Ageing well in the community: social representations of well-being promotion in later life

A Cambridgeshire-based study in collaboration with the University of Cambridge and Age-UK Cambridgeshire, funded by Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (Brazil) and Cambridge International Scholarships

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January 2017

ACKNOWLEDGEMENTS

The researcher, Bruno Medeiros, would like to take this opportunity to thank the clients, families, and staff members and volunteers at Cherry Tree Day Centre, Ambury Road Day Centre, and The Oasis Centre; who kindly gave their time to participate in this study. I am also extremely thankful to the visitors and clients involved in the visiting scheme. Your openness and insights were very helpful during this project. Furthermore, I would like to thank Lynne Byrne, Gloria Culyer, Beverly Young, Dee Potter for their invaluable help and support for this project. Finally, I am thankful to Allyson, Mickey Hewitt-Illes, Ann Tait, Lynne Hayden, and all the lovely staff members and volunteers who collaborated with me during my fieldwork in the day centres. I have learned so much with your experience of supporting the elderly.

CONTENT

INTRODUCTION

This study aimed to explore well-being in later life and how best to promote it. The researcher was primarily interested in service users' perspectives of what it means to feel well in later life. To explore these views, he conducted an ethnography of day centres and the visiting scheme at Age-UK Cambridgeshire. In so doing, he observed practices of support and interviewed clients, family caregivers, and staff members and volunteers. Different opinions, ideas and beliefs about well-being promotion were compared and combined to provide a holistic picture of service provision. Previous research has mainly focused on older adults, not considering the impact of other groups (families, volunteers) in defining wellness and interacting with the elderly.

Research shows evidence on the role of communities in mediating health-related practices (Campbell & Jovchelovitch, 2000; Howarth, Foster, & Dorrer, 2004) and well-being (Thoits 2011). However, much is yet to be known about the role of communities in promoting health. This report provides a summary of findings from this study that was designed to address this gap, with a view to promoting better services to the elderly.

Therefore, firstly, a short review of the rationale for this study will be presented. Relevant concepts associated with ageing will be discussed to clarify the importance of studying well-being in later life. Secondly, I will describe the study design, characteristics of participants and settings, and the methods used to explore their views of wellness. I will also discuss my experience of participating as a volunteer in the day centres and how I got to know more about the support provided by the visiting scheme. Thirdly, I will

present the findings of my observations and interviews across different day centres and the visiting scheme. Finally, I will present important practical points to be further discussed in this organisation.

WELL-BEING IN LATER LIFE: WHY IS IT IMPORTANT?

Living longer constitutes both a reason for celebration and a concern in modern societies, as longer life expectancy challenges social and health care systems (European Union, 2012; Cambridge County Council, 2012; Qualls & Zarit, 2009). This increasing longevity affects the way in which western societies try to promote health and social care. For instance, in March of 2013, the House of Lords released The Select Committee on Public Service and Demographic Change report on the prospect and implications of the ageing population in the United Kingdom (UK). It stressed the need for adapting services and recommended changes in public policies, health, and social care systems. **In this context of renewed interest in ageing, well-being promotion has regained considerable attention in ageing societies.**

Two of the main policy responses to ageing populations took place in the field of social gerontology. Successful and active ageing policies constitute international and domestic frameworks with a clear focus on healthy ageing in western countries (Foster & Walker, 2015; Matzke, 2011; WHO, 2002). For instance, the World Health Organization proposed the concept of active ageing as an international framework for ageing healthily, even though notions of active ageing had been used in gerontology research during the 1960s (Kildal & Nilssen, 2013). As a policy framework, it refers to the "process of optimising opportunities for health, participation and security in order to enhance quality of life as people age," (WHO, 2002, p.12). The focus on "active" refers to continuing participation in all spheres of life, not simply being physically active or able to work.

Concomitantly this renewed interest in ageing, *happiness*[1] has become a major object of interest in local and international policies (Frawley 2015)**.** In the UK, new measures to appraise progress have moved away from a strict economic ethos (e.g. Gross Domestic Product) (Chiripanhura 2010). In this context, global assessments of quality of life, and, in particular, social and material well-being have been considered in government's attempts to promote flourishing (Thomas & Evans 2010).

Despite significant changes in policies regarding ageing, older adults have scarcely been consulted when policymakers design interventions that aim to promote well-being (Bowling, 2006). Furthermore, major demographic and policy changes demand the investigation of 'significant groups' directly collaborating with social care organisations, namely older adults and family caregivers. Although research has been done with older adults with severe mental health problems, less is known of the 'general population' of older people supported by informal caregivers and social organisations (Cohen, 2003; Cummings & Kropf, 2011; Hilton, 2005). Similarly, given the shift from a more institutionalised focus on health and social care to an increasing focus on informal care in the UK and elsewhere, family caregivers are also involved in planning and delivering mental health care for the elderly (Brown, 2010; Pickard, 2012, Qualls & Zarit, 2009; Stoltz et al., 2006).

[1] Definitions of happiness and its correlates (well-being, life satisfaction, flourishing) vary in both scientific and policy-oriented literature (Cromby 2011). In this study, I will adopt the terms happiness, human flourishing and well-being (wellness) interchangeably. Since works in social representations consider social understandings of all sensitive term such as mental illness, madness, mental health and well-being (Foster, 2001, 2003 Zani, 1995), I will focus on lay understandings of different groups about wellness. Nevertheless, I am aware of possible problems derived from the lack of a definition for happiness.

Empirical research suggests that collaborative management of mental health problems is regarded as more efficient than treatment conducted solely in specialized mental health services (secondary care) (Chew-Graham et al., 2004). In this context, voluntary organisations are also included in governmental and local plans for promoting (mental) health in the community (DoH, 2001; Cambridge County Council, 2012). Nonetheless, **there has been a scarcity of research that addresses the extent to which people working in voluntary social organisations make sense of these governmental changes and understand their role in promoting positive mental health to older adults in the community.**

Therefore, the ageing population and the increasing demand for adequate mental health services will require an in-depth investigation of how different social groups, directly involved in promoting mental health for the elderly, understand these new demands. Such understandings are usually translated into practice at a micro and macro levels. In this context, **this report will present empirical data on how groups involved in community support understand well-being promotion in later life.**

RESEARCH DESIGN

COLLABORATION WITH AGE-UK CAMBRIDGESHIRE

Throughout the project, I adopted a more collaborative approach to research which involved taking perspectives of different stakeholders into account when investigating well-being promotion (Barnes et al., 2013; Dewing, 2007; Langan & Morton, 2009). This collaborative approach involved constantly negotiating access to different groups amongst staff members and volunteers, and informing them about my research actions. Moreover, the ethnographic design enabled me to explore older adults' ideas of health and social support in a collaborative and spontaneous manner, particularly by interviewing them about their meanings of well-being promotion. I interacted constantly with them in the context of the day centre, adapting my questions and checking my interpretations with them in line with this process.

I conducted fieldwork in two settings: day centres and the visiting scheme. In December 2012, I met with the senior operations manager to discuss my ideas and ask for potential collaboration. We agreed upon the importance of evidence-based practice of supporting the elderly in the community, and the need to explore how Age-UK Cambridgeshire is practically involved in promoting mental health in later life. Additionally, the administrative board was interested in new ways of delivering support services, decreasing hospital admission, and acquiring evidence-based knowledge on their practices. We identified three main areas of research: 1) daily practices in day centres; 2) social support by different groups involved with the day centres; and 3) the visiting scheme.

In agreement with staff coordinators, three day centres were selected (Field Maple Day Centre, Aspen Day Centre, and Tulip Tree Day Centre). To maintain confidentiality, I will use pseudonyms to refer to day centres and participants. These locations reflect relatively different socio-demographic areas, ranging from an urbanised to a more rural context.

Within this organisation, relevant social groups are directly involved in providing psychosocial support in later life:

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

f) *Clients involved in the visiting scheme.* Clients who receive support via the visiting scheme. Their views on what brings well-being to their lives in the context of more social isolation and frailty.

DISTRIBUTION OF GROUPS

Field observations helped me to invite relevant informants to be interviewed. In other words, these **participants were regarded as holding strategic positions** within this organisation (Hammersley & Atkinson, 2007). They could explain concepts, rituals and practices in the day centres. In total, **I interviewed 59 informants** during the fieldwork[2]. Specifically, 27 clients (45%), 5 family members (10%) and 27 staff and volunteers (45%) agreed to participate in in-depth interviews. Clients' age ranged from 65 to 95 years old. **Clients' average age was 82 years old**. Most clients (n = 15, 57%) live in their own accommodation; the remainder of participants live in rented accommodations (n = 2; 7%), with family (n = 2; 7%), or in sheltered accommodations (n = 2; 7%), and only one lives in a mental health institution. Staff members and volunteers' age range varied from 26 to 89 years old. Staff members and volunteers' average age was 60 years old. Their experience of working and volunteering in day centres or the visiting scheme varied from six months to 28 years. Family members' age range varied from 46 to 92 years old, and their average age was 61 years old. The majority of this group (n = 5; 83%) were the main caregivers of older relatives with a form of dementia.

[2] Some interactions with participants were also included in the analysis. Informal conversations are relevant data sources in ethnography (see Foster, 2003b, for an example). They uncovered contextual meanings of daily practices in a more *natural* way.

Table 1. Distribution of participants in day centres,[3] Cambridgeshire.

Interviews in day centres				
Day Centre	Clients	Family members	Staff/volunteers	Total per setting
Field Maple	10	2	10	22
Aspen	8	3	3	14
Tulip Tree	6	-	3	9
Total per group	24	5	16	45

From the table above, one may question the **small number of family members in comparison with the other groups**. Recruiting relatives outside the daily life experiences of day centres proved to be difficult. Despite the efforts of staff to introduce me to the families, some of them did not show interest in the study or were not geographically located near the research setting. The most accessible ones were those who constantly visited the day centre, and interacted with staff and volunteers to support their older relatives. Eventually, my attempts at recruiting family members uncovered the social dynamics within those day centres.

In addition to these groups, I sought to include volunteers and clients who were enrolled in the visiting scheme. I hypothesised that this segment presents different expectations, experiences and opinions of services and care[4]. Table 2 presents the number of interviews with clients and volunteers in the visiting scheme.

[3] I used pseudonyms to refer to the day centres.
[4] The organisation's administrative board was also interested in knowing volunteers' and clients' views on *well-being* in different settings (day centres *versus* visits at homes).

Table 2. Distribution of participants – visiting scheme.

Interviews within the visiting scheme				
Visiting Scheme	Clients	Family members	Volunteers	Total
	2	1	11	14

The uneven number of participants reflects the characteristics of this group. Most of the older adults were in a vulnerable situation (e.g. illness, physical limitation, frailty) and were not willing to be interviewed at home. Open-ended interviews with clients and volunteers happened in different parts of Cambridge or villages surrounding this city.

Table 3. Socio-demographic characteristics

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

ETHICS

Before, entering the field, **the project was approved by the Psychology Research Ethics Committee at the University of Cambridge.** Additionally, since some of the participants were regarded as a vulnerable group (older adults aged 65 and over and suffering from physical and mental health conditions), I underwent an enhanced Disclosure and Barring Service (DBS) check with the voluntary organisation.

This procedure also allowed me to be a volunteer while I was observing people's interactions in the day centres. Additionally, it gave me access to participants in their residences, thus reaching more isolated groups within this charity.

For each interview, I informed clients, family members and staff and volunteers about the purposes of this encounter. Given the fact that they already knew my research objectives, I established a more appropriate rapport before each meeting. The font size of the Information Sheet was increased to enable participants with sight limitations to read it. Furthermore, I explained all details to all groups via the information sheets making sure participants took an informed decision to participate in this study. I also presented an Informed Consent Sheet to ensure that participation was informed and voluntary, and that informants had the right to withdraw at any time without having to justify their decision. Interviews were recorded and transcribed verbatim. Four research assistants[5] helped me to transcribe all data. They all signed a confidentiality agreement and received instructions on transcribing the material verbatim. I used the qualitative data analysis software ATLAS.ti 7 (Friese, 2014) to organise, code and systematise data from observations and interviews.

METHODS

This project consists of an ethnography of a voluntary organisation which supports older adults to live independently in the community. This approach to researching is defined as

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

'the study of people in naturally occurring settings of "fields" by means of methods which capture their social meanings and ordinary practices' (Brewer, 2000, p.10)

This case-oriented study focused on people's views of *well-being in later life* or *ageing well* and support mechanisms. Two main methods were used:

1) **Participant observation** – During the fieldwork, I volunteered to work in day centres, serving hot drinks, helping older adults to move around the day centres, setting up tables for meals, and assisting staff members in conducting group activities. **I spent six to eight weeks in each setting** and familiarised myself with staff, volunteers and clients as well as the daily routine of day centres. In this time, I had informal conversations with clients, volunteers and staff members, observed their interactions and invited some of them to in-depth interviews which explored meanings associated with their practices. Participant observation allowed me not only to familiarise myself with the research setting, but also to build **relationships of trust with members of daycentres (Banister, Burman, Parker, Taylor, & Tindall, 1994).**

2) **Individual interviews** – participants were asked to talk freely about 5 major themes extracted from my research questions and the ethnographic notes (See below**). Interviews with clients and volunteers happened in the day centres, coffee shops, and people's homes (in the case of clients involved in the visiting scheme).** The length of time for each interview varied from 21 to 82 minutes. For the visiting scheme, I contacted the visiting scheme manager and asked her to circulate an email explaining my research purposes and inviting participants to the study. As a second step, I asked the volunteers to contact their clients and enquire about their availability for interviews. This procedure aimed at

undermining any stress caused by being invited to an interview by a *stranger*. Before each interview, I sent an information sheet via email explaining the reasons for the study. In each meeting, I presented an Informed Consent Sheet and allowed participants to ask me any questions about the nature and implications of the study.

Table 4. Topic guide for the interviews

Themes explored during the interviews	
Psychological well-being in later life	Definitions of well-being; contextual features of well-being; impact of life experiences on well-being.
Changes in later life	Meanings of main cognitive and physical changes in later life.
Mental health in later life	Mental health promotion; experiences of living with dementia.
Role of the family	Family members' role in supporting the elderly; the relationship between families and the day centres.
Institutional support in later life	The role of the day centre in promoting well-being; clients and volunteers' views on the visiting scheme; rationale for the activities.

SUMMARY OF RESULTS

What are the conceptions of clients, staff members and volunteers regarding well-being in later life?

Overall, **well-being was defined as the result of many factors such as emotions, cognitive functioning, psychological resources, social support, and demographic changes**. Three main dimensions characterised well-being in later life: 1) Activity; 2) Independence; and 3) Psychosocial and physical gains.

I will present the main themes and the subthemes in the **table 5**. These results refer to their views, opinions and my observations of their interaction in both the day centres and the visiting scheme.

Table 5. Themes explored in the interviews

Definitions of Well-being in Later Life	
Main Themes	Sub-themes
Well-being is the outcome of an active lifestyle	• Active mind and body • Activity is a protective factor • Active engagement with life • Participation in the community
Well-being means independence	• Preserved independence • Preserved functionality • Preserved autonomy • Coping strategies to maintain independence
Physical and Psychosocial Gains	• Extended health • Well-being is a holistic state • Well-being due to a healthy lifestyle • Well-being is an outcome of adaptation • Positive mindset to feel well • Life satisfaction to feel well • **Well-being via family support** • Loneliness and Social Isolation

Activity

Overall, clients defined well-being as result of keeping an active lifestyle. *Human activity* is one of the most important factors in their multifaceted conception of well-being.

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

Corroborating Bowling's (2008) study on British lay views of active ageing, participants also view well-being as a function of keeping oneself mentally and physically healthy. They highlight the need to keep their minds and bodies functioning to avoid deterioration. Therefore, stimulating the body (via exercises, going out, household tasks) and the mind (via crosswords, puzzles, social interactions) are relevant resources to keep oneself socially active.

R[6]*: For you, what is psychological well-being?*

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

Victoria[7], 66 years old, client, Field Maple

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

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

Helen, 90 years old, client, Aspen Day Centre

[6] Throughout this report, I will use the initials R and P for researcher and participant respectively.
[7] I will use pseudonyms to refer to participants in this study.

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

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

Martha, 83 years old, client, Field Maple

Psychological well-being is not only seen as a function of the mind, but it involves bodily experiences, namely the possibilities and constraints imposed by the body. Both dimensions are intertwined in participants' representations as they draw a closer link between mind and body when defining well-being. In fact, clients share a functional representation of ageing well in which functionality is the underlying principle of the good life. Thus, psychological well-being is a reflex of positive interactions between an active mind and a fit body. These findings corroborate Vaillant's (1990) longitudinal study on determinants of successful ageing in a sample of 204 Harvard College sophomores. That study indicated a closer relationship between psychosocial aspects and physical health in healthy ageing. Clients emphasise that a balanced interaction between the mind and body protects them against what they consider a *natural deterioration with age.*

Passivity is associated with the ageing process. This emphasis on keeping physically fit and active as a sign of health and wellness was also shared be the volunteers.

… as long as we can still, it's good for us to go up and down stairs to keep ourselves, we try to keep ourselves as physically fit as we can...

Laura, 76 years old, volunteer, Field Maple

2) Activity as a protective factor in later life

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

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

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

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

Victoria, 66 years old, client, Field Maple

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

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

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

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

Jenny, 81 years old, client, Aspen

3) Active engagement with life

Clients also represent well-being as an outcome of a daily engagement with life. Performing house tasks, walking, buying, and driving all seem to contribute to a feeling of satisfaction with life. This emphasis is highlighted not only by clients but also by the visitors. Again, passivity is associated with the term *old age*.

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

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

Jenny, 81 years old, client, Aspen

… But the way I look at it, if you are 90 years old, you may as well keep doing what you are enjoying because, you know, you are not gonna live forever at 90, and do what keeps you happy and, you know, if it causes her… not [to] *feel as well, still she needs to do it because it's something that is important to her. And I never tell someone that they are old, you should take it easy. They know when they need to take easy, you know, just keep doing what you are doing.*

Michelle, 69 years old, visitor

clients reflect these professional and societal goals in stating the importance of functionality on a daily basis. These findings also corroborate previous research on the

value of unpaid activities in promoting a sense of wellness in later life (Boudiny & Mortelmans, 2011; Clarke & Warren, 2007; Ranzijn, 2010).

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

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

Jenny, 81, client, Aspen

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

Victoria, 66, client, Field Maple

Older adults' views constitute important markers of what sort of active engagement brings satisfaction. **In this study, active ageing means an active engagement with daily issues, and the ability to remain connected to previous social roles and daily occupations.** If, on the one hand, European social policies advocate a meaning of ageing based firmly on a normative framework of participation and economic productivity (Foster & Walker, 2015; Walker & Foster, 2013), on the other hand, older adults in community support share more modest views of activity. This was further supported by the absence of the categories of *work* and *paid job* in clients' social representations of wellness. Categories such as *work, paid job,* and

career have been found to be salient in social representations of wellness held by younger generations (Moreira et al., 2015). Absence of the category *work* in the representation of active life may also be a result of the advanced age of most clients in this study. As a result, this group tends to ascribe a different meaning to activity in advanced later life; one which reflects both their adjustments to daily issues and a cultural orientation towards healthy ageing.

4) Participation in the community

Well-being is also seen as the outcome of being engaged with society, particularly with neighbours, family members and fellow older adults. The realisation of being helpful, of participating in society or contributing to people's lives is relevant to life satisfaction and the reinforcement of an active identity. These views parallel the WHO's (2002) framework of active ageing.

> *I think…* [older people] *should have care, but I would encourage them to pay a little bit, for their own well-being, because then they know they're not living off the system.*
>
> Victoria, 66 years old, client, Field Maple

> R: *You don't, you definitely ... What do you feel when you don't go out?*
>
> P: *Well, I am so bored and useless, yeah.*
>
> R: *Why useless?*
>
> P: *Oh, because I am just sitting there. I have a carer coming to me every day like, they come in the morning, and they come in for tea so I like, and about five,*

six o'clock of nowhere to make sure I am alright, I take my tablets, ... because of my tablets, because I said, I wasn't taking them.

Anabelle, 84 years old, Aspen Day Centre

R:[8] *And tell me John. Nowadays, what are the things in your life that make you feel well?*

P: That make me feel well?

R: Yes, in your life nowadays?

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

John, client, visiting scheme

5) Reasons for volunteering

Staff members and volunteers justified their involvement in the day centres and the visiting scheme as a way of maintaining themselves active in the community. Their commitment to social support would serve as an important coping strategy to deal with loss of social roles as one progresses into later life.

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

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

Meryl, 66 years old, visitor

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

Sally, 67 years old, volunteer, Aspen

R: Why is so important for your coming here?

P: Well, because, otherwise... What in the world would I do stuck at home, … But, mhm, well I couldn't, I couldn't. I'd have to come here! If not, not here as a helper, as a bloody member [laughs]...

Julie, 89, volunteer, Field Maple

The roles of *helper* and *supported* are blurred in the experience of some volunteers who also face physical and social challenges associated with ageing. As described in Chapter Three, the age range of volunteers varied from 26 to 89 years old (M=60). Some of them have a long experience of volunteering in that organisation. Therefore, supporting others also serve as an important coping strategy to keep active and re-state value in old age.

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

Independence

Independence is a central component in clients' views of well-being. Previous research has demonstrated that the perception of independence is a central condition to age with quality (Knight & Ricciardelli, 2003). Clients understand independence as the capacity of being autonomous in taking decisions and be mobile.

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

Becky, 83 years old, client, Field Maple

R: What is well-being for you?

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

Jess, 82 years old, client, Aspen

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

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

Clare, 88 years old, client, Tulip Tree

It is not surprising that clients see independence as a core value in their lives – Physical limitations, social isolation and loneliness are the main threats for those unable to move socially.

1) The importance of functionality

Clients emphasised the need to preserve functionality in later life. Being functional means to be able to maintain social roles in life. Functionality is relevant if it enables them to maintain a view of themselves as active members of society. In this context, autonomy and environmental mastery (being able to perform daily tasks) are central components of their views of well-being (Hahn & Oishi, 2006; Ryff & Keyes, 1995).

P: No, I'm very independent. Yeah. I love to do things for myself. I couldn't have my daughter waiting on me.
R: Nice. What kind of things do you usually do?
P: I read a lot and I love to cook. I do a lot of cooking.

Melissa, 81 years old, client, Aspen

R: How do you see yourself?
P: I'm very dependent.
R: Very independent?
P: Very independent, yeah. I mean I do all my washing, I do all my housework, I do my own cooking, I do it all myself and I enjoy doing it and it keeps me busy.
Sally, 82 years old, Aspen

2) Active and Independent Identity

More than a functional state, **independence is an expression of how clients and volunteers see themselves (identity) in later life.** Being independent means to

have a positive assessment of someone's position in life. This subtheme was shared by both clients and volunteers.

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

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

Clare, 88 years old, Tulip Tree Day Centre

However, the idealised state of autonomy depicted by clients is not shared by community supporters. They tend to see **autonomy as desirable but not fully achieved state**, given the level of support older clients need to maintain themselves as active in the community.

And I think it's definitely nice for people to feel they have elements of independence certainly, isn't it? It's you know, it's very good for your psychological well-being to know that 'oh, if I want I can do that, if I want I can just pop down to the shop' ... So, it's definitely nice to know you have the ability to be independent I suppose if you are dependent in one area of your life it's nice to be ... have a feeling of independence in another, but yeah, it's not as straightforward as ....

Jeff, volunteer, Field Maple

The ideal state of independence is challenged by the day-to-day trials faced by some clients: physical limitations, financial constraints, cognitive problems, and limited mobility are some of their challenges. **Thus, a perceived loss of functionality and autonomy is a threat to someone's identity.** It is mostly manifested as a

form of ambivalent thinking, a conflict between a previous (and more active) way of being and a new and more limited mobile life.

At the moment, I feel sort of, I don't wanna do nothing, I can't do nothing on my own. I want somebody to guide me, to help me; but, then, I sit there sometimes and say, 'Why should I let other people do things for me while I can do [them] *myself?' And then, another thing is telling me 'No, let somebody else to do, somebody else do for you.' So, you've sort of like got two minds: one saying, 'Do it!' And the other one saying, 'Don't do it!'. And it is a choice on which one, which one I am gonna, I am gonna pick.*
Mike, 65 years old, client, Field Maple

In order to deal with these negative feelings and preserve a positive view of themselves, clients, family members and staff members and volunteers engage in different strategies. Next, I will present two of them.

2.1) Coping strategies to maintain a positive identity

Clients, staff members and volunteers and family caregivers come up with **two different, but interrelated strategies, to undermine the ambivalence of dependence and reaffirm an active identity: negotiating independence and assisting independence.** Figure 1 displays the interconnections between these symbolic and social actions and the complexity of issues faced by older adults, family caregivers and staff members/volunteers in community support. Physical, cognitive and social constraints are the main sources of feeling unwell or ambivalent about one's place in society. Therefore, clients negotiate the amount of support their receive whereas staff

members, volunteers and family caregivers assist older adults to preserve their functionality.

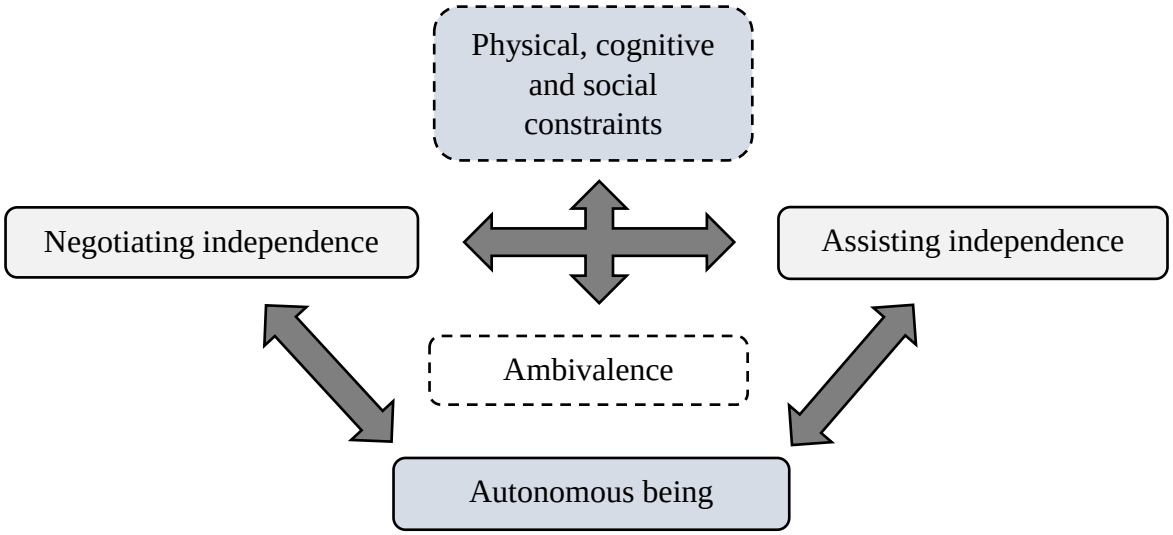


Figure 1: Identity negotiation to affirm an ‘independent identity’.

2.1.1 Negotiating independence

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

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

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

Karen, 83 years old, client, Field Maple

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

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

Julia, 84 years old, client, Aspen

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

Family caregivers also negotiate the amount of support they give to older relatives. Although support is deemed necessary, they feel ambivalent about removing their family members' sense of autonomy. This is clear in one of the family caregivers' narrative of daily support.

I try to give her as much independence as possible, because [sometimes] there is something she can't do, and it's unsafe, which I look at the health and safety point of view. But when this happened for the first time, I used to think, 'Right, I will take her independence away', because I was doing quite a lot for her. I let her dress herself, even though it's not appropriate to go out, you know, I let her dress herself.

Bob, 49 years old, family member, Field Maple

R: If you think about… from your perspective, on a scale from dependence to independence, how would you classify Beth nowadays?

P: She's probably, on a scale of 1 to 10, she's probably about a 6 to independence, so she's not bad, as in she's washing and dressing and feeding herself, and all those sorts of things. She's able to do the washing, it's just she does need help with the processing side of things so she's losing that little bit of independence. And she knows she needs money, and she remembers she needs money, and she can deal with money but she won't remember where she's put it, so that side of independence she's having to lose, because we're having to manage looking after it so it's safe, but I still want her to have access to it, so she knows how to use it still.

Sue, 50 years old, family member, Aspen

Family members negotiate diverse practices to foster their loved ones' sense of independence, as in the examples of collaborative decision-making and planning a monthly diary of actions. Similarly, in a day centre, a volunteer acknowledges the need to negotiