of health in influencing capabilities for functionings that mattered; the second chapter builds upon this and in drawing upon participants current experiences of living in different settings examines the interplay of individual and socio-spatial factors to develop a relational and contextualised understanding of how capabilities were shaped. The third chapter focuses on experiences and processes of relocation. It explores reasons for moving and the implications of moving for participants' capabilities.

### **6.1 Introduction**

This chapter sets the context for the chapters that follow. The next section (6.2) provides a brief profile of the settings and participants. This is followed by an overview describing the different kinds of functionings that mattered to the participants' in section 6.3. By using a particular participant's example in section 6.4, I portray and highlight the interconnected and complex linkages between various capabilities that matter and the capabilities that a person has. The theme of health emerged as a dominant cross cutting theme in participants' accounts. Section 6.5 presents a themed analysis of the role of health both as impairment and as a valued functioning in differentially influencing

capabilities for various functionings. The key findings are then discussed in section 6.6 followed by a concluding chapter summary.

## 6.2 Setting and participant profile

In-depth interviews were conducted with 26 participants drawn from domestic, sheltered, very sheltered, and care home settings across Dundee and Broughty Ferry (Table 6.1).

	Dundee(primarily Lochee)	Dundee(primarily Broughty Ferry)
Type of setting	Number of participants recruited	Number of participants recruited
Domestic	4	5
Sheltered	2	3
Very sheltered	3	-
Care home	6	3

**Table 6.1. Profile of participants by setting and location**

### 6.2.1 Setting profile

Participants were recruited from more and less affluent parts of Dundee City. Place of residence varied by the nature and type of support it offered and the physical characteristics of the property. In domestic settings that comprised of ordinary housing, support (in the form of community services) was linked to the person. In supported accommodation, (sheltered, very sheltered and care settings) some forms of support were part and parcel of the accommodation.

Sheltered and very sheltered settings where participants lived varied in design, and by providers (housing association and local authority owned). Self-contained housing units within these settings were available only on a rental basis. Place of residence of different participants within these settings was located both: in purpose built complex along with relevant communal facilities (including libraries, laundries, gardens, communal social spaces and, in the case of very

sheltered settings, dining facilities); and, in terraced housing with individual back gardens.

The housing units that were visited in sheltered and very sheltered settings were fitted with emergency alarms units, had adapted bathrooms, and intercom facilities. Purpose-built complexes were fitted with lifts. Some participants lived in one-bedroom units and some others in two bedroom units. Guest room facilities too were available. The individual (public) rooms that were visited by virtue of interviewing participants too were of varying sizes even within the same complex. Settings were located in residential suburbs with easy access to bus stops. All of the visited settings had on-site scheme managers from Monday –Friday (9-5pm) and residents could receive telephone calls from the managers over the weekend if they specifically requested for one.

Care homes that were visited were both under private and charitable ownership and included both residential and nursing care homes. Some care homes were modern purpose built complexes and others were housed in what previously had been older large family houses, but all were fitted with lifts. While three of the four care homes that were visited were located in residential suburbs, one was situated right in the centre of the town in Broughty Ferry. The individual private resident rooms in care homes that were converted from older family houses seemed much more spacious than the ones in modern purpose built care homes. The converted care homes had more communal lounges and spaces. While two of the care homes had large gardens the other two only had small landscaped patios. All care homes had appointed activity coordinators. One of the care homes boasted a bar and a library, another had its own hair dressing salon, and a third one had a chapel within the

care home. One of the care homes was in the process of being fitted with en-suite shower facilities. All the four care homes had easy access to bus stops.

Participants living in domestic settings included both owners and tenants living in a range of housing types. The housing types included detached houses, semi-detached houses, flats in traditional tenements and modern apartments with lifts. Those living in detached and semi-detached houses had spacious gardens in the front and back. Those in tenements had small yard type back or front gardens. These were either directly observed by the researcher or described by the participants.

### **6.2.2 Participant profile**

A total of 16 women and 10 men between the ages of 65- 96 (at the time of interviews in 2012) participated in the in-depth interviews. 24 such interviews were undertaken where two out of the 24 interviews were carried out with couples (Jack and Jill; Stuart and Sara in tables 6.2-6.4). The key characteristics of participants by age, gender, living arrangements, self-reported health conditions, and previous occupation by setting are presented in the tables 6.2 to 6.4 below. Many participants reported a range of health conditions. Reported health conditions included arthritis, diverticulitis, heart attack, stroke, Parkinson's, macular degeneration, fibromyalgia, and multiple sclerosis. Some health conditions were on-going and continuous (for example, Parkinson's, age related macular degeneration) and others occurred as episodic or discrete events (for example, stroke, heart attack, and injuries related to arthritis). A few had (or continued to have) multiple health problems. Three participants, two women and one man also reported providing care for their spouses who were living with various health conditions, such as, Alzheimer's, stroke, chronic obstructive pulmonary disease, and

Parkinson's. A few reported having no health conditions. To maintain confidentiality names of the participants have been changed.

	Age	Gender	Living arrangement	Self reported health conditions and impairments	Previous occupation
Tom	88	Male	Alone (bachelor)	Stroke (Impaired physical mobility)	Staff Nurse
Kate	80	Female	Alone (widow)	Age related macular degeneration (visual impairment)	Physiotherapist Spouse (Lawyer)
Maggie	79	Female	With spouse	No reported condition	Postmistress Spouse (administrator in head post office)
Henry	73	Male	With spouse	Stroke and heart attack (Impaired physical mobility and breathlessness); suffers from depression;	Baker (managerial capacity) Spouse (worked in the bakery)
Nina	89	Female	Alone (widow)	Balance not good	Cleaner at school Spouse (Bus driver)
Penny	82	Female	Alone (widow)	Age related macular degeneration (Visual impairment)	Did not work (after marriage at 19), Spouse (Businessman)
Peter	72	Male	Alone (widower)	Stroke (Impaired physical mobility and partial speech impairment)	Engineer and manager (building works company)
Jack and Jill	80 and 76	Male and Female	Married couple	Jack: Dropped foot; onset of Parkinson's (Impaired physical mobility) Jill: no reported condition	Jack: Customs officer Jill: Nurse

**Table 6.2: Key characteristics of participants in domestic settings**

	Age	Gender	Living arrangement	Self reported health conditions and impairments	Previous occupation
Rita (S)	80	Female	Alone (widow)	No reported health condition	Training administrator Spouse (Engineer)
Darren (VS)	67	Male	Alone (divorced)	Fibromyalgia (Impaired physical mobility)	Field contractor
Tara (VS)	89	Female	Alone (widow)	Age related macular degeneration (Visual impairment)	Psychiatric nurse Spouse (worked in transport sector)
Joe (S)	65	Male	Alone (widower)	Arthritis and diverticulitis (hip injury and impaired physical mobility)	Truck driver *
Cathy (VS)	81	Female	Alone (widow)	Spondylitis; and arthritis sorted (following knee replacement surgery)	Cashier Clerk *
Meg (S)	80	Female	Alone (widow)	Heart attack; Diabetes (Impaired physical mobility)	Office worker*
Betsy (S)	84	Female	Alone (widow)	Arthritis (Impaired physical mobility)	Factory worker*
Diane (S)	79	Female	Alone (widow)	No reported condition	Office worker*

\* Spouse's occupation not known

S – sheltered setting; VS – very sheltered setting

**Table 6.3: Key characteristics of participants in sheltered and very sheltered settings**



	Age	Gender	Living arrangement	Self reported health conditions and impairments	Previous occupation
Jim	82	Male	Alone (widower)	Osteoarthritis (Impaired physical mobility)	Engineer*
Tina	85	Female	Alone (widow)	No reported health condition	Housewife*
Benny	88	Male	Married couple	Age related macular degeneration (Visual impairment)	Director (Private company) Spouse (housewife)
Bob	89	Male	Alone (widower)	Stroke (Impaired physical mobility); Depression	Truck driver*
Peggy	89	Female	Alone (widow)	Age related macular degeneration (Visual impairment)	Factory worker Spouse (Scaffolder)
Jane	96	Female	Alone (widow)	Age related macular degeneration (Visual impairment)	Worked in a grocery shop Spouse (Shop manager)
Sally	86	Female	Alone (widow)	Leg amputated (Wheelchair mobility)	Factory worker Spouse (Driver)
Stuart and Sara	81 and 78	Male and female	Married couple	Stuart: Multiple sclerosis (impaired physical mobility and prone to falling) Sara: Stroke (impaired physical mobility)	Stuart: Clerical worker Sara: Hospital assistant

\* Spouse's occupation not known

**Table 6.4: Key characteristics of participants in care settings**

The main focus of the analysis was on developing an understanding of interactions between people and place in shaping capabilities (for valued functionings). In doing so, however, two considerations were significant. Firstly, it was important to elicit what kinds of functionings mattered to older people. Here, rather than presupposing and imposing value judgments about the kinds of functionings that older people value, the participants were asked about the kind of things that mattered to them

(as indicated in chapter 5). And secondly, asking participants to identify and articulate what mattered to them offered a contextualised account that then provided the basis for exploring the interplay of individual and socio-spatial factors in shaping capabilities. The following section provides a brief overview of the functionings that participants valued or thought were important in their lives.

### 6.3 What matters to older people

Participants mentioned a range of functionings that they valued. A plurality of functionings in different domains mattered for each participant. Clearly, the importance of these functionings varied from one person to the next. The kinds of functionings mentioned more frequently broadly included, getting out and about from the place of residence, doing meaningful activities/having something to do, having and (or) maintaining good health, being and feeling safe and secure, family and friends, exercising choice and control over valued activities, managing daily necessities of life, and, participating in social life. Other functionings though important were not frequently mentioned, including, practicing faith, not being lonely, supportive care relationships, taking care of one self (self-care), and, living in current place of residence. Having sufficient finances too mattered to some and is a resource that might be important in a number of domains.

The Table 6.5 below provides an overview of the functionings variously identified by the participants by broad domains. The notations at the end of the quotes in the table stand for (SS: Sheltered setting; CHS: Care home setting; DS: Domestic setting; VSS: Very sheltered settings)

Domain	Functionings that matter	Sample Illustrative quotes
Life	Having good health; Avoiding depression; Not being anxious; Feeling safe from intruders; Feeling secure in relation to health; Managing daily necessities of life; Being clean, not smelly; Eating well	<b>Diane:</b> Mainly to have health that is very important [...] I feel, without my health, that severely curtails every thing. If you cannot go out, health plays a very big role, it would play a very big part in my life (SS) <b>Peggy:</b> My cleanliness, that's important to me, very important [...] My mother had eight of family and you were not allowed to go about 'grubby', as she used to call it [...] There's nothing worse than smelly people (CHS)
Relationships	Having a family and friends; Companionship; Enjoying social roles (being a parent and grandparent); Being looked after; Experiencing supportive service relationships; not being lonely	<b>Maggie:</b> Family is definitely important [...] I have a great grandson, I never thought I had live to see a great grandson, he is a topper (DS) <b>Tina:</b> [...] it was the best thing I ever did coming in here [CARE HOME], it's where they make me feel comfortable and nice [...] like at night I get a cuddle and wee things, I said to them, I am not a Mrs... I am Tina [...] it makes such a difference (CHS)
Work and play	Getting out and about beyond place of residence; Socialising in day clubs, with friends and family; Doing meaningful activities (watching television, reading, enjoying walk, driving car)	<b>Penny:</b> I'm here at the community centre (day club) every day [...] there's dancing. It just varies, it's the company and you can play, there are cards [...] It's good fun. (DS) <b>Diane:</b> My biggest enjoyment comes from books and which I don't need to go out to do. I can just read forever (SS)
Self-direction	Making decisions; exercising choice and control over doing valued activities; Keeping independent; Self-esteem; participation in community matters (e.g. day care centre; staff resident meetings in care home); Being who one is;	<b>Tara:</b> I like my own independence [...] I have always been independent [...] making decisions and things like that (VSS) <b>Sally:</b> the activities woman she would like me to go for everything and I say to her I don't want to go and play dominoes every day and talk about nostalgic things as much as they are enjoyable (CHS)
Knowledge	Enjoy different views and opinions on world matters; Learning new skills (e.g. painting, computer use); Accessing information (related to care and care giving, pension); Sharing information; Living in a familiar environment	<b>Kate:</b> friends with ideas that you could spark off, I really appreciate that (DS) <b>Sally:</b> I have always been curious [...] you find yourself looking at news items for things that are going to happen [...] down at the harbour there is a lot of stuff going on and I am really interested in that (CHS) <b>Nina:</b> you are hearing different stories and if you can advise anybody I think you should do that [...] (DS)
Religion	Practicing faith; Attending church	<b>Kate:</b> [...] and the church matters [...] I think it gives you a lot of strength because nobody's life will be total bed of roses (DS)

**Table 6.5: Functionings that variously mattered to participants**

Exploring why particular functionings mattered revealed interconnections and interdependencies. For instance, some talked about the importance of good health as supporting the capability to go out from the place of residence or the capability to exercise choice and control over what they want to do and when. Others talked about going out as contributing to the capability to be healthy. Although, many participants mentioned broadly similar things such as driving a car (and something they could no longer do) as being important, emphasis on the capabilities that driving a car supported was very context specific. For some, driving a car had been important in contributing to maintaining social relationships and managing daily necessities of life, for some others, driving contributed to a valued gendered (masculine) identity, and for some others, driving contributed to being independent in pursuing valued activities.

#### **6.4 Interconnected nature of valued capabilities across an individual**

This section provides an individual's case example (Tom's in Table 6.6) to illustrate more fully the plural nature of valued capabilities and the complex ways in which these capabilities were interconnected. Tom's case usefully illustrates that dynamic valued capabilities can clash, and, potentially, trade-offs have to be made. Tom's case example however, does not in any way imply that other participants valued the same capabilities or their contexts were similar.

Tom is a bachelor and lives in an upstairs flat in a tenement on his own. He suffered a stroke many years ago and since then his mobility is impaired. According to Tom, he can climb up the stairs on his own but coming down the stairs is difficult even with the side rails to hold on to and takes a lot of time. He even knows the exact number of steps that he needs to negotiate.

**Tom:** See long time ago, about 10 years ago [not clear] I had a wee stroke and of course well and affects my hand and leg [...] the leg was weak to start with but now since then it is much weaker and as you can see now it is completely gone off.

**Manik:** You are on the first floor you said. So is there a lift?

**Tom:** No, no, walk up 11 stairs.

**Manik:** Walk up 11 stairs and that is not an issue?

**Tom:** No, I can walk up but coming down is a different thing (pause) I have to take my time I eventually get down but slowly....

Impaired mobility had impacted other areas of Tom's life too. Fear of falling meant he avoided doing self-care tasks (bathing and dressing) and he was attended to by social care assistants both in the morning and evening. He also mourned the loss of not being able to do activities he had previously enjoyed.

**Tom:** I get a carer in the morning and a carer at the night. Well morning one comes to give me a shave and shower and night one comes to get me ready for bed. Although, probably at night I can do it myself but I am always afraid of falling. I used to enjoy beautiful scenery, long walks and had a wee cocker spaniel my sister's, and I used to take it out but now it is all... since I had this....

He emphasised that health was important to him, but he had only realised its value now that he did not have it. Tom openly reflected about how before his impairment he had assumed health as a given and had not consciously given much thought to in his everyday life until it was compromised and affected a range of functionings. And now he had to face this as well as adapt to it.

**Tom:** Before I had this problem, I took everything for granted and that nothing would happen to you and then of course this thing happened and I just got to put up with it.

### **SOCIALISING**

Tom valued socialising. He went out almost on a daily basis.

**Manik:** So you come to this centre (day club) on a Wednesday and where else do you go out?

**Tom:** I go socialising in the Ferry in [...], there is a pub there. I have been going there for six years now. I go there four times a week. We have good time especially on a Wednesday [at the club]

Being able to socialise was valued in the context of loneliness brought about by loss of valued relationships and by consequence, reduced social networks. Tom had lost his sister who used to live with him a couple of years ago. And over the years, other age related changes had occurred simultaneously such as, loss of friends thereby affecting Tom's valued relationships and social network. Being lonely for him was an outcome of reduced valued social networks. He mentioned having no contact with his neighbours.

**Tom:** [...] when my sister was alive well we used to socialise with some neighbours further up street but well since she died everything is different [...] and of course lots of friends I knew in the area have died. It is quite a change [...] Loneliness more than anything else. I read a lot and watch television quite a bit. Although, I have a television in the house, but, you want to get out sometime [...]

As Tom revealed, having a nephew living locally, was significant in contributing to his capability for socialising.

**Tom:** [...] well I mean he [NEPHEW] takes me to all these places I didn't know before. He introduced me to the social clubs and everything.

### **SOCIAL AND SERVICE RELATIONSHIPS**

Tom not only had the capability to socialise, but his nephew and the nephew's wife supported capabilities for a number of other functionings such as, shopping and, managing other household tasks (laundry and housecleaning).

**Tom:** Well as I say my nephew he does all the shopping and I just put into the microwave [...] his wife she does it [CLEANING AND LAUNDRY] He comes in every day, he does the shopping and everything generally on a Monday, he goes into shops and I give him the money.

Being able to act in accordance with his values despite limitations imposed by health and age related changes was important in itself, but having support from his nephew and the availability of personal care services, further, gave Tom a sense of control over his life and reinforced his sense of self.

**Tom:** [...] of course if they [NEPHEW AND NEPHEW'S WIFE] hadn't been here I don't what I would have done [...] [IN RELATION TO SUPPORT FROM PERSONAL CARERS] you feel more at ease; you feel you are not so helpless as you would be otherwise.

### **ON-GOING CHANGE, CONTINUITY OF PLACE AND CAPABILITY TRADE-OFFS**

Deteriorating mobility however signalled a temporal dimension and held implications for getting out and about over time as Tom lived in an upstairs flat in a tenement block. Although he already found it difficult to negotiate the stairs, maintaining continuity of place was very important for Tom. He had been given the option to move to a ground floor flat that he had refused.

**Tom:** There was a lady who I met and she said I was entitled to a ground floor flat and I said no, I don't want to move (pause) you know when you have been in a flat for 17 years you don't want to leave it, don't want to leave the place. I said no I prefer staying here. The thought of moving is difficult [...] when you think back of all the things you have done when you were young and I was very happy here [...]

**Manik:** Even if you are not able to get out of the flat in the future?

**Tom:** Well (long pause). I don't know. I don't want to spend time worrying about it and more you worry worse it gets, so I try not to worry.

It was in this context that Tom chose not to think about the future and was unwilling to discuss it any further as it was distressing and made him anxious.

**Table 6.6: Case example – Tom (interviewed at the day club)**

Tom's numerous valued capabilities: to socialise, to not feel lonely, manage daily life, to feel confident and in control, maintain continuity of residence and self were shaped by a cluster of other member capabilities (for other functionings). These included, having a family living locally, being able to manage daily life, being able to access appropriate transport and support to get from home to the pub or day club on a daily basis, and being able to access support with personal care tasks.

Support with personal care was not just a matter of hygiene related tasks, but indirectly and positively contributed to his capability to participate in social life. These member capabilities in turn reinforced the valued capability to maintain continuity of place of residence, and a sense of self. Despite the fact that he could foresee and was experiencing change in his mobility related functionings, however, his attachment to place of residence made it difficult for him to make trade offs between two valued capabilities: the capability of maintaining continuity of place and the capability to get out and about.

## **6.5 Health: a dominant cross cutting theme**

In teasing out the interconnections between capabilities for various functionings, what became apparent from reviewing the participants' accounts were the extensive references to experiences of health (self and/or spouse), both in the past and on-going, in relation to, what people said they valued doing and what they were actually able to do. Health emerged as a dominant cross cutting theme. References were made both to physical and mental health and included reports of how some participants were affected by their health conditions (section 6.5.1) Others talked about health as something that allowed them to pursue other valued capabilities, and hence, actively sought to maintain and

manage (section 6.5.3). In exploring the interplay between individual and socio-spatial factors in shaping capabilities (for valued functionings), it therefore, became important to first attend to the implications of health in influencing capabilities for various valued functionings.

### 6.5.1 Impact of impairments

Health conditions (self and/or spouse) and, subsequent impairments for some, directly and indirectly influenced a range of functionings to varying degrees. Functionings that were affected are indicated as underlined in the quotations below and have been discussed under the key themes of mobility, exercising choices, control, competence and identity, doing basic household tasks, reduced social networks, feeling secure and safe, in no particular order. While acknowledging that there were some commonalities across the range of functionings that were impacted for individual participants, the purpose of identifying the above themes is to highlight the diversity of functionings that were influenced.

#### Mobility

Directly, for some, health conditions affected mobility and sensory related functionings. Mobility and sensory related functionings included driving a car, walking, climbing the steps, and doing specific and meaningful (leisure) activities. Indirectly, a cluster of other functionings were influenced, such as, managing daily necessities, getting around, using public transport, maintaining social relationships, visiting friends and family, freedom to get out and about as and when, and, sense of identity, although, these varied across participants. Some mobility related functionings are interconnected. For example, it is not possible to use the public transport if an older person cannot walk to the bus stop.



Kate: I have had to give up my car because of macular degeneration in eye [...] It is hard to do the big shop without the car [...]

Manik: So you miss it for the shopping?

Kate: And the social things, you know, I have friends around the place and it is quite a walk and maybe the bus does not go there [...] And you can help, you can give other people a lift, you know, that kind of a thing.

[Kate, 80, widow, living alone, domestic setting, macular degeneration of eye]

Henry: I used to [drive] but when I had a stroke I had to give it up [...] I have got a taxi card<sup>ii</sup> [...]

[Henry, 73, living with spouse, domestic setting, tenant, multiple health conditions]

Joe: I could use the stairs hardly. I can use the stairs now but I still have difficulty going downstairs I can get up no problem. [...] cannot play golf anymore. I used to play golf all the time [...]

[Joe, 65, hip injury due to arthritis, lives alone, sheltered setting]

Jack: [...] one of the things that is not so good is that I'm no longer able to drive. So we don't have a car [...] when I had the car, I always drove, so... which was a men's thing really [...]

Jill: We have bus passes. But my husband isn't able to get on the bus and we have the four-wheel rollator there, but it's inconvenient to take on a bus [...]

[Jack, 80, diagnosed with Parkinson's, and Jill, 77, Jack's wife, domestic setting]

The nature and the extent of the impairments varied across these participants and that had implications for the mobility related functionings that were directly impacted. For Kate, visual impairment meant giving up the driving and, for Joe, the functioning of climbing the steps and playing golf was affected. But for some others, like Henry and Jack, a range of mobility related functionings were impacted including driving, walking, using the public transport, and, for a few, getting around on their own. For Jill (Jack's wife) the strenuous effort required to push the wheelchair on and off the buses meant that converting the characteristic of wheelchair (a resource that allows movement) into the capability to use public transport was not possible.

Some mobility and sensory related functionings that were affected, such as, walking, and seeing are functionings that enable other functionings such as, walking to the bus stop, taking the bus or getting around from one place to another freely. In this sense, walking and seeing could be seen as functionings that are foundational for other and more complex functionings.

### Exercising choices

Progressive health conditions for some signalled on-going change and revealed a temporal dimension to functionings. This was highlighted in the concern expressed by some participants regarding the impact of increasing impairment on exercising choices in relation to doing what they valued in the near future. In Kate's case it was reading and for Jack, it was about attending church.

Kate: And my sight too it won't be so good if I cannot see it simply won't and I am not a very musical person [...] I listen to radio a lot but I choose not to listen to music. It is not that I don't like music but it is not something I would choose to do. I would choose to read a book or something verbal kind of things I like.

[Kate, 80, widow, living alone, domestic setting, macular degeneration of eye]

Jack: The church [...] it's a source of pleasure for us [...] I think, as you get older and ill, it's more important (laughs)[...] the faith must help. And I would not like to stop going to church. I would not see that as a way forward at all. It may become, but not through choice.

[Jack, 80, Parkinson's, living with spouse, domestic setting]

One participant in particular remarked that the pain from severe osteoarthritis precluded him from having any aspirations. For Jim, not being able to avoid pain limited his freedom to choose and negatively influenced his sense of purpose.

Jim: I don't have anything to keep me going. Mean, I can't go for walks, I don't have dogs I can't take them out anymore. Life is empty [...] there is nothing I could do because of the pain.

[Jim, 82, Osteoarthritis and other health conditions, care setting]

### Control, Competence and Identity

For some, impairments not only affected a range of functionings but, additionally, influenced their sense of control, competence and identity. Jane who was visually impaired mentioned how she was unable to accomplish seemingly simple tasks and the frustration that it caused her. Personal appearance mattered to her. Not being able to exercise control over her appearance affected her sense of identity (social identity).

Jane: I am restricted in a lot of ways really. Sometimes when I go to the wardrobe and I say what's that now, it is frustrating and even a banana, you have to get someone to do that, to peel it, I really get frustrated with that. Then I cannot see in the mirror and I don't know how my hair is in the morning

[Jane, 96, macular degeneration, lives alone, care setting]

For Jack on the other hand, on-going health conditions and increasing physical impairment were affecting the functioning of playing bridge. Bridge was not only a valued activity that he enjoyed for its own sake, but he considered himself a good player. In this context he described how his deteriorating health was increasingly making it difficult for him to be able to be who he was. The sense of loss and the accompanying realisation that he was not able to be who he used to be and wants to be was profound.

Jack: With the bridge, I'm almost certainly going to have to give up the bridge because I'm not coping with it and I used to be a very good bridge player. And that sort of thing, psychologically, is hitting me quite hard [..] one of the things I'm trying....to hang on to [disruption] To be who I have always been but it's becoming more and more difficult.

Jack's wife: It is your health that's limiting you, isn't it?

Jack: Of course it is. I'm so helpless against it [...]

[Jack, 80, Parkinson's, lives with spouse Jill, domestic setting]

#### [Household and personal care tasks](#)

Health directly and indirectly influenced the ability to carry out personal care as well as household tasks such as house cleaning, laundry, and cooking. Some remarked about the difficulty in undertaking basic household tasks and others commented about the influence of progressive impairments on not being able to do household tasks in future. Kate was experiencing on-going change vis-a-vis her eyesight and could foresee how it might impact the upkeep of the house.

Kate: [...] My sight is getting worse and I can manage to see dust as it is [...] But I mean, time may come [when upkeep of house becomes difficult]

[Kate, 80, widow, living alone, domestic setting, macular degeneration of eye]

For Sara and Jim, on the other hand, gardening and cooking had not been mere tasks but activities that were valued in their own right. For Sara, gardening was a source of pleasure and for Jim an activity he enjoyed and that contributed to his sense of self and identity.

Sara: I used to do the garden, cut the grass, do all the weeding .I couldn't do it now and I enjoyed it too [...] One of the daughter's came up every week to give it [THE HOUSE] a good Hoover [..]and she did the big shop every week for us [...] I had the carer coming in at 8 in the morning and we also had them again at 7 pm in the night [...] to give me a wash or shower

[Sara, 78, stroke, lives with spouse, care setting]

Jim: [...] I liked cooking , I am a good cook. And this osteoarthritis set in and oh! so much effort to cook, you know. They got me a chair so that I could half stand and half sit in the kitchen, but even with that...I had sort of eased up on the eating [...] do need somebody with me when I am having a shower just in case I do pass out.

[Jim, 82, Osteoarthritis and other health conditions, lives alone, care setting]

Participants' functionings were not only affected by their own health conditions. As some mentioned, poor or ill health of the spouse, too, impacted upon participants' functionings.

### Social networks

For Rita, her husband's impairment influenced participation in existing social networks. Difficulties in visiting friends due to the physical features of friends' houses together with the lack of empathy on their friends' part subsequently closed off such social spaces.

Rita: Our social life became more restricted with friends because, we could travel, but, we could not go to a house (whose toilet was up a stair and it is quite unbelievable that people don't understand that, you know [...]) That was a real learning experience because the people whom you classed as your friends just really disappeared I have never gone back to old friends.

[Rita, 80, spouse had a stroke, sheltered setting]

Joe similarly experienced a loss in his social circle because his impairment did not allow him to participate in leisure (sport) activities. By virtue of not being able to participate in-group sport activities and boast a sporting identity, his sporting friend circle disappeared.

Joe: You lose a lot of friends because you are not able to go out with them and stuff like that so nobody seems to bother to come around [...] I think it is health because you cannot do what they want to do. You cannot play golf, you cannot play soccer; we used to raft racing which I cannot do anymore.

[Joe, 65, hip injury due to arthritis, lives alone, sheltered setting]

### Feeling secure

Benny and Rita gave voice to their fears and worries about falling ill themselves or dying and its consequences for their spouse's care. Spouse's poor health brought in future oriented considerations that influenced sense of security and was fundamental to the participant's wellbeing. Stuart and Sara, a couple, both had health conditions that made them prone to falling even within the familiar environment of their house. For them, the fear of falling at the same time was a safety concern.

Benny: [...] right now I know that she's [WIFE] going to get help if she needs it [IN CARE HOME [...]] If anything happens to me I know that she'll stay here and be well looked after

[Benny, 90, spouse has Alzheimer's, care setting]

Rita: And, it is quite funny when you are in a situation that you are caring for somebody you very shortly learning that you are second-class citizens. I was very lucky that I only fell ill once and I could not have sat in bed because he had appointments to go to. And then all of a sudden you begin to realise that what if anything happens to me you worry what is going to happen to him.

[Rita, 80, spouse had a stroke, sheltered setting]

Stuart: Well I was looking after my wife and I fell twice in the house in one day [...] if both of us fall at the same time, we had really be in a stew. So as soon as the health visitor came in she said, 'you cannot live like this, what if your wife falls and then you fall', [...] And the family said, 'you are not safe living here, what if you both fall at the same time', which could have happened.



Sara: I did have a fall, the same week, went down like that.

[Stuart (81), suffers from multiple sclerosis, Sara (78), suffered a stroke, live together, care setting]

### 6.5.2 Mapping out the impact of impairments

Mapping out the influence of impairments on functionings by participants as below (in figures 6.1 to 6.3) highlighted the differential nature, extent and type of the functionings that were directly and indirectly impacted (across an individual participant).

Mapping however, also revealed interpersonal variations in functionings that were impacted even where some participants reported having the same health condition. For instance, Kate, Tara and Jane reported having been diagnosed with macular degeneration. Kate had been diagnosed approximately over a year ago, Tara, over two years ago and Jane four years ago. Kate lived on her own in a domestic setting, Tara was in a very sheltered setting and Jane was living in a care home (at time of interview).

