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**No country for old men?: the role of a ‘gentlemen's club’ in promoting social engagement and psychological well-being in residential care**

**Article (Accepted version)  
(Refereed)**

**Original citation:**

Gleibs, Ilka H., Haslam, Catherine, Jones, Janelle M., Haslam, S. Alexander, McNeill, Jade and Connolly, Helen (2011) *No country for old men?: the role of a ‘Gentlemen's Club’ in promoting social engagement and psychological well-being in residential care*. *Aging & mental health*, 15 (4). pp. 456-466.

DOI: [10.1080/13607863.2010.536137](https://doi.org/10.1080/13607863.2010.536137)

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Running Head: GENDER AND WELL-BEING IN RESIDENTIAL CARE

No country for old men? The role of a 'Gentlemen's' Club' in promoting social  
engagement and psychological well-being in residential care

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*Abstract*

Objective: Social isolation is a common problem in older people who move into care that has negative consequences for well-being. This is of particular concern for men, who are marginalised in long-term care settings as a result of their reduced numbers and greater difficulty in accessing effective social support, relative to women. However, researchers in the social identity tradition argue that developing social group memberships can counteract the effects of isolation. We test this account in the present study by examining whether increased socialisation with others of the same gender enhances social identification, well-being (e.g., life satisfaction, mood), and cognitive ability.

Method: Care home residents were invited to join gender-based groups (i.e., Ladies and Gentlemen's Clubs). 9 groups were examined (5 male groups, 4 female groups) comprising 26 participants (12 male, 14 female), who took part in fortnightly social activities. Social identification, personal identity strength, cognitive ability, and well-being, were measured at the commencement of the intervention and 12 weeks later.

Results: A clear gender effect was found. For women there was evidence of maintained well-being and identification over time. For men, there was a significant reduction in depression and anxiety, and an increased sense of social identification with others.

Conclusion: While decreasing well-being tends to be the norm in long-term residential care, building new social group memberships in the form of gender clubs can counteract this decline, particularly amongst men.

No country for old men? The role of a 'Gentlemen's' Club' in promoting social engagement and psychological well-being in residential care

For most of their lives men are in a privileged social and economic position relative to women. However, this changes as men grow older. With increasing age, men become a distinct minority in terms their actual group size. Only 32% of the UK population aged 85 and over (420,000) are men, compared to 68% (914,000) women. This raises questions about men's increasing marginalisation and whether this experience has a detrimental impact on their psychological well-being. This may be a particular concern for men who live in long-term care. Living in residential care is generally perceived as challenging and can have a negative impact on a person's sense of self-continuity and their understanding of who they are (Iwasiw, Goldenberg, Bol, & MacMaster, 2003; Lee, Woo, & Machenzie, 2002). Moreover, for older men in care their status as a numerical minority is likely to be a more salient aspect of their day-to-day living than it would be in the general community because the majority of care workers and most other residents are female. Numerical marginalisation is also compounded by several other factors. First, the ageing process is associated with a loss of physical strength, control, independence and social power (Wanklyn, 1996) and this tends to contradict male (self-) stereotypes that associate masculinity with being athletic, competitive, aggressive and powerful (Prentice & Carranza, 2002). Second, men typically find it more difficult to draw on effective social support and this might put them in a position of disadvantage relative to women in a care context. In particular, in the seminal review by House, Landis, and Umberson (1988) it was argued that men have less experience with social relationships and this can contribute to their reduced effectiveness in drawing on social support when under stress. Men's increasing marginalization may therefore be associated with decreases in well-being as it may strip older men of their sense of identity, lead to

fewer encounters with other men and decrease access to forms of contact that help men adjust to, and feel comfortable in, residential care. Despite these potential barriers to men's well-being in these settings, the experience of older men is largely ignored, with most research on aging and gender focusing on women (Canham, 2009; Fleming, 1999). The present study addresses this gap by investigating the effectiveness of gender-based social groups in improving the well-being of *both* men and women in care.

*Social support and well-being*

The association between perceived social support and better physical and psychological health is one of the most robust in health psychology (Beals, Peplan, & Gable, 2009; Uchino, 2009). There is now a considerable amount of evidence that social interaction and engagement can have a range of positive consequences for health (for a recent review see; Holt-Lunstad, J., Smith, T.B., Layton, J.B., 2010; Jetten, Haslam & Haslam, in press). For example, greater social integration and membership of social groups reduces the risk of stroke (Boden-Alabala, Litwak, Elkind, Rundek, & Sacco, 2005), protects well-being during recovery from stroke (Haslam, Holme, Haslam, Iyer, Jetten, & Williams, 2008), reduces memory decline (Ertel, Glymour, & Berkman, 2008), and can reduce vulnerability to dementia (Fraglioni, Paillard-Brogr, & Winblad, 2004). This research complements the social isolation literature which in turn highlights the negative effects that reduced social contact has on physical and mental health (e.g., Berkman, 1995) and the associated risk of ill-health and mortality (Holt-Lunstad, Smith, & Layton, 2010; House, 2001; House, Landis, & Umberson, 1998; House, Umberson, & Landis, 1988). Importantly, we know that these effects are particularly pronounced for older adults (Tomaka, Thompson, & Palacios, 2006).

Most of this research, however, has focused on community-dwelling adults. Hence, we know relatively little about social engagement and social support among older people living in

long-term care. Yet, findings from the few studies that have been conducted with people in residential care show that social interaction and relations has positive effects on well-being. For example, Garcia-Martin and colleagues (Garcia-Martin, Gomez-Jactino, Martimportugues-Goyenechea, 2004) found that diverse leisure activities (e.g., fitness exercise, computing, handcraft, and art lessons) had a positive effect on perceived social support, and that this was associated with decreased depression and increased life satisfaction. More recently, Park (2009) showed that the development of meaningful relationships with other residents and staff was a critical factor in increasing mental health (see also Barkay & Tabak, 2002; Cheng, 2009; Cummings, 2002). Complementing this work, there is some evidence for the negative experience that men may encounter in care. Based on interviews with 21 men in long-term care, Moss and Moss (1997) found that ageism, the relatively negative context of long-term care in general, and physical frailty threatened men's positive views of their masculinity, which had a negative effect on their psychological well-being (Moss & Moss, 2007; Thompson, 1994). Although these studies show a positive association between (social) engagement and well-being, they say very little about the mechanisms through which we gain social support. We believe that social identity approaches offer the theoretical framework needed to address this gap in the health literature.

*The social identity approach to health and well-being*

The findings reviewed in the previous section are consistent with, and could be explained by, recent research that has been informed by a social identity approach to health. According to this approach, membership in social groups, such as those centered in church, family, recreation, or work, are critical in forming a shared sense of identification through which people are able to understand who they are and gain the social support needed to protect and enhance health and well-being (see Haslam, Jetten, Postmes, & Haslam, 2009; Jetten, Haslam, Haslam, & Branscombe, 2009; Jetten, Haslam, & Haslam, in press). When these groups are internalized as

part of a person's social identity, they provide individuals with a sense of belongingness and connectedness to others because those others are incorporated into their self-definition. Hence it is not groups in and of themselves, but rather people's strength of identification with them that determines the degree to which they will be beneficial for our health. The stronger these identity-based ties are, the more people feel similar, close and responsible for others in the group (Levine, Prosser, Evans, & Reicher, 2005). In this way too, social identities provide a basis for the provision and receipt of effective social support from others (Branscombe, Schmitt & Harvey, 1999; Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005; Tajfel & Turner, 1979) and a resource in times of challenge (Jones & Jetten, 2010).

As alluded to earlier, the beneficial effects of such social support have been demonstrated in a range of contexts. People who have access to social groups live longer (e.g., Berkman & Syme, 1979; Durkheim, 1897/2000; House, Robbins & Metzner, 1982), show cognitive integrity (e.g., Baumeister, Twenge & Nuss, 2002), experience less pain (e.g., Platow, Voudouris, Coulson, Gilford, Jamieson, Najdovski, Papaleo, Pollard & Terry, 2007), are less prone to physical illness (e.g., Cohen, Doyle, Skoner, Rabin & Gwaltney, 1997), and experience enhanced life satisfaction (Knight, Haslam, & Haslam, in press; Park, 2009). However, fewer studies have shown the direct link between the strength of identification with others in supporting health and well-being. Crabtree, Haslam, Postmes, and Haslam (in press) showed that for individuals with mental illness, identification with others who were members of a relevant support group provided a basis for social support and had a positive impact on self-esteem by buffering them from the effects of stigma. Similarly, Jones and colleagues (in press) found that for individuals with acquired brain injuries (ABIs) the development of group-based social relationships (i.e., perceived support) promoted increased life satisfaction after these injuries. In both these studies receiving effective support from group members (i.e., others with a mental illness or an acquired brain injury,

respectively) with whom one shares a particular social identity had a positive impact on well-being (e.g., Cohen & Wills, 1985). In addition to these effects on well-being and life satisfaction, identity processes have also been shown to influence cognition. For example, Jetten, Haslam, Pugliese, Tonks, and Haslam (2010) found that older people's sense of identity helped them counteract, and adjust to, the negative effects that memory loss has on well-being. Whilst memory decline is often considered simply in medical or biological terms, these data highlight the importance of complementing medical models with those that examine the social dimensions of memory loss.

Despite the clear role for identity processes in protecting and promoting mental health and well-being, this is rarely a focus for treatment or intervention in residential care. Recently, however, researchers have sought to redress this situation. First, Knight, Haslam and Haslam (in press) showed that when a group was established within which care residents were empowered to make decisions about the décor of a new care facility, this had a positive impact on their levels of social interaction and their identification with fellow residents and staff. Significantly too, this also led to improved mental and physical well being, as assessed by both self-report and care staff ratings (see also Gleibs, Haslam, Haslam, & Jones, 2010a). Along slightly different lines, Haslam, Haslam, Jetten, Bevis, Ravenscroft, and Tonks (2010) have shown that group-based interventions can enhance both the well-being and cognitive performance of residents in care. These researchers compared the effects of individual and group-based activities on well-being, arguing that the latter should have an advantage over the same activities delivered on a one-on-one basis because they are more likely to foster a sense of shared social identity. Consistent with this argument, it was found that only group-based interventions improved residents' cognition and well-being — with group reminiscence enhancing memory performance and group skittles enhancing subjective well-being. In both cases there was evidence of maintained sense of social



identification with others in care, whereas one-on-one reminiscence not only led to a reduction in such identification but was also associated with no enhancement in either cognition or well-being.

In summary, it appears that positive interaction and engagement with others is the basis for development of a sense of social identification from which positive effects on various dimensions of health (physical and cognitive), social functioning and well-being emerge (see also Amiot, Terry, Wirawan, & Grice, in press; Blader & Tyler, 2009; Gleibs, et al., 2010a). Helping people to develop such identification by encouraging them to build new and meaningful social ties is therefore an important vehicle via which we are likely to achieve positive health outcomes.

#### *The present study*

As noted in the introduction, the relatively negative context of long-term care in general and the lack of social support and engagement for older adults in these settings may decrease psychological well-being. These challenges might be even greater for men, who are typically the numerical minority in care and have greater difficulty in drawing effective social support — two factors which contribute to their increased isolation relative to women. Importantly, though, previous research also shows the restorative value of strategies for increasing social engagement in residential care homes. In particular, there is growing evidence which points to the value of group-based interventions, that enhancing well-being by increasing individuals' sense of shared social identification and thereby provides a basis for the provision and receipt of effective forms of social support.

Extending this line of research, the present study sought to investigate the impact of a social group intervention that had a gender focus on residents' social identification and well-being. In this, it had a particular goal of seeking to enhance the well-being of men in long-term care. To this end, older people residing in long-term care were recruited to take part in a gender-based social group intervention, initiated by a care home provider, and these residents were followed over the course of

the initial 12 weeks of this intervention. On the basis of a social identity approach to health, we predict that participation in gender-based groups should be associated with positive outcomes because group interaction provides a basis for participants to build a sense of shared social identity (a sense of ‘us’) that (1) strengthens their sense of personal identity or the notion of a sense of self (Postmes & Jetten, 2006), (2) encourages cognitive engagement (Ertel et al., 2008; Haslam et al., 2010), and (3) promotes well-being (Haslam et al., 2009; Knight et al., in press). However, because men’s identities are likely to be more threatened than those of women in this context, we also expected that they would stand to benefit more from the process of social identity building and hence would benefit most from this intervention.

## Method

### *Participants*

Initially, 30 residents (18 female, 12 male; Age:  $M = 85.34$ ,  $SD = 7.94$ , range 62-99) across six care homes (Care home (CH)1:  $n = 8$  [ $n_{\text{male}}=4$ ], CH2:  $n = 2$  [ $n_{\text{male}}=2$ ]<sup>1</sup>, CH3:  $n = 3$  [ $n_{\text{male}}=1$ ], CH4:  $n = 3$  [ $n_{\text{male}}=3$ ], CH5:  $n=9$  [ $n_{\text{male}}=3$ ], CH6:  $n=5$  [ $n_{\text{male}}=0$ ]) were recruited into the study. All were residents of residential care homes run by the same provider in the south-west of England, Cornwall Care. Four participants (13%; all female) were unable to complete the study due to ill-health ( $n=3$ ) or were unavailable for an interview at the time of data collection ( $n=1$ ). Accordingly, the final sample comprised of 26 residents (14 female, 12 male; Age:  $M = 86.06$ ,  $SD = 7.94$ , range 70-90 years) across the six homes (CH1:  $n = 7$ , CH2:  $n = 2$ , CH3:  $n = 2$ , CH4:  $n = 3$ , CH5  $n=8$ , CH6:  $n=4$ ).

### *Procedure*

The Psychology Ethics Committee at the researchers’ university provided approval for the study. Care home residents were contacted by their managers with a view to taking part in a study on ‘engagement and well-being in residential care’. Managers contacted residents and invited them

to join a gender club – either a Gentlemen’s or Ladies Club. For the purpose of the present research, outcomes were monitored at two time points (within four weeks of commencement of the clubs and 12 weeks after the first measurement point), though the intention was that the clubs would continue beyond this point. Participants could generally choose the activities in which the group took part. These activities included outings (e.g., to museums), flower arranging (female only), movie afternoons, and lunch-time outings. Groups met on a fortnightly basis and were facilitated by one staff member of the care home, who was of the same gender as the group members. Generally, the activities were chosen by the members of the club and did not follow a specific program. Participation was voluntary and rather informal and participants chose to take part in each session. Meetings were at a fortnightly basis and where both ladies and gentlemen's club existed in the same care home the meetings alternated on a fortnightly basis. All facilitators were experienced care staff, had introductory training in delivery of the activity, and could ask the Education and Training Coordinator of Cornwall Care for support if needed.

The study was designed to evaluate the effect of gender clubs on the well-being of participants. Participants were interviewed at both measurements points. One member of the research team met with participants individually to administer the survey, which took approximately 45-60 minutes to complete.

### *Materials*

A series of measures was administered at two time points to assess identity, cognitive ability, and well-being. If not stated otherwise, responses were given on five-point scales (1=*completely disagree*, 5=*completely agree*). The first page contained some demographic questions (Time 1 only) and we provided details about the study as a whole. The questionnaire assessed five key constructs as described below.

Two scales were used to assess social identification with others in care and personal

identity strength (Jetten et al., 2010).

(1a) *Social Identity* was measured with two items adapted from a social identification scale developed by Doosje, Ellemers and Spears (1995). The items were “I see myself as a member of [care home].” and “I am pleased to be a member of [care home].” and they were highly correlated,  $r_{t1} = .70, p < .001, r_{t2} = .80, p < .001$ .

(1b) *Personal Identity Strength*. This scale comprised five items ( $\alpha_1 = .72, \alpha_2 = .63$ ) to assess the extent to which participants had a clear understanding of who they were. The items were adapted from a self-clarity scale developed by Campbell, Trapnell, Heine, Katz, Lavallee, and Lehman (1996) and a personal identity strength scale devised by Baray, Postmes and Jetten (2009). Both measures have recently been used to assess identity strength in older adults (Haslam, et al., 2010; Jetten et al., 2010). These items were: “I know what I like and what I don’t like”, “I know what kind of person I am”, “I have strong beliefs”, “I know what I want from life”, and “In general, I have a clear sense of who I am and what I am”. Higher ratings indicated a stronger understanding of self.

(2) *Cognitive ability* was measured with the *Addenbrooke’s Cognitive Examination Revised* (ACE-R; Mioshi, Dawson, Mitchell, & Arnold, 2006). The test has been widely used in previous research and assesses performance in five domains: attention/orientation, memory, verbal fluency, language, and visuospatial ability. Scores from each domain are summed to give a total out of 100. The ACE-R is sensitive to dementia (a score less than 88 gives 94% sensitivity and 89% specificity for dementia) with good sensitivity and specificity in diagnosing dementia (Mioshi et al., 2006).

Well-being was indexed using two measures:

(3a) *Life satisfaction* was indexed using a single item; “I feel frequently satisfied about

myself" (Andrews & Whitney, 1976).

(3b, 3c) The *Hospital Anxiety and Depression Scale* (HADS; Zigmond & Snaith, 1983) was used to assess both *anxiety* (seven items) and *depression* (seven items). This test was designed for use in medical outpatient clinics in order to detect clinical cases of anxiety and depression and to assess the severity of anxiety and depression separate from physical symptoms (the latter being a common confound in assessment of these variables in older adults). However, it has been used (e.g., Haslam et al., 2010) and recommended for use (e.g., Clare, 2002) with older adults, particularly for those with dementia. Each item is rated on a four-point scale (from 0 to 3) with lower scores indicating lower levels of anxiety and depression.

## Results

Scores on all measures were subjected to a 2 Gender (male, female) X 2 Time (Time 1, Time 2) mixed ANCOVAs with Time as the within-participant factor and age as the covariate. Relevant means, standard deviation and statistics are presented in Table 1<sup>2</sup>.

### 1. Identity

*Social identification.* In line with prediction, we found a marginally significant interaction between time and gender,  $F(1, 22) = 3.70, p = .06, \eta_p^2 = .14$ . This reflected the fact that for male participants, identification was low at T1 ( $M=3.12, SD=1.31$ ) but increased over time ( $M = 3.87, SD = 1.22; p = .09^3$ ), while for female residents identification was initially higher than it was for men ( $p = .02$ ) and did not change significantly over time (T1:  $M = 4.16, SD = 0.68$ ; T2:  $M = 3.91, SD = 1.14; p = .44$ ). No other effects were significant, all  $F_s < 2.1, p_s > .27$ .

*Personal identity strength.* Analysis revealed a significant main effect for time,  $F(1, 22) = 7.99, p = .01, \eta_p^2 = .27$ , but no main effect for gender,  $F(1, 22) = 0.30, p = .57, \eta_p^2 = .01$ , and no interaction between time and gender,  $F(1, 22) = 0.80, p = .78, \eta_p^2 = .004$ . This effect reflected the

fact that for both female (T1:  $M = 3.80$ ,  $SD = 0.93$ ; T2:  $M = 4.35$ ,  $SD = 0.56$ ;  $p = .04$ ) and male participants (T1:  $M = 3.97$ ,  $SD = 0.76$ ; T2:  $M = 4.42$ ,  $SD = 0.44$ ;  $p = .08$ ) there was evidence of an increase in personal identity strength over the period of the intervention.

## 2. Cognition

We examined whether male and female participants differed in terms of their cognitive ability - as assessed by ACE-R scores - and whether engagement in the Gentlemen's or Ladies clubs had an effect over time. This analysis revealed a marginally significant main effect for gender,  $F(1, 20) = 3.53$ ,  $p = .075$ ,  $\eta_p^2 = .15$ . Among female participants cognitive ability was higher (T1:  $M = 57.00$ ,  $SD = 26.98$ ; T2:  $M = 60.38$ ,  $SD = 28.71$ ), than for male participants (T1:  $M = 42.50$ ,  $SD = 18.82$ ; T2:  $M = 43.30$ ,  $SD = 18.79$ ). Neither age as a control variable, change over time, or the interaction between time and gender revealed any significant effects, all  $F$ 's  $< .50$ . There is thus no evidence that cognitive function changed as a result of engagement in the gender-based groups. Generally, female participants displayed superior cognitive ability to males, but this effect did not reach conventional levels of significance.

## 3. Well-Being

*Life satisfaction.* Analysis of this measure revealed a significant interaction between time and gender,  $F(1,21)=4.88$ ,  $p=.04$ ,  $\eta_p^2=.19$ . This reflected the fact that, for male participants, life satisfaction increased from T1 ( $M=2.80$ ,  $SD=1.39$ ) to T2 ( $M=3.70$ ,  $SD=1.70$ ;  $p=.09$ ). For female residents life satisfaction was significantly higher at T1 ( $M=4.00$ ,  $SD=1.11$ ) than it was for men ( $p=.03$ ) and did not change over time (T2:  $M= 3.79$ ,  $SD=1.12$ ;  $p=.42$ ). No other effects were significant, all  $F$ 's  $< 1.7$ ,  $p > .21$ .

*HADS-Depression.* The analysis of *depression* scores also revealed a significant interaction between time and gender,  $F(1, 21) = 4.86$ ,  $p = .04^4$ ,  $\eta_p^2 = .18$ . In line with our findings

for life satisfaction, male participants' depression was higher at T1 ( $M = 5.27$ ,  $SD = 3.52$ , range from 0-15<sup>5</sup>) but decreased significantly ( $p = .03$ ) at T2 ( $M = 2.36$ ,  $SD = 2.29$ , range 0-6). For female participants depression at T1 ( $M = 3.00$ ,  $SD = 2.38$ , range 0-8) and T2 ( $M = 2.69$ ,  $SD = 2.46$ , range 1-9) was lower than it was for men ( $p = .047$ ) and there was no significant change over time ( $p = .62$ ). No other effects were significant (all  $F$ s  $< 2.1$ ,  $p$ s  $> .15$ ).

*HADS-Anxiety.* Similar results were found for *anxiety*. Again, the only significant effect was an interaction between time and gender,  $F(1, 21) = 4.86$ ,  $p = .04$ ,  $\eta_p^2 = .19$ . Among male residents anxiety was initially higher (T1:  $M = 5.36$ ,  $SD = 3.64$ , range 0-12) but this decreased over time (T2:  $M = 3.36$ ,  $SD = 2.50$ ;  $p = .09$ , range, 0-7). For females, anxiety was initially lower than it was for men (T1:  $M = 2.76$ ,  $SD = 2.86$ ,  $p = .05$ ). This increase over time was not significant (T2:  $M = 3.53$ ,  $SD = 3.47$ ;  $p = .39$ ). None of the other effects approached significance, (all  $F$ s  $< 1.2$ ,  $p$ s  $> .27$ ).

Overall, then, the pattern of results for the well-being measures showed that participation in the gender-based club was especially beneficial for men. Accordingly, while well-being was maintained at reasonably high levels over time for women who participated in Ladies Clubs, participation in the Gentlemen's Club increased men's life satisfaction and decreased their depressive symptoms. Contrary to prediction, there were no significant effects on cognition.

#### 4. Relationship between variables

On the basis of the social identity approach, we argued earlier that social identification should generally be associated with enhanced well-being. Thus, we should find that social identification is negatively correlated with depressive symptoms and anxiety, but positively correlated with life satisfaction. In line with this reasoning, we found that social identity at T2 was negatively associated with depression at T2,  $r(23) = -.37$ ,  $p = .04$ . This effect also remained

after partialling out the effects of age ( $r_p(21) = -.40, p = .03$ ). Identification and anxiety were also negatively related,  $r(23) = -.10, p = .31$ , but this effect was not significant. Social identity was also positively correlated with life satisfaction,  $r(23) = 0.23$ , but this effect non-significant,  $p = .14$ .

### *Discussion*

The present research was designed to investigate the potential benefits for health and well-being of creating gender-based social groups — specifically, a Ladies and Gentlemen’s Club — for residents in long-term care. Three key findings emerged from the study. First, we found that the engagement in gender-based social groups was especially beneficial for male participants. Participating in a Gentlemen’s Club led men to report higher levels of life satisfaction, and at the same time it reduced symptoms of depression and anxiety. Moreover, it also led participants to report higher levels of social identification with other members of their residential community. Significantly too, at the beginning of the intervention several of the male residents were found to experience problematic levels of depression (i.e., scoring  $> 8$ ; Westoby et al., 2009;  $n = 4$  (33%)) and anxiety ( $n = 3$  (25%)), but after 12 weeks, no-one reported symptoms above the benchmark of 6 (indicating no anxiety/depression). Second, for female participants, general well-being and identification was high to start with and both were maintained over the course of the intervention. Third, the gender-based groups led to higher levels of personal identity strength for male and female residents, thus enhancing participants’ understanding of who they were as individuals (a pattern that accords with effects previously reported among support groups established to support individuals with acquired brain injury; Jones et al., in press). However, there was no evidence that gender-based social clubs led to improved cognitive performance for either men or women. While this finding appears inconsistent with reports that social relationships can arrest the cognitive decline of people living in the community (e.g., Ertel et al., 2008), it mirrors evidence



from recent studies in which cognitive benefits were only observed if groups had a strong cognitive focus (e.g., stimulating memory through group-based reminiscence; Haslam et al., 2010).

As outlined earlier, gender differences in longevity have led to an imbalance in the numbers of older men and women in society and in care. This “feminisation” of the older population (Fleming, 1999) has resulted in an emphasis on older women in (sociological) gerontological research. Moreover, academics, and as well as care institutions, have a tendency to treat older people as de-gendered (Thompson, 1994; Silver, 2003). The gender imbalance and the de-emphasis on gender identities can have important implications for men’s psychological well-being and the way they think about and perceive themselves. For example, Canham (2009) argued that getting older might be especially challenging for men because they will tend to compare themselves to a dominant masculinity script and become aware that they fail to match its prescriptions. More specifically, masculinity is a cultural construct and is (in a Western society) related to behavioural and affective traits such as toughness, power, control, independence, restricted emotions, assertiveness, and aggressiveness that we associate with “being a man”. Yet, institutionalisation in a care setting is almost by definition related to a loss of control, power, independence, and the opportunity to act assertively (or aggressively) (Iwasiw et al., 2003). Thus, for men in particular, living in care might enhance perceptions of losing an important part of their social identity and lead to a sense of personal distress (Canham, 2009). In line with this suggestion, Barefoot, Mortensen, Helms, Avlund, and Schroll (2001) observed that men, but not women, showed an increase in non-somatic depression symptoms from age 60 onwards. Barefoot and colleagues explained these results in terms of a shift of social roles and that the loss of social networks might be greater for men than for women (see also Moss & Moss, 2007). They further argued that the experienced loss of their identity as a man, which might be related to the

perception of decreased social support, might be associated with increased depressive symptoms (but see Bergdahl, Allard, Alex, Lundman, & Gustafson, 2007; Djernes, 2006).

In line with this argument, the findings of the present study suggest that giving men the opportunity to interact and engage with other men in care can have positive benefits. On the basis of the social identity approach, we would argue that this is because the creation of gender groups (in this case a Gentlemen's Club) allows them to counteract experiences of marginalisation by sharing gender-related experiences. Although we did not include a measure of marginalisation in the present study, we have qualitative data from the same group of participants that suggests that men were aware of their minority position. One man, for example, said in a follow-up interview (see Gleibs, Sonnenberg, Haslam, Jones, & McNeill, 2010b), "There are only what, really six blokes here. At one time, it was all female." Yet another explained, "When we have dinner in the dining room, we have our tables and the ladies would be on their seats and you would be on your own. I don't think there are many men here".

Yet, by being part of a gender-based group, we could show that men's social identification with the care home increased and that these participants in particular were able to (re)develop a sense of shared identity. Here, then, it appears that the gender-based group serves as a source of social support that can enhance health and well-being by increasing residents' identification with those around them (Gleibs et al., 2010a; Knight et al., in press). This was expressed eloquently by a male resident, who stated after the intervention, "Yes, we become a team, a team."

To strengthen this case, it would be useful in future research to include a measure of residents' identification with their club, which was not included in the present study because the groups were the informal and hence we focused on the more stable group membership of the care home itself. It is also the case that, through participation in gender-based groups, we were hoping to increase residents' general sense of identification with the care home and its community and not only a more

subordinate identity with the social group itself. In this way, we hoped to enhance residents' sense of "feeling at home" in the home, as a crucial basis for social support. This idea is in line with research by Tyler and Blader (2003; Blader & Tyler, 2009; see also Knight et al., in press) who have demonstrated that positive interactions with others (associated with fair treatment) can help to build a wider sense of shared identity, and that this can have a range of positive effects on social and organizational functioning (see also Amiot et al., in press; Gleibs et al., 2010a).

For women we found little change in well-being (life satisfaction, mood) and identification over the course of the intervention. This does not, however, indicate that this social group intervention had no positive impact on women's life in care. In fact, the mean ratings of the life satisfaction scale as well as the social identity measure were high at the commencement of the study (mean range = 3.80 to 4.46 on a five-point scale) and those for depression and anxiety were correspondingly low (mean range = 2.69 to 3.53, and all well below the critical value of 8), which may indicate that ceiling and floor effects precluded opportunities for further improvement.

Importantly, for all participants we found an increase in personal identity strength. Thus, it would appear that one of the positive consequences of taking part in a gender-based social group was that it gave all residents the opportunity to reinforce and consolidate their understanding of who they are. This observation is in line with suggestions that being part of a meaningful group can provide its members with a heightened understanding of themselves as individuals that can have a positive impact on well-being (e.g., Jetten et al, 2009; Jones et al., in press; Sani, Bowe, & Herrera, 2009).

#### *Limitations and future research*

Although this study provided support for our hypotheses, our capacity to draw definitive conclusions on the basis of its findings is clearly limited. In particular the study's sample size was small and this, in turn, placed some constraints on the statistical analyses performed. Having said this,

effects were all medium in size (explaining between 14-27% variance of the respective outcome variable) suggesting that there is a reasonable justification for investing effort in conducting further studies of this type to replicate and extend our findings.

Moreover, although the main findings of this study are consistent with previous theorising and empirical work, further research is needed to explore the causal sequence of relationships between variables. Not least, this is because alternative causal pathways (e.g., relating to the relationship between negative mood and identity) are both possible and plausible. Another concern might be that our sample consisted of exclusively White-British participants and we did not request information about sexual orientation. Thus, while we argue that greater social engagement will increase well-being, we assume this on the basis of a relatively homogenous group of participants with no apparent cultural diversity.

We were also somewhat restricted in the number of items we could use, given our concern to reduce the burden on participants and avoid overload. However, fruitful future avenues for research would be to include measures of perceived social support and importance/enjoyment of the social activity. From some of the qualitative interviews we conducted after the completion of this study, we know that participants enjoyed the activities and talked about the importance of the social club. For example, one male resident noted, “Yes, (.), I mean I think it’s [the club] essential, I mean when you are confined to a place like this (...) I looked forward to it greatly.” In answer to the question: “How important is the men’s club?” another male resident said, “Important- quite yeah- when you belong to something you have got to put it first.” A female resident said, “If it wasn’t for the Club, I’d nothing, they have coffee mornings here but it’s not the same.” (Gleibs et al., 2010b).

As we did not directly measure social support we also have no direct evidence for our suggestion that it is in fact membership in the gender-based club that enhanced perceived social

support. We have, however, recently obtained evidence for this assertion in another intervention study conducted in care (Gleibs et al, 2010a). In this study, where water clubs were implemented, we found positive effects of social support on the well-being of the older adults who took part and these were partly attributable to its capacity to build a sense of shared social identification (for a similar demonstration see also Knight et al., in press). This finding, in addition to the present study, points to the importance of group membership for maintaining and promoting mental health for older adults in residential care.

In the present case, the fact that this study did not have these features is largely a reflection of resource constraints and geographic location. Relatedly, it also reflects the logistical challenges that arise from conducting intervention studies of this form. Importantly, though, we believe that the present study provides evidence that can be used as a basis both for conducting further research to test the ideas that we have outlined, and for justifying the funding that would be required to conduct a study of sufficient scale to address the limitations we have identified.

Moreover, despite its shortcomings, we would argue that the value of the present study lies in its ability to test and support specified theory-based hypotheses (see also Michie & Abraham, 2004). Generalization is thus made not on the basis of the data per se, but on basis of the theory that these support (Turner, 1981). And here confidence in our conclusions is strengthened by the fact that the present findings are consistent with hypotheses derived from a large body of research in the social identity tradition (Haslam et al., 2009).

#### *Concluding comment*

In the context of our aging population, there is currently a great emphasis on maintaining and, if possible, enhancing the well-being of older adults in care (Ice, 2002; Joseph Rowntree Foundation, 2009). Our findings are important in their own right and are consistent with a growing literature, which supports a social identity approach to health and well-being (Haslam et

al., 2009; Jetten et al., 2009, in press). Moreover, the present findings are consistent with claims that group-based activities are an important vehicle for delivering interventions to this population (Haslam et al., in press). Additionally, the study supports the claim that more research on activities for people living in care homes and their effects on psychological well-being is needed (Harmer & Orrell, 2008). Generally, this work is consistent with social psychological literature, which sees social groups and activities as central for life experience — especially when they add structure and meaning to people’s perception of their environment. In this respect we argue that the development of meaningful groups can prove especially beneficial for men in long-term care by providing them with the social and psychological resources to meet and overcome the particular changes and challenges they face (Jones & Jetten, 2010). This point was made rather more straightforwardly by one male resident when he remarked: “The club has saved my life.”

This point is one that we note with some irony, for in earlier phases of the life cycle there is evidence that exactly these same processes can prove beneficial for women. In particular, when women find themselves marginalised because they constitute a numerical (and power) minority in the workplace, there is evidence that they can derive significant benefits from gender-based support groups (e.g., women’s networks) that allow them to develop a sense of meaningful social identity and thereby deal more effectively with the range of challenges they face (Hersby, Ryan & Jetten, 2009; see also Haslam & Ryan, 2008). Yet, where such networks are established, it is not uncommon for them to be ridiculed and dismissed — typically by men — on grounds of inequity.

It may be the case, then, that by seeing social identity-based support groups as a solution to the problem of there being ‘no country for old men’, we are in a better position to see why these can be also be a solution for other marginalised groups in society. In this, we may be afforded insights that allow us not only to create better countries (and communities) for members

of this one group, but better countries (and communities) for all.

### *Acknowledgement*

Work on this paper was supported by a grant from the Economic and Social Research Council (RES-062-23-0135) awarded to the second and fourth authors and a British Academy Small Grant (SG-52142) to the first three authors. The authors would like to thank Pamela Bretschneider, Kathryn Bristow, Jo Hague, and Sonya Saroyan for help with the data collection. We are grateful to staff and residents of Cornwall Care Limited for allowing us to conduct this research and for their help in the facilitating the study.



## *Notes*

<sup>1</sup> More men were members of the gender-based group ( $n = 2$ ) but not available for data collection due to ill-health.

<sup>2</sup> While MANOVA is often used instead of repeated ANOVA, the sample size in this study was relatively small and hence the power of this analysis would be limited. Accordingly, we followed the practice of previous similar studies (Jetten, et al., 2010; Haslam et al., 2010) and conducted a series of univariate ANCOVAs to test the particular effects we predicted as opposed to a single MANOVA (Huberty & Morris, 1989).

<sup>3</sup> All pairwise comparisons are based on Bonferroni adjustments for multiple comparisons.

<sup>4</sup> The Bonferroni adjusted p-value for the well-being measures is .013. A Bonferroni correction accounts for a possible alpha-inflation because of our multiple-testing and uses a family-wise error adjustment. The usefulness of this correction and the interpretation are considered disputable. For example, adjusting for the Type 1 error decreases power and increases the risk for a Type II (or false-negative results; Feise, 2002; Perneger, 1998). To disentangle this dilemma, and to lower the alpha-level and maintain the beta-level at the same time, we would need to increase the sample size, which was not possible in the present study and thus limits the conclusions we can draw from this study.

<sup>5</sup> A score of 0-7 represents no anxiety/depression, 8-10 mild, 11-14 moderate and 15-21 severe anxiety/depression. A score of 8 or more is recommended for use in the UK National Health Service to represent the presence of depressive symptomatology (Westoby, Mallen, & Thomas, 2009).

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Table 1. *Residents cognitive ability, well-being and identification (Means and Standard Deviation)*

<i>Measures</i>	<i>Gender</i>	<i>Time</i>		<i>F-values</i>		
		T1	T2	Gender	Time	Gender x Time
(1 a) Social Identity	Female	4.16 (0.68)	3.91 (1.14)	2.06	.93	3.71 <sup>+</sup>
	Male	3.12 <sub>a</sub> (1.31)	3.87 (1.22)			
(1 b) Personal Identity Strength	Female	3.80 (0.93)	4.35 (0.56)	0.33	7.99**	0.08
	Male	3.97 (0.76)	4.42 (0.44)			
(2) ACE-R	Female	57.00 <sub>a</sub> (26.98)	60.38 <sub>a</sub> (28.71)	3.53 <sup>+</sup>	.10	.20
	Male	42.20 <sub>a</sub> (18.82)	43.30 <sub>a</sub> (18.79)			
<i>Well-Being</i>						
(3 a) Life Satisfaction	Female	4.00 <sub>a</sub> (1.11)	3.79 (1.12)	1.66	0.19	4.88*
	Male	2.80 <sub>a</sub> (1.39)	3.70 (1.70)			
(3 b) Depression	Female	3.00 <sub>a</sub> (2.38)	2.69 (2.46)	1.62	0.21	4.86*
	Male	5.27 <sub>a</sub> (3.52)	2.36 (2.29)			
(3 c) Anxiety	Female	2.76 <sub>a</sub> (2.86)	3.53 (3.47)	1.21	1.96	4.86*
	Male	5.36 <sub>a</sub> (3.64)	3.36 (2.50)			

*Note:* \*\*p<.01, \*p<.05, <sup>+</sup>p<.10

Means with the same subscript indicate a significant difference between female and male participants (p≤.05, two-tailed tested); there are no significant differences between male and female participants at Time 2.