Figure 6.1: Case study example: Rita

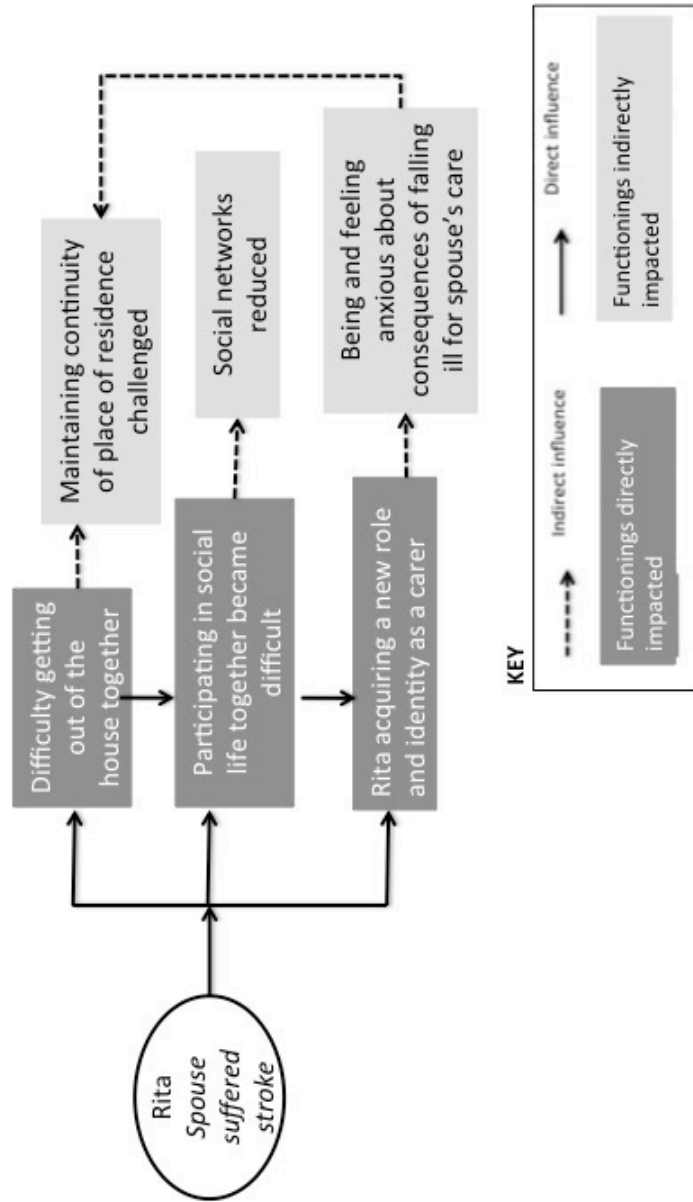


Figure 6.2: Case study example: Jack

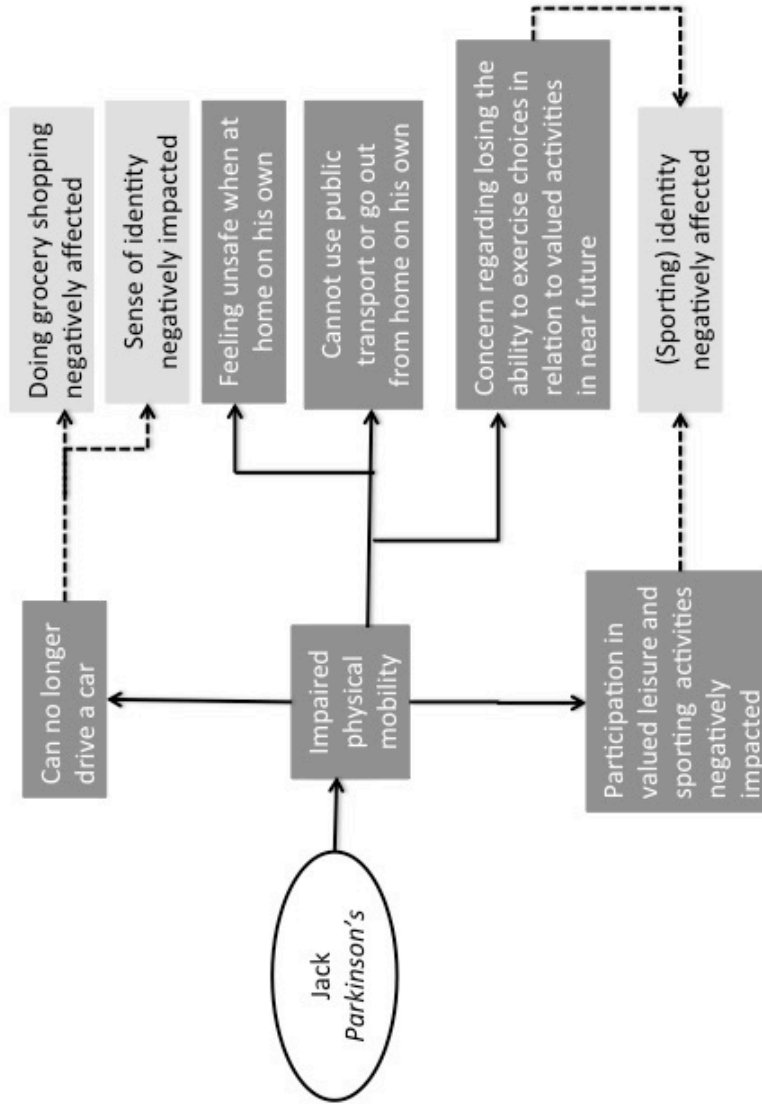
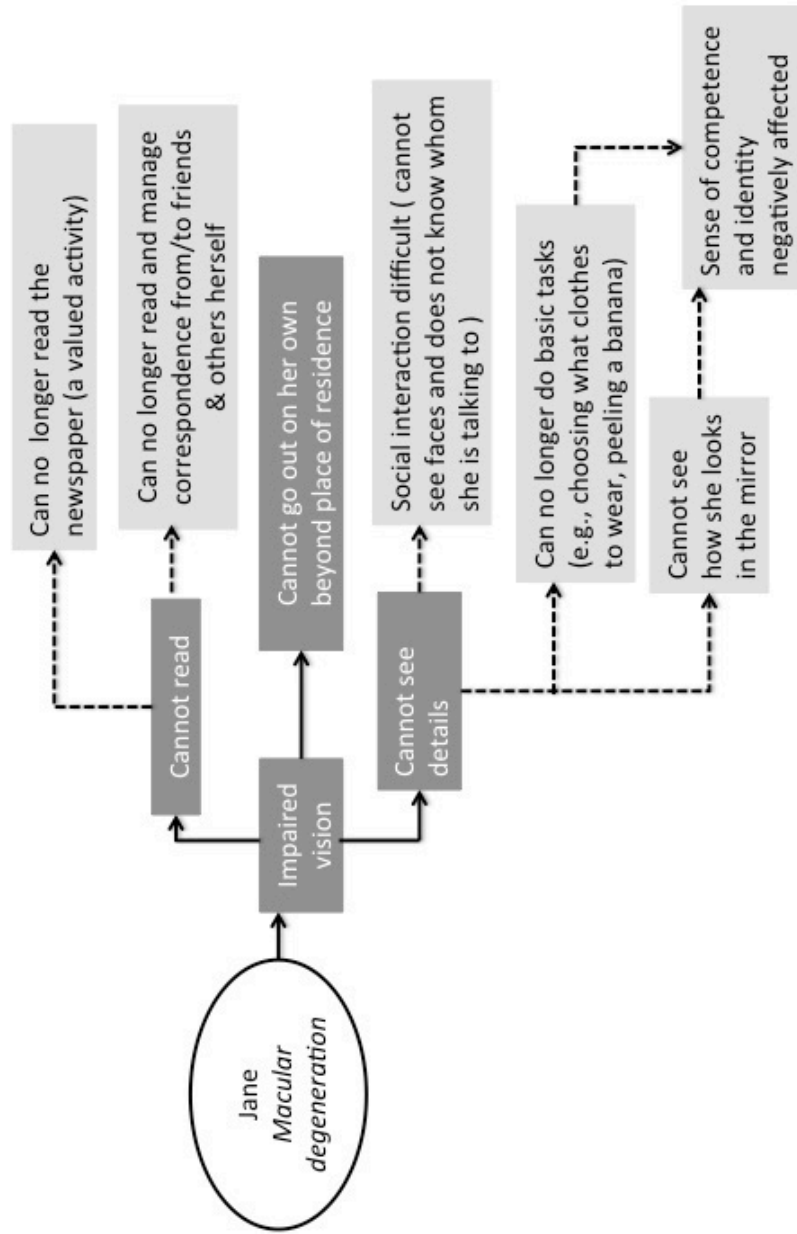


Figure 6.3: Case study example: Jane



Kate, Tara, and Jane revealed how reading was a valued activity for them. Kate could still read but was experiencing deterioration, as she could no longer see the hymn number on the church board. She was concerned about not being able to read in the future and Tara talked about reading in the past tense, as did Jane. Jane had enjoyed reading the newspaper. Big print was an option but not for reading for a great length of time as Tara mentioned. Kate could still go out on her own, Tara and Jane could not go out on their own outside the place of residence. Deteriorating eyesight had affected their balance.

Kate: Oh yes [READING A LIFELONG INTEREST]. My father taught English and books were the things in the house [...] My sight is all right at the moment although it is not as good as it was. And I know that because we go to Church and we have hymns and the number is up on big board and I cannot read it anymore.

Tara: Oh, I could lose myself in a good book, could lose myself [...] When I could not read that was really terrible for me because I was a great reader all my days and that was awful. [ON READING] the reading kind of changed [...], after the war I read books about war [...] then I liked adventure stories and autobiographies, people who have done something in their lives.

Jane: I was never a reader of books or anything, I didn't have time with looking after two men, [laughs] I used to really like my newspapers.

Being able to see was also linked to managing daily life and social relationships including, being able to read and deal with utility

correspondence, notices, and managing finances, receiving and sending out personal greetings or letters. Tara and Jane could no longer do these things on their own and relied on support from their respective families. Jane additionally needed support with selecting clothes, peeling a banana or unwrapping butter (described in section 6.5.1 on control, competence and identity of this chapter). Tara relied on the microwave (fitted with vision aids) but had stopped cooking on the stove for safety reasons.

Tara: I miss that [READING] and the cooking. Like frying, if you put oil I cannot see how much and I am always worried if I have put too much and it would go up. I just don't do it I have stopped it.

Jane: I have to wait till the carers or my niece is up to read my [GREETING] cards.

Even though all three participants mentioned the impact of impairment on valued activities of reading (different things), the extent and the severity of the impact on reading as a valued activity and being able to see for enabling a range of other valued activities varied. What was different was the duration of the time that these participants had had the impairment for.

Although I acknowledge that perhaps individual biological characteristics might have a role to play, yet, the analysis seems to suggest and imply temporality: that increasing impairment resulting from progressive health condition might dynamically and differentially influence functionings for the same person as time progresses. Of course,

the participants' unique individual contexts meant that they had capabilities for some functionings, but not for others.

### 6.5.3 Health: a valued functioning

While impairment to varying degrees played a role in influencing functionings negatively, being healthy positively supported capabilities for various other valued functionings. Health as it emerged from participants' accounts was not only viewed as a personal characteristic framed in terms of particular impairments. Many participants variously attached value to good health both intrinsically and instrumentally: a valued functioning in its own right that had to be maintained and as enabling capabilities for other valued functionings.

Penny described herself as having good health and mentioned good health as being important to enabling the freedom to do and be, to go out and about almost on daily basis as and when she wished to.

Penny: Well, the important thing for a good life is good health. And I've, touch wood, been very, very fortunate that I have good health.

Manik: Why is that important? Why is good health important for you?

Penny: Why is it important? Important to anyone, surely.

Manik: Still?

Penny: I can do what I want to do, I can go out and I'm not, fortunately, I'm not bed ridden or things like that. I mean, I'm very very fortunate, I can go out every day to family and see the family and friends.

[Penny, 82, macular degeneration, lives alone, domestic setting]

For Penny, not being 'bed ridden' was important when she described herself as possessing good health. Not being bed ridden was instrumentally valuable in supporting the capability for other valued functionings of getting around and seeing/visiting family and friends.

While Kate was concerned with the impact of visual impairment on various valued functionings, at the same time, she valued the functioning of good health and described herself as having 'very good health'.

Kate: What matters first of all is my own health because if you don't feel well, you don't enjoy anything. And if you are worried about your health it is hard to ignore it [...] and I have always had very good health so it has not been a problem.

Her understanding of good health was informed by her occupational context and her perception about certain health conditions such as stroke and Alzheimer's'.

Kate:[...] because I was a physiotherapist and I know that older people sometimes, we had get patients who had hardly moved out of a chair for ages and latterly I worked in a limb fitting centre. Sounds gruesome but it was not. People came at a very low ebb in their lives and you taught them for 6 weeks to walk on artificial leg. So many of them were very very unfit and most people who lose legs it is not an accident, it is diabetes and I know that these people would come in and you could hardly get them out of a chair.



Kate:[...] thing I dread most because I think it is much worse to have a stroke than be paralysed from waist down for example. Because, it affects your mental processes more and a stroke is a very devastating thing if it bad enough. So that worries me really and you hope that you don't lose your wits, you know. have Alzheimer's [...]

The capability to maintain health was therefore important to Kate as evidenced from the various healthy behaviours and practices she engaged in. Having a bus pass also contributed to her capability to be healthy.

Kate: So I try and keep myself reasonably fit, which is why I sleep, upstairs [...] there is a bedroom downstairs but I go upstairs. You have to keep doing that because otherwise you lose it [...] I try and eat sensibly but I have a terrible sweet tooth so I have to try and control that [...] I go to a yoga class and I go to a tai-chi class. It is very good mentally [...] when I walk I try and walk a little bit faster than I need to walk. I make myself do that so that it is a little bit of an exercise [...] Then you have a garden and you are out you are trying to do things in the garden and it is just a healthy way of life.

Manik: And where do you go for your tai-chi and yoga classes?

Kate: At the [...] sports centre in city [...] twice to yoga and three times to tai-chi [...] So I am very pleased with my bus pass. It is marvellous.

For Rita, having good health was instrumentally valuable to support the capability to be independent. Like, Kate, Rita too engaged in healthy

behaviours and practices to maintain the functioning of being healthy. But, at the same time, activities she engaged in such as, walking, were moderated in light of the awareness of the ageing self.

Manik: So you said health is important to you and you try to keep well. Why is it so important for you?

Rita: I feel if I keep the health I will keep independent. I do as the health lady [AT CARER CENTRE] says, *'you can put as much in your mouth as you wish but you have to work to get it away'*. So I do weight management like that. I don't stop eating, but I do careful eating.

Rita: I walk as much as I can but the group walk [WITH CARER CENTRE] is only once a month. Well I would have liked to continue with the ramblers, but they go too far now. The problem is I used to keep really fit and really well, aerobics and all and the ramblers we did 12 -15 miles you know, but, once you stopped and getting older you have to weigh up.

[Rita, 80, lives alone, sheltered setting]

On the other hand, having the capability for the valued functioning of getting out and about beyond the place of residence was intertwined with and contributed to Joe's capability to avoid depression.

Joe: Most important thing would be your health. As long as I can get out and about I am fine, but if I am stuck in the house I don't like it much at all. I like to get out every day if I can. Winters is a bit of nuisance, not so much last winter, but, two years ago it was really bad and I was not getting out for about two months and I was getting depressed, just sitting and looking at four walls.

[Joe, 65, hip injury due to arthritis, lives alone, sheltered setting]

Similarly, for Benny, going out and about for outdoor walks was valued as a functioning to support the capability to maintain physical health.

Benny: We like going out and about for walks, with my wife [...] I don't want to finish up that one day I sit up here and I can't walk, I've been sitting too long, haven't given myself exercise and the same for my wife. We both want to get some exercise and some fresh air. I don't want to see her where she suddenly can't walk.

[Benny, 90, spouse has Alzheimer's, care setting]

## 6.6 Key findings

a) A number of functionings across different domains mattered to each participant. Exploring why something was important revealed that it was whether one had capabilities for various valued functionings that differentially mattered. For instance, some functionings were valued both in their own right and as contributors to other capabilities. Capabilities for various functionings were also interconnected in a range of ways (Tom's case illustration).

b) Capabilities for a number of functionings that were valued (and some of which were no longer available) across different domains were directly and indirectly influenced by personal heterogeneities in health with respect to impairments. Being healthy or having good health emerged as being intrinsically valued in its own right and instrumentally valuable in contributing to and supporting capabilities for a range of other functionings.

c) Walking and seeing emerged as functionings that were in some sense foundational and enabled a range of other functionings such as getting out and about on one's own, driving a car, using public transport, self care tasks, upkeep of house, reading, or managing correspondence. And getting out and about beyond the place of residence was foundational for maintaining engagement in different valued spheres of one's life. The nature, type, and extent of the impairment mattered. Depending upon the nature, type and extent of impairment multiple mobility related functionings (walking, using public transport, climbing steps, driving), could be adversely affected.

d) Increasing impairment resulting from progressive health conditions has implications for choice related and identity capabilities. Progressive impairment might not only dynamically and differentially influence what one is able to do over time, but, also, potentially influence one's identity capability (who one is and who one wants to be in the future) and the capability to choose and exercise choices.

e) Not only does increasing impairment differentially influence what one is and does but also has implications for what one can do over time, i.e., maintaining capabilities for some valued functionings too might be dynamically shaped over time for the same person depending upon her (or his) material and social context.

## 6.7 Chapter summary

This chapter described what mattered to older people in their daily lives. A number of functionings in different domains mattered to the participants though some were more frequently mentioned than others such as, health, getting out and about, and family. When discussing about

the kind of things that were important and exploring why they were important references to health as a vital and significant domain kept cropping up. Attending to the role of health in the lives of the participants' hence became important. Health mattered because it played a significant role (directly or indirectly) in contributing to other capabilities and (or) influencing the achievement of some functionings.

Attention to individual diversities in impairment and its differential influence on functionings in this chapter set the scene for a deeper engagement and understanding of how place interacted with the individual to shape capabilities in the subsequent chapters. The next chapter examines the interplay between individual and social-spatial factors in shaping capabilities and that for some were influenced by health related impairment. In doing so, the next chapter attempts to develop a contextualised understanding of the relationship between people and place.

## **Chapter 7 : ANALYSIS – CURRENT EXPERIENCES OF LIVING IN DIFFERENT SETTINGS**

### **7.1 Introduction**

Descriptions of what participants were able to do and be, together with, what they valued doing and being were extended to as well as influenced by experiences and interactions with places where they lived. These experiences emerged as being useful in illustrating and setting out the complex and myriad ways in which contingent individual contexts, place, and valued capabilities (and functionings) interweaved to influence the kind of lives that participants were able to lead. Drawing upon participants' experiences of living in their current place of residence, this chapter is devoted to unpicking and highlighting the diverse ways in which these interactions occurred, shaped experiences of place (s) and enabled capabilities for valued functionings (or not).

The following section (7.2) provides a brief profile of the key residential characteristics of the participants (table 7.1). Section 7.3 describes and discusses key themes within participants' everyday experiences of living in different settings. Though valued capabilities, particularities of place, and contexts, were unique to each participant, yet, there were cross cutting themes that emerged from their narratives. Each theme has been discussed in detail in various subsections with relevant quotes and passages from participants' accounts. Section 7.4 summarises the key findings from the analysis followed by a concluding section.

Participant (s)	Accommodation (Current)	Time in current residence (Years)	Ownership status (Current)
Jim	Care home	3	Resident
Tina	Care home	6 months	Resident
Benny	Care home	3	Resident
Bob	Care home	3 months	Resident
Peggy	Care home	2	Resident
Sally	Care home	2	Resident
Jane	Care home	5	Resident
Stuart & Sara	Care home	1 month	Resident
Rita	Sheltered bungalow (2 bed)	12	Tenant
Joe	Sheltered flat (1bed)	7	Tenant
Betsy	Sheltered flat (1bed)	6	Tenant
Diane	Sheltered flat (1bed)	1	Tenant
Meg	Sheltered bungalow with garden (2bed)	15	Tenant
Diane	Sheltered flat (1bed)	1	Tenant
Darren	Very sheltered flat (1bed)	2	Tenant
Tara	Very sheltered flat (1 bed)	4	Tenant
Cathy	Very sheltered flat (1bed)	5	Tenant
Henry	Housing association bungalow with garden (1bed)	5	Tenant
Tom	Upstairs flat in a tenement (2bed)	17	Owner
Peter	Ground floor flat with a garden (1 bed)	6	Owner
Penny	Upstairs flat in an apartment with a lift (1 bed)	4	Owner
Nina	Semi-detached house with garden (3bed)	53	Owner <sup>ooo</sup>
Maggie	Semi-detached house with garden (1bed)	45	Owner <sup>ooo</sup>
Jack and Jill	Detached house with garden (3 bed)	33	Owner <sup>ooo</sup>

<sup>ooo</sup>Participants have not moved from their current place of residence since they purchased the property

**Table 7.1: Key residential characteristics of participants**

## 7.2 Key residential characteristics of participants

Table 7.1 provides a brief profile of participants' residential characteristics. Current residential settings included domestic, sheltered, very sheltered and care home settings. The length of time in residence varied across the sample ranging from a minimum of 1 month to a maximum of 53 years. The sample comprised of seven owner-occupiers,

ten tenants (including those living in sheltered and very sheltered accommodation), and nine residents (of care settings).

### 7.3 Key themes within everyday experiences of living in different settings

Key crosscutting themes that emerged from participants' narratives have been summarised and set out in the table (7.2) below. Each theme attempts to capture, portray, and convey a situated understanding of the different facets of the complexity of people -place relationships. Though some themes overlap, each theme illustrates and illuminates the complexity by foregrounding and focusing on specific and different experience(s) of living in different settings.

	Major themes
1	Dynamic nature of individual and (or) socio-spatial factors
2	Enabling and disabling experiences of place across the individual
3	Geographic proximity and supportive social relationships
4	Access, availability and quality of resources
5	Meanings attached to activities, objects and places
6	Social group activities in supported settings
7	Social spaces beyond place of residence

**Table 7.2: Major themes**

#### 7.3.1 Dynamic nature of individual and (or) socio-spatial factors

Some accounts highlighted how health and age related changes and changing social relationships within the neighbourhood variably affected participants' capabilities. Not only were some capabilities differentially impacted but participants' relationship to places where they lived was redefined with consequences for sense and perception of place.



### Loss of valued relationship

Sally lost her husband after a year of moving into the care home. Capability for experiencing some valued functionings such as, being with and enjoying her husband's company, having someone to talk to, having particular roles (that of a wife) became unavailable.

Sally: After my husband died, I didn't want to be on my own, no one to speak to and I kept thinking, I miss him, because we usually had a blether [...]

[Sally, 86, wheelchair mobility, lives alone, care setting]

Losing her husband potentially triggered a reflexive re-evaluation of the kind of things that mattered to her in the changed context. Following her husband's demise, Sally, strongly felt that she did not want to be on her own and functioning of continuing to living amongst others became important to Sally. This influenced her decision to continue living in a care home although she had the option to go back to sheltered accommodation.

Sally: I mean family say you want to go back to sheltered housing but I said no, no I wouldn't because I don't want to go back [...] I don't want to live on my own [...] No, there are bodies here. Well, I have been surrounded by bodies since I was born. It's not easy living on your own, not when you have not been used to it [...]

Sally's example demonstrates that sometimes it is only in moments of change or transition that what shapes a particular capability is revealed. For her, presence of others (both staff and residents of care home) revealed itself as supporting the reflexively re-evaluated and valued

opportunity to live amongst people. The social environment of care home not only supported her capability to live amongst people but also influenced the capability to maintain an aspect of identity that she was comfortable with. Valuing living amongst other people has to be understood within her broader social context of interpersonal proximity of relationships that she had enjoyed and engaged with in the past. Presence of others shaped capability for contingently (valued) functioning and in turn influenced sense of place. For Sally, in this context, the care home as a place signalled familiarity, belonging, and security.

#### Changing social relationships within the neighbourhood

Neighbourhoods as places too change over time. For Nina, not only did the changing social relationships within the neighbourhood reduce opportunities for socialising, but also impacted capabilities for other valued functionings and as such, redefined her relationship to the neighbourhood. The changing nature of place (neighbourhood) was reflected in the moving away of old neighbours. Not only had the continuity of valued neighbourhood relationships been disrupted as Nina's old neighbours had moved away, but, capabilities for functionings such as, doing shopping, feeling and being safe too were adversely affected.

Nina: [..]it is all different neighbours now. The neighbours before used to get them to do messages, and now it is all younger people who are coming in and we don't have the same contact. We speak to them you know but we don't have the same contact and well if anybody was unwell we used to go in and see

[Nina, 89, balance not good, lives alone, domestic setting]

The role of the neighbours in shaping her capability to be safe was revealed in wake of an incident, i.e., a falling episode. Nina recounted her experience of falling down in the house and commented upon the present neighbours as being neither a source of practical support nor contributing to her sense of security.

Nina: But that last time when I fell in the house, I lay there from 4 in morning till dinnertime when I was able to go phone my daughter and nobody.... The blinds were drawn all day and they know I am up early and things like that and nobody came to the door to see if (pause) that is the only thing now, you know what I mean... you miss the old neighbours [...] Next-door neighbour he died so his wife went away to sheltered housing and yet other ones went to different houses.

Absence of significant others (old neighbours) and its influence on her capabilities shaped interaction with neighbourhood. Consequently, for Nina, the neighbourhood had become less important as social relationships in place changed. She further made references to 'young people' and limited interaction with these neighbours, to hint that capability to develop and build supportive relationships with new neighbours was limited. And yet, her expectation of support from these neighbours was based upon relational practices exercised in the past.

#### [Onset of health impairments](#)

Health impairments can also influence perception of place, and, in turn, influence what an older person might value. Jack and his wife Jill live in an affluent part of the city in a detached 3- bedroom house they own. The functioning of walking for Jack had already been affected during a prior

hip operation that damaged his sciatic nerve and left him with a dropped foot. As a result Jack had to give up driving and could not climb steps. More recently, however, Jack was diagnosed with Parkinson's (about six months or more at the time of interview with both Jack and Jill) and that had affected a range of his mobility related functionings such as, walking short distances without getting tired, going out on his own or using the public transport (bus) even with support. Personal and situational factors influenced Jack's perception of his neighbourhood as a safe place and the capability to be safe became a significant concern within the particular context of being at home on his own sometimes.

Jill: when I was going out, I furnished my husband with the button [community alarm], but we left the door open. Now, actually, he didn't like it. He didn't like the door open, though this is a quiet street and a quiet house and you would really never bother at all, but then there is the off chance. ...[...]

[Jack and Jill, 80 & 76, Jack has Parkinson's, live together, domestic setting]

Although, Jack was supportive of the fact that his wife continue to engage in activities that mattered to her, it nevertheless had a practical downside for him. Jack had to be at home on his own for the duration of the time that his wife was away. This was problematic in the context of his impaired mobility because the main door of the house had to be kept unlocked at all times to secure access for emergency support services and especially when he was home alone.

Jill: But he was anxious about the door being left open, so we just got this key thing just yesterday and put it on. And it's got, I'll show you on the way out, you have a number on it and you set the

number and turn it and the wee door opens and you've a key in there. Now I have phoned the alarm people and they have the number of the keypad.

For some others, meanings attached to capabilities for particular functionings were re-evaluated and the capability under consideration was enhanced. Tara had moved into a very sheltered setting from a rented two bedroom flat in one of the multi -storied apartments in a less affluent part of Dundee, approximately four years ago (at time of interview). The capability to be safe from intruders had been a primary concern at that point of time. Following the move, her vision deteriorated and she was diagnosed with age related macular degeneration.

Tara: [...] four years ago my eyes were nowhere near as bad as they are now. I mean I had glasses, I did not know they were going to go like this. And I was able to go out and about myself but I cannot do that now because I would fall. My balance is no good with my eyes [...] and my eyesight [...] they say it is age related macular degeneration.

[Tara, 89, age related macular degeneration, lives alone, very sheltered setting]

As she recounted, the move to very sheltered setting had been made to support the capability to feel safe and secure from intruders and in relation to growing old generally.

Tara: [LIVING HERE IN VERY SHELTERED SETTING] Oh it is security [...] Well, the cameras they have got up outside, then the main door is locked and you have got your own door locked. So that is how you feel, secure, you feel people cannot get in

[...](laughs) When you are old and on your own you do not want intruders coming in, you are no able.

Retrospectively, and following the onset of visual impairment, Tara additionally valued living in the very sheltered setting as it enhanced her capability to feel safe and secure in a different way.

Tara: [LIVING HERE] It is a blessing and because if anything happened they have name and addresses of all your family and then we have the pull cord and so you pull the cord and that way you know there is somebody at other end and they will contact your family and you will get attention. That is another part of the security.

Individual factors such as, impairment (Jack and Tara), loss of valued relationships (Sally) and place related factors, such as, changing residential mix of the neighbourhood (Nina) negatively influenced capabilities for various functionings. Not only were some capabilities negatively impacted, but also, consequently, capabilities for new functionings emerged as being valuable in light of the changed circumstances (Sally and Jack) or the meanings attached to (Tara) and perception of having (Nina) capabilities for particular functionings was re-evaluated. At the same time, meanings attached to and perceptions of place, variously at the scale of the place of residence and (or) neighbourhood were differentially influenced.

### 7.3.2 Enabling and disabling experiences of place across the individual

Participants' valued capabilities for a number of plural functionings. Interplay of social -spatial and personal characteristics however, variably mediated, facilitated, and constrained the degree of freedom that participants could exercise in relation to different valued capabilities (Kate and Maggie) and (or) in relation to the same capability (Peggy). Experiences of place were therefore not uniformly enabling or disabling across different spheres of a participant's life.

#### Getting out and about and doing (grocery) shopping

Kate lives on her own in an affluent suburb of Dundee. Her immediate and only family (son and son's family) live in another city in Scotland. Adequate and affordable neighbourhood bus services for Kate, supported her capability to get out and about, and, socialise despite having given up driving when diagnosed with age related macular degeneration. Not only did adequate and affordable bus services together with her capability to walk and use the bus, facilitate her capability to go out and about and socialise, but also, having this alternative supported her capability to adapt to her changed circumstances.

Kate: [...]this is a very good house because it has good public transport [...] I am very pleased with my bus pass. It is marvellous.

[Kate, 80, widow, lives alone in her own house, Ferry]

However, her capability to do grocery shopping was reduced.

Kate: It is hard to the big shop without the car. It is a nuisance because I don't... I mean people would offer me a lift but I don't want to ask for help unless I absolutely have to but that is the only drawback. Well, my main shopping used to be in [PARTICULAR SUPERMARKET] which is just up there and it is perfectly possible to walk there; but I don't want to lug heavy messages back home. There is one bus every hour but the last time I tried it just sailed past me at the stop. So if I have anything heavy I do ask a friend for a lift [..]I could get a taxi, that is perfectly possible. But when I was brought up taxi was for special occasions. You just did not hop into a taxi and I cannot [..]also, they have got quite expensive.

Kate: sometimes I do a big grocery shop that way [ONLINE], but I would prefer to go to the shop and do it there.

A number of personal, social, and spatial factors interacted to constrain the capability to do grocery shopping. The value placed on doing the big grocery in person at a particular supermarket, reliability of bus service to supermarket, lack of bus services (or knowledge about such service) that provided door-to-door transport and delivery of shopping, and perhaps, not having family living locally constrained her options. Kate was hesitant to ask friends for a lift. So, while Kate had the capability to do grocery shopping the freedom to choose how to do so in accordance with her values was not there.

On the other hand, for Maggie, another participant, her capability to get out and about beyond the residence as well as to bring home (impromptu) shopping as and when she wished to was constrained. Maggie lives with her husband who was diagnosed with Alzheimer's about 4 years ago (at the time of interview) in a less affluent part of



Dundee. Maggie had given up driving and her husband could no longer drive. For Maggie, opportunities to go out on her own were interlinked to her husband's health. Although, Maggie's husband had access to personal care services and support from the hospital, however, Maggie had little time for herself and, as such, going out to the town for a little while and (or) attending the Carer Centre meeting was for her an outing.

Maggie: I like to pop out for an hour, go down to the town. [HUSBAND'S POOR HEALTH] just means that you are at the house; I go out to the carers' meetings, that is an outing but no.....

[Maggie, 79, spouse has Alzheimer's, lives with spouse, domestic setting]

Poor bus services in the neighbourhood however imposed constraints not on her capability to get out and about but on her freedom to go out as and when she wanted to as well as impacted her impromptu shopping experience.

Maggie: I like to pop out for an hour go down to the town. Now the problem there is that the bus service is pretty poor. The bus service starts about half past 8 in the morning, it is an hourly service and stops at half past 2 in the afternoon. If you are out, it means I have to get a bus up to the [NEXT NEAREST STOP] and walk through there to here. And I don't have heavy shopping, but if I have shopping then I have to bring it to here [...] At the weekends there is no bus service for this area. You have to walk to the [NEXT NEAREST STOP] and by the time you have walked there you could be in town.

Availability of public transport services in her neighbourhood had changed and deteriorated over time. Maggie described how services had changed over time and particularly, its differential and negative impact on her.

Maggie: We used to have an excellent service and they took it off. It was a circular bus which was ideal because at the time my husband was still at the shop when I retired, I could go down to the shop if help was needed or go visiting. The bus service was there.

Access to bus services was not a problem to many others in the neighbourhood because as Maggie noted, '*most of people here have cars*'. So while for those who had a car the bus services might have constituted an alternative, for Maggie, bus transport was the only option she had. But, her freedom to go out as and when was curtailed and constrained by the lack of adequate bus services in the neighbourhood. Walking facilitated her capability to go out and about but it meant walking to the next nearest bus stop. Having her family living locally however, allowed her to maintain and achieve the functioning of doing grocery shopping despite having given up driving. Access to social resources, her son's car, supported the capability to do grocery shopping.

Maggie: Shopping [...] I have my son and he will come with his car and take us to the supermarket

In both the above examples, the degree of agency that each participant could exercise in relation to different but valued capabilities varied. Both

Kate and Maggie had capabilities (for the functionings mentioned above) but, the freedom to choose how to achieve the functioning was not there: for Kate, vis-a-vis the grocery shopping and for Maggie vis-a-vis the capability to get out and about and do impromptu shopping. Maggie's account draws attention to the deteriorating nature of service resources in the neighbourhood and its differential impact on her in terms of not having an option vis-a-vis the mode of transport. Having the capability to walk to the next nearest bus stop was foundational and key to supporting Maggie's capability to get out and about on her own. Kate's example highlights that depending upon the capability under consideration, the interplay of personal and place characteristics varies. The same resources of place, i.e., bus services, that contribute to her capability to be mobile become disabling in relation to the shopping encounter.

#### Being and feeling in control

An individual's experience of place in relation to one specific capability too may not be uniformly enabling or disabling. Peggy had moved into a care home approximately two years ago. She is visually impaired and cannot see details such as recognise facial features<sup>iii</sup>. Physical and social dimensions of the care home variably interacted with individual circumstances, values, perceptions and past experiences to affect the capability associated with exercising control and generated feelings of being (and not being) in control.

For Peggy, past experiences moderated and variably contributed to supporting or undermining her capability to be and feel in control. She remarked about the degree of control she exercised in relation to who came into her room in the care home. This was contrasted with her past experience of receiving care at home where she had lost control over her

environment and over her doings. Her room in the care home in this instance signalled control over the physical environment and freedom to choose to access support if and when she needed it.

Peggy: [IN CARE HOME] anybody comes in, it's to do with your lunch here's what we're having, what's your choice" things like that. But they don't run in and out your room all day like unless I wanted them [gestures to the buzzer in the room]. See that's the point that I think would irritate the older people. Cause they've been used all their days to their own bit and if somebody starts telling you, this and the next thing, you're going to "who does she think she is?" [...] If you need them, they're there. I think that's a good thing, really, myself.

[PREVIOUSLY AT HOME] People were coming in to help you. [...] would come in, not just one, it'd be a couple would come in. And I always felt I had to take a back seat when they came in. You felt the house wasn't your own. They were in and out, in and out, in and out. [...] And then they wanted to wash you and clean you and I like to do that myself. Cause, that was part of me living on my own, looking after myself, you know?

[Peggy, 89, widow, visually impaired, lives alone, care setting]

In contrast, not being able to choose how a functioning is achieved together with the importance and value attached to doing certain things impacted Peggy's capability to feel in control. In this particular instance, the social routines of the care home had implications for capability to exercise control and thereby constituted a disabling experience of place. Not being able to do specific things by herself, such as, making a cup of

tea for herself undermined the capability associated with exercising and feeling in control.

Peggy: It's just you know you're not in charge. You're not in charge [IN A CARE HOME] [IF I WERE IN CHARGE I WOULD] please myself when I got up, which I do just now and please myself when I want to make a cup of tea when I want, which you can still get just the same. But it's not like doing all these wee things yourself. That's all it is.

Perceptions about how others (staff in the care home) might perceive her request (for preparing tea herself) prevented Peggy from speaking up. She was confident about her own situated ability to prepare a cup of tea by herself. However, the perception that staff may hold about her capacities and, which in turn, was grounded in her perception about the skills and capacities of other residents in the care home presented a barrier to speaking up.

Peggy: I don't think they [CARE HOME STAFF] would like that [HAVING A KETTLE TO PREPARE TEA IN THE ROOM]. I think it would be a wee bit dodgy, wouldn't it? Yeah, cause some of them are really not capable. I consider myself capable. But I don't know if they would consider me capable.

Feeling and being in control may not be limited (or supported) by external factors (of place alone). Fluctuating health can itself be a constraint on being and feeling in control. For Peggy, bad days vis-a-vis health generated feelings of not being in control. The capability to access and experience supportive care relationships in such instances

supported her capability to feel and be in control in relation to managing the impact of ill health.

Peggy: [...] you are not even in charge of are of yourself, of yourself, even [...] there's these days when I can't hardly walk and then I thank God I'm not on my own [...] I feel that, if I don't feel well, they're [CARE HOME STAFF] on hand. [...] I do know I'm very well cared for here.

[Peggy, 89, widow, visually impaired, lives alone, care setting]

Peggy's example illustrates that degree of freedom that one can exercise in relation to a specific capability might be variable. The capability to be and feel in control, for Peggy, had a personal, temporal, spatial, and social dimension. Different configurations of and interactions between dimensions of place, past experiences, perceptions, (ill) health episodes, and valued activities potentially supported or undermined her capability to feel and be in control. Peggy's example also demonstrates the challenge of deciphering from a capability such as being and feeling in control, about the different kind of things that might matter to people within that and are related to a specific capability in complex ways.

### **7.3.3. Geographic proximity and supportive social relationships**

Social relationships mattered to participants' and their accounts highlighted the role of geographic proximity in shaping capabilities. These social relationships variously included, family, friends, neighbours, as well as, staff and residents in supported settings as discussed below each under separate headings.

## Family

Social relationships with family were centrally important for most participants. Except for three participants, others in the sample had family (adult children, grandchildren, sisters, brothers, nephews, nieces) living locally within the city or within Scotland. Relationships with family were valued in their own right as they contributed to feeling valued and loved, cared for, added meaning to their lives, and provided social roles (and identities) of being a parent or a grandparent.

Penny: Give me my life, as it is, my two daughters' husbands are super; the girls are exceptionally good. And the grandchildren and great grandchildren, I love them all. No, it's just a great family life.

[Penny, 82, domestic setting, lives alone, widow]

Meg: I have three sons and two daughters, 13 grandchildren and 6 great grandchildren (laughs). And I see them all. So I am quite happy.

[Meg, 80, sheltered setting, lives alone, widow]

Henry: None of the children are mine, they are all stepchildren but they all call me Dad because I have had them since they were that high (gestures)

[Henry, 73, domestic setting, lives with his wife]

Participants' accounts also indicated how such relationships were significant in contributing to capabilities for various other functionings. These included, managing daily necessities of life (grocery shopping,

clothes shopping, upkeep of the house, laundry, managing utility bills), handling personal finances, getting out and about, having someone to have a conversation with, having access to knowledge and information, encouraging participation in activities or social life of the community, and, feeling emotionally secure.

Geographic proximity was key to stabilising deteriorating individual capabilities for some (particularly, for capability deprivations that are impacted by health impairments and possibly not reversible)

Tara: As I say when I get mail or letters now I cannot read them now [...] I just leave them and my eldest son comes and sorts it out and pays the bills [...] He has the power of attorney [...] And my daughter does my shopping for on a Sunday for a week [...] and she gets my pension. She is one with pension book. Just like there is a letter from Council and he will come tomorrow and take it away. It is four pages and I don't know how the Council expects older people to fill it all in.

[Tara, 89, visually impaired, lives alone, very sheltered setting]

Sara: I was not much for going out [POST STROKE]. If we were going out the girls they come for us and take us out but I don't think I have got the confidence to walk out with this [WALKING STICK]

[Sara, 78, impaired physical mobility, lives with spouse, care setting]

For a few, having family living nearby expanded the freedom to choose how to achieve certain functionings and, possibly, at no extra cost in terms of physical exertion and/or obligations. For Jack and Jill, having



their daughter and her family living in close proximity was a source of practical and emotional support.

Jill: And we're exceedingly lucky, because my daughter just lives five miles along the road [...]and she's a marvellous support to us, now that my husband is really quite frail and [sighs] she's a really good help [...]Sees things to be done and does them and no matter, you know, she's a very good help [...]

Jack: My wife's daughter takes her shopping, once or twice a week.

[Jack and Jill, 80 & 76, married couple, Jack has Parkinson's, live together, domestic setting]

And for some others, other capabilities such as, managing self-care, participating in social life of community, and not feeling/ being worried or anxious were variously expanded.

Meg: In fact even my tablets are delivered. I didn't know anything about that either but my daughter in law, her father got them and she came with me to the doctor and she said my mum should get it [PILLBOX] too [...] it is really good. That comes from the pharmacy up the road. A man comes and brings every Wednesday [...] and it is all done automatically.

[Meg, 81, impaired physical mobility, lives alone, sheltered setting]

Nina: She [DAUGHTER] stays in C Street, it is not that far from me [...] my daughter does my bedding and trousers and if there is anything I cannot do she does it. I am no worried about it [...]

[Nina, 82, balance not good, lives alone, domestic setting]

In contrast, for other participants whose family did not live locally, freedom to choose how to achieve certain functionings was limited and had implications in terms of physical exertion as Cathy commented.

Cathy: I have got three cousins in Australia so they are not much help [...] I could do my housework but could not kneel or anything, but I managed to do everything else. I never had anybody to help me because I don't have any family so I just had to get on with it [...] my knees was torture, even going out to the shops around the corner, it was an effort [...]

[Cathy, 81, arthritis, lives alone, very sheltered setting]

In a few narratives, there were expectations from close relationships as indicated by Bob's comments and when these were not met, capability and quality of relationships were negatively affected.

Bob: [...] when I took the stroke I said I hope I'm going to be able to keep my car but I couldn't do it [...] I gave it to my grandson [...] how many people can you get to take you out to something that you love. Fishing (pause) I asked the boy and he come once, he never come back you see [...] the grandson I gave my car to. I gave it to the wrong grandson I should have gave it to the other one, because [...] he never comes up to see us, what can you do.

[Bob, 89, impaired physical mobility, lives alone, care setting]

For participants living in supported setting, seeing family (face to face interaction) was important but acquired greater significance in the light of the fact that some could not go and visit their families. Accessibility of the family's residence and toilets were important considerations in being able to visit family. Personal characteristics (for example, physical impairment, wheelchair mobility) and features of place (for example, presence of steps, upstairs toilet) were frequently mentioned in constraining the capability to go out to visit family at their homes.

Joe: [...] it is not convenient for me to get there [niece's residence]. Stairs you know, three flights of stairs to get up. It is all right going up it is coming down that is a problem. Niece comes and sees me every Sunday.

[Joe, widower, lives alone, sheltered setting]

Participants' remarks also revealed that, relationships were interdependent and mutually reciprocal. Some participants' contributed to their families' capabilities for various functionings, such as, being financially supported, being employed, and, seeking advice.

Henry: [...] my oldest granddaughter she comes and does the housework [...]she does the housework on a Monday and a Thursday [...] I give her cash in hand, she get £20 on a Monday and £20 on a Thursday. She does not work; she has got two young children, 9 and 10. If I had asked somebody from corporation it would have cost more than £10 anyway and which I was going to do. I mean the money did not bother me but she said, 'granddad, it will help me out' because she is not working.

[Henry, 73, impaired physical mobility, lives with spouse, domestic setting]

Tara: [...] in the family if somebody is going on holiday or something I just help them or give it to [MONEY] them but, not that they need it. But my daughters they are not wealthy and not as comfortable as they could be so I help them out if I can with money.

[Tara, 89, visually impaired, lives alone, very sheltered setting]

Sara: I always said to them [SONS AND DAUGHTERS] when they were smaller, 'don't listen to this person or that, if you want to know anything come and ask us, we will tell you' and they still do. Oh yeah! I think even the grandchildren do that, don't they [TO HER HUSBAND]?

[Sara, 78, impaired physical mobility, lives with spouse, care setting]

Maintenance of relationships with family was not affected by geographic proximity and was variously done through the phone and internet (and where some member of the family lived outside the city or country). But, capabilities for many functionings such as, procuring daily life essentials and managing household tasks, reading, communicating, and managing bills etc., as well as, getting out and about, amongst others, depended upon frequent and face-to-face interaction. These might have been difficult to sustain on a regular basis if geographic distances were large.

However, geographic proximity on its own may not be enough as Bob's example illustrated.

The quality of relationships too played a significant role. As empirical examples also revealed, capabilities for some functionings, such as, managing personal finances and financial information, which were so readily shared and accessed, signalled the underlying importance of trust within relationships. The issue of trust has implications not only for the achievement of some capabilities, but for people who do not enjoy or have close interpersonal relationships, it highlights the difficulty of achieving such functioning through formal sources of support.

### Friends

Friends were more important for some than others and supported capabilities for a range of valued functionings. Many of these friendships as participants mentioned were long standing and had been built over the years through: affiliations with social institutions such as the church, clubs, and (or) through being together at school, work or university. Maintenance of such friendships included both face-to-face interactions and other means of communication such as the phone or through letters.

Jack and Jill's friends supported their capability to attend church, something they both valued, and participate in social activities organised by the church, when Jack could not drive and Jill gave up driving.

Jack: The church. It's a source of pleasure for us.

Jill: [..]we have some very nice church friends as well, as I say, that picks us up and takes us places and things [..] We get picked up in the morning [CHURCH FRIENDS] and I go to the guild and my

husband got the carpet bowling and, yeah. And there's Saturday morning coffee at the Kirk as well. There's, between 10 and 12, there's a coffee morning and it's nice as well. You just meet everybody and have a wee chat; it's really pleasant.

[Jack and Jill, 80 & 76, married couple, Jack has Parkinson's, live together, domestic setting]

Friendships offered companionship, but also supported the continued capability to participate in valued social and leisure activities such as playing bridge, going out socialising or on holidays, bingo and bowling: activities, that for some, had previously been undertaken with their partners. As Kate commented,

Kate: And I am very lucky, after my husband died and I don't have anybody else here, my husband and I liked travel and we travelled very much [...] am lucky to have this friend with whom I could go on holiday [...]She is in South of England.

[Kate, 80,visually impaired, widow, lives alone in her own house, Ferry]

Long standing friendships importantly also contributed to and reaffirmed sense of self or identity capability. What some participants frequently highlighted about these relationships was the implicit and shared knowledge about each other, through common and shared experiences, likes and dislikes. While for some these relationships were present and available, some others spoke about these valued relationships in the past tense.

Tara: As I say, as you get older you can count your friends on one hand practically but there is a lot of acquaintances. And two of my really good friends used to come here and visit me and they both died and I really miss them you know. And one of them, I had known her for 50 years so we had plenty in common so I really miss that.

[Tara, 89, visually impaired, widow, lives alone, very sheltered setting]

Kate: My friend with whom I go on holiday, we shared a flat when we were young working women and it was very trying when you start work, it always is. So we started from there and [...] we shared a lot and she always kept in touch [...] I don't know when we were young we kind of giggled and laughed at same things [...] and just that we both know what we like and don't like.

[Kate, 80, visually impaired, widow lives alone in her own house, Ferry]

But for some, long standing friendships broke down when the capability to participate in shared social and leisure activities due to various health impairments was constrained (as for Rita and Joe, and described with quotes in section 6.5.1, chapter 6). And, for a few others, like Benny, the unpredictability of his wife's moods (who had Alzheimer's) and friends who too were not doing so well themselves meant that meeting up with friends in person became difficult.

Benny: Well, she gets, 'Oh I don't want to do that, don't want to do that.' I can't really make an appointment to go any place with my wife because when it comes to the time for getting ready she's just

as likely to say, 'I'm not going, I don't want to'. So you can't meet friends and leave them, phoning them and telling them we're not coming. So, we kind of stopped that [...] we used to go for a meal with the two of them [ANOTHER MARRIED COUPLE], even in the Ferry here, when we came here. They'd come down and we'd have a meal together, but he can't walk very far now and difficult for him to come and difficult for [MY WIFE] now making appointments. I don't have a car and [...] most of our older friends, they've not got cars and they're depending on buses and things like that, so it's not so easy

[Benny, 90, spouse has Alzheimer's, lives with his wife in a care setting]

Relationships were maintained but the capability to go out with friends socially became difficult and this was something that was echoed in other accounts too.

### Neighbours

Neighbours were variably important to participants and there were variations in degree of connection or the amount of contact they had with them. Some neighbourhoods were experiencing change due to changing residential mix of the residents, while some other neighbourhoods were not as evidenced from participants' accounts. For some, old neighbours had moved away while others remarked that they had had the same neighbours for as long as they had lived in a particular property. Changing social relationships (reflected in the intergenerational distance) within (less affluent) neighbourhoods as for Nina (described in detail in section 7.3.1 of this chapter), negatively influenced the capability for security, and social interaction as younger families moved in.



On the other hand, having the same set of neighbours as in some other (and more affluent) neighbourhoods variably supported participants' capabilities. For Jack and Jill, who had lived in the same neighbourhood for the past 33 years (at time of interview), the neighbourhood as a social place too had changed. Considerations of providing access to emergency support services at all times to attend to Jack brought out the changing nature of social interaction, the role of the quality of social relations and personal characteristics of the neighbours (such as health status) in limiting practical access to neighbours as sources of support.

It reflected to some extent the practical limitations of living amongst neighbours who too were ageing and experiencing problems not un-similar to the couple. Jack and Jill shared a positive relationship with one of their neighbours. But neighbour's ill health meant that she could not be called upon to support Jack's capability to feel safe by leaving the access key with her for emergency services when Jill went out and about beyond the home. And not wanting to be obligated to her other next-door neighbours prevented Jill from asking them for support in this specific context.

Jill: Yes we've got very pleasant neighbours, we don't run out and in or socialise. I mean, I used to go quite a lot to next door, but my neighbour is not very well now and my husband needs my attention so, but we're perfectly friendly with our neighbours, they're all nice.

Jill: Two of my neighbours have keys, but my neighbour on this side is so really poorly, you couldn't bother her. And I don't really want to be obligated to the ones on this side, though they're perfectly pleasant, I don't want to be obligated

[Jill, 76, married, lives with her husband Jack who has Parkinson's, domestic setting]

For Kate, on the other hand, her neighbours were friends and supported her from time to time with odd household jobs such as fitting the radiator or feeding her cat while she was away on holiday. Kate too had lived in the same neighbourhood for the past 40 years and had the same next-door neighbours. That her neighbours were not in poor health and that Kate was comfortable and confident to ask for support when she needed it might have played a role in shaping her capabilities.

Kate: [NEIGHBOURS] Friendly. Particularly on one side we have some social comings and goings and they are so kind [...] anything you wanted help with they would help. And on the other side too. When I am away they will feed the cat and I don't ask them to do that for more than a week. And that is a big help. If something does not quite work or it is broken I go and ask them to help. Now I had got a cover for the radiator and it was self -assembly. I tried and tried until I got demented and then I asked my neighbour to help.

[Kate, 80, visually impaired, widow, lives alone in her own house, Ferry]

Individual values and resources too mattered. Henry clearly mentioned that he was willing to be friendly and offer support, but not socialise as the capability to socialise meant spending money. Henry also did not mention having any friends when asked and having enough money to support capability to manage daily life and living was important to him.

Henry: I know very little about my neighbourhood. I keep in touch with people next door [...] we keep an eye on their house when they are away. We sit and chat sometimes [...] but I am not one for bringing neighbours into my house and all that [...] I like to keep myself to myself. If they say hello or good morning I will do the same. But I don't go out of the way into other peoples' houses and I don't encourage them to come to mine [...] It is not that I am better than anybody else but I don't believe in it. I have not got the money to spend on drink and pour it down drain like that. Any money I earn is to pay my bills and keep my head above water and a bit of money in bank for a rainy day.

[Henry, 73, impaired physical mobility, lives with spouse, domestic setting]

Though neighbours were geographically most proximate, their role in supporting capabilities as it emerged from the analysis depended upon the interplay of a number of individual and social factors.

#### Staff and residents (supported settings)

In supported settings, presence of staff and other residents differentially influenced participants' capabilities and their experiences and perceptions about place. Individual values coupled variably with characteristics of the setting, the quality of service and (or) the service encounter shaped capabilities for various functionings as well as influenced experiences and perceptions about place.

For Sally who lived in a care setting, the presence of staff and residents contributed to the valued capability to live amongst others following the passing away of her husband (as described in section 7.3.1 in this

chapter). But for Benny, the care home as a place was a constant reminder of human suffering. Social and spatial factors both contributed to this negative perception about the care setting and also contributed to negatively influencing his capability to practice faith. Living in close proximity of other residents for him meant seeing people with varying levels and severity of health conditions and impairments on a daily basis. This coupled with failure of the church Minister to visit him and his wife in the care home negatively influenced his capability for spiritual belief and practicing faith. Benny was previously an elder in his church.

Benny: I always believed there was a god [...] My mother brought me up to believe that there was [...] but when I came in here [CARE HOME] and looked at some of the people that live here and I thought, 'Why does god allow that? Why does a god allow that to happen?' People live their life like that and don't know what's going on. They can't even feed themselves and have to get someone to feed them and it made an awful dent in my faith and as far as going to church was concerned that was me finished. The minister couldn't come when we needed him, wanted you to go to his church [...] for twenty odd years I was an elder in the church which is five minutes from here and my wife was a member of the church too.

[Benny, 90, spouse has Alzheimer's, lives with his wife in a care setting]

For Cathy, who now lived in a very sheltered setting (having moved approximately 5 years ago), geographic proximity to other residents offered the opportunity to develop new friendships. Cathy had no other living immediate family except for three cousins who lived in Australia. She had appointed her friend's daughter as the executor of her will.

Cathy: I met a lady here, I got really friendly with her [...] My friend upstairs she is my next of kin now and her daughter is my executor and I have got my will sorted out (laughs) but I am not wanting to die yet. I have everything prepared.

[Cathy, 81, arthritis, lives alone, very sheltered setting]

Although living in the very sheltered setting offered Cathy the opportunity to develop friendships, individual values, and personal characteristics of other residents too might have played a role in shaping her capability to form new friendships. Many participants who lived in care home settings however reported that the fact that some other residents had dementia made it difficult to make a conversation and (or) develop friendships. Individual preferences with regards to friendships too mattered. As Peggy commented not having any shared history made it difficult for her to make new friends. For Peggy the television was her preferred companion.

Peggy: A lot of them have that Alzheimer's. And they don't know you the way you know them. If I see Joan coming in, I'll say, "oh here's Joan," to myself "here's Joan." But when I walked over to Joan, it's just a blank, I mean, I'm nothing to her. I just feel it's hard to make conversation with anybody [...] Yeah, I don't always want to taken to somebody to speak [...] You feel you're there and you're here to make conversation and going mad trying to think of something to say [...]

Manik: Why? Why's that?

Peggy: I mean, it's not like I could say to my friend about her cousins or uncles or aunties; I know nothing about them. And

what's your conversation about "what do you do for your lunch?"  
And that television is my life, there. If that went, I would be lost.

[Peggy, 89, widow, visually impaired, lives alone, care setting]

The quality of service and service encounter too was important in enabling various capabilities. What and who people could do and be or were enabled to do and be was linked to the relational aspects of their service encounters as well as to the characteristics of a particular service. For instance, as illustrated in the examples below, the relational aspects of the service were valued for how it made participants feel about themselves (communicated with in way that was valued, enabled participants to feel safe in the knowledge that that they were supported, showing interest in the person).

[CARERS] Very good. Always someone asking, 'how are you, how are you?

[Peter, 72, impaired speech and physical mobility, lives alone, domestic setting]

Darren: The first managers were not very good at all and they have not got a permanent manger here at the moment but they are very good. I have to wear this alarm and they only tested it twice in a year and half and new managers here test it once every month. And one day I was lying in bed and could not get up and manager came up and shouted through door because I did not answer the phone and made sure I was alright whereas the previous managers did not even bother.

[Darren, 67, impaired mobility, lives alone, very sheltered setting]

For Bob, being in the care home enabled him to feel valued and relaxed as he could promptly secure help with things as and when the need arose.

Bob: [...] you're able to talk to these people [STAFF], they're really interested in you, it's not like people walking past you [...] and you are relaxed, you've just got to say if you want to talk to any of the nurses about something like you know maybe a hole in your trousers or something that somebody has to stitch up, some of the nurses can help you like you know.

[Bob, 89, impaired physical mobility, lives alone, care setting]

Caregiving also meant more work for Jill and attending to domestic tasks and upkeep of the house was difficult. Tasks like putting up the curtain rails too had become difficult. The importance of low level and affordable service support in the form of handyman services was highly valued in this context. While their daughter and her family were there for them, it was important to Jill to not burden their family unnecessarily. Maintaining the quality of family relationships was important and having an alternative option in the form of a handyman contributed to the capability to maintain good relationships.

Jill: you know, there's a district handyman, it's a handyman attached to the social services, and they come and do jobs and it's £3.19 for a quarter of an hour. So, I mean, I had them to put that curtain rail up, because it was going to be far too awkward for my son in law and I'm going to use them far oftener, because it's a

shame to be annoying, well disturbing them [family], because the boys [grandchildren] need a lot of attention.

[Jill, 76, married, lives with her husband Jack who has Parkinson's, domestic setting]

Experiences were not always positive and were linked to the varying practices of supported settings and (or) the varying qualities of the carers. Benny who lived in a care home, pointed out how meals were not presented well and staff did not act in ways, which showed concern either about whether one enjoyed food (the social experience of food) or whether one had enough to eat (the nutritional experience). For Sally, who had wheelchair mobility, experiencing good care was important but her experience varied depending upon the person who was attending to her. It was not only about the way in which carers handled various physical tasks but also about how some of them ignored Sally as a person. But at the same, Sally, in commenting about the wider context of social care system, saw herself as a part of the 'older group'.

Sally: Not all [personnel] are capable [...] you don't feel so confident with them and they take longer to do things and they sort of gossip with one another instead of talking to the residents [...] it would be annoying if the other carer started talking to me about what happened the night before or anything like that instead of saying hello to the woman who was in the room.... You know that's the way I feel about it.

Sally: I mean you can see complaints about all over the place There is not enough people (social care workers) and they are not respected for the job and the fact that there are lot more older



people needing care. I mean it is a problem; it is definitely a problem

[Sally, 86, wheelchair mobility, lives alone, care setting]

Another participant had become mistrustful of the sheltered housing system, particularly, as it related to the capability to feel secure. For Diane who lived on her own in a sheltered setting, the morning call from the warden was very important. She recounted a recent experience of one of her neighbours who had chosen not to have a morning call and was found dead in her flat but a couple of days later. In this context, Diane was concerned about the recent notification of changes to sheltered housing where she lived. One aspect of the change related to dispensing with Saturday and Sunday morning calls. Diane acknowledged that the option to receive a call if she so wished would be available. But she also voiced her doubts about the continuity of the service in times to come just as on-site warden service had been removed.

Diane: [...] there is a morning call from the warden/manager around Sunday morning. If you have a morning call, she will call to find how you are and I think it is a good thing [...] because there is no one here being a Sunday warden, manager, sorry was off at 5 o'clock Friday and there is no one here until 9 o'clock Monday morning. It is a long time.

Diane: The new thing is, I don't know, Manik whether you have heard about this, there are going to be lots of changes in sheltered housing [...] One of the things that will be done away with will be morning calls which I think is a very bad idea [...] I mean there

would be no one making a call on Saturday and Sunday but if you wish it can be arranged and someone can call you from another complex like this but then I expect that to be done away with like everything else.

[Diane, 79, impaired physical mobility, lives alone, sheltered setting]

#### 7.3.4 Meanings attached to specific capabilities and places

Some narratives suggested that in shaping (or not) capabilities for various functionings, how the capability under consideration was valued held significance. As such, whether capabilities that mattered could be achieved too was variably influenced. Other narratives provided insights into how in relation to specific capabilities, meanings, that participants ascribed to places where they lived were contextually interpreted and understood.

##### How a specific capability is valued

Unlike Jack, for whom driving a car was a valued part of his identity capability and intrinsically valuable (quotation introduced in section s of chapter 6), for Kate, driving was instrumentally valuable to support other capabilities. She mentioned that she had learnt driving very late and had never been a confident driver. For Kate, the driving itself was not valued but practices related to driving were.

Kate: But, I was never a confident or a very happy driver [...] I really got the car too late because when my husband was alive he drove the car [...] I had a licence. We never really agreed when I was driving, it was never quite right so I thought (laughs)

[Kate, 80, visually impaired, widow, lives alone in her own house, Ferry]

So while for Kate, interplay of individual and socio-spatial factors (capability to walk, use public transport and adequate and affordable bus services) facilitated capabilities for mobility related functionings (going out, socialising), Jack experienced a profound sense of loss as the capability to exercise a valued identity that was tied to driving a car became unavailable to him and could not be modified by socio-spatial factors.

Tara's and Henry's examples too illustrate a similar point in relation to the specific capability to do food shopping. They both had the capability to do food shopping, but each one of them valued food shopping in different ways. Tara could not exercise the capability to do food shopping as she valued and that also held implications for her capability to enjoy eating. She mentioned that opportunities to go to the supermarket such as, social support from her daughter and community transport options were available, but she had stopped going to the supermarket after a few trials. Her visual impairment, perception of being a hindrance to others, and not being able to read food labels undermined her confidence and willingness to go to the supermarket. Her visual impairment in relation to the specific functioning of reading labels and perhaps the environmental design contributed to her constrained capability to buy food by herself.

Tara: [...] I don't go shopping, cannot go because I cannot see what I am buying [...] I go so slow and I feel I am in folks way. And that is one thing I miss, I miss not being able to go to the shops and get myself something for a change. You know how you say, try that,

try that... I mean the family is good and I tell them what I am wanting but it is the same thing at times [...]

[Tara, 89, visually impaired, lives alone, very sheltered setting]

Henry on the other hand, indicated that he was not keen about shopping and buying food himself and hence, the interplay of individual and socio-spatial factors contributed to his capability to do food shopping.

Henry: I don't go shopping; I hate it. My daughter does the shopping on a Monday and my son does shopping on a Friday [...] we are well covered [...] So we make a list out on a Monday and a list out on a Friday of what we want, food wise and anything else and we give them the money and they get it for us.

[Henry, 73, impaired physical mobility, lives with spouse, domestic setting]

For Jill, the meaning attached to a valued activity had changed in light of her new identity as a caregiver. Jill expressed her sense of frustration and stress with the nature of her husband's illness. Having time to self was important to de-stress. While swimming had always been a valued activity for her, it had assumed greater and a different relevance in light of changed circumstances to enable her capability to de-stress. Her husband and daughter were supportive of her engagement in a valued activity to support the capability to be who she was.

Jill: when we retired, actually, one of the hotels just along the road had a swimming pool opened and that was when I started swimming every day. I swim every day and that is my time (with emphasis) (and it needs to be something very important that I don't go for my swim [...] and I am stressed, I have to tell you, I am

finding this situation very stressful [...] my daughter is most emphatic that I need to get out.

Jack: its important that she (my wife) hangs onto the person that she's always been.

[Jack and Jill, 80 & 76, Jack has Parkinson's, live together, domestic setting]

#### Meanings ascribed to places

The meanings participants ascribed to places too were not fixed and immutable but were contextually interpreted in relation to the capability that participants had for specific functionings including, for some, the capability to be who they were or wanted to be (identity).

Nina was a proud homeowner, and she reflected that having lived in the same house for a long time (over 53 years at time of interview), it was an extension of her self.

Nina: I think when you have been living in the house for so long you have got it the way you want it and things like that and you can open your front door and things like that. I just really like it.

[Nina, 89, balance not good, lives alone, domestic setting, around Lochee]

But it soon became apparent that for her the experiences within the home were of less significance than the experiences of getting out from the home.

Nina :On a Monday I go up the road to a club, a Tuesday I come here (another day club) and then I go bingo (laughs) with my friend. Wednesday I go with friend to bowling club and then I am here (day club) on a Thursday. I am not out on a Thursday night or a Friday night. I go on Friday morning to a hairdresser but that is that [...].

This was not surprising because getting out of the home was important in supporting the capability to meet other people and socialise. Nina described herself as a sociable person. It was a part of her identity and, hence, meeting and speaking to people mattered to her. Even as a young working class wife and mother, it had been important to her.

Nina: Well I am one of these people that if you were coming in and sitting on your own I would come and speak to you. I think it is natural for me [...] I think making for a good life is [...] when you are out and you speak to people, keep contact with them [...] I got work in the school, a cleaning job and I was there for 24 years until I retired when I was 60. I had to do it in a way to get money but I liked it in when you go in and all the people, I liked to meet people.

The capability to get out and about beyond the home was foundational to supporting the capability to meet other people for Nina. In this context, the relative importance attached to a particular capability and how the potential anticipated loss of such capability may become instrumental in shaping meanings of place and perhaps, impact other capabilities is illustrated in the excerpt below. In stressing the valued capability to get out to meet people Nina commented about the adverse impact on other

capabilities (i.e., her mental wellbeing) if a time came when she would not be able to go out from the home. The home in such a situation would negatively impact her capability. Nina also showed an awareness of the wider social issues of loneliness and social isolation for older people when she made a comment about what reasons underpinned these issues.

Nina: Means a lot of to me to get out and meet people. I think if you are living at home on your own and you can go out keeps you going. If I think I was in the house and could not get out anytime, I think I would deteriorate. I think that's what is wrong with a lot of people, they are not seeing anybody; not speaking to anybody you know [...]

For Sally on the other hand, who lived in a care home setting, the capability to live amongst others (as described in section 7.3.1) enhanced her sense of place. But, on the other hand, service encounters undermined the specific capability for privacy and alienated her sense of place.

She mentioned the lack of sensitivity and concern amongst staff about importance and implication of seemingly simple actions such as 'closing the door behind'. Lack of attention to repeated requests signified disrespect and such repeat encounters undermined the capability for privacy.

Sally: My husband used to say to staff, 'this is our home, would you kindly close the door'. (Laughs) He was quite a gentleman. He was wanting to making a notice and put up on door saying 'please close the door'. So trying to tell them that and you feel that

they (emphasis) feel it is their job, it is not our house, our home  
[...]

[Sally, 86, wheelchair mobility, lives alone, care setting]

For Sally and her husband, the room symbolised a private space. Based upon this relationship that they had reflexively constituted with the room (the physical space) they voiced their concerns to staff. Failure on the part of staff to close the door behind was interpreted by Sally and her husband as communicating the contested nature of place and alienated rather than encouraged their sense of belonging.

As the above examples reveal, for some, how a capability was valued, then brought into focus the interplay of individual and socio-spatial factors to shape capabilities (or not). It also revealed that in some cases, as for Jack, socio-spatial factors could not modify the capability under consideration. In some other instances, it was in the context of particular capabilities (and, for some like Nina, both in the present and future) that meanings attached to places where people lived were contingently and contextually interpreted. Experiences of place in relation to specific and different capabilities for the same person (Sally) too were diverse.

### **7.3.5 Social group activities in supported settings**

A number of participants drew attention to different aspects (both individual and place related) of participation in group activities in supported settings. Some like Sally and Benny commented upon organisational issues of space, and, resources in the context of personal characteristics of residents in the care home. Others, such as, Cathy interweaved issues of change (in the type of residents in sheltered settings) with individual values in relation to social activities. Individual



values too mattered (Meg) and some like Diane and Joe valued the capability to volunteer and organise social activities where they lived. And other experiences, such as Tina's, brought into focus the difference between social contexts.

Cathy valued participating in social activities. However she valued participating in activities that were available within the sheltered setting. She no longer wanted to go out to day or lunch clubs in relation to the specific functioning of participating in social activities, although she had the capability.

Cathy: I like it fine when it is here [ACTIVITY] but I don't think I would like to go out for anything. I am getting stuck in the mud.

[Cathy, 81, arthritis, lives alone, very sheltered setting]

She was also one of the three self-appointed organisers in the very sheltered setting that she lived in.

Cathy: At the moment there is not much going on but my friend and I we run the bingo. And we have a fish supper night, that is up to us, we provide the money for that and in the summer we hope some of us will be able to go for day trips, some place and we can eat, a wee tour around and back again

In this context, she remarked how the changing nature of residential mix (increasing number of people with a range of impairments) in the very sheltered setting was making it more and more difficult to organise activities and get people to participate.

Cathy: see when I came here first (5 years ago) the people who were in they were not bedridden. Now we have got an awful lot of folk in here with Alzheimer's. It was not like that to start with, a lot of people used to go down to the lounge, we used to put the music on and get a laugh you know. But not so much now [...]; you never see them for weeks, it is a shame but cannot help it. Anyway we just have to struggle on. I think we were taking a wee bit bad with that because we had never had that before

Sally commented on the lack of dedicated spaces for holding social activities. The public and social space within the care home (i.e., the lounge) served as a multiple activity space, space for entertaining visitors, a place for relaxing and watching television.

Sally: This [CARE] home does not have any space for entertainment or exercise and if the activity woman [APPOINTED CO-ORDINATOR IN CARE HOME] wants to do anything it has to happen in the lounge cum dining room. And our lounge because the television is on the whole time it just does not happen.

[Sally, 86, wheelchair mobility, lives alone, care setting]

She further observed that although organised social activities were encouraged, issues of space together with lack of resources of time and staff for supporting people (as many could not walk or get about on their own even within the care home) to participate held implications for organisation of and by consequence not having enough residents participating in social activities.

Sally: And care home sent down a directive that we should have a tea party every on Wednesday and Friday. Out of all three wards, one day four, another day five, another day three who could attend the tea party. [CARE HOME] you are not taking into consideration the kind of bodies that are there [...] there is only about 2 people actually walk, rest of them they are all in wheelchair, they cannot walk and takes a job for them to get them from wheelchair to other chair you know [...] The point is there is an activities woman, there are about 24 on this floor and 10 downstairs [...] If you have any kind of activities, you need to be given time and if the carers are busy, which they are, then it does not happen.

Individual values too contributed to shaping capabilities for social participation within sheltered settings as Meg commented. At the same time, however, it also became obvious during the interview that she was already embedded in her faith network and associated social activities.

Meg: they have a lot of things going on they have like bingo and other things. I don't go, I don't go. To be honest Manik there is a lot of gossiping that goes on in there. I don't need I feel I don't need it so I don't go.

[Meg, 81, impaired physical mobility, lives alone, sheltered setting]

Others, like Diane, valued the capability to organise social activities in the sheltered setting where they lived. Diane believed that involvement of the manager was not required. Having moved only a year ago (at time

of interview) into the sheltered setting, she was managing a range of social activities where she lived.

Diane: [...] one of the other things is we have a morning tea on Monday, Wednesday and Friday and we have usually afternoon tea on every day of the week except Saturday and Sunday...so this is something else the manager does and that is totally unnecessary[ ...] so I said to her if it is alright with you, and I said, I don't mind doing the afternoon teas. I have got experience of sheltered housing with my parents [...] people prefer to have their own committee...arrange for their own monies [..]So I decided to on a sales table, I had one a few months ago just outside the reception area just one table [...] we did rather well and it was nearly seventy pounds.

[Diane, 79, impaired physical mobility, lives alone, sheltered setting]

Tina lived in a care home in the affluent part of the town. Notwithstanding that personal characteristics and values too might have played a role, but her comments highlighted the potential role of personal financial resources in enabling capability to participate in a range of social activities beyond the home.

Tina: [...] the staff is super and we get some very good outings. And [ACTIVITY COORDINATOR] takes us out [...] she takes us to a show, theatre [...] now we were out last week and we went into a pub and had, we had a meal there, it wasn't really a pub it was a restaurant but we got a drink and we had a sherry and a meal so it

was nice. [...] And we're going away for a weekend. [...] Don't quote me but I think it is Loch X.

Tina: I was telling my son, you know, places we've been to and he says, I know, I've got the bill.

[Tina,84, widow, lives alone, care setting]

Residents living in care homes in less affluent part of the town referred to social activities that were organised in the care home (e.g., tea party, exercise sessions) and around the care home (such as, a walk in the vicinity of the care home) or the occasional bus trip.

### 7.3.6 Access, availability, and quality of resources

For some participants, diversities in health impairments variably influenced interactions with place, differentially affected, and shaped capabilities for various valued functionings. Access to, availability of, and quality of resources (social, financial, emotional support and resources as well as material features of place) emerged in these participants' narratives as being important in shaping capabilities and individual experiences of place.

#### Resources and multiple capabilities (across an individual)

(Informal) caregiver's personal characteristics, material features of place of residence, and formal support (access to community alarm service, carer centre service) influenced: the capability to continue to live together for Jack and Jill, for Jack to continue living at home and, enabled Jill to cope with caregiving demands. As a caregiver, Jill's good health and the physical layout of their house not only, contributed to Jack's

capability to be with his wife but also to continue living at home. The significance of good health and its implications for continuing to live at home emerged in the following conversation:

Manik: Anything else which is important for good life?

Jack: I think good health, which I haven't got, so that's a big miss, a big miss.

Jill: And I'm lucky, because I'm well and he's lucky, because I'm well.

Jack: Yes. I don't think I would be as well as I am if it wasn't for my wife. So, we're lucky, or I'm lucky that we've got each other. I think I would be in a home if she weren't here.

[Jack and Jill, 80 & 76, Jack has Parkinson's, live together, domestic setting]

The physical design and layout of the house too had been significant in shaping Jack's capability to continue living at home. Physical adaptation of house to accommodate Jack's current mobility status was made possible due to the availability of a room and a bathroom on the ground floor of the house.

Jill: we had the double bed up the stair and then when my husband had [health] problems we moved and this was the office, we had an office. So the office was moved up the stair and the bed down the stair [...] because husband was having bother with the stairs [..] We had the bath taken out and we have a walk in shower now [...] a power shower and a wee stool, it's very handy, it's nice.

Jill's new role as a caregiver enabled access to the Carer centre and their resources and networks to enable her capability to manage stress.

Jill: it's only just since July that I've been involved with them [carers]. Well she just comes and has a wee chat and sees if you've got problems. So there's that, but the carers had a thing and there's a stress management course and I'm going to it, because I'm stressed [...] because he needs a lot of help and attention and I am able to give him it. But there are times when it's very wearing. I'm no saint, I have to admit.

While material features of the setting mattered, For Tara, familiarity with and knowledge about the very sheltered setting where she lived was instrumental in promoting capability to feel confident and competent. Her capability to walk was contingently and variably shaped at different scales of place. Tara felt confident to walk and move about freely on her own within the sheltered environment setting despite her visual impairment. Flat and even surfaces, availability of the lift supported free and safe movement. But she avoided getting out beyond the place of residence on her own. The outdoor environment was an unknown. Having a family living in close proximity supported her capability to get out and about.

Tara: My balance is no good with my eyes, it is alright in here [SHELTERED SETTING] because everything is flat and I know where everything is but the family is good they come and take me out [...] I could go down the lift and outside into the garden. It is a lot different walking on this and walking on road [...] I only go

outside with my family, use my stick and they have a car and we usually go from door to door you know.

[Tara, 89, visually impaired, lives alone, very sheltered setting]

#### Resources and specific capabilities (across different individuals)

For many participants, getting out and about beyond the place of residence was foundational for maintaining engagement in different valued spheres of their lives and a valued capability in itself. As such, different combinations of personal and place-based factors were significant in enabling (or not) capabilities, particularly, where participants had health related impairments.

Family and friends variably supported the capability to participate in daily and social life, but sufficient personal finances and entitlements (such as a taxi card) gave participants the freedom to get out and about whenever they wished. Jack and Jill mentioned that they valued having sufficient finances, though, not directly in the context of going out together. Although participants in the sample had access to these resources, this may not always be the case.

Jill: we still manage to get out and about and that is very important [...] but [what we are able to do is] becoming much more limited, because of his ability to walk [...] we get a taxi down and a taxi back, or if we need to go to the town, we get the taxi into the town. But, it's very difficult for him, he tires quite easily [...]

Jack: We can get a taxi anyway from here and we do have, in fact, a card, which enables us to have the fares reduced [...] so we're never stuck.



[Jack and Jill, 80 & 76, Jack has Parkinson's, live together, domestic setting]

Using the public transport was not a genuine opportunity for some participants with health related impairments. But even with support, the physical strength of the carer was an issue as Maggie commented in shaping the capability to go out together. Maggie also valued financial security and reported not having any money worries, but at the same time she also made specific references to her husband receiving only a part of his pension. Personal events over the life course had negatively impacted upon her husband receiving a full pension. Implicit within her account was how that extra amount of pension might have been a valuable resource.

Maggie: We used to have two cars but none of us are driving now. [...] You are relying on somebody [family] taking you [out]. He can't walk far. He has got a pushchair, but I wouldn't be able to get off and on buses.

Maggie: With my husband having to give up his work, his pension was frozen and [...] it is now a part pension. His pension was frozen which meant a reduction in his pension when he retired, and he couldn't claim unemployment money because he left his job to help our son out. But [...] we are not worried about money and things like that [...] we can pay our bills and all that.

[Maggie, 79, spouse has Alzheimer's, lives with spouse, domestic setting]

Maintaining access to formal entitlements too was not guaranteed as some accounts suggested. Following a falling episode, within her place of

residence, Nina was entitled to a community alarm and a blue badge<sup>iv</sup>. Perspectives of experts (the doctor in this instance) on the nature of (mobility) problem can be influential in maintaining access to entitlements and by extension, in this instance, influencing the capability to get out of the car. Once, she was able to walk again, Nina's blue badge was withdrawn. Her daughter upon investigating further found out that the Council had received a doctor's letter proclaiming that Nina was able to walk again and hence not eligible for the badge anymore.

Nina: Aye, I fell in the house and I was in [THE HOSPITAL] and I could not walk and I could not do anything about it because all the tendons they are twisted in my leg. So I had the badge up to just July and then they said I was not getting it. So my daughter phoned [the Council] and asked why and I think it was through one of the doctors, he had said I could walk.

[Nina, 89, balance not good, lives alone, domestic setting]

Her daughter was instrumental in securing the badge back for her although it had been a laborious process requiring persistent effort. Nina was indeed able to walk again but as she remarked, the badge for her was not about walking related issues but issues related to car parking and getting out of the car. The doctor however had viewed mobility in a very limited and functional way.

I got it back from the Council. You have to pay £20 and you get it. It is not that. If you get near where you are going it is fine but the other parking places I have to get the door open a good bit to get this out (gestures to leg) and there wasn't enough parking space.

Access to and availability of resources (social support and financial of self and family) was important but the quality of the resources too mattered to enable the capability to get out and about as some participants commented. For instance, having access to a car was significant as taxis were an expensive option. Not only was having access to the resource (car) important, but also the characteristics of the resource (e.g., size and space aspects of the car) acquired significance in relation to the nature of impairment (carrying the wheelchair, walking frame etc.). The accessibility of potential public locations too mattered as these influenced where participants could go. Lack of accessible toilet facilities and wheelchair access curtailed where people could go. Individual preferences too mattered, as some like Sally, who had wheelchair mobility, were not keen to go out shopping but wanted to go to the museum or the public gardens. Outings were planned around issues of access.

Sally: They [FAMILY] have tried me to go into their cars, because we have been going out in taxis and taxis are quite expensive and they can only take you there and back. Well, I got into M's [daughter] car okay [...] and you just cannot go because if the toilet is not suitable you cannot go. We went to find out different places that we can go to and if necessary go to the toilet, that's quite a consideration.

[Sally, 86, wheelchair mobility, lives alone, care setting]

Quality of resources of the place of residence too mattered. Lack of an outdoor garden space in the care home influenced Sally's capability to get outdoors on her own as and when she wished using her wheelchair.

Going outdoors was therefore either done with support from the activity coordinator or family.

Sally: [WHAT MATTERS TO ME IS] to get out [...] just for a walk, I am not a shopping person [...]. And the way the home is built on a hill, we really don't have a garden. There is a wee bit paved area but there is nothing for people to have a walk. You miss that. The activities woman has taken me out quite a few times... roundabout, in the area [but] she can't take me out all the time.

Support from family was a big part of many participants' lives for many different valued capabilities, however, as Tara's example illustrates, the characteristics of the functioning under consideration too influenced the kind of resources that were required in shaping capabilities. Tara is a Catholic and faith is important to her. Going to church on her own was no longer possible for her because of her visual impairment and unlike some other churches whose Ministers came into the very sheltered setting where she lived, there was no representation from her church. Going out with family was however not feasible, because although some of Tara's family lived in the same city, they did not attend the same church.

Tara: I am a Catholic, oh aye, aye believe in my faith very much [...]

Manik: Do you go to church now?

Tara: No I am no able now. I could not go and there is nobody here to take me [...] I could not go alone to church somebody would have to come with me [...] my daughter [IN DUNDEE] she goes to a different church and she does a lot there, she runs a club

there and my son he goes to another church [...] These two are really busy in their churches.

[Tara, 89, visually impaired, lives alone, very sheltered setting]

### 7.3.7 Social spaces beyond place of residence

Participants' variously reported about the significance of places such as, the day club, the carer centre, and the church as valuable arenas in shaping capabilities for multiple (valued) functionings (and vis a vis the church, functionings other than practicing faith). The functionings frequently mentioned included: socialising, doing valued activities (knitting, playing Wii, learning new skills) avoiding depression, and having a sense of purpose. Participants gave voice to the various ways in which these different places impacted their capabilities. Many participants also commented on how the day club expanded their capability to choose between having somewhere to go or stay at home. For some (Henry and Rita) situational contexts shaped their knowledge of and interaction with day club and carer centre respectively. And for others (Meg, Jack and Jill, and Nina) the church and day club had always been a part of their broader social context and as such these places already held significance for them in connection with other valued aspects of their life.

Henry had multiple health conditions including depression, a heart condition, and physical impairment resulting from a stroke. He had been advised by his doctor to participate in social activities as well as furnished him with information about various kinds of local places that support social activities. Upon the advice of his doctor Henry started visiting the day club six years ago. He continues to go to the centre

regularly, i.e. three days a week and reflected that going to the centre had made a positive difference to his life in different ways.

Henry: Hospital, just like social services they come and tell me to keep myself active. Because I was depressed. I am still on depression tablets they told me about clubs etc. and I had never heard of them before [...] [...] Well it [DAY CLUB] has got me out because I was getting like my wife, wasn't coming out. This [DAY CLUB] has changed it I don't have to be dragged out because I want to go out which is a difference [...] Three days a week. I come to the club which gives me company as well apart from my wife all the time.

[Henry, 73, impaired mobility, lives with spouse, domestic setting]

The day club not only contributed to capabilities for functionings such as avoiding depression, having a sense of purpose, and opportunities for social interaction but, also offered other opportunities for learning new things. Painting was one such activity that Henry chose to experiment with, and, which indirectly, expanded Henry's capabilities for various other functionings such as, earning income, and raising his self-esteem, The activity indirectly also contributed to Henry's capability to belong to a community of interest.

Henry: Painting, because I never started painting until I came to [DAY CLUB][...] So tried that and [...] after a few weeks I wasn't bad at that and sold [...] four paintings after that. So not bad at all [...] Proud when they are sold [...] there are six of us plus the two teachers, which is good.

Nina's example on the other hand points to the negative implications of the day club for multiple valued capabilities in the context of changes taking place within the day club. The particular day club had a special significance for Nina. Her affiliation with the club was long standing. Nina described herself as a sociable person who liked to meet people and hence coming to the day club supported capabilities for multiple valued functionings, such as, socialising, having a sense of purpose, and maintaining a valued identity

Nina: [COMING TO DAY CLUB] 30 years I think, first with my husband and then on my own [COMING HERE IS IMPORTANT BECAUSE] you get up in the morning, you don't have to say to yourself, 'oh, what am I going to do' and you say, 'oh, I am going to the club, I am going to meet so and so'. It just gives you some life you know to come and meet people.

[Nina, 89, widow, balance not good, lives alone, domestic setting]

Bundling of activities and services in terms of attaching conditions to the membership of day club however, meant a reduction in individual capability to choose how to participate for Nina. Reduced capability to choose in turn held negative implications for the above-mentioned capabilities. Nina did not mind paying the admission fee and also acknowledged that prices for food would naturally go up over time. She had issues with packaging of services and not having a choice to be a member only without having to eat at the day club.

It [DAY CLUB] has changed an awful lot. Well, there is more disabled coming now, there were disabled people coming before, but there seems to be more now. But, to me it is not run the same

its not. Things have changed [...] I come, pay my £3 admission and now they are stopping that. They are stopping the admission fee and they are putting up the teas up to £4 and if you don't take that you cannot come. I will find some other place to go [...] a lot of friends I have made, aye, I don't think I would miss anything else.

[Nina, 89, widow, balance not good, lives alone, domestic setting]

Situational context had also shaped Rita's engagement with the carer centre. Rita now lives on her own in a sheltered setting. Her son lives in a different country and she is estranged from her daughter. Rita's role as an informal carer for her husband had initially given her access to and information about the carer centre. She described the role the carer centre played in her life while her husband was alive and the role it continues to play in her life now that she is on her own.

Rita: [...] when I knew my husband was dying and I have to say that was a very difficult time because I had to be bright and cheerful for him and the someone said, 'what about the carers'? And then phoned them and a lady came, she deals with palliative care and if she had not appeared I don't know what I would have done [...] I would never have coped because it was all too much because I was just on my own.

[Rita, 80, lives alone, sheltered setting, no reported health condition]

Rita's engagement with and access to the carer centre did not stop after her husband passed away. She valued and continued going to the centre for the various learning opportunities it offered along with opportunities for social interaction. Rita also described herself as a sociable person



who liked to meet people and that might have contributed to her motivation to continue going to the centre.

Rita: Oh! the courses are valuable. Well I am a volunteer with the walking group so I was on a first aid course. I have been on a leader course, and I have been on a course which is about looking after your money, photography group [...]. The social aspect of it is good because you are meeting different people. Now I was away seeing the pandas with a group who, there were eight of us, and I knew five of them. So that is how I meet.

Capabilities for various and valued functionings that were mentioned by participants were linked to multiple dimensions of their lives including life, relationships, activities, self-direction, faith and knowledge. Participants' life worlds therefore encompassed places at different scales (place of residence and places beyond the residence). Participation in these social spaces was also shaped by capabilities that these participants obviously had, such as, capability to get out and about, access to personal and financial resources, and, various motivational sources, but this might not be the case everywhere.

The above examples also highlighted that capability changes for different participants occurred in different directions. For many, capabilities for various functionings were improved (such as avoiding depression for Henry), capabilities were expanded (for social interaction and meeting new people for Rita, Nina), and capabilities for new functionings were acquired (having a sense of purpose, learning and skill based activities as for Rita and Henry). For some like Nina, capabilities were also negatively affected. Bundling of activities and services may not always be desirable

particularly if it removes flexibility and consequently impacts negatively upon the freedom to choose. Further, the broader policy shift towards providing person centred services is defeated.

#### **7.4 Key findings**

a) Capabilities and sense of place (s) are dynamically shaped by age and health related changes and (or) the changing nature of social relationships within place. The interplay of individual and socio-spatial factors might not only negatively influence some valued capabilities but also may bring about a change in what people value. Capabilities for these valued functionings might bring into play a new and different configuration of interplay of individual and socio-spatial factors. This interplay may variably facilitate, and (or) constrain participants' valued capabilities with diverse implications for sense of place.

b) A related finding highlights that it may not be possible to anticipate the implications of change (for example, some events/episodes) in full for an older person's capabilities and sense of place (for instance, falling in Nina's example or, as in Tara's case, knowing how her vision would deteriorate). What combination of individual and socio-spatial factors shape, contribute to or constitute the capability (or not) under consideration may be only revealed during or after the event or episode.

c) Sense of place, can potentially be a key factor in influencing a valued capability (Jack), while, in other instances, sense of place (enhanced or reduced) could be an outcome that is linked to whether one has the valued capability under consideration (Sally, Nina, Tara). The meanings ascribed to the place (s) where older people live too may not be fixed but might be contingently and contextually interpreted in relation to what one is able to do and who one is able to be and over time (Nina and Jim).

Sense of place can be influenced in different directions depending upon the capability under consideration and in relation to the same person and place (Sally).

d) The interplay of individual and socio-spatial, the amount and the kind of resources required might vary depending upon the specific capability under consideration. This then may have implications for the degree of agency that an older person might be able to exercise in relation to the different valued capabilities across different spheres of his/her life (Kate and Maggie) or the same capability (Peggy).

f) How a specific capability is valued too might be significant (Peggy , Jack, Kate, Tara and Henry) in shaping whether the capability can be (or not) modified and facilitated by the interplay individual-socio-spatial factors.

e) Another finding highlights that spatial inequalities exist not only between different neighbourhoods (for instance, adequacy of bus services for Kate and Maggie), but within neighbourhoods as well. Lack of a resource can impinge peoples' capabilities in different ways. While bus service for some (Maggie) might be the only effective option to secure a specific capability, for others in the neighbourhood who have access to a car, lack of such a resource might only lead to a reduction in options.

f) Relationships with family emerged as being significant to many participants. Close personal relationships potentially enable capability for affiliation, meaningful engagement and are intrinsically valuable. Geographic proximity to family together with the quality of relationship can stabilise as well as expand many valued capabilities, although,

geographic proximity can be more significant for some capabilities than others.

g) Geographic proximity of staff and residents in supported settings might affect the residents variably. Proximity can contribute to shaping (or not) of valued capabilities (Sally, Cathy, Benny,) in relation to individual values, characteristics of setting, of residents, and quality of service plus service encounters.

h) In addition to individual values and quality of relationships, personal characteristics of neighbours (Jack and Jill, Kate) in domestic settings too might play a significant role in enabling capabilities. Friends can potentially contribute to a number of capabilities. As with neighbours, the personal characteristics of friends too are significant in shaping particular capabilities for face-to-face social interaction and participation (Benny). Some capabilities, such as, being able to go to church, can be better supported by friends or neighbours (who attend the same church) rather than family (Tara).

i) Heterogeneities in the nature, extent and type of impairment might variably influence the amount, kind and type of resources (both formal and informal, material and social) required to shape various capabilities. As such, socio-spatial factors can become significant in facilitating capabilities. Diversity in individual circumstances in terms of access to, availability of and the quality of resources means that some might have more capabilities than others.

j) Places beyond the residence and immediate neighbourhood can support and make available opportunities to exercise and develop capabilities for multiple functionings. Generating an understanding of

implications of such places for various individual capabilities thus becomes important, as does the influence of changing practices within such places for individual capabilities (Nina).

k) While issues of space, time and resources can be addressed to some extent in promoting participation in social activities in supported settings, the issue of securing participation of residents might be more challenging. On one hand, participation in social activities is based on individual values and therefore highly voluntary. On the other hand, participation in social activities also requires a certain critical mass to make it fun and enjoyable, and to support contributions towards collective financial resources for social activities in sheltered settings.

## **7.5 Chapter summary**

In this chapter, I have explored and described the complex and entwined nature of interactions between people and place and the underlying processes occurring at multiple place and temporal scales. There is a complex relationship between valued capabilities and places where people live. Heterogeneity in personal and social circumstances and contexts of the participants meant that experiences of living in particular places were diverse and not uniformly enabling or disabling even for the same individual. Capabilities were dynamically shaped and affected by changing nature of individual and place factors that in turn influenced what people valued, their sense of place and meanings attached to place. Interplay of individual and socio-spatial factors variably facilitated, mediated and constrained participants' capabilities for various functionings that mattered. Not only did participants value plural functionings but the analysis also highlighted the variable degrees of freedom that they could exercise in relation to different valued capabilities.

In next chapter I look at a specific group of participants who had changed their place of residence in an attempt to secure capabilities for some functionings. The chapter explores in detail their reasons for moving and examines the implications of moving for participants' other (individual) capabilities.

## **Chapter 8 : ANALYSIS – EXPERIENCES OF RESIDENTIAL RELOCATION**

### **8.1 Introduction**

This chapter focuses on a specific group of participants within the sample who had changed their place of residence and talked at some length about the reasons for change in place of residence. The analysis seeks to appreciate and understand reasons for moving and the implications of moving for participants' valued capabilities. The chapter is organised as follows: the following section (8.2) describes the key residential characteristics of the participants. Section 8.3 provides an account of participants' reasons for moving into different kinds of setting. Section 8.4 explores the implications of moving from one setting to another for participants' valued capabilities. The significance of place in shaping capabilities is illustrated in section 8.5 followed by a discussion about the temporal dimension of capability changes in section 8.6. The key findings are then discussed in section 8.7 followed by a concluding chapter summary.

### **8.2 Key residential characteristics of participants**

Tables (8.1-8.3) provide the key current and previous residential characteristics of participants' who had moved at some point of time in their lives into different kinds of settings. As shown below, a substantial number of participants had moved residences. While some had moved from domestic to other domestic settings, others had variously moved from domestic to sheltered settings, domestic to care settings and/or sheltered to care settings.

**Table 8.1: : Key residential characteristics of participants  
(Domestic to domestic settings)**

Participant	Type of accommodation moved into and moved from		Time in residence (Years)	Ownership status		Location of residence	
	Current	Previous		Current	Previous	Current	Previous
<b>Henry</b>	Housing association bungalow with garden (1bed)	Upstairs flat in a tenement with access via communal stairs (2bed)	5	Tenant	Owner	Dundee	Dundee
<b>Peter</b>	Ground floor flat with a garden (1 bed)	Upstairs flat in a tenement with access via communal stairs (2bed)	6	Owner	Owner	Dundee	Broughty Ferry
<b>Penny</b>	Upstairs flat in an apartment with a lift (1 bed)	Upstairs flat in an apartment with access via communal stairs (1bed)	4	Owner	Owner	Broughty Ferry	Broughty Ferry
<b>Tom</b>	Upstairs flat in a tenement with access via communal stairs(2bed)	Upstairs flat in a tenement with access via communal stairs (2bed)	17	Owner	Tenant	Broughty Ferry	Broughty Ferry



**Table 8.2: Key residential characteristics of participants  
(Domestic to sheltered and very sheltered settings)**

Participant	Type of accommodation moved into and moved from		Time in residence (Years) Current	Ownership status		Location of residence	
	Current	Previous		Current	Previous	Current	Previous
<b>Rita</b>	Sheltered bungalow (2 bed)	Upstairs flat in a tenement with access via communal stairs (2bed)	12	Tenant	Owner	Dundee	Dundee
<b>Meg</b>	Sheltered bungalow with garden (2bed)	Upstairs flat in a tenement with access via communal stairs (2 bed)	15	Tenant	Tenant	Dundee	Dundee
<b>Joe</b>	Sheltered flat (1bed)	Semi-detached house (2bed)	7	Tenant	Tenant	Broughty Ferry	Dundee
<b>Betsy</b>	Sheltered flat (1bed)	Semi-detached house (2bed)	6	Tenant	Owner	Broughty Ferry	Fife
<b>Diane</b>	Sheltered flat (1bed)	First floor flat (2 bed)	1	Tenant	Tenant	Broughty Ferry	Aberdeenshire
<b>Darren</b>	Very sheltered flat (1bed)	Upstairs flat in a tenement with access via communal stairs (1 bed)	2	Tenant	Tenant	Dundee	Dundee
<b>Tara</b>	Very sheltered flat (1bed)	Upstairs flat in an apartment with lift (2 bed)	4	Tenant	Owner	Dundee	Dundee
<b>Cathy</b>	Very sheltered flat (1bed)	Semi-detached house with garden (2 bed)	5	Tenant	Owner	Dundee	Dundee

**Table 8.3: : Key residential characteristics of participants  
(Domestic/sheltered to care home settings)**

Participant	Type of accommodation moved into and moved from		Time in residence (Years)	Ownership status		Location of residence	
	Current	Previous		Current	Previous	Current	Previous
<b>Sally</b>	Care home	Sheltered flat (1 bed)	2	Resident	Tenant	Dundee	Dundee
<b>Jane</b>	Care home	Upstairs flat in a tenement with access via communal stairs (2 bed)	5	Resident	Owner	Dundee	Dundee
<b>Stuart &amp; Sara</b>	Care home	Ground floor semi-detached house (2 bed)	1 month	Resident	Owner	Dundee	Dundee
<b>Bob</b>	Care home	Upstairs flat in a tenement with access via communal stairs (1 bed)	3 months	Resident	Owner	Dundee	Dundee
<b>Peggy</b>	Care home	Upstairs flat in a tenement with access via communal stairs (1bed)	2	Resident	Tenant	Dundee	Dundee
<b>Benny</b>	Care home	Detached house with garden (4 bed)	3	Resident	Owner	Broughty Ferry	Broughty Ferry
<b>Tina</b>	Care home	Detached house with garden (3bed)	6 months	Resident	Owner	Broughty Ferry	Broughty Ferry
<b>Jim</b>	Care home	Detached house with garden (3bed)	3	Resident	Owner	Broughty Ferry	Broughty Ferry

### **8.3 Reasons for moving**

Narrating their comparative experiences of living in different places, participants gave accounts of places (place of residence) they had moved from. These accounts highlight how contingent individual contexts and place characteristics interacted to de-stabilise capabilities. The illustrative examples below have been selected to reflect the diversity of individual contexts, different aspects of place, and at times the mutually reinforcing nature of relationship between the two in de-stabilising capabilities. Particular accounts have been chosen that reflect: different lengths of time since moving, different reasons for moving and different kinds of circumstances surrounding the moves and are organised around three illustrative themes.

#### **8.3.1 Material and social dimensions of place**

Material and social dimensions of place as well as particular situated contexts can have implications for capabilities to manage the impact of health conditions and to live well. Interdependencies and interactions that existed and occurred between participants and places where they lived operated variously at different scales of the house and neighbourhood. Place factors and personal characteristics interacted and mutually reinforced each other to produce disadvantage with negative consequences for capabilities: personal and environmental factors at the scale of the house for Henry and personal and social factors at the scale of neighbourhood for Jane.

Henry had moved from his own upstairs flat in a tenement to a rented adapted bungalow (owned by housing association) about 5 years ago. He could not exercise the functioning of climbing the stairs without getting breathless. That his wife too could not exercise the functioning of

climbing the stairs without getting breathless was a significant factor as well as a well-being concern for Henry.

Henry: I had two heart attacks, I had a stroke and had a quadruple bypass and that is when I had my stroke when I came out of the bypass [...] I sold it [FLAT] when I got unwell because I could not climb stairs very well [...] The doctors said I should not be climbing stairs [...] moved into the present bungalow 5 years ago [...] there were about 36 stairs to climb before you got to your front door and health people /social services put up bannisters for me going up because I could not take it. I went halfway up and had to sit down before taking the next lot [...] the wife has got COPD very very bad. She was finally struggling up the stairs, came with all the messages and everything and it was far too much [...]

[Henry, 73, impaired mobility, lives with spouse, domestic setting]

Jane too had lived in an upstairs flat in a tenement before she moved into a care home 5 years ago. She is visually impaired and finds it increasingly difficult to see people unless they are in close proximity. Jane reported how the neighbourhood where she had lived for over 40 years had changed. While change in social relationships in neighbourhood made the familiar unfamiliar, vulnerability caused by visual impairment and not knowing the new neighbours interacted to affect her sense of security. Jane reflected that place of residence, her home, had increasingly become lonely for her.

Jane: I was not too bad only when my sight went that was it. It has not got much worse but couldn't tell ... I mean if you came to the door you had to be very much nearer before I could recognise

you, it is an awful handicap really [...] Now if you get bad neighbours or anything, because the older people have all died and younger people coming in.... I was lucky with my neighbours when I went there (her own flat and neighbourhood) first.... because when we went up there first it was a good scheme but they are letting in anybody now [...] I have never liked to be alone somehow or other. I don't like lonely places, no, people love country and all that but....

Manik: And (where you lived) had become lonely for you?

Jane: Ah ah yes. Well there was only one neighbour left that was two flights up [...] Well actually I really wanted to come in because the neighbours.... It was just the mere thought, because neighbours now are not what they used to be. They were all a lot younger than me so I did not expect them to be like me [...]

[Jane, 96, widow, macular degeneration, care home]

For Jane, health impairment via its negative influence on capabilities for various functionings such as, forming new social relationships/ getting to know people/ becoming familiar with changing social environment/not being lonely hampered adaptation to a changing external context. For Jane, losing the confidence to live on her own stemmed from the dynamic nature of context. Consequently, the changed social landscape was alienating for her. With the exception of one neighbour, whom Jane had known for a very long time all other neighbours were new and younger. Though she did not make reference to any particular experience with her new neighbours, but the nature of ties with new neighbours were at best ambivalent.

Material and (social) features of place were significant factors in supporting or undermining a range of capabilities. Particularly, where participants had various kinds of health impairments, the nature of support required depended heavily upon features of the place of residence. For Henry, not only did material features of place directly impact capabilities associated with managing the impact of his health condition (such as not climbing steps), but indirectly for him affected a range of other capabilities related to managing daily life and freedom to choose.

Converting the impaired (bodily) ability into the capability to get out of the flat for both Henry and his wife was made more difficult by material features of the tenement that provided access to the flat by climbing two flights of steps. In the context of his health conditions, negotiating stairs to get in and out of the flat had implications for security of his life. On one hand, getting out of the residence was at a minimum necessary to maintain and manage other functionings for instance, daily necessities, albeit, at the cost of rendering the functioning of life insecure. On the other, deploying the strategy of not getting out of residence frequently had implications for social isolation and Henry's mental wellbeing as he suffers from depression.

Having to negotiate stairs to get out of the residence reduced Henry's effective freedom or capability to choose to go out or stay at home freely with negative consequences for other functionings.

Henry: [...] We weren't going out when we were in the other house, we were staying in a lot.

Both the above examples highlight that the nature of material and social factors, were, both fixed and dynamic, and over which Henry and Jane had limited control in terms of adapting or modifying the environment. For Henry, the scope for making modifications or adaptations to place setting was limited due to the nature of housing design where individual flats are accessed by communal set of stairs (fixed characteristics of place). And, Jane had to contend with the dynamic characteristics of place, i.e., neighbourhood as a changing and evolving social entity. Negotiating the place of residence in both instances was about securing capabilities for functionings of being and feeling secure (Jane) and, having the freedom to choose to go out from the home without negative implications for other functionings. (Henry).

### 8.3.2 Dynamic valuations

The following two experiences illustrate the complex dynamics that operate in relation to caring, place, and valued capabilities. Contingent contexts triggered a reflexive re-evaluation and interpretation of place: particularly, its role in supporting capabilities for what had become valued functionings.

Benny moved into a care home along with his wife when she was diagnosed with Alzheimer's 3 years ago. He remarked about not being able to cope with her deteriorating health condition on his own. Being able to continue living with his wife was important and the wife's illness threatened a particularly valued functioning.

Benny: I wanted to stay with [my wife], be together and that was it. I'd have rather stayed in our house, but it was impossible to stay [...you couldn't cope on your own, which I knew I couldn't

because on many occasions, I had to phone my son and tell him to come down right away. I couldn't handle it. She was getting too aggressive.

[Benny, 90, spouse has Alzheimer's, care setting]

Capability as the freedom to choose between various options may be constrained due to a variety of reasons and under such conditions availability of options may not hold much significance. Benny had wanted to care for his wife at home or move into a sheltered setting. Spouse's health condition demanded a particular kind of place setting, i.e. the care home setting. Due to the prohibitive cost of home care, the home place in this instance could not be reconstructed as a caregiving space and simultaneously secure capabilities for two valued functionings: being able to provide care for spouse, and being able to continue living with spouse. Similarly, the option of moving into a sheltered setting became unavailable to them. The example however also highlights the role of monetary resources in promoting Benny's valued capability of living together with his wife in a care setting.

Benny: I had it all planned out that we were going to buy a sheltered house and at least we would have a warden there and we wouldn't be on our own, we'd have someone to help us, but they said [Social services] that that just couldn't be. You'd have to have a sort of live-in nurse, anything could happen with dementia and that was social services said you'd really have to get a live-in nurse. Unless you had the money to do that where you are, because you couldn't do it in a sheltered house [...] he gave me an



example of what it would cost just to have a nurse at night and it was going to be a tremendous amount of money.

Rita's context is similar to Benny's to the extent that her husband's health condition necessitated a re-negotiation of place of residence. Rita and her husband moved from their own flat to a sheltered setting 12 years ago when her husband suffered a stroke. In the context of her husband's impaired mobility, Rita described the struggle of getting out of the flat every time they had to go out and about. Constraint posed by the interaction between the impaired mobility and the physical environment on the capability to get out and about was however, not the only issue.

Rita: [...] If we went out it took ages to get out and we could only get out a wee while because we had all that way to get back [...] but no it was a case [...] of either we stayed there and have no life because to get out was such an ordeal, or move.

[Rita, 80, lives alone, sheltered setting, no reported health condition]

Particular and contingent circumstances can usher in new considerations and re-evaluations of the kind of things that matter and become significant. Rita in her new role and identity as a carer remarked becoming anxious about implications for managing her husband's care if she fell ill.

Rita: And, it is quite funny when you are in a situation that you are caring for somebody you very shortly learning that you are second-class citizens. I was very lucky that I only fell ill once and I could not have sat in bed because he had appointments to go to.

And then all of a sudden you begin to realise that what if anything happens to me you worry what is going to happen to him. We needed I felt we needed a back up [...] and that because we did not have anybody [...]I haven't got any relatives at all because I am only child and so is he [...]My daughter lives down in London and my son lives in Germany. To let you understand my daughter has not had anything to do with us for a long time.

Rita's example highlights that what might become important in supporting capabilities for contingently valued functionings may only become apparent when a particular situation arises. It was only in the particular context of her husband's health condition that the significance of need for and lack of availability of informal social support emerged and ushered in a re-evaluation of home place as a secure refuge. The home place was re- interpreted as being lacking in social resources and networks to support what was regarded as valuable, and, by extension, home place was unable to moderate anxiety and worry.

The last vignette differs from all of the above in respect of the context. While the above examples relate to contingent contexts of health and care for self or spouse, the following example pertains primarily to the socio-economic context and its place and capability implications.

### **8.3.3 Socio-economic context**

Darren moved from an upstairs flat in a tenement to a very sheltered setting over 2 years ago. A series of bad marriage relationships not only made him bankrupt but he also suffered a breakdown. He stopped working at 50 and lived on incapacity benefits until he turned 60 and started receiving pension. Relationship breakdown and serious financial problems affected his accommodation arrangements. Darren approached

the Council and was accommodated in an upstairs one-bedroom council flat in an area of his choice. He had to stay there for 11 years before he could move again.

Darren: [...] My ex wife and her solicitor took everything I had [...] I came back here and I had a breakdown [...] I had to start from scratch and the council put me in a flat and that was knocked down after a year they put me in another flat. [...] I asked to be put near [this area] so that I could be near my stepdaughter's and take my grandson to school and sort myself out [...] I did not have any money. All I got was incapacity benefits, no social security. Because I worked all my life, I just got incapacity benefits and at that time I had about £3 a day to spend (and laughs).

[Darren, 67, lives alone, very sheltered setting, impaired physical mobility]

While Darren acknowledged that the particular neighbourhood was of his choosing, the social environment of the tenement he was accommodated in impacted upon his mental wellbeing and capability to get out and about. Fear for security of his property reduced the freedom to choose to go out and about.

Darren: Oh! I had a drug dealer across the door from me, a drug dealer down the stairs [...]. I used to get my bell rung, drug addicts on stairs all night, sometimes I get my bell ringing 2, 3 or 4 in the morning or knocking on my door thinking I was selling drugs [...] I couldn't do anything [...] I could not really go out, because if I went out I was frightened my house would be broken into, because sometimes there would be over 10 people, drug addicts on my stairs [...] you could not describe what happened [...] I knew

everybody around [in neighbourhood] but the flat was terrible  
[...]

Some capabilities can be significant inputs for other capabilities. In this instance, Darren's lack of capability to hold assets/financial resources constrained the capability to freely decide to move to a different place. For Darren, becoming unwell mediated the relationship between place and capabilities. Becoming physically impaired opened up access to statutory services and contributed to his capability to relocate to a different place setting.

Darren: I could not get help from doctors, could not get help from council nobody wanted to help me [...] I told them [doctors] where I was living and I wanted moving and they were not interested and I just gave up in the end [...] [Health wise] All my nerves are gone [...] what was it, 2008, I completely lost the use of my legs for four days and from then I got really bad, the pain was horrendous [...] I could not walk, I could not get up the stairs [...] I went to social services at [...] and I was crying. I told them I had to be moved because I was too ill [...] and this is how I got in here [very sheltered setting].

Different aspects of place, particularities of broader and immediate situations and contexts, risk to existing capabilities, and contingently valued functionings interacted to shape what participants were able to do and be (or not) with implications for continuity of residence. The above vignettes highlight the heterogeneity of individual contexts and draw attention to the fact that older people might prioritise different capabilities and may need different kinds of support to be able to live

well and which could possibly include moving from their current place of residence.

Being able to move from current place of residence to secure capabilities for various functionings potentially draws attention to the 'genuine opportunity' that different older people might have to shape place biographies in line with personal biographies. In the above examples such 'genuine opportunity' was to a large extent dependent upon the individual as well as broader policy context. Control over property influenced the opportunity to shape place biographies particularly for Rita and Benny. Presence of specific health conditions for Henry and Jane provided opportunity to shape place biographies via access to statutory services (social care services). Darren's opportunity to shape place biography, on the other hand was limited: he neither had the resources (property or finances) nor a health condition to start with. Poor housing situation and its influence on his capability to be go out and about as and when he wished was not sufficient to shape access to a different place setting. His experience also points to the privileged nature of health discourse over housing discourse in practice.

#### **8.4 Implications of moving for other individual capabilities**

Participants' accounts suggest that moving from one setting to another (domestic to domestic, domestic to sheltered, domestic/sheltered to care home) to secure and stabilise some capabilities had implications for various other individual capabilities.

Broadly, four categories of capability changes were identified. First are *expanded* capabilities, and include those capabilities that participants' already possessed but which were augmented or enhanced. Second type includes *reduced* capabilities, meaning capabilities that were lost and(or)

were diminished. Third, *opportunity* capabilities, refer to those that were either difficult to achieve in the previous setting or became available upon moving to a new setting. And the fourth type, *unaffected* capabilities, includes those that were not affected either positively or negatively by a change in setting. Although, the fourth category appears to contradict the notion of change, but is a significant category in so far as to understand under what conditions and why capabilities remain unaffected despite moving.

Using individual cases drawn from the sample, the tables (8.4-8.10) below set out the different kinds of capability changes (in the four categories outlined above) in moving from: domestic to other domestic and supported settings. Capability changes across individual participants have been presented to highlight how a range of capabilities were affected.

#### 8.4.1 Domestic to Domestic Settings

##### Henry

Henry and his wife had moved from their own upstairs flat in a tenement in Dundee to a rented (adapted) bungalow owned by the housing association 5 years ago, also within Dundee. Henry commented on the various capability changes that he had experienced (Table 8.4). He reflected how a change of place of residence had not only secured the freedom to get out and about beyond the house as and when he wished to but also expanded his capability to enjoy interaction, reciprocation, and engagement with his family on a frequent basis. His adult children and grandchildren lived in close proximity.

The bungalow had a garden (in the front and back) and that offered Henry the opportunity to do gardening, and contributed to enabling his

capability for an activity he loved. He further commented that they could have looked at a number of other places but when they went out to visit

Category of capability change	Description of capability change	Illustrative Quotes
Expanded (Capabilities which already existed but have now been augmented)	Being able to enjoy frequent interaction and engagement in family life	[...] it is handy for the family[...] I am surrounded by them [...] my daughter lives round the corner, my son lives here, my grandson here and my other son lives here (points out on an imaginary map to show that they are all living very close around)[...] and they visit quite often and phone [...] to make sure if I am okay. That is a great advantage [...] It is company really (HENRY)
Reduced (Capabilities diminished or lost)	Being able to continue being a home owner Being able to choose to be a home owner or tenant	I mean when you have got your own house for 20 odd years and you have to sell it, is a big comedown for me, because it was a bit of pride for me, owning my own house [...] and I could not afford to buy a brand new bungalow. (HENRY)
Opportunity (Capabilities difficult to achieve in previous setting or have become available upon moving)	Being able to pursue the valued activity of gardening  Being able to live in a pleasant and safe environment; Being able to feel relaxed	I had always had that [LOVE FOR GARDENING][...] I have always been interested in it and I get pleasure out of it [...] [IN PREVIOUS FLAT HAD] a shared garden at the back with woman underneath but it wasn't the same [...] And [IN PRESENT BUNGALOW] it was a big garden in front and a big garden at back so I took it [...] even if I am as ill as I am I love my garden. (HENRY)  [...] The bungalow it encouraged me to sit outside because we bought deck chairs and umbrellas, well, we did not have that in the other house [...] the other thing is it is awfully quiet here [NEIGHBOURHOOD] whereas round at the other house it was awfully noisy [...] police were never out of the street. So in one way I was glad to get out [...] where I am now I find I can relax more even though there are kids running about, you can put up with that but I can relax more, I can be more of myself (HENRY)

**Table 8.4: Henry: Implications for various other individual capabilities (domestic to domestic setting)**

this particular property he and his wife did not want to see any more properties: the garden clinched the deal for him and for his wife not having to negotiate stairs any more. The interlinked capabilities to live in a safe and pleasant neighbourhood and feel relaxed too became available. The capability to be a house owner and continue being a house owner however became unavailable, as Henry could not afford to buy a property in the open market. His capability to choose whether to be an owner or a tenant too was reduced. Being a house owner was a matter of pride for him and a defining aspect of his identity.

#### Peter

Peter had moved with his wife (who has since passed away) from an upstairs flat they owned in a tenement block in Dundee to a ground floor flat in Broughty Ferry 6 years ago. While at the previous flat, Peter suffered a stroke that left him physically and partially speech impaired. In moving to the new place of residence his capability to be a house owner remained positively unaffected (Table 8.5). The ground floor flat not only enabled his freedom to get out of the house but also contributed to his capability to participate in social life of the neighbourhood and to go out confidently on his own as and when he wished to.

Peter's daughter in law and son had taken the initiative to encourage both Peter and his wife to move to a new place, as his wife had initially been reluctant to move. The interview conversations suggested that had the adult children not encouraged the move, Peter and his wife might have continued to live in the previous flat. The daughter in law and son also supported the search for the new property and in addition to ensuring that the new property secured the freedom to get out and about



with ease for Peter, being able to live in close proximity of adequate public transport services was another important consideration.

Category of capability change	Description of capability change	Illustrative Quotes
Opportunity (Capabilities difficult to achieve in previous setting or have become available upon moving)	<p>Being able to do things confidently on his own</p> <p>Being able to participate in the social life of the community</p>	<p>If I want to do anything I could just go ahead and do it (PETER)[...] normally I would go with Peter to the hospital for appointments. I was working night shift last week and Peter had to go for diabetic screening clinic [...] at nine in the morning. So he said, 'I will go myself'. So he took the bus, did his appointment and came back again, which he would not have done before. [PREVIOUS FLAT] It was only one floor up but two flights of stairs [...] Peter found it difficult to get out and about. (DAUGHTER IN LAW)</p> <p>You tell me if I am wrong, when you were in B. street, you used to spend your day at the window watching the world go by without taking part in it whereas here he is definitely taking part, he talks to all these women who live around here, chats to the window cleaner [...] Whereas before when you were in Dundee you did not go out [WHEN PETER AND HIS WIFE MOVED TO NEW FLAT] the two of them sat outside on their deck chairs [...] and they got to know everybody [DAUGHTER IN LAW]</p>
Unaffected (capabilities that were not impacted positively or negatively by the move)	Being able to continue being a home owner	Yes, [OWNED THE FLAT] in B. street and this one.

\*Peter is partially speech impaired and had invited his daughter in law along for the interview at his place of residence

**Table 8.5 Peter: Implications for various other individual capabilities (domestic to domestic setting)**

#### 8.4.2 Domestic to sheltered and very sheltered settings

##### Joe

Joe moved from a semi-detached house (where he was a tenant) in Dundee to a sheltered setting (continued being a tenant) in Broughty Ferry 7 years ago following a hip injury. Being in a sheltered setting that had a lift and where his flat was all on one level secured his capability to move around freely within the house and enabled him to get out and about with ease. Joe reported a number of capability changes (Table 8.6). Moving into a quiet neighbourhood had expanded his capability to concentrate while working with stamps, a valued hobby. Being in a sheltered setting offered him the opportunity to contact other men living in various other sheltered settings to support his capability to form new social networks and relationships. This was significant in the light of the fact that social networks that he once had were lost when he could no longer engage in group activities such as playing golf due to a hip injury.

Knowledge about Broughty Ferry developed as part of his working life and the fact that he knew a couple already living in the same setting at that point of time contributed to his capability to continue to living in a familiar environment despite moving. But in moving he voiced concern for his family who had to come to Broughty Ferry to visit him particularly as his hip injury prevented him from visiting them at their place of residence.

Category of capability change	Description of capability change affected by change in setting	Illustrative Quotes
Expanded (Capabilities which already existed but have now been augmented)	Being able to pursue a valued activity in a quiet environment (Joe)	[IN NEW FLAT] it is quiet, there is no rowdy kids going about which is a godsend for my hobby because I don't like getting distracted when I am doing it. For my stamp hobby, I also do coins. It used to be rowdy where I used to stay before, teenagers and all, near the shops. They were rowdy, just shouting and bawling [...] (JOE)
Reduced (Capabilities diminished or lost)	Being able to live nearer to family (Joe)	You are more away from the family though. My nephew stayed up in Douglas as well and my niece stays in, she has recently moved to Douglas about two years ago. So you are away from them and it is more of a travel for them to get down here. (JOE)
Opportunity (Capabilities difficult to achieve in previous setting or have become available upon moving)	Being able to form new social relationships and participate in social life (Joe)	When I moved here there was not much going on as far as games and stuff was concerned. So I organised the dominoes then I asked that manager at the time, 'do you think any other (sheltered housing) residents within this area would be interested in dominoes? But it was only one of the complex in Dundee that took it up and at one time there used to be nine of us, we are down to three because some of them are not able to play anymore they are housebound more or less [...] I go down there and they come up here and we play a game of dominoes in the lounge here. That is how I have made new friends. (JOE)
Unaffected (capabilities that were not impacted positively or negatively)	Being able to continue living in a familiar environment (Joe)	There are quite a few areas they have sheltered housing but I thought Ferry would be better for me. I know quite a lot of people in Ferry that is the reason I moved here. There was also an old neighbour, they have passed on [...] They were here at that time which was a help, you knew someone here.

**Table 8.6: Joe: Implications for various other individual capabilities in moving (domestic to sheltered setting)**

## Diane

Diane moved from a two bedroom flat (rented) in Aberdeenshire to a sheltered setting (rented) in Broughty Ferry about a year ago. Accessing good quality treatment for her husband who had Alzheimer's and having a grand daughter in Dundee who worked in the health care system prompted Diane and her husband to make the move. Within a space of the year Diane lost her husband. Diane reflected on a number of capability changes that had occurred (Table 8.7) and particularly how in moving from one city to another, a number of capabilities had been reduced. Diane acutely felt the loss of some capabilities that were linked to familiarity, knowledge, and social relationships that living in a place for a length of time promotes.

Diane's daughter and granddaughter had chosen the particular sheltered accommodation for her and her husband ahead of their move. Diane had not been able to participate in choosing the accommodation herself and now reflected on her reduced capability to live in a spacious accommodation. She also reflected upon the difficulty of forming new social relationships in the sheltered setting, as she was neither familiar with nor had the knowledge about the place (Dundee city): shared knowledge that could potentially support social interaction and a shared social identity.

Diane voiced out her concerns regarding the capabilities that had diminished. At the same time however, she reflected on how by moving to Dundee, the 'genuine opportunity' to participate in the life of her great grand children had expanded along with the capability to secure access to care and support if and, as and when she needed.

Category of capability change	Description of capability change affected by change in setting	Illustrative Quotes
Expanded (Capabilities which already existed but have now been enhanced)	Being able to participate more frequently in the life of her great grandchildren	One of the reasons why I would like to stay here is I would like to see my great grandchildren growing up as well. (DIANE)
Reduced (Capabilities diminished or lost)	<p>Being able to live in a familiar environment;</p> <p>Being able to enjoy other valued social relationships</p> <p>Being able to enjoy frequent social interaction even if becomes housebound</p> <p>Being able to form new relationships</p> <p>Being able to live in a spacious accommodation</p>	<p>We did not have a family there [PREVIOUS PLACE OF RESIDENCE] but we lived there for many years, lots of friends [...] when I come out of the property, there was a bus stop there and I could go all the way to Inverness or I could get the bus and go around the corner and take me to Asda [...] and walking on the High Street, that is all my shops on both sides of the road, Marks and Spencer's and everything. I have not changed countries or anything like that. But it is very different. Simply because the people are very different (DIANE)</p> <p>[...] My life is such wider from where I come from; I am lucky to have the kind of people as friends that keep in touch with phone calls or letters that I do keep in touch and that but it is not the same (DIANE)</p> <p>I wouldn't like a time to come when I am housebound especially here. I wouldn't want to be and I don't know why here more than, I feel if I am at home at [PREVIOUS PLACE] I have got so many friends up there, and so if I was housebound people will come and visit. Not just them but their families was well. Here, that would be different. My daughter would visit, my granddaughter, she might bring my great grandchildren, you know but other than that [...](DIANE)</p> <p>Seventy-five per cent of the people here come from Dundee and few of them from the Ferry. This is where they were born, brought up, went to school and so if you have a group such as this on a Friday morning, [...] that is what they talk about. I don't belong here [...] It doesn't mean anything for us and it comes up a lot and I suppose it would be easier if we belonged either in Dundee or the Ferry. (DIANE)</p> <p>[...] We had fairly large home [...] large [TWO BEDROOM] we had a kitchen, dining room</p>

		and I had taken this place unseen. My daughter and granddaughter, they viewed it, arranged for carpeting and all. And I brought [...] no dining table or anything like that. I knew that there would no space and just about enough space for meals and watching TV [...] I wondered where I would do the ironing [...] because by the time you got the ironing board up, it was more in the bedroom [...] (DIANE)
Opportunity (Capabilities difficult to achieve in previous setting or have become available upon moving)	Being able to live near family and have access to support and care;	She [GRAND DAUGHTER] said but what happens if you get ill? Well I can't really do anything if I get ill you know. I know what you are saying. I have got good friends but I can't expect them to keep, take care of me when I get ill. So she said, I should think about. And so I did think about it. And I decided I would stay put [...] (DIANE)

**Table 8.7: Diane: Implications for various other individual capabilities in moving (domestic to sheltered setting)**

### Cathy

Cathy had moved from a semi-detached two-bedroom house she owned into a very sheltered flat (rented) within Lochee area approximately five years ago (at time of interview). She had lived on her own in the semi-detached house since the passing away of her husband about 14 years ago. Cathy reflected on how she had not felt safe living on her own and had decided to move from her current residence. She reflected on how the neighbourhood over time had become frequented by drunks and drug users. Despite taking safety precautions (e.g., safety locks on the main door, intruder light alarms) Cathy commented on how she was constantly worried about her house being broken into. Moving into a very sheltered setting secured Cathy's capability to feel safe and also brought about a change in other capabilities (Table 8.8)

Category of capability change	Description of capability change affected by change in setting	Illustrative Quotes
Expanded (Capabilities which already existed but have now been augmented)	Being able to do grocery shopping	[...] my friend upstairs her daughter has a car and she takes her once a night on a Tuesday to Tesco's at about 3 pm. And she takes me as well. I used to take a taxi back because I could walk to Tesco but could not walk back carrying my shopping [...] And on Friday, the wee ASDA bus comes and picks us up about 1 pm and you get an hour there and they bring us back again (CATHY)
Reduced (Capabilities diminished or lost)	Being able to have enough space to accommodate belongings	I managed to get most of my furniture but could not get table and chairs [IN THE NEW FLAT] because there is no room for table and chairs, but I have got past the stage when you invite folks for a meal you know[.]I don't even have room here to keep suitcases but luckily we have got room downstairs to keep odds and ends , so I got my suitcases in there (CATHY)
Opportunity (Capabilities difficult to achieve in previous setting or have become available upon moving)	<p>Being able to form new social relationships</p> <p>Being able to live amongst others</p> <p>Being able to eat and enjoy her meal</p>	<p>I met a lady here, I got really friendly with her and [...] she is my next of kin now and her daughter is my executor and I have got my will sorted out (laughs) (CATHY)</p> <p>[AT PREVIOUS REISDENCE] once you shut your blinds at night you thought well that is it. In here at night maybe just going along to rubbish room to put rubbish at night and you will meet somebody and you will have a bit of gossip you know. [I] like the movement around. Here [VERY SHELTERED FLAT] you have got company all the time if you wanted [...] if you are on your own this is ideal. (CATHY)</p> <p>I eat downstairs [IN VERY SHELTERED SCHEME DINING FACILITIES] I used to say to myself, I will get such and such for my dinner and get it all cooked. When I came to eating it, I am not really wanting that and it would end up in the bin. But here, you are getting it just laid it in front of you it is great. (CATHY)</p>

Unaffected (capabilities that were not impacted positively or negatively)	Being able to freely do and be  Being able live in a familiar environment	I love my wee flat I come in and say this is fine. I can do what I like I do not have to answer to anybody . I don't do anything different from what I did across the road [PREVIOUS RESIDENCE] (CATHY) I could remember this place [VERY SHELTERED SCHEME] when they were building it up because I used to go to the church[...]I have always been here [IN DUNDEE]. I just don't fancy going away to another place [FERRY]. I am a home bird you know. I have been happy here (CATHY)
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**Table 8.8: Cathy: Implications for various other individual capabilities in moving (domestic to very sheltered setting)**

Cathy had no family of her own except three cousins in Australia. Moving into a very sheltered setting offered Cathy the opportunity to meet other residents and that supported her capability to form new and close friendships. She mentioned not having any other close friends. Living in close proximity to staff and residents enabled access to company and being able to live amongst others. Provision of meals in the very sheltered setting enabled Cathy's capability to eat and enjoy her meal in a way she valued. The availability of a bus service to and from the supermarket and support from the friend's daughter expanded her capability to do grocery shopping. Cathy had moved within the same wider neighbourhood and her capability to live in a familiar environment remained positively unchanged.



### 8.4.3 Domestic/sheltered to care settings

#### Sally

Sally and her husband (deceased at time of interview) moved from sheltered accommodation (rented) into a care home about 2 years ago locally within Dundee. Securing the capability to live together in the flat became difficult owing to physical impairment for both Sally and her husband. Impairment constrained the capability to walk and the flat was not spacious enough to allow conversion to wheelchair mobility of two users into the capability to live together in the same flat. While space constraints necessitated moving from that particular flat, the fact that her husband wanted to move into a care environment and for which they were both eligible, guided the move into a care setting.

Sally commented on how some capabilities had expanded while some others had reduced (Table 8.9). Most of Sally's family lived in Scotland and she valued the capability of seeing them often. Since Sally could not go out to visit her family at their place of residence due to accessibility issues, it was all the more important for her to be visited by her family.

Not only did Sally's capability to enjoy food expand particularly in relation to her past experience of meals on wheels (in sheltered setting), but the interconnected nature of capabilities meant that her capabilities to be well nourished and do self-care activities by herself were also promoted. Sally's husband had moved into the care home before her as she was in hospital during that time. So, Sally had limited capability to participate in processes related to choosing the accommodation. Their daughter chose the accommodation for the parents. Not being able to participate reduced her capability to do work and leisure activities as she valued as well as reduced the capability to personalise her room.

Category of capability change	Description of capability change affected by change in setting	Illustrative Quotes
Expanded (Capabilities which already existed but have now been augmented)	<p>Being able to see her family</p> <p>Being able to enjoy food and be adequately nourished</p> <p>Being able to do some self-care activities herself</p>	<p>I am seeing them more than when at home you know (laughs). I mean as long as Dad and I were okay in wee flat we only saw them now and again but, no I am seeing more of them (SALLY)</p> <p>[WHAT IS IMPORTANT TO ME IS] to eat well [...] I have not been constipated for a while now.... it's the food, I reckon [...] Unfortunately it [HEALTH] is improving too much (laughs)[..] When we were in sheltered housing [...] we ended up trying meals on wheels, we tried Wiltshire and we didn't like fancy food, we liked good food [..]My daughter started cooking at weekend [...] that was from Forfar, she was not even in Dundee. That was a bit better [..] [IN REFERENCE TO MEALS ON WHEELS] Quality of food. I don't know how anybody could have stuck them. (SALLY)</p> <p>[...]when I first came here I was not strong I had lost all weight I had to get help to go from bed to chair and likewise to the toilet. That was annoying me because you wanted to do that for yourself but as you are well fed here and as I put on weight I got the strength I was able to do these things[.] ( SALLY)</p>
Reduced (Capabilities diminished or lost)	<p>Being able to do work/leisure activities as per her preference</p> <p>Being able to personalise her room in care home with her choice of furniture</p>	<p>I miss the table, I always like a table to sit at and do things. [...]One day I had lot of paperwork [...] I had got out all papers. No table, I always liked a table, but I had it all out on drawers [..]there is no room for it [PUTTING A TABLE] here. They [FAMILY] are giving me jigsaws ... it would need a table [..] (SALLY)</p> <p>Well in other house, sheltered housing, we had our own furniture [...] When we came in here, [daughter] says, mum you do not need furniture, you have to get rid of that, it is all furnished up and she thought it was fine. I didn't really like that (SALLY)</p>

**Table 8.9: Sally: Implications for various other individual capabilities in moving (sheltered to care setting)**

### Stuart and Sara

Stuart and Sara, a married couple moved into the care home a month ago (at the time of interview) from their semi-detached house (owned) locally within Dundee. Constant anxiety about the implications of both of them falling at the same time (due to their respective health conditions) prompted the move to a care home. Both reported a range of capability changes (Table 8.10).

In choosing to move into a care home with a chapel, their capability to practice faith and on a daily basis expanded. Some capabilities like being able to see family and Stuart's continued engagement in valued activities beyond the place of residence remained positively unchanged. They had moved within the same wider locality. The couple reflected that they valued the capability to participate in health and social care activities that were offered by the care home for the residents. But Sara missed the capability to do specific things that she could do by herself while Stuart commented that he did not, *'Yeah, I have no cleaning do here at all (and laughs). It is great...'*

Category of capability change	Description of capability change affected by change in setting	Illustrative Quotes
Expanded (Capabilities which already existed but have now been augmented)	Being able to practice religion daily (Stuart & Sara)	[CHOOSE THE PARTICULAR CARE HOME] More for religious aspect than anything else [...](STUART) We get to church everyday which is a plus isn't it? (SARA)
Reduced (Capabilities diminished or lost)	Being able to do specific things herself (Sara)	[...] It is people doing things for you that you had rather do yourself. In the house we had our tea, and then we would say we will do the dishes now so that we can sit together and watch the news, so I liked that part whereas here, they come and take away your cup and it is washed [...] (SARA)
Opportunity (Capabilities difficult to achieve in previous setting or have become available upon moving)	Being able to participate in social /health activities (Stuart and Sara)	[...] We come down to the lounge and join in with everybody on what is going on. And we had the physio lady today, so we did all the exercises and I don't actually mind the physio, it is for your own good [...] and then a lady that comes in she, what does she do (to her husband)(SARA). Reminiscing, so everybody joins in and it is quite interesting. (STUART).
Unaffected (capabilities that were not impacted positively or negatively)	Being able to see family (Stuart and Sara)  Being able to continue to engage in valued activities (STUART)	It [SEEING FAMILY] has not changed an awful lot, The two boys are in Glasgow and they come through every fortnight don't they. And I have got sisters and they come, don't they [...][THREE DAUGHTERS COME UP] every night, we should have somebody tonight, they have a little timetable so we have always got somebody (SARA) I: And did they come so frequently when you were in your own house? R2: Oh yes... (STUART)  He goes to his bowling on a Monday and you go to football on a Saturday. Nothing has changed really. It is much of a muchness (SARA) I have been going since I retired, 16 years ago [LIVING IN CARE HOME HAS NOT MADE] really any difference (STUART)

**Table 8.10: Stuart and Sara: Implications for various other individual capabilities in moving (sheltered to care setting)**

In terms of capability changes, the tables above illustrate mixed implications for a range of individual capabilities and across various dimensions: including life, self-direction, religion, knowledge, the frequent ones being, relationships, and activities. A change in place of residence to secure some valued capabilities did not in all instances only negatively impact other capabilities.

The analysis highlights that each participant experienced a combination of capability changes across different categories but not under each category of capability change. The reasons for this variability might possibly be attributed to both logical and methodological gaps. The logical gaps could potentially relate to diversity and heterogeneity of people and situations, what they value as well as to the features of settings they moved into which do not allow making like for like comparisons. For instance, for some, capabilities associated with managing daily life such as doing food shopping, household chores etc., enhanced due to relocating from domestic to domestic or sheltered settings but these capabilities were not significant in care settings.

The analysis also indicated that some participants talked only about changes that affected them. For example, those who were able to maintain ownership of property despite moving did not highlight this aspect of capability change but those who could not articulated it strongly. One could argue thus that those who did not speak out about it did not value it enough in the broader scheme of things but it is also possible that 'taken for granted' nature of what was left unsaid during the interview may have played a role or because the implications of moving did not challenge or put these capabilities at risk.

Participants variously also placed differential emphasis on specific capabilities and a particular example highlights this point. For instance, Henry and Rita had moved from domestic to domestic and domestic to sheltered settings respectively and in the process their capability to be an owner-occupier was reduced. The two participants had the same (reduced) capability but, the emphasis and value attached to the capability varied. For Henry, ownership of house was related to other capabilities associated with self-esteem and identity. Not having sufficient resources to purchase a new property reduced the capability to be an owner-occupier and expressing the identity of being and continuing to be an owner too became unavailable to him (Table 8.4).

For Rita on the other hand some other capabilities became significant: such as, being able to secure support and help as and when needed in light of her new identity as a carer. She commented on how particular circumstances gave rise to contingent values that mattered over and above attachment to place: *"18 years and we had to sell, that was our own flat in[...]I know a lot of people say, oh no, I wouldn't sell my flat' but it was a case of either we stayed there and have no life because to get out was such a ordeal[...]or we would have other hassle in looking for another house"*. Such examples point to nuanced and contextual understandings of what matters and why and how it can in some instances, change over time.

Many capabilities changes outlined above were directly and/or indirectly related to the material, social, and symbolic dimensions of place (s) both in respect of the settings that participants' moved from and into.

## 8.5 Significance of place

Table 8.11 below highlights place dimensions and scale (s) related to the capability change(s). For instance, directly, material and social features of place (e.g., presence of a private garden, level garden space to walk upon, and social activities in sheltered setting) influenced participants' capability to do valued activities such as gardening (Henry), walking (Jim), developing new social networks (Joe). Indirectly, Stuart's capability to engage in valued activities of football watching and bowling were unaffected due to the unchanged wider physical and social environment despite moving from a domestic to care setting.

Capabilities to do and be were linked to various place scales. Places at different scales ranging from the room to city were implicated. For example, Sally's capability to do and be (work/leisure activity) was related to place at the scale of 'room', Henry's capability (to garden and own a house) at the scale of 'house' and Stuart's capability (to bowl and attend football matches) was related to place at the scale of the 'city'.

That capabilities expanded, reduced, became available (opportunity) or remained unaffected underscores the significance of various place dimensions and scales in considering implications of place. Different capability changes that occurred also revealed a temporal dimension.

Capabilities	Related Place dimensions			Place scale
	Material	Social	Symbolic	
Participate in family life and reciprocity		Henry, Diane, Stuart & Sara	Henry, Diane	Neighbourhood, City
(Valued) activities	Henry, Sally, Jim, Peter	Rita, Stuart & Sara,		Room, House, Neighbourhood, City
Safe, pleasant and quiet environment	Henry, Joe	Henry, Joe		Neighbourhood
Participate in social life	Peter	Rita, Joe, Stuart & Sara, Cathy		House, Neighbourhood
Own a house			Henry	House
Live in a familiar environment	Diane	Diane, Joe,	Diane, Cathy	House, locality, city or town
Form new relationships and reciprocity (e.g., volunteering)		Rita, Joe, Diane, Cathy	Rita, Cathy	Neighbourhood, Locality

**Table 8.11: Dimensions and scale of place**

## 8.6 Temporal dimension of capabilities that were affected

The analysis suggests that different kinds of capabilities that variously expanded, reduced, became available or remained unchanged could broadly be grouped into three distinct categories in relation to the dimension of time (Table 8.11). One includes capabilities, that might be '*possible to anticipate in advance*' of the move as to how such capabilities will be affected. Second includes those that are *related to particular experience of living in a place*, and third group comprises of capabilities that *develop over time*. These might not possible to anticipate in advance as well as take time to build and develop. The table below illustrates the three groupings.



Possible to anticipate in advance	Experience related	Develop over time
Being able to live in a familiar environment	Being able to live in a safe and pleasant environment	Being able to do things confidently on one's own
Being able to do valued activities	Being able to pursue valued activity in a quiet environment	Being able to form new social relationships
Being able to be a home owner	Being able to avoid stress in relation to providing care	
Being able to enjoy valued relationships (face to face)	Being able to feel in control vis a vis doing and being	
Being able to choose to do and be		

**Table 8.12: Temporal groupings of different type of capabilities that are related to moving from one setting to another**

### 8.6.1 Possible to anticipate in advance

How some capabilities (illustrated above) might be affected is to some extent possible to anticipate in advance of the move and as the analysis suggests is linked to the capability to choose and the availability of options. Choosing here relates to having options in terms of location of the accommodation, nature of accommodation sought and that which is available (domestic, sheltered, care home), type of accommodation (features of accommodation including space, size etc.) as well as having the freedom to choose.

Where freedom to choose is not available/possible, capabilities to do and be as in the case of Sally (being able to do valued activities, being able to personalise room) may be reduced with implications for developing a sense of place. Where freedom to choose is available/possible, capabilities, as for Rita (being able to live in a two bed sheltered accommodation), Joe, Cathy (being able to live in a familiar environment), Henry (being able to do valued activities), Stuart and Sara (being able to practice faith daily) may expand, remain positively

unaffected, or become available and support maintenance and development of sense of place.

The extent to which Sally could be involved in choosing a particular care home was limited because she was in hospital at the time. Instead, her daughter made the choice of a particular care home. Not being able to participate in decisions related to choosing between different care settings not only affected her capability to do various activities but also affected her identification with place and sense of self. Sally described how the scope of personalising the room with her own furniture was not there and not being able to make the place 'her own' impacted her identification with place.

In some instances, nature of choices that participants could make, were variously constrained in relation to different aspects of the relocation process. For example, the analysis reveals that having options to choose from may not be available in all aspects of the move. For Henry, the choice of continuing to be a homeowner was not available due to lack of material resources, but the option to choose from different types of rental accommodation existed. Continuing to be an owner became unavailable to him. Conversely, having the freedom to choose as well as having options to choose from different types of accommodation gave Henry the opportunity to: express an alternate valued identity (that of a gardener), enabled him to pursue a valued activity (gardening) that was not possible in previous residence, develop a sense of place that derived from identification with his current (new) place of residence.

Having the freedom to choose as well as the availability of options may be valuable in its own right, but choosing in some instances may be more complex and difficult as Diane's situation exemplifies. For her, making a

decision to stay put (in current residence in a new city) or return (to previous residence in another town), involves choosing between capabilities to secure present or future functionings, and both of which matter. Continuing to stay means having the capability to access support and care in future plus its positive implications for her capability to participate in the life of her great grand children and consequently, for her role related identity capability. Negatively, continuing to stay has implications for other individual capabilities, for instance, her capability to enjoy other valued social relationships, to live in a familiar environment, and diminished place related identity capability.

### **8.6.2 Experience related**

The second group of capabilities that were variously affected appear to be related to the experience of living in particular places. While an older person may possess the knowledge before moving about some capabilities, such as, safety aspect of a particular neighbourhood or the way care homes operate in terms of kind of things (e.g. domestic tasks) that one can do (or not), it might still be difficult to know a priori how his/her capability (ies) would be affected. Current and past experiences of living in particular places then become significant in how some capabilities are affected.

Past experiences of living in other places provided the comparative lens through which participants' evaluated specific capability changes, such as, being able to avoid stress, being able to live in a quiet and safe environment and/or feeling in control. What is significant is that capabilities of all participants except one in the 'experience related' examples shown in the table 8.12 expanded or became available upon moving.

Issues of adaptation appear to play a role in how some capabilities are experienced and understood. Looking at the kind of capabilities that were affected by experience of living in particular places, one could argue that some of these participants were previously living in less favourable conditions and yet none of these participants referred to lack of above mentioned capabilities as being a primary or even a reason to move. This revelation could be dismissed on basis of argument that such capabilities did not matter enough in the broader scheme of things that were valued. Yet, these capabilities were valued in hindsight in so far as participants thought it important to mention them.

While the reasons for above examples of capability changes appear to be grounded in past experience of living in other places, reasons for some capability changes may be more difficult to disentangle. For example, in the case of Sara whose capability to feel in control was reduced, it is difficult to decipher from my data whether the preference to do things by herself is shaped by habits, routines or values vis a vis what she was perhaps used to do when living on their own (domestic setting) or whether it is shaped by the nature of place (care home) that she currently resides in.

### **8.6.3 Develop over time**

The third group of capability change examples include capabilities that although related to the experience of living in a place might only develop over a certain period of time. For instance, Joe's and Rita's capability to form new relationships was influenced by experience of living in a particular place, such as sheltered setting, where the opportunity to meet and socialise was readily available to the residents. Similarly, Peter's capability to be able to do things confidently on his own was related to

the physical experience of living in a ground floor flat with easy access to public transport services.

However, in developing such capabilities, there might also be a role for agency and value. For example, the opportunity to form relationships as in Rita's case was available to all residents of sheltered setting but the choice of exercising the capability may also depend upon and vary with the value and willingness attached to a particular doing or being. And as Peter's case illustrates, the knowledge that he could get out of the house with ease at any time coupled with repeated routines involving going out and about might have supported the development of capability to do things confidently on his own.

Diane's case however highlights the challenges for participating in and forming new relationships in moving from one city to another. Participating in social conversations became difficult for Diane although she commented about being a sociable person when she said, "*I can talk from here to there*". Not having been born or brought up in Dundee meant she did not have the shared sense of place about schools, churches and other places in Dundee unlike other residents and which often were the main topics of conversation. But the fact that she had been in Dundee only for a year too might have played a role.

More importantly, the different emphasis on time in the three groups of capability changes signifies that individual experiences of capability changes may vary at different points of time and the consequences of moving on some capabilities may not become obvious immediately after the move.

## 8.7 Key findings

- a) Moving from one place to another can be a way to secure and stabilise capabilities for priority functionings and the opportunity for which may not necessarily be available to everyone to the same extent. In some situations, moving from one place to another might be a way to decouple disadvantage in addition to stabilising some capabilities. The phrase 'priority functionings' has been used to demonstrate that moving from one place to another might involve a conflict and a trade-off between valued capabilities: capabilities that an older person has and capabilities that contingently might become important to consider.
- b) Contingent, dynamic and diverse contexts involve new and/or a situation specific reflexive evaluations about what is important, which, in turn might influence how older people prioritise and act to secure capabilities for priority functionings. Value attached to different functionings may vary and some might become more important than others.
- c) Various dimensions of place (including the material, social and symbolic) and places at different scales can be significant in supporting, undermining, mediating and moderating capabilities for many functionings. It is important to recognise that developing an understanding of significance of place for capabilities is not limited to the scale of residence. As the analysis reveals various places at different scales might be implicated in supporting or undermining capabilities.
- d) The category of capability changes associated with moving show that change in place of residence could have mixed implications (both

positive and negative) for individual capabilities. It also highlights that the capability to participate in processes of relocation at various levels (e.g. what kind of setting to move into, in which locality) might be differentially and socially shaped, and at times might be beyond the older person's control.

- e) The different categories of capability changes also indicate that it is possible to anticipate in advance about some capabilities that may be affected prior to the moving hence, signifying a role for informed interventions to contribute to peoples' capabilities and potential implications for cultivating and developing a sense of place. Some other capabilities might be linked to the experience of living in a particular place. What these capabilities might be (as the examples in the analysis highlighted) suggests that opportunities for modifying the experience of living in a particular place could possibly be modified by attending to some of capabilities. That some capabilities might develop over time highlights the dynamic nature of wellbeing as well as points towards the need for some form of support for developing capabilities particularly where older people move from one city to another.

## **8.8 Chapter summary**

This chapter described and explored participants' (those who had relocated to different kinds of settings at some point of time) reasons for moving and the implications of moving for various capabilities. The analysis highlighted that participants' variously moved to secure and stabilise capabilities for some priority functionings and to decouple disadvantage brought about by the interplay of individual and socio-spatial factors. In identifying different categories of capability changes

and paying attention to the capabilities that participants had prior to the move and following the move, the analysis noted links between processes that tie moving from a particular setting to moving into a particular setting. The different kinds of capability changes highlighted that relocating can have mixed implications for an older person. At the same it suggested that knowledge about how and what kind of capabilities might be affected is possible to anticipate in advance for some and not for other capabilities and additionally has implications for cultivating a sense of place.

The next chapter in bringing together key findings from the three analyses chapters discusses and attempts to understand the processes by which valued capabilities and interrelationships of place and wellbeing are shaped.



## Chapter 9 : DISCUSSION

### 9.1 Introduction

This chapter discusses how a relational perspective to exploring older peoples' experiences of living in different settings permitted insights into the processes by which capabilities and interrelationships of place and wellbeing were shaped. I bring together different accounts from each of the analysis chapters 6, 7, and, 8 to reveal the importance of understanding processes of change in older people's lives as well as discuss relocation as a specific type of 'change' in the following section. I then go on to interpret the findings in relation to the components that were set out in the conceptual framework in Chapter 4 (in sections 9.3 – 9.6). The conceptual contributions of this study demonstrating greater complexity and linkages within and between these components are highlighted next (section 9.7). The methodological reflections and strengths and limitations of the study are provided (in sections 9.8 and 9.9 respectively) followed by a chapter summary.

### 9.2 Significance of processes of change

This study demonstrates that people-place relationships are not a static phenomenon but rather a dynamic process. The study highlighted that the lived experiences of participants, the capabilities they had, and those that mattered were in flux. The fluidity of older people-place relationships hence points towards examining the *context specific processes of change* in older peoples' lives. As the analyses chapters revealed, participants variously or in combination, experienced age, health, and place related changes. What was however, diverse across the cases was: the nature, extent and the pace of change; its variable impact

on (some) valued capabilities directly, and, indirectly, on some other valued capabilities; and, the diverse ways in which change was perceived and experienced.

*Health-related changes*, and, subsequent impairments for some, clearly *impacted various valued capabilities*. It was possible to see the variations in the degree of limitations that health impairments variably placed on several valued capabilities. For instance, some had sensory impairments, such as problems with vision and that consequently influenced, for instance, the capability to drive a car. Some others had movement impairments that variably influenced multiple mobility related capabilities that were not limited to being able to drive a car, but also included capabilities to walk, climb steps, use public transport and go out on their own.

The cumulative effect of change directly and indirectly on 'valued capabilities' hence, was *multi-dimensional, multi-level and non-linear*. Some functionings such as, seeing or walking, were foundational for many other capabilities, for instance, being able to do valued activities, self-care tasks, get out and about on one's own. The capability, 'to get out and about' was itself foundational for engagement in various valued spheres of life. The temporal impact of progressive health related impairments for some (Jack, Kate, Tara, Jim and Jane) was evident in erosion of 'capabilities' associated with certain skills, exercising and having choices to do valued activities, with further implications in turn for their sense of competence and identity.

The impact of change brought about by health related impairments for some variably occurred alongside on-going processes of age related changes, such as, loss of valued relationships, and (or), place related

changes, such as, residential turnover, cutting back of services (e.g., bus services) particularly in less affluent neighbourhoods. Change was also evident in more affluent neighbourhoods. For instance, though relatively stable in terms of residential mix, some accounts however highlighted that neighbours too were experiencing age and health related changes.

Place related changes *highlighted the changing nature of social relationships within a place* (less and more affluent neighbourhoods) that for some (Nina, Jack, Jane) variably influenced specific capabilities that living in a place for a long time promotes (i.e., sense of familiarity, security, belonging, affiliation). For some others (Maggie) the changing nature of services in the neighbourhood influenced the capability to get out and about beyond the place of residence as and when she wished. And for many participants, differing combinations of age, health and place-related changes had implications for continuity of place of residence (picked up and discussed separately below in sub-section 9.2.1)

Accounts also revealed *how change differentially affected participants*. For instance, those who had lost their spouse or loved ones described experiencing loneliness. Some (Tom, Tina, and Sally) experienced what Dahlberg and McKee (2014) refer to as ‘social loneliness’ (resulting from a reduction in valued social networks that provide companionship and belonging), while, some others (Jim) experienced ‘emotional loneliness’ (absence of an attachment figure, in this instance, the participant’s wife). In the context of experiences of ‘loneliness’, the capabilities these participants valued too were specific and different. Tom lived alone but wanted to get out of the house on a daily basis to combat loneliness, but some others like Sally and Tina did not want to live on their own.

The analysis offered a glimpse into processes that suggest *a shift in what one values in changing situations over time* (Jack, Sally, Tara, Nina in chapter 7; Henry, Jane, Benny and Rita in chapter 8). Reflexive re-evaluations were involved and new capabilities became significant; identities were negotiated and reworked with implications in some instances, for participants' sense of place. Past, present, and future oriented considerations, availability and access to resources went hand in hand in assessments of contingent and problematic situations.

At the same time for many participants, some things, such as, not having good health signified a sense of loss and good health was valued in absentia. Many accounts were peppered with phrases such as, 'I used to', 'I cannot do' in relation to their impairments and various valued spheres of their lives that participants could no longer engage in. And for some others (Penny, Kate, Joe in chapter 6) despite varying types and degrees of impairments, having good health was not 'taken for granted' and the capability to maintain health was a valued capability in itself.

What clearly emerges from the analysis is *a need to pay attention to processes of change within dynamic and shifting interactions between person and place*. The analysis suggests that the significance of age, health and/or place related changes lies in the fact that these changes in specific contexts and for specific participants *brought in their wake other diverse changes*. In many instances, depending upon what change influenced (in terms of ways of life and living), and how it was experienced or perceived, intersected with diverse individual and socio-spatial factors to dynamically shape capabilities. For instance, the capability to do shopping was impacted by not being able to drive a car for some participants who had impairments. However, where participants had family living in geographical proximity (e.g., who had a

car and were willing), the capability for shopping was secured and did not present a cause for concern. But for some participants who were living alone and (or) did not have a family living close by, the capability to do shopping emerged as a particular concern as public transport in the neighbourhood or taxis were not a viable alternative and asking friends for a lift was not a preferred option.

The temporal and dynamic nature of some individual factors (e.g., progressive health condition) implies that *increasing health related impairment might differentially influence valued functionings for the same person over time*. Thus, capabilities for securing these functionings not only imply diverse interactions of person and place at different points of time, but may also create the need for diverse inputs for the same person over time.

As indicated in an earlier section, change for some had implications for continuity of place of residence. The next section specifically addresses the theme of relocation paying particular attention to the processes of relocation.

### 9.2.1 Dynamics of residential relocation

#### [Why and where people relocate?](#)

A relational perspective encouraged looking at *processes* that for some shaped relocation trajectories into different settings thereby revealing complex and nuanced insights into why and where people move. Negotiating place of residence and relocating variously into domestic, sheltered, and/or care settings as the analysis suggested was a way to secure and stabilise capabilities for various *priority functionings*. More than often *risk to multiple interlinked capabilities* emerged as underlying

motivations for relocating. The kind of capabilities participants talked about included:

- a) Capabilities to manage the impact of their own and/or their spouse's health conditions, or age related losses on their daily lives (for instance, maintaining and securing capabilities for mobility, managing loneliness and anxiety, security of life, and accessing treatment/ supportive care for particular health conditions);
- b) Capabilities associated with implications of death and dying on managing health and care support for the spouse;

The phrase 'priority functionings' has been used to demonstrate two things: (1) how participants intervened into and participated in situations (or life events) that perhaps for many could be best described as 'un-chosen situations'; and, (2) prioritising meant choosing between 'valued capabilities' including identities - between capabilities that were associated with living in a particular setting and capabilities that contingently became more important to secure and stabilise. For instance, for some prioritising meant trading their capability to be an owner-occupier and the related identity within, in exchange for, the capability to manage daily life. For some others it meant trading capabilities that living in a particular place promotes (e.g., familiarity, attachment, and knowledge about a particular place) in exchange for the capability to access good healthcare and/or continued participation in valued goals and projects.

The analysis revealed that it was not ill health, loss of spouse, or the social features of neighbourhoods per se that triggered relocation.

Rather it was the *complex processes shaped by the interplay of differing configurations of interacting aspects*, such as, material and (or) social features of the place of residence and neighbourhood, health impairments, priority values, availability of formal support, *that variously held implications for participants' valued capabilities*. For some (Henry, Jane and Rita, chapter 8), there was a clustering of disadvantage as multiple valued capabilities were impacted and *relocating was a way to decouple the disadvantage creating interactions of health impairments and material (and/or social) features of place of residence*. These participants lived in tenements and as such, an opportunity to modify or adapt the places where they lived to support various capabilities was in this instance, limited.

As noted by some others (Luborsky, Lysack and Van Nuil 2011; Rabiee 2012), my findings too draw attention to the *role of significant others in decision-making processes in relation to relocating*. For some (Peter, Stuart and Sara, and Tara) it was their adult children who had initiated discussions about relocating, although these participants acknowledged a self-awareness of unwelcome consequences of maintaining continuity of residence. These were also amongst participants who described sharing a good relationship with their children, and who, in turn had also offered their parents the option of co-residing with them.

Thinking relationally about how relocation trajectories are shaped highlights and reminds us that some choice-related capabilities are socially shaped and mediated and are at times beyond the person's control. Decisions relating to where to move were shaped by values, priorities, severity of health conditions, features of the new setting, some inkling of the trade-offs that may be required, availability of means

(resources), eligibility for formal support and not staged processes that follow each other in a particularly organised sequence.

Analysis highlighted that *decisions and options regarding where to move might operate at multiple interlinked levels*: (1) moving into a particular kind of setting; (2) moving into a particular setting in a particular locality; and, (3) moving into a particular setting in another city. Depending upon the person and specificity of the situation, exercising options in relation to where to move was variably enabled or constrained at different levels. For (Benny and Stuart & Sara), moving into a care setting was shaped by their own and (or) spouse's health condition, but they had the 'genuine opportunity' to choose what care home to move into, and in which part of the town according to their values. Diane chose to move nearer to her grand daughter who worked within the health care system in order to secure good health care treatment for her spouse. But in doing so she and her spouse had to move into a different city from the one they currently lived in.

Future oriented considerations for some (Rita) shaped the decision not to move into another domestic setting and chose instead to move into a sheltered setting. Some by virtue of having assets and sufficient finances (Jim, Peter, Tina, Tara) or by access to formal support based upon criterion of demonstrated need (Henry, Sally, and Jane) had more options to relocate to settings and localities of their choice, and unlike one particular participant, (Darren, chapter 8) had more options in effecting a decision to relocate.

Re-conceptualising residential relocation as an on-going, complex and contextualised process (Massey 1994) rather than as a 'static snapshot' (Golant 2003; Morgan et al 2006) not only offered insights into how



different relocation trajectories were shaped but also drew attention both to capabilities for various functionings that participants had before the move and after the move as set out in the next section.

#### [Implications of relocation for capabilities](#)

My findings highlight that moving variously from domestic into other domestic or supported settings to secure and stabilise capabilities for priority functionings had *mixed implications* for other individual capabilities.

Four categories of capability changes that were identified in the analysis noted the (1) enhancement, (2) reduction, (3) addition of new capabilities, and, (4) highlighted capabilities that remain unchanged across different participants, and that were distinct from reasons to move. Distinguishing between different categories of capability changes that were experienced by individual participants offers a way to capture and understand the complexities associated with relocation. Participants variably experienced a combination of capability changes across the four categories and across various domains such as life, self-direction, religion, knowledge relationships and activities.

That capability for various functionings was enhanced, reduced, added and/or remained unaffected in the context of moving contributed to new insights in relation to foreseeability of capability changes.

#### [Foreseeability of capability changes](#)

My findings revealed three groupings in terms of foreseeability of capability changes upon moving, i.e., capabilities about which it was possible to anticipate in advance of the move as to how these are likely to be affected, capabilities that were tied to the experience of living in a

particular place and lastly, those that might not be knowable prior to the move as well as, may take time to build and develop. The analysis highlighted that it is possible to anticipate to some extent how some capabilities may be affected, prior to the move, as these are tied to the practical aspects of relocating: ownership status, location of the accommodation, nature, type, and features of the accommodation to move into and some of are amongst the reasons for moving.

*Where one relocates to* therefore has implications for *valued capabilities*. What emerged, as being significant was that where people could exercise choice related capability (ies), there was enhancement, addition and/or capability under consideration remained positively unchanged. Such capabilities included for example, being able to live in a familiar environment, in a similar sized accommodation as the previous one, do valued activities, practice faith daily, enjoy valued relationships (face to face), personalise space, and express valued identities.

Where valued capabilities were reduced these respectively related to not having monetary resources to continue being an owner occupier, a valued identity (Henry) and not being able to participate in decisions related to choosing between different sheltered and(or )care settings (Diane and Sally). The analysis also confirms what some have noted (Reed, Payton and Bond 1998, Eales, Keating and Damsma 2001) about reframing our understandings particularly about supported settings not only as destinations for receiving care but also as places that are situated within familiar communities of place or interest.

My study also suggests that some capability changes are linked to the experience(s) (both current and previous) of living in particular settings. For example, although it is possible to anticipate in advance of the move

that one would be moving into a safer neighbourhood or into an adaptable or supported accommodation, it may still be difficult to know a priori how one's capabilities would be affected, how one would feel about or adjust to that. Participants' judgments about these capability changes were evaluated in context of past experience of living in other settings.

That some capability changes may be emergent and linked to the experience of being in a particular place then presents opportunities to work towards improving the experience of being in a particular place. But the fact that judgments about current experiences are framed in context of past experiences of other places also needs cautious treatment. It might be fruitful to engage with individual values, identities and experiences in context of past experiences of living in other places but at the same time if capability shortfalls were to occur in relation to their current settings and of which they have no prior comparisons to make from then it is not clear how would they judge those experiences.

The third set of capability changes noted in the analysis were those that although related to the experience of living in a particular place may not be knowable in advance and also take time to build and develop, for example, being able to build new relationships, develop confidence (Peter and Rita). However as noted in the analysis in chapter 8, the building of such capabilities drew upon the interplay between opportunities of place, agency, and valued capabilities over a period of time.

The three categories denoting the *foreseeability of capability change are not necessarily mutually exclusive*. For example, it is possible to anticipate in advance that moving from one city to another (and with which one is

not familiar) would impact capabilities associated with being able to live in a familiar environment. Equally, developing capabilities that promote familiarity with the new environment are linked to the experience of living in a particular place (the city one moves into) as well may take time to build and develop. The three categories of capability changes therefore have a temporal dimension. For instance, it might be possible that for Diane (who moved from one city to another a year ago at time of interview and as illustrated in chapter 8) the experience of social relationships might be very different (and positive) several years down the line and so would her sense of place.

The next few sections (9.3 – 9.6) attend to interpreting participants' experiences under the four components outlined earlier in Chapter 4. These are: 1) Individual and socio-spatial factors shaping capabilities; 2) Plural nature of freedoms; 3) Inter-relatedness of places; and, 4) Sense of place. As outlined in Chapter 4, these components were central to the conceptual framework for relationally exploring older peoples' experiences and making sense of interrelations between place and wellbeing.

### **9.3 Component 1: Individual and socio-spatial factors shaping capabilities**

As discussed in chapter 4, human diversity has been given a central place in the capability approach: it highlights the personal, social, economic, environmental and cultural factors that constitute sources of variation amongst different individuals. The analytical focus is on the individual-context relationship to understand whether individuals have 'genuine opportunities' to do and be (or not) what they consider valuable. The analysis confirmed that *the interplay of the individual and socio-spatial factors that shaped capabilities varied* depending upon person and the

specificity of the situation. At the same time, the analysis highlighted, how the *relative combination of interacting individual and socio-spatial factors also varied depending upon the valued capability under consideration*. The capability approach also notes that some individual and socio-spatial factors that constitute sources of variation amongst individuals also act as ‘conversion factors’. Conversion factors could be personal, social and environmental and draw attention to how the presence or absence of these conversion factors might enable or constrain a particular capability (Robeyns 2005).

The following examples from the analyses chapters do three things: first, they highlight the various individual and socio-spatial factors that were significant in shaping and constituting capabilities (e.g., family, public services, characteristics of the interacting factors, material features of place, bodily impairments, sense of place); second, how in relation to specific valued capabilities, these factors might be more or less significant; and third, capturing what constitutes a conversion factor and whether the conversion factor is enabling or disabling has to be grasped in relation to the processes and interactions that shape capabilities.

### 9.3.1 Family

Having a family living nearby can variably stabilise some deteriorating individual capabilities such as, managing information and bills, household tasks, doing shopping and, getting out and about. Family can also support the expansion of capabilities for some, such as, being able to see family on a regular basis, having more options to do shopping, get out and about. However, having a family living nearby might not support some specific valued capabilities, such as, being able to attend church. Rather, as the analysis highlighted friends who attend the same church can contribute to enabling the capability.

'Geographic proximity to family' coupled with the 'quality of relationships' are conversion factors that can enable multiple valued capabilities. Where one or the other of these factors is missing, some valued capabilities might be constrained.

### **9.3.2 Public services**

Depending upon the context, the availability of adequate public transport service can be another significant factor in shaping the capability to get out and about freely beyond the place of residence. Particularly in the context of not having any other means (e.g., car, lift from family) to secure the capability to be mobile during the daytime, the lack of adequate bus services can be a missing (environmental) conversion factor. But, where older people have different mobility related impairments (absence of personal conversion factors) that limit the capability to get out and out beyond the place of residence on their own by public transport, adequate availability of bus services might not be significant. If the focus is shifted towards the capability to go out by public transport as a couple together and where either of the partners has a mobility related impairment, other 'conversion factors' come into play, such as, the physical strength of the carer to wheel the spouse into and out of buses. This then might constrain the capability to use public transport.

### **9.3.3 Characteristics of the interacting factors**

Depending upon the person, context and capability under consideration, access to and availability of resources (social support and financial resources of self and family) is important but as the analysis highlighted

characteristics of the resources can be a significant conversion factor. For instance, where older people have different types of impairments, having access to a car can be significant as taxis might be an expensive option in shaping the capability to get out and about beyond the place of residence. Not only is having access to the resource (car) important, but, the characteristics of the resource (e.g., size and space aspects of the car) acquire significance in relation to the nature of impairment (carrying the wheelchair, walking frame etc.).

#### 9.3.4 Material features of place

The study findings also highlight that where personal conversion factors are absent by virtue of various bodily impairments, *capabilities for various functionings depend heavily upon the material and social features of places*. Depending upon the person and situation, material features of place (e.g., accessing flat through a flight of stairs, spatial layout of the accommodation such as an upstairs toilet and sleeping quarters) can generate conditions that constrain capabilities or the nature of the accommodation (e.g., availability of a downstairs room and a toilet) can facilitate modification to directly support mobility related capabilities and continuity of residence.

#### 9.3.5 Sense of place

Sense of place as the analysis highlighted can contribute to maintaining the continuity of residence and identity capability or sense of self. But the same sense of place can present a barrier to the capability to make decisions or plan ahead in relation to relocation, especially, where older people have progressive health conditions.

### 9.3.6 Bodily impairments

Bodily impairments can constrain capabilities for many different functionings. But, the fact that formal support is contingent upon demonstrated need (based on poor health criteria) can be influential in paving access to formal support and so enable relocation to secure and stabilise various capabilities as the analysis highlighted.

The analysis also revealed that formal support may not be available to older people particularly, those living in deprived neighbourhoods who do not have health related impairments but may wish to relocate to secure their capability for security and safety. Such older people who also may not have the necessary material resources to effect a decision to relocate then can become doubly disadvantaged. Formal support and the 'genuine opportunity' to relocate might become available only upon contracting health problems. Specific (health related) contexts (of self or spouse) can also potentially provide access to new support networks (e.g., carer network, day clubs) that in turn can contribute to expanding and developing new capabilities (chapter 7).

## 9.4 Component 2: Plural nature of freedoms

As discussed previously in Chapter 4, Sen (2002) notes:

"First, more freedom gives us more *opportunity* to achieve those things that we value, and have reason to value. This aspect of freedom is concerned primarily with our *ability to achieve*, rather than with the process through which that achievement comes about. Second, the *process* through which things happen may also be of fundamental importance in assessing freedom" (p. 585)



#### 9.4.1 Opportunity and process aspects of freedom

The study revealed that depending upon the specific capability under consideration, the person and specificity of situation, not only *can the interplay of individual and socio-spatial factors vary but the amount and the kind of inputs required too can vary*. For example, the same resources of place, i.e., bus services, that can enable the capability to be mobile in relation to various spheres of an older person's life can become disabling in relation to the shopping encounter. This then has implications for the variable degree of agency that an older person has in relation to the different valued capabilities across different spheres of his/her and/or in relation to same capability.

*The observed variations in the degree of agency in the analysis supported identification of the plural nature of freedoms (opportunity and process) that participants valued and (or) had in relation to a particular capability. Paying attention to the nature of freedoms associated with each capability that an older person has and discerning whether both or one or the other aspect of freedom (opportunity and/or process) is valued might be significant for two reasons: one, in highlighting the nature of gaps that contribute to constraining freedoms and whether or how these can be modified (or not); and, two, for making informed judgements about how to support the wellbeing of older people.*

For instance, two participants (Henry and Tara) both had the capability to buy food (opportunity aspect) but each one of them valued it in a different way. For one participant (Henry), going to the supermarket and buying food (process aspect) was not important but for the other (Tara), it was important. Not being able to go to the supermarket and buy food of her own choice (process freedom) also had implications for her capability to eat as she valued.

How a specific capability is valued (intrinsically and/or instrumentally) too might hold implications for the achievement of the specific capability under consideration. For some driving a car was a valued part of their identity capability and both intrinsically and instrumentally valuable (Jack), and for others (Kate), driving was instrumentally valuable to support other capabilities. So, depending upon how a capability is valued: the interplay of individual and socio-spatial factors can contribute to shaping capabilities (as for Kate) or the capability, such as, being able to exercise a valued identity that is tied to driving a car (as for Jack who has physical impairment) might not lend itself to modification by socio-spatial factors.

#### 9.4.2 Diversity in personal attributes

The study drew attention to *diversity and heterogeneity in personal attributes, values and their role in shaping how availability of resources and opportunities that living in different settings offered may or may not translate into a capability or a 'genuine opportunity'*. For instance, living in a communal setting (care home or sheltered setting) the opportunity to meet and socialise is available to residents. However, as the analysis highlighted, particular capabilities including for identities, such as being 'sociable', 'outgoing' or a 'loner' contributed to shaping participation in social and group activities or developing new relationships.

Some valued socialising and or making friends and which motivated them to participate in social activities within the setting and beyond the setting (Rita and Joe). Other contextual aspects too may have played a role, as some participants did not have a family, or a family living nearby. Others were more creative in using their agency. A male participant

noticing that there were not enough men in the sheltered accommodation that he lived in made contact and liaised with other men across different sheltered settings to form a men's group. Gleibs et al (2011) note how older men in supported settings can be a minority and marginalised group and emphasise the need to promote social identity based groups such as a men's club in enhancing wellbeing of older men in care settings.

Many studies on social isolation and loneliness note that participation in leisure activities for older people can enhance social connectedness but that people may not have the knowledge, resources or support to navigate and utilise available opportunities (Tetley et al 2007; Habron et al 2013). Examples highlighted in the analysis of this study also revealed that some were not aware of particular places such as, luncheon or social clubs that offered opportunities for social interaction in the first instance and who due to their limited mobility related functionings could not access these group activities without support. There were still others who did not have the confidence to become a part of such networks and needed encouragement and persuasion. As such, in accessing such group activities and the opportunities that these places offered, close interpersonal relationships emerged as being vital (Toepel 2013).

*Sometimes opportunities that different settings might offer to residents may not translate into capabilities, as the formal availability of opportunities on its own may not be enough to realise capabilities. For instance, participants in residential and sheltered settings drew attention to issues of participation in leisure activities within the setting. The issue was not about the organisation of in house activities but about the effective implementation and carrying out of these activities that were sometimes abandoned and at other times did not have enough*

people participating to make it enjoyable. Personal characteristics of residents, lack of resources of staff and time that were required to support (frail) people to participate, particularly in care settings were highlighted as reasons that constrained participation. Issues of space within some care homes to support participation in social activities were also raised. Sheltered settings too faced a similar problem. Although, some participants valued organising collective activities, they commented that lack of numbers due to the increasingly frail nature of the population meant that capability for fun and enjoyment was adversely affected.

### 9.5 Component 3: Interrelatedness of places

The analysis revealed that participants' experiences of 'place' were not confined to their residences or immediate neighbourhoods, but were, in fact, much broader than that. *Different places at different scales of the residence, wider locality and the city can be implicated in shaping and realising of various capabilities thereby signifying a spatial dimension to capabilities* (as illustrated in Figures 9.1 and 9.2). This finding confirms and reiterates a need to conceptualise places drawing upon an understanding of peoples' life-worlds as points of confluence of social relations, both immediate and wider and not as distinct and neatly categorised bounded entities that people inhabit (Massey 1994; Ewart and Luck 2014; Gardner 2011).

*Place of residence and places beyond the residence were interrelated in so far as they variously contributed to maintenance, expansion and development of individual capabilities.* The analysis suggests that participants' relationship with places beyond their residence was variously connected to valued aspects of dimensions of life, relationships,

activities, and faith. Their life-worlds comprising of various routine and valued life projects connected their place of residence to places beyond the residence.

Figure 9.1: Spatial dimension of valued capabilities – Example 1 (Henry)

Valued capabilities	Place dimension	Capability change
Capability to do gardening	Material – having a garden in the new place of residence; symbolic-valued identity of being a gardener 1	New capability acquired <b>+C</b>
Capability to be a home owner	Symbolic – being a home owner was a matter of great pride and self-esteem 2	Capability reduced as could not afford to buy a new house <b>-C</b>
Capability to live in a safe and quiet neighbourhood	Social – no anti-social behavior in the neighbourhood 3	Capability enhanced <b>+C</b>
Capability for participating in family life	Material and social dimension: geographic proximity to adult children 4	Capability positively unchanged <b>C</b>
Capability to get out and about beyond place of residence	Material and social – house does not have steps and provides easy access; entitlement to taxi card for getting out and about 5	Capability enhanced <b>+C</b>

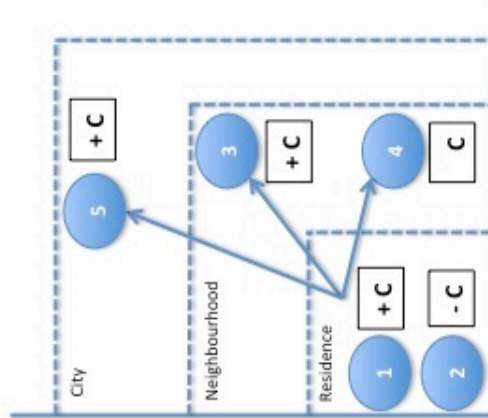
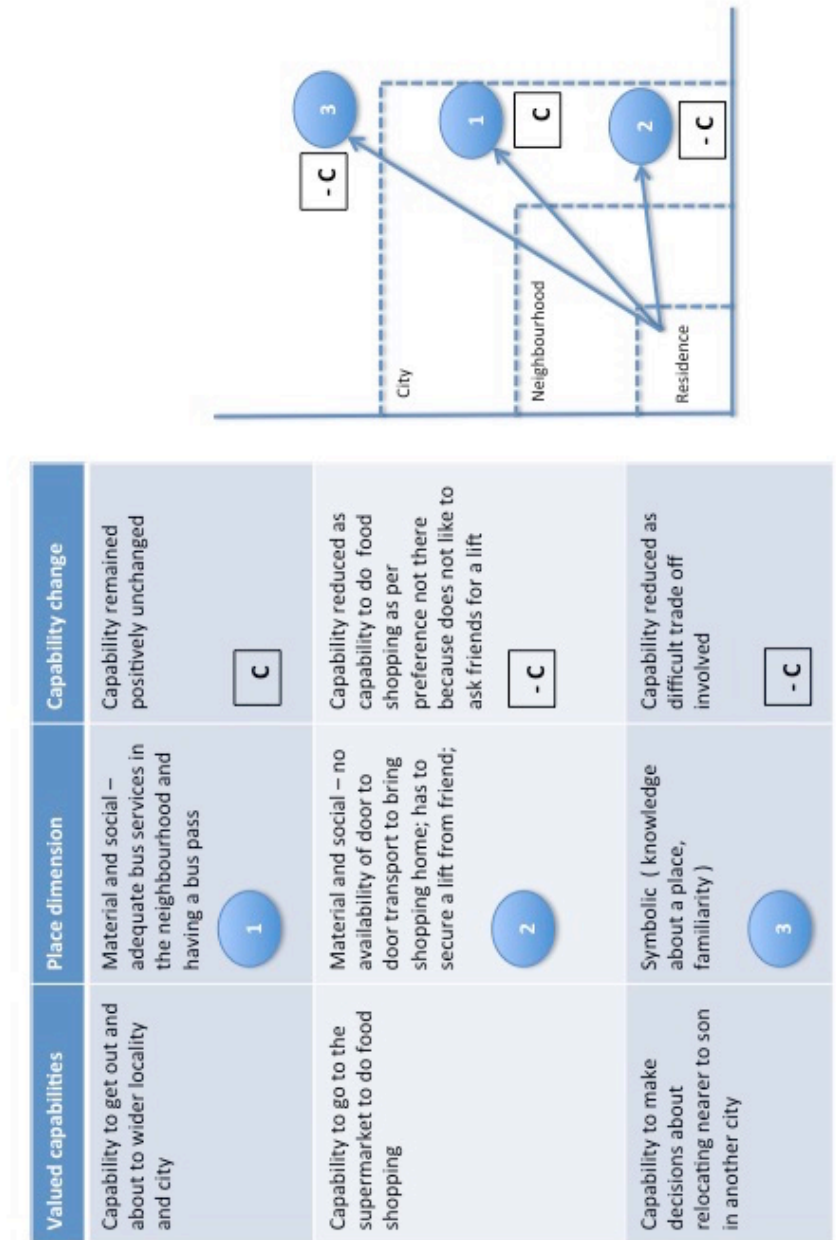


Figure 9.2: Spatial dimension of valued capabilities – Example 2 (Kate)



Places beyond the residence included organised social spaces such as, the church, the community centre, carer centre, social and activity clubs, as well as the more informal public meeting spaces such as cafes, restaurants, gardens and walking routes. *The significance of organised and informal social and public meeting places needs to be understood within diverse contexts of older peoples' lives.* Public meeting places can acquire a particular significance as a meeting place with family and friends, particularly, where older people have impairments and where accessibility of family's residence curtails visiting them.

While the issue of accessibility to public places has often been highlighted and is important, findings also reveal that social location of the family too is an important component in shaping the capability to get out and about. So, for instance, a person with wheelchair mobility may require means of transport that can accommodate a wheelchair and/ or a walking frame as taxis may be an expensive as well as a difficult to maintain option for frequent exercise of capability to get out and about. Hence, if family and (or) friends are to help with this, the amount and kind of resources they possess too become significant.

*A key feature of organized social spaces was that they influenced capabilities for multiple functionings.* The analysis suggests that these spaces can become meaningful in variably: (a) supporting capabilities associated with managing the impact of various health conditions (e.g., to cope with stress, depression, access support with caring duties, open up spaces for social interaction that have previously been closed off); (b) expanding capabilities for (e.g., socialising and affiliation, expression of valued identities); and (or), (c) supporting development of (e.g., skill and

learning based activities, self-esteem, sense of purpose, income, and identity) capabilities.

But as the analysis revealed, accessing these opportunities requires a cluster of other capability inputs for instance, being able to get from A to B with or without support, or, being able to afford associated costs. For some, living in residential care settings, the issue of personal and/or family resources might result in relying upon the care home policies and practices in realising such capabilities. This study noted variations between different residential care home settings and potential role of personal and formal resources in supporting capabilities for participation in social and valued activities beyond the care home that did not involve the family. In particular, participants located in affluent care homes in the city had more capability for social participation beyond the residence.

*Findings also offer a glimpse into the interdependent nature of places* (Massey 1994). Some evidence suggests that interdependence amongst places where the fortunes of one place might be tied to fortunes of another may have implications for individual capabilities. For example, a participant's experience of the day club in reducing her capability to participate in social life of the club was contextually related to the change in the club's policy. The option to purchase individual particular services (e.g, membership only or membership plus lunch, tea) was reduced as services and activities were bundled together as a package. One explanation for the change in policy might have to do with the increasingly frail nature of people attending day clubs as noted by the participant, but, it might also be tied to economic downturn in UK and the impact of public spending cuts on voluntary and charitable organisations.



In highlighting the differential role that various scales of place might play in older peoples' lives, the *study calls for a more sensitive treatment of scale in relation to older people* (Gardner 2011). An analysis that is sensitive to differential role of scales of place however also raises a methodological challenge for conducting large-scale studies as well as up scaling from micro level studies. The next section in synthesising findings about sense of place adds further complexity to issues of place and scale.

## 9.6 Component 4: Sense of place

The study findings reveal that in some instances, *sense of place and meaning(s) attached to places where older people live are not fixed and immutable but relationally constructed and scaled in relation to specific capabilities*. While the notion that “scale is the actor’s own achievement” (Latour, 2005:185) is something of a mainstay in contemporary studies on human geography, this has not necessarily been emphasised in environmental research as concerns older people. Different places at different scales such as, the room in the care home, the garden, the home, the neighbourhood, social clubs, the wider locality and the city were involved in generating unique specific encounters that not only facilitated and (or) constrained various capabilities to do and be but with consequences for sense of place. Influences that can enable or constrain capabilities can also alter sense of place.

Depending upon the person and the context, *sense of place and meanings attached to place can change over time within the context of changing social relationships within the neighbourhood and (or) with changing individual context*. Study findings suggest in relation to specific capabilities, particular places can gain or lose meanings. *Sense of place*

*can also be influenced in different directions depending upon the capability under consideration and in relation to the same person and place.* A place can hold different meanings for the same person. For example, Sally's sense of place was tied to the social dimensions of the care home, i.e., valued capability of being able to live amongst people, but at the same time, not being able to personalise her room due to the presence of fixed furniture in the room negatively influenced her sense of identification with place as well as her sense of self. Contested meanings of place too can influence sense of place.

A salient finding highlights that *participating in processes related to relocation can have positive implications not only for particular capabilities but also for developing a sense of place.* Paying attention to the processes and mechanisms by which participants', particularly, those who had relocated to various settings cultivated a sense of place highlights the variably mediating role of features of place, close personal relationships, experiences, knowledge about place, shared memories, specific service encounters, and aspects of identity in supporting new ways of making sense of places. This finding confirms that sense of place can be maintained, cultivated and developed (Cuba and Hummon 1993; Johansson et al 2013).

The processes of identifying *with or against a place* involved drawing of relational boundaries (Rose 1995). Some of these boundaries drew upon identification with particular areas within the city: grounded in experiences of being born, brought up and married in the same general area, others were grounded in familiarity and knowledge acquired with particular places through their working lives and for some others deciding to live in Dundee or Broughty Ferry was related to perception of Dundee being home as opposed to Broughty Ferry. It also confirms what

some have noted (Reed, Payton and Bond, 1998, Eales, Keating and Damsma, 2001) about *reframing our understandings particularly about supported settings* not only as destinations for receiving care but also as places that are situated within familiar communities of place or interest.

*The material and social features of different settings can be significant* in developing a sense of place and self. Having a garden in the relocated setting can allow expression of valued capability, a chapel within the care home can contribute to continued and expanded ability to practice faith and having the option to choose such a care setting can permit emphasising valued identities over others. Being able to personalise the material space of the room, being able to live in close proximity of good public transport services, and, opportunities for social interaction in communal settings can variously contribute to cultivating a sense of place.

The study also highlights that *close personal relationships* can also mediate the development of sense of place. For example, the family by supporting the older person to become embedded in new social networks can promote familiarity with the new living environment. The experience of living in a new setting too can be significant in shaping identification with place. This as the analysis suggests could be related to social characteristics of place such as living in a safe neighbourhood as well as to more fluid service encounters within place.

Empirical findings also suggest that *where older people relocate from one city to another, making the unfamiliar familiar might be more difficult as well as take time*. For instance, for (Diane) who had moved from another city to Dundee, not having shared memories of attending such an such school, church etc., as a result of not having been brought up in Dundee

presented a cultural challenge to her social experiences and to developing a sense of place.

The next section in bringing together the four components and combining insights permits a fuller appreciation and understanding of the complex, interlinked, multidirectional, and dynamic nature of relationships between people and place that shape capabilities.

## 9.7 Conceptual contributions

Empirical findings point towards a *complex* understanding of people and place relationships that shape capabilities as a *process* that unfolds in *diverse* ways in specific interactions and in specific places (to include contexts). The conceptual framework permitted exploring the multiple processes through which older people might experience, negotiate, and engage with impact of change on capabilities that matter including their valued identities. The conceptual components outlined in the framework on their own would not necessarily enable an understanding of complex nature of people-place relationships. Rather, these components need to be held in tension to reveal interactions and intersections that differentially mediate the relationships between the older person and place in shaping capabilities.

### 9.7.1 Diversity and heterogeneity

The diversity and heterogeneity in individual circumstances and contexts suggests that individual and socio-spatial factors may not only vary from one person to the next but some are dynamic and can change over time for the same person. These can include, for instance, age and potentially, health related changes, changing residential mix and social relationships within neighbourhoods or the introduction of cutting back

of services. These dynamic factors directly and indirectly can influence and perhaps bring about a change in what people value, the capability for which then might depend upon a new and different configuration and interaction of individual and socio-spatial factors. The interlinked nature of capabilities means that a number of other individual capabilities too can be influenced.

A capability lens enabled consideration of health related impairments both as a source of personal heterogeneity and as an aspect of human diversity. Such consideration permitted nuanced insights into the nature, type and extent of health related impairments across participants and supported an understanding of: (a) the differential impact of diverse kinds of impairments on valued capabilities; (b) recognition of the role of impairment in structuring as well as being structured by interactions between people and place; and, (c) the need for diverse and more resources to exercise valued capabilities for some.

### 9.7.2 Focus on specific valued capabilities

A relational perspective to exploring and making sense of *specific persons embedded in specific places (contexts)* was central to the conceptual framework. But the study findings highlight the need to add '*specific capabilities*' to the framework. Depending upon the person, their situated and wider context and the specific capability under consideration, the configuration of interacting components varied for the same person and across different people. Experiences of place were therefore not uniformly enabling or disabling for the same person and over time.

Findings highlight and confirm that spatial scale matters in understanding the connections between place and capabilities. Different places at different scales, and different dimensions of place (social,

symbolic and material) contributed to shaping capabilities for multiple and valued specific functionings. For instance, the fact that a capability can be specified at different levels, such as, the capability to get out and about, the capability to get out and about outdoors, capability to get out and about for a walk or to a particular destination (e.g., town, public gardens, shops) brings into play different considerations in terms of inputs required.

Some inputs are linked to: *the characteristics of the place of residence and the destination place* (e.g., type of place and scale), accessibility of the place, transport availability or door to door transport for shopping; *some to the characteristics and context of the person* (bodily ability, values, resources, entitlements, and social support); and, *some to how a specific capability is valued* (opportunity aspect and process aspect). The analysis suggests that the interacting factors can be specific, multiple, and varied, highlighting interdependencies within differing configurations in shaping (or not) the capability under consideration.

### 9.7.3 Fluid meanings of place

*Meanings attached to place and sense of place too is not static, and, as evidenced in the study can influence or be influenced by processes that shape capabilities.* Change in sense of place (e.g., perception of neighbourhood as a unsafe place) could be linked to individual changing contexts and can be key to influencing other capabilities, such as, the capability to feel safe. Or, whether a person has a specific valued capability can contribute to enhancing or reducing their sense of place.

Some examples highlight how a capability to participate in social conversations and develop new relationships can rely on having a shared sense of place in relation to knowledge, practices, and familiarity with

place (e.g. having studied in a particular school, or how things have changed in Dundee over time). A place can also hold different meanings for different people and influence specific and diverse capabilities. For example, the care home setting and proximity to other people supported the valued capability to live amongst other people (e.g., for Sally), while proximity adversely affected the capability for spiritual belief and practice of faith (e.g., for Benny).

#### 9.7.4 Relocation as a specific process of change

A relational perspective on relocation highlights three aspects: *firstly*, moving the discussion beyond establishing potential triggers of relocation (health related events or age related losses) or identification of a range of individual and place related factors to a *focus directly on peoples' lives and what they are actually able to do and be* (Sen 2009; Johansson et al 2013); *secondly*, reframing potential life events/situations as key junctures or biographical points in a person's life can provide insights into the complex processes by which diverse relocation trajectories are shaped.

Paying attention to life events/situations is important because it is at these key junctures that complexity of interactions between individual and socio-spatial factors can raise, particular, contingent, and specific issues of choice, control, and, decision making, and by extension, relocation trajectories. *And finally*, examining processes of relocation highlights the need to attend to variations between specific choice related capabilities, such as, being able to decide where to relocate (setting, locality and city), or being able to effect a decision to relocate, as each potentially addresses different aspects of relocation.

*In reconceptualising processes of relocation and adjustment as parts of the same process and not discrete events*, the study also demonstrates that: a) moving from one place to another can have implications for various individual capabilities and, b) that capability changes might occur in different directions as the interplay of individual and socio-spatial factors brings into play features of the new settings. The study findings also suggest that capability to participate in processes of relocation at various levels might be one crucial element in shaping other capabilities and developing a sense of place.

The next section offers some methodological reflections on the study.

## **9.8 Methodological reflections**

In using qualitative methods to understand how capabilities were shaped, the study highlights the benefits of qualitative accounts but also raises some issues and these are discussed below.

### **9.8.1 Biographical accounts and advance knowledge**

Though the study was cross-sectional, it incorporated a biographical component. Biographical accounts usefully highlight that in some instances, what opportunities are available or open to choose from as well as whether certain aspects of place, person or the context may constitute a resource or not may only unfold in specific situations and encounters. For example, some commented how in light of their particular illness they had thought about moving into a sheltered setting. However the severity of health condition shaped their relocation trajectory into a care setting. For another couple, the nature of their illness and securing the capability for valued functioning of not being constantly anxious about falling at the same time shaped their move into a care setting. The option of staying at home or moving into a sheltered



setting became unavailable to them. This may also partially explain why prospective accounts about moving or not moving into particular settings do not necessarily map out in the ways that people envisage.

Some other examples suggest that specific episodes may reveal whether and what individual and socio-spatial factors contribute to or shape a particular capability. For instance, it was not until one participant fell within her house that she realised that she could not count upon her current neighbours as a source of help. For another participant, it was his illness that provided him access to institutional support and thereby the opportunity to relocate into a safer neighbourhood. There is also evidence that specific episodes can affect the perception of what constitutes a resource. For example, a participant lived in a safe neighbourhood in a better part of the town. He did not have any previous negative experience of break-in, but, following the onset of health related impairments, his perception of the safety of his neighbourhood in contributing to his capability to be safe changed.

A central concern of the capability approach is that focus on what people are able to do is not enough. Knowledge about the genuine opportunities and freedoms that people have, to choose, to do or not to do, is also important. However, as the above qualitative accounts reveal, in some instances, it may not be possible to know beforehand about the opportunities that people have and can only be grasped by looking at the processes that shape capabilities.

### **9.8.2 Challenge of abstracting general kinds of capabilities**

Qualitative interview accounts pose a challenge to whether it is feasible and possible to abstract from the specific contexts what general kind of

capabilities matter (most) to older people. Plurality of values and diversity of contexts within which these values are situated present a challenge to making generalisations beyond a specific point. For example, participants talked about specific activities such as, going out and about from the house which was variably associated with being able to meet friends, being able to go out for a walk, being able to attend to specific personal projects or just being able to get out of the house. Similarly, the capability associated with being and feeling in control was tied to specific interpretations within specific contexts. Not only did such interpretations naturally vary from one person to another but they also mattered in different ways to the same person.

Making generalisations about what kind of capabilities matter most to older people may also result in misleading and 'implicit all' assumptions. What mattered to older people in this study as stated earlier is not very different from what previous research has highlighted but what is different is attention to the specific contexts and circumstances within which the mattering occurred and with reference to which it was articulated.

## **9.9 Strength and limitations of the study**

This research looked broadly across issues of place and wellbeing for older people. The study built upon a vast and rich literature on place and wellbeing drawing upon different disciplinary perspectives. Engaging with such literature enabled me to explore concepts of 'place' and 'wellbeing' in the broadest sense and to me that is a key strength of this study.

Another strength of this study was in adopting a biographical perspective. It has helped me explore the *processes* of change, the *dynamic* nature of capabilities and, gather nuanced insights into the *complexity* of older peoples' lives. It has alerted me to the temporal dimension of capability changes and following on from that the fact that individual experiences of (some) capability changes might vary at different points over time. But I also realise that I have relied on methods that depend on recall. However by keeping the 'lived' and 'told life' in focus I have in analysing the data avoided arriving at straightforward explanations.

In writing up the analysis I have attempted to capture the processes that contribute to the complexity of peoples' lives, which I would argue is a strength of this study but, at the same time, I have struggled with writing about it. As Adam (2008) notes, 'matter in space is visible; processes are not (pg: 10). Although writing about processes is not easy, the attempt has strengthened the study.

This study was exploratory and interpretive in nature. My sample was a small one. I recognise that my sample did not include people from ethnic groups, migrant older people, older people living in rural settings, older people with dementia, or homeless older people and I did not investigate the particular experiences of place and wellbeing among them. The research has privileged the experiences of older people and has not engaged with their families and(or) practitioners who might be just as important to advancing relational understandings of place and wellbeing.

The sample however has been varied and robust enough to capture the richness, complexity and variability of experiences of living in diverse domestic and supported settings and advance the potential usefulness of

relational thinking. My study does not make any generalised claims about the different kind of capabilities that might matter to older people. But the research findings clearly demonstrate - that individual and contextual factors that constitute a capability are relative and contingent upon the capability under consideration. This then suggests that identifying opportunities and overcoming barriers to realising capabilities might benefit from examining the complex processes that shape capabilities. The study also alerts us to the possibility of a number of capability changes that older people might experience in moving from one setting to another. Cataloguing such capability changes might provide insights into the circumstances that enable and constrain as well as suggest how these can be modified.

### **9.10 Chapter summary**

This chapter brought together key findings from the analyses chapters and reflected on some of the study's contributions in relation to key components that were earlier identified in the conceptual framework (chapter 4). The chapter also offered some methodological reflections on use of the capability approach and highlighted the strengths and limitations of the study. The next chapter in revisiting the overall aim and research questions and highlighting the contributions of this study to knowledge, policy and practice concludes the thesis.

## Chapter 10 : CONCLUSION

### 10.1 Overview

The overall aim of this research was to *explore what matters for the wellbeing of older people and how this might shape and be shaped by interrelationships of place and wellbeing* and was concerned with the questions:

- 1) What opportunities and constraints do different place settings offer in shaping the valued capabilities of older people?
- 2) How are relocation trajectories into different settings shaped for those who move? What are the implications for older peoples' valued capabilities?

In this final chapter, key findings are drawn together to summarise and provide answers to the two main research questions in section 10.2. Following on from which, section 10.3 outlines the key contributions this study makes to both academic literature followed by contributions to policy and practice (in section 10.4). The thesis concludes by suggesting topics that emerged from the research and warrant further investigation.

### 10.2 Answering the research questions

The three analyses chapters 6, 7, and 8 provided the empirical basis for answering the research questions. At a more generic level, the discussion (Chapter 9) offered a richer and fuller understanding of the dynamics that shape interrelationships of place and wellbeing in the lives of older people.

**Research question 1: What opportunities and constraints do particular place settings offer in shaping the valued capabilities of older people?**

Insights into capabilities that mattered to participants, the capabilities they had, and sensitivity to diversity in health related impairments (in Chapter 6) enabled a contextualised exploration of how capabilities were constituted and shaped especially in relation to where participants' lived (in Chapter 7). Though participants valued many different capabilities across various domains, the importance of which varied from one person to the next, their accounts highlighted the significance of health in their lives. Health was framed both in terms of impairment with consequences for valued capabilities and as a capability input to support other valued capabilities. The analysis highlights the importance of taking note of individual diversity in the nature, extent, and type of health impairments that can not only directly and indirectly influence what valued capabilities are affected and over time, but, can also play a significant role in shaping older peoples' interactions with place.

Participants' experiences of living in different settings were variably underpinned by on-going change in individual contexts (health related changes in self and (or) spouse, loss of valued relationships), changing residential mix in some neighbourhoods, as well as in sheltered, very sheltered settings, and residential care homes, cutting back of services in some neighbourhoods, and(or) changing practices within some settings. Some changes were associated with particular events (e.g., a fall, a heart attack) while others were continuous and progressive (e.g., deterioration in vision, physical mobility, changing residential mix of neighbourhoods and supported settings). Such changes though variably experienced offer three valuable insights into the implications of change. One, change can

raise challenges for many different but interlinked valued capabilities with diverse implications for sense of place. Two, whether an older person has a particular valued capability might become visible only in situations of crisis or change and the factors contributing to shaping the capability under consideration be revealed as available or missing. And, three, that new capabilities can become important.

The analysis suggests that places could have diverse and mixed effects, facilitating and (or) constraining across different older people and for the same older person in shaping valued capabilities. Depending upon the situational context, and the valued capability under consideration, differing configurations of a range of individual and social-spatial factors can interact to shape the valued capability (or not). The analysis indicates that not only can individual and socio-spatial factors vary from one person to the next but also some of these factors are more dynamic and likely to change over time for the same person.

Participants' valued capabilities were linked to places at different scales thereby highlighting a spatial dimension to capabilities. For instance, being able to personalise the room in a supported setting, being able to walk in the garden or do gardening, being able to participate in valued activities (solo and group) in the immediate neighbourhood (supported setting) and beyond, being able to go to the supermarket in the wider locality or being able to live in a safe and pleasant neighbourhood. The analysis also suggests that sense of place is dynamic, can be cultivated, enhanced or reduced in relation to specific and different valued capabilities for the same person in relation to the same place. Sense of place can also be a constituent of a specific capability, for instance, to maintain continuity of place of residence or the capability to participate

in social relationships that rely on a shared sense of place (e.g. having local knowledge about a particular city).

The discussion (Chapter 9) demonstrated the usefulness of adopting a relational perspective (set out in Chapter 4) to developing an understanding of how opportunities and constraints offered by particular places in shaping valued capabilities played out in different ways across different older people, for the same older person, and over time. The opportunities and constraints that particular places offered varied according to specific valued capabilities and specific situations and hence, a priori designation of either individual and (or) socio-spatial factors or of particular place settings as uniformly facilitating or constraining can be misleading.

The study enabled the consideration that contingent and relative mix of interacting individual and socio-spatial factors (that shape a specific valued capability, and under what circumstances and for whom) has to be engaged with in a situated context. For instance, we might conclude that support from family tends towards contributing to a number of valued capabilities of an older person. It does not however, imply that this is true for all capabilities that an older person might value, or would apply in all contexts.

Sense of place emerged as being relationally shaped. A relational perspective confirmed that places at different scales were interrelated to the extent that they variably and differentially supported multiple capabilities that were valued by an older person. And further contributes to our understanding that places at different scales matter in supporting the wellbeing of older people.



**Research question 2: How are relocation trajectories into different settings shaped? What are the implications for older peoples' valued capabilities?**

The analysis (Chapter 8) highlighted that reasons for moving out from particular settings were linked to securing and stabilising capabilities for various priority functionings, i.e. capabilities for functionings that contingently became more important than some other capabilities and that could not be secured in the current place of residence. Different combinations of individual and socio-spatial factors in interaction often negatively impacted multiple and interlinked valued capabilities. Where participants had health impairments, material and social features of some places (e.g. living in an upstairs flat in a tenement accessed by a flight of steps, changing residential mix of the neighbourhood, considerable nature of alterations required) often precluded adaptation to enable capabilities without moving.

The analysis suggests that relocation trajectories into different settings can be variously and simultaneously shaped by a number of interrelated factors: severity of health conditions (self and/or both), features of new settings, availability of resources (social and financial), future oriented considerations, and, eligibility for formal support. Exercising choices in relation to what kind of setting to move into can sometimes be outside the person's control and especially in relation to particular kinds of health impairments. Depending upon the person, the situational specificity, eligibility for formal support, and (or) availability of financial resources, some can have more options than others in moving, and, into settings and localities of their choice than others.

Relocating variously to different settings can have mixed implications for a number of other valued capabilities. As set out in Chapter 8 participants variously experienced a number of capability changes in different directions. Capabilities were enhanced, reduced, added, and (or) remained unchanged. In developing an understanding of why capability changes occurred in different directions the analysis suggests that the capability to participate in decisions relating to the move and socio-economic circumstances might be significant.

Looking at the different kinds of capabilities that were variously affected (Chapter 8) highlights that some capability changes can be anticipated prior to relocation while other changes cannot be planned for as they may take time to develop. The fact that some capability changes can be anticipated prior to relocation has implications for cultivating and developing a sense of place. That some capabilities might take time to develop suggests that individual experiences of wellbeing are dynamic. The study also reveals the experimental nature of relocations where prior knowledge about how some capabilities can be affected might not be possible to anticipate in advance but, at the same time, shows how the experimental aspect can also support development of new capabilities.

As noted in the discussion (Chapter 9) the study by reconceptualising relocation as a process that is dynamically and relationally shaped permitted insights into the interplay of a range of individual and social factors - that for some influenced multiple capabilities with implications for continuity of place of residence. The study suggests that continuity of place of residence while valued can become less significant in comparison to the continuity of other capabilities (including identities) that are not possible to sustain in the current place of residence. The study thus demonstrates the need for conceptualising both: (1) places

where older people relocate from and into, and; (2) relocation and adjustment, not as discrete bounded entities and events but as dynamic processes of meaning making that are spatially and temporally contingent.

### **10.3 Contributions of this study**

In this section, I discuss key contributions to knowledge from this research under three broad headings and in relation to wider literature presented earlier in the thesis, followed by contributions to policy and practice.

#### **10.3.1 Relational understanding of people-place relationships**

A key contribution to knowledge from this study is that processes shaping older people-place relationships and wellbeing are dynamic and complex. And, hence this study encourages relational understandings of place and wellbeing that are currently under-represented in literature. Incorporating a relational and biographical perspective prompted looking at the processes and interactions that permitted insights into the temporal and spatial dynamics of older people-place relationships in shaping wellbeing. The study findings suggest that a capabilities perspective and dynamic conceptions of place can contribute to generating useful information about: how valued capabilities can be enabled or constrained in a variety of ways by features of place and context; how older people negotiate place to secure valued capabilities; and, how valued capabilities in turn can support creation of a sense of place.

A relational perspective emphasises a situated conception of older person in their particular context. Hence there is a need to conceptualise

the relationship between place and wellbeing in ways that privileges neither the individual nor the context and can address heterogeneity in personal attributes and socio-spatial contexts of older people. Such a conceptualisation also requires moving away from presupposing older people as a bounded group defined by the shared attribute of, for example, place attachment or seeing older people and places where they live as discrete entities.

Place and wellbeing have acquired renewed importance in light of ageing in place strategies in social care, health, and housing policies. Hence, it is all the more important to develop a dynamic and relational understanding of relationships of place and wellbeing. The relational nature of capabilities and place usefully remind us to be wary about working from presumptions about some places as being better than others for older people. Such presumptions that are based upon ideas about continuity, stability, independence, and attachment may not be contextually sensitive to address issues of place and wellbeing in older peoples' lives.

### **10.3.2 Heterogeneity in health impairments**

This study demonstrates that an understanding of the interrelationship of place and wellbeing would be incomplete where health impairments differentially, directly and indirectly together with a number of other socio-spatial factors influence a range of valued capabilities. Hence, where an older person has health impairments, it is important to recognise and reveal how the nature, type and extent of impairment together with other individual and socio-spatial factors can modify (or not) the consequences of impairment for valued capabilities.

Review of literature on place had highlighted an undifferentiated understanding of age and health related changes. Similarly, wellbeing literature with the exception of a few (e.g., Clarke and Gallagher 2013) too revealed either a lack of focus on age and health related impairments or a narrow focus (based upon medical model of health) that did not attend to consequences of impairments on broader ways of living. And, some ecological models of ageing by taking an atomistic, functional view of the person overlook the consequences of particular impairments for their wellbeing.

In critiquing the medical model, the social model of health has been influential. In place based approaches to wellbeing developed by health geographers (Kearns and Gesler, 1998), health is understood as being socially constructed and experienced. While this work is a vital starting point in generating understanding of wellbeing, implications of health impairments as they directly, indirectly and differentially affect older peoples' ways of life and living have been ignored.

The significance of health for older people and for public policy is widely acknowledged in both policy and academic discourses. Yet, taking note of heterogeneities in impairments becomes important both: in relation to the different kinds of inputs and support that different older people; or, an older person with impairments might require to exercise valued capabilities and over time. Moran et al (2013) in an English study note that the community care policy of individual budgets does not offer a sufficiently large enough budget to enable older people to participate in social and leisure activities. Hence, it is not just access to entitlement that matters but also whether the entitlement can support valued capabilities. More recently, some have noted (Schwanen, Hardill and Lucas 2012; Gilroy 2012) that active ageing discourses notwithstanding,

there is a need to acknowledge that some older people might experience impairments and to accommodate this within relational understandings.

### 10.3.3 Processes of relocation

Much of the research on older people has focused on identifying how ageing in place can be promoted and in doing so overlooked how older people are affected by neighbourhood change and how they negotiate such change (Burns, Lavoie and Rose, 2012). My findings while confirming this add new insights by highlighting a data gap in relation to identification of older people who neither have the resources nor the ability to mobilise resources to positively influence the impact of neighbourhood change on valued capabilities. The study findings indicated some participants did not have a medically assessed need or a particular impairment but whose capabilities are nevertheless undermined may be not by material features of residence but by the social features (e.g., anti-social behaviour, drug trafficking in tenements) of place of residence and also did not have the necessary resources to relocate.

The Scottish Government, in an analytical paper discussing the implications of an ageing population for housing (quoting Croucher, Holmans and Wilcox 2009), observe the limited research that has been undertaken on older peoples' housing. They rightly note a need to identify older people who may need support or specialist housing and/or housing adaptations. And in doing so, existing data sets such as, information on attendance allowance (which is a measure of medically assessed need) and Scottish Household Conditions Survey (which includes a specific question in relation to adaptations for people with disabilities) have been drawn upon. Such data sets however may not

capture older people in vulnerable housing situations who do not have a medically assessed need or health impairment.

Another gap identified in literature (chapter 2) related to how relocation and adjustment to the new setting were seen as separate events and the lack of attention to capturing changes (positive and negative) in wellbeing. This study by re-conceptualising residential relocation as an on going, complex and contextualised process drew attention to capability changes that occurred for various participants in different directions. These categories of capability changes offer a way to appreciate the complexity of older people's lives. At the same time, the insight that some capability changes can be anticipated prior to relocation while others cannot has implications for practice.

By conceptualising relocation and adjustment as parts of the same process this study has demonstrated that despite relocating to new settings, older people can cultivate familiarity and experience a sense of belonging. Some studies (Cutchin 2003; Petersen and Minnery 2013) in relation to supported settings have highlighted that where places can support connection with particular identities, occupations and/or objects, sense of place can be developed. But as my study suggests, development of sense of place need not be a post-relocation concern and the capability to participate in processes of relocation at various levels in the relocation process may be one crucial element in developing a sense of place.

Literature on supported (primarily residential care) settings has often highlighted that older people who move voluntarily adjust better than those who move involuntarily, but, it is rarely discussed what distinguishes voluntary from involuntary moves. An alternative

explanation perhaps might be that those who do not adjust have not had the capability to participate in processes of relocation. But this study in contributing and adding to sparse literature on moves from domestic-to-domestic and sheltered settings highlights that the distinction of voluntary/involuntary does not do justice to the fact that older people have to find a way of participating in chosen as well as un-chosen situations and events in their lives.

This study looked at individual experiences but in the process brought to attention issues that may well have implications for wider policy and practice and it is to these I turn to in the next section.

## **10.4 Implications for policy and practice**

### **10.4.1 Policy**

Relational understandings of place and wellbeing relationships and diverse lived experiences of older people raise questions about the stable notion of some settings as being better than others as well as alert us to making a priori assumptions about different settings. The study findings seem to suggest that there may be no ideal places to live in, rather appropriateness of the place may well depend upon complex combination of different interacting individual and socio-spatial factors with mixed outcomes in terms of maintaining continuity of residence or relocating. Relational thinking facilitated a nuanced understanding of different ways in which particular settings might support or undermine capabilities. Hence, it prompts suspending assumptions about older people and places where they live and also highlights that attending to gaps in opportunities or resources might not be best addressed in one particular way.



Previous research has highlighted that promoting the agenda of ageing in place at home as the option rather than one amongst a range of options has ignored older people living in vulnerable housing situations such as the homeless, those living in private rented sector and those with specific illnesses such as dementia (Means, 2007). This study adds older people to the list who find themselves in vulnerable housing situations by virtue of living in deprived neighbourhoods. Further some older people might be doubly disadvantaged, as, they may not have, the financial resources or the capability to mobilise resources (e.g., access institutional support) to effect a change in their circumstances or as in this instance relocate.

Discourses can be powerful and as the analysis highlighted the privileged nature of health discourse might hold negative implications for older people who may not have health issues but experience particular forms of neighbourhood exclusion as well as lack material resources. Social institutions in this instance themselves may constitute a potential constraint to supporting valued capabilities.

Such has been the focus on promoting 'ageing-in-place at home' that issues of neighbourhood change and linked issues of social exclusion have not received much attention. While tackling social exclusion underpins the National Outcomes Framework for Community Care, Scotland (2012) this has been limited to people who are in receipt of community care services.

The research evidence though small, points towards a need for urban and social policy in Scotland to explore issues of social exclusion for different older people. There is also need for generating appropriate data

sets in the long term that can contribute to identification of people who may be at risk and vulnerable to different and multiple forms of social exclusion. Existing datasets relying upon measures such as attendance allowance, percentage of community care service users who feel safe may capture those older people for whom housing and health issues intersect but may not capture older people who may experience forms of exclusion that are not health related. Kneale (2012) further notes that in Scottish context, there is currently no equivalent dedicated data set such as the English Longitudinal Study of Ageing (ELSA) to build upon.

#### 10.4.2 Practice

In the specific context of relocation, findings of this study have implications for social work practitioners. The analysis highlighted the importance of capability to participate in choices and decisions relating to different aspects of relocation process. In identifying implications of relocation in terms of capability changes, empirical findings revealed that where older people were able to participate in choices regarding the new setting, some capabilities were maintained, enhanced and added despite relocation. Hence, it may be important to ensure that older people are able to participate as well as are encouraged to participate as it has implications not only for particular capabilities but also for developing sense of place.

It is also important for practitioners to be sensitive to variations in the specific individual circumstances and to recognise that relocating sometimes may involve making difficult trade-offs between 'valued capabilities'. Therefore it is all the more important that responsiveness to individual contexts, identities and values does not begin only after one has relocated to a new setting but is a part of the relocation process. It

might be beneficial to encourage people to speak up about the kind of things that matter to them so that relocation process is not just about finding adapted suitable accommodation but also an opportunity that older people may have to improve upon or develop new capabilities.

Some evidence also suggests that different people may also need different kinds of support at various points in the relocation process. For instance, people who relocate from one city to another, may need information as well as some form of support to develop familiarity with new place and become embedded in new social networks.

The study also suggested that relational aspects of service encounters may not only be influential in supporting or undermining one's sense of self but in doing so may also mediate one's sense of place. Provision of care has always been the cornerstone of care settings but the availability of care in the community has meant that for some, regardless of whether they live in domestic, sheltered or care settings, service experiences are a part and parcel of daily life.

As noted earlier in the discussion (section 9.4), the opportunity and process aspects of freedom draw attention to how a valued capability can be enabled or constrained in different ways if the focus is only on the opportunity and not on the process by which the capability is shaped. The analysis also suggested that older people might attach differential value to opportunity and process aspects. Hence, informed judgements to support wellbeing of older people must attend to both these aspects, as different kinds of interventions might be required.

Although further exploration using a 'capability' lens is warranted, the study offered some limited insights in relation to some community care

services and particularly their role in supporting or undermining a range of capabilities. As noted in the study, the day club supported capabilities for a range of functionings, such as, socialising, forming social relationships, sense of belonging and purpose, developing self-esteem, expressing particular identities, developing new identities as a result of various opportunities, and/or having a place to go to beyond the home. The role of day clubs also sits well with the Scottish Government's espoused four national outcomes of improving health, tackling social exclusion, improving wellbeing and independence and tackling social isolation and loneliness amongst older people.

Findings from this study also have relevance for planners, for instance in relations to issues of transport, bundling of services, and issues of space. A particular example however suggested that bundling of services by day clubs might reduce flexibility to choose how to participate. This might variably have implications for individual capability of continued participation in these social arenas and other linked capabilities. The example also offers insights into wider linked issues of some aspects of social exclusion, the policy emphasis on enhancing opportunities for social connectedness of older people and possibly the lack of integration between different service agendas (Scharf et al 2002).

If day care centres form a part of that broad policy initiative particularly, where, the neighbourhood no longer functions as a social space for older people, (Ziegler 2012) and as was the case for this participant as well, not only is the policy shift towards providing person centred services defeated but older peoples' capability to access such social spaces to minimise the impact of social exclusion experienced in neighbourhoods too may be negatively impacted. There is therefore arguably a need to ensure that such social spaces do not have to struggle for resources.

Another related issue highlighted by the study was about the cutting back of (bus) services in neighbourhoods that might disproportionately impact older people who might have no other means of getting out and about (e.g., drive a car or secure a lift from family) during the daytime. Accessing social opportunities, participation in valued spheres of one's life might be adversely affected if the capability to get out and about is not secured. This means that adequate bus services should be made available. But, if services are reduced or cut, there is a need to devise a system prior to reduction of or cutting of services that can capture those who might be disadvantaged in the process and supported with alternative means of transport. The analysis has also highlighted how issues of space particularly in supported settings can negatively impact capabilities for valued functionings. Some of these settings were recently built and it raises questions about how housing space standards are arrived at.

Foreseeability of capability changes due to progressive health conditions for some highlighted challenges in relation to the capability to make decisions about moving or thinking about moving. Some had categorically refused to move when the social worker offered to support relocation to a ground floor flat. But the variable, dynamic and changing nature of capabilities and the fact that residential reasoning about staying put or relocating might change over time (Nygren and Iwarsson 2009; Peace, Holland and Kellaher 2011; Granbom et al 2014) means that practitioners might need to proactively continue to engage with older people in such situations.

The changing residential mix of supported settings points to a different set of issues. In residential care settings, the analysis highlighted the need for more resources of people, time, and space if the work of the appointed activity coordinators has to move beyond the rhetoric. For sheltered settings, it might mean encouraging people who are keen to lead the organisation of activities to be supported and facilitated with appropriate skills and training to secure participation.

### **10.5 Further research**

The exploratory and broad nature of this study has suggested a number of areas for further research. The need for a study on social exclusion to examine the conditions that exacerbate disadvantage and vulnerability and the role of social spaces beyond the home in shaping capabilities was highlighted earlier in the discussion. Another topic worth pursuing is exploring older couples' experiences when one or the other has to move into a care home and its implications for valued capabilities and wellbeing of both partners. Service and care encounters present another challenging area for further exploration. As the findings highlighted, why some older people might not speak up about the kind of things that matter to them and how older people might be empowered and encouraged to do so requires further investigation.

The role of impairments in shaping interactions with place and its implications for capabilities was evident in this study, but the impairments were acquired in later life. However, it might be worthwhile exploring how capabilities of older people who have had impairments from a relatively early age and are now ageing are shaped. It may also offer new insights that might be useful for addressing issues of place and wellbeing for older people who acquire impairments in later life. There is also a dearth of research that engages with the experiences of older

people who in relocating from one setting to another, move to another city. The reasons for and implications of relocation could benefit from further methodological work involving a longitudinal exploration to understand how capabilities might be shaped over time.

This thesis has demonstrated the potential usefulness of employing a capabilities perspective and relational thinking on place to make sense of older peoples' experiences of place and wellbeing. Through an in-depth exploration, this study has shed light on the complex and fluid nature of older people-place relationships that dynamically shape capabilities and sense of place. The conceptual framework has enabled a contextualised and combined exploration of both compositional and contextual factors and their interaction - thus permitting a well-rounded appreciation and nuanced analysis of interrelationships of place and wellbeing. The study suggests that the concept of place brings a spatial dimension to thinking about the capabilities of an older person. And, a capability perspective highlights how place becomes unique, sometimes enabling and sometimes disabling when multiple, specific, and interconnected valued capabilities of an older person are taken into consideration.

I believe that the conceptual framework of capabilities and place adopted in this study could potentially be a useful starting point for other studies with older people including some of the more specific groups that I was not able to include in this study (for example, people with dementia, people from minority ethnic groups, people living in rural areas). By exploring a range of issues from different perspectives and in diverse contexts, the framework would benefit from further development and contribute to understanding - how older peoples' capabilities can be expanded and how enabling places can be made.

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## Appendices

## Appendix 1: Ethics Approval



School of Psychology

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### University of Dundee Research Ethics Committee

University of Dundee,  
Dundee,  
DD1 4HN.

26 April 2012

Dear Mrs. Gopinath,

**Application Number: UREC 12028**

**Title: Wellbeing and place: an exploration of peoples' views**

Your application has been reviewed by the University Research Ethics Committee, and there are no ethical concerns with the proposal. The Committee makes a judgement in terms of the Guidelines issued by the British Psychology Society (Code of Conduct, 2006; Ethical Principles for Conducting Research with Human Participants, 2009), and the Medical Research Council Ethics Guide on Medical Research Involving Children, 2004). Any approval given is on the basis that you undertake to follow the relevant Guidelines.

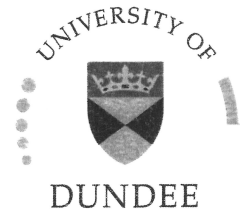
I am pleased to confirm that the above application has been formally approved.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Astrid Schloerscheidt'.

Dr Astrid Schloerscheidt  
Chair, University of Dundee Research Ethics Committee

Appendix 2: Participant information leaflet



**WELLBEING AND PLACE**  
**An exploration of peoples' views**

Participant information leaflet

**The University Research Ethics Committee of the University of Dundee  
has reviewed and approved this research project**

### **PARTICIPANT INFORMATION LEAFLET**

My name is Manik Gopinath. I am a doctoral research student in the University of Dundee. I am carrying out research to explore peoples' experiences of wellbeing in domestic homes and in residential care facilities. The study is being carried out within Dundee.

#### **What is the research about?**

I would like to find out about what is significant to you in terms of your wellbeing and how where you live affects your wellbeing. So, I would like to hear from you about:

- Your life story
- What matters to you for a good life
- What you think is good & bad about where you live and how that affects what you are able to do & not do

What you and other people tell me will allow me to build a picture about the importance of where people live for their wellbeing. I will share the findings of my study with people who can guide policy and the provision of support services & care.

**When will the research be conducted?**

The interviews will start in April 2012 and will carry on until March 2013.

**What will happen if you agree to take part?**

I will arrange to visit you, either at your home or somewhere else such as a community centre if you prefer. It would be helpful if you could allow an hour or more so we have time to talk. We can take a break and/or stop the interview whenever you like. If we don't manage to cover everything in one conversation, I will ask if we can meet again once more if you don't mind. I would find it very helpful to audio-record our conversations and then use that to write down what you say so I can remember and think carefully about it. But I will only record the conversation if you agree to this.

**Confidentiality**

What you tell me in the interview will remain confidential. I will not tell anyone who gives you support or care about what you have told me. I will not identify you by name when I talk or write about my research.

**Do you wish to participate?**

If you are over 60, happy to speak with me for an hour or more, and, are currently using support services from social services, private or voluntary agencies, and/or managing with support from family & friends, then I would be very glad and grateful for your participation. **Please note** participation in this research is entirely your choice. You can also withdraw from the study at any time without giving a reason. Whether you choose to take part or not will not affect any care or services you currently receive.

If you might like to take part, please complete the enclosed yellow reply slip. You can send the reply slip back to me in the attached pre-paid envelope. I will then contact you and will be pleased to answer any questions that you may have about the study. If you are happy to take part, we can agree when and where to meet. Alternatively, you can phone me on 07988519032 or email at [m.deepakgopinath@dundee.ac.uk](mailto:m.deepakgopinath@dundee.ac.uk) to indicate your interest to participate.

### Appendix 3: Informed consent form

#### WELLBEING AND PLACE: AN EXPLORATION OF PEOPLES' VIEWS

##### INFORMED CONSENT FORM

**By ticking the boxes and signing below you are agreeing that you have read and understood the Participant Information Sheet and that you agree to take part in this research study.**

- I am willing to talk to the researcher about my experiences
- I am willing for the researcher to audio-record our conversation
- I understand the researcher will not use my name when she talks or writes about the research
- I understand that information gathered from our conversation will not identify me by name and will be held securely with a reputable research organization to be used only for further research and study purposes

-----  
**(Participant's signature)**

**Date:**

-----  
**Manik Deepak Gopinath (Mrs)**

If you would like to meet me again before you decide, or if you have any questions about the research, you can get in touch with me by

**Phone:** 07988519032

**Email:** [m.deepakgopinath@dundee.ac.uk](mailto:m.deepakgopinath@dundee.ac.uk)

**Letter:** Manik D Gopinath, Room G37, School of Environment,  
Tower Building, University of Dundee, Perth Road, DD1 4HN

**The University Research Ethics Committee of the University of Dundee has reviewed and approved this research study**



## Appendix 4: Topic guide

Could you please start by telling me a bit about yourself and your life?  
You could start wherever it makes sense to you.

1. Thank you. That was very helpful. Expanding on what you have just told me, I would like to know more about what living here means to you?
  - Explore in detail the respondent's history with the place
  - Probe the significance of that place to the respondent
  - What for you is good and bad about living here
  
2. Could we now think about what matters to you for a good life, for your sense of wellbeing? I would like to go through the aspects you mentioned and some others and we will pick up each of these for discussion one by one  
*[Note: the researcher will pick up on the domains of wellbeing discussed with the respondent and refer to the prompts section of topic guide to flexibly explore what matters]*
  - Explore what about the stated dimension is important?
  - What do you do to realise /maintain these important dimensions?
  - What are you not able to do in relation to these dimensions? Why?
  - Explore how living here makes it easier or harder to realise or do the things that you say are important for your wellbeing.
  
3. At present and looking forward, do you have any particular concerns or big worries?
  - Nature of concern(s) and why a concern
  - How and when did the concern become important?
  - Perceived or actual impact on your life & consequences
  - Have you shared your concerns with anybody? Whom and why?
  - Are you addressing these concerns? How?

4. I would like to ask you a bit more about some of the things you have mentioned. It sounds as though xxxx was a challenging issue/time for you. Could you tell me a bit more about the issue/time?

*[Note: the researcher will make links to the respondent's life story and sensitively explore these experiences with the participants]*

- In what way was it a challenging time/issue?
  - How did you cope with it?
  - Did you have to make any changes/adjustments? If so, what kind?
  - Who made the decision regarding the changes/adjustments? Did you seek help? From whom?
5. I would now like to explore with you your experiences and expectations of any community services you use and/or any support that you currently receive. Can you describe to me what your experience of receiving support/care/using day care services is like?
- Nature of the support/Who gives you support/ your relationship with your carer
  - What prompted the need for support and what options did you have
  - Who initiated the process and your role in the process
  - Has receiving support made a difference to your life? How?
  - What is good and bad about receiving support? Why?
  - Does receipt of support make any difference to the meaning of this place for you? If yes, then how and why? If no, why not?
6. Could we reflect back on your experiences of moving and settling here *[Note: this is for participants who have moved to other domestic and supported settings]*?
- What prompted the move/ Where did you move from/Why did you move here
  - What other options did you have
  - Decision making process and influences in relation to moving
  - Managing the move and sources of support that you drew upon
  - Impacts of the move on your life and lifestyle
  - Further consequences of the impact if any
  - What made it easier or harder for you to adjust here

- Looking back, how do you feel about the move now
7. Do you think this place has changed at all over time? If so, then how and why? Looking forward do you see yourself living here or are you contemplating a move?

### **Prompts for exploring wellbeing domains**

#### Life/Health/Security

How does living here make it easier or harder for you to support your life, your health and security, whichever way you understand it – whether living here adds to your comfort and health or whether it makes it harder for you manage;

#### Friendships

How important are social relationships for you – these could be relationships with your family, friends, neighbours, care staff or your social worker- how does living here make it easier or harder to maintain and form relationships - whether you are able to get the support or help when you need it, meet up with and entertain friends and family here, make new friends or living here leaves you feeling lonely or isolated and unable to participate in the social life you wish to have;

#### Self-direction/expression

For some being their own person, expressing themselves, making decisions about how one wants to live their life, getting support and being able to do things that are meaningful and worthwhile in ways you want to, giving voice to their opinions and preferences is important- Is that important to you - in what way and how does living here support that

### Work and play

What about engaging in activities or hobbies that are meaningful to you or make you feel good/relaxed/satisfied or creates value for you or for others? It could be something you do on your own or with other people, it could anything like solving puzzles to gardening or going to the local pub or helping out with charitable work - it may have nothing to do with earning more respect, or showing off or income- something you enjoy doing for its own sake, to advance your skills.

### Faith/Religion

Faith/ a belief system/ spiritual realisation and practice is important to some people- is that important to you – whether living here makes it easier for you to engage in faith/spiritual practice or makes it difficult for you to pursue your beliefs

### Knowledge

For some people knowing about things, following up on a particular hobby/subject is important – whether it is learning ways of doing things, acquiring skills or learning just for the sake of it – does that matter to you and does living here enable or constrain you in any way

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- <sup>i</sup> Given that the research is being conducted in Scotland, this research will focus primarily on the policy initiatives for older people in Scotland whilst making linkages to the wider UK context where applicable
- <sup>ii</sup> Taxi card scheme: is a local authority run concessionary travel scheme for people
- <sup>ii</sup> Taxi card scheme: is a local authority run concessionary travel scheme for people who have a permanent impairment and are not able to use local bus services.
- <sup>iii</sup> At the time of interview in the care home, I saw the photograph of her carer pasted on Peggy's door and asked her about the carer. Peggy mentioned that she could not tell without knowing the name, as she could not recognise faces.
- <sup>iv</sup> The Blue Badge Scheme is designed to help people who are unable to walk, or who are virtually unable to walk, to travel independently, as either a driver or as a passenger, by allowing them to park close to their destination (Dundee City Council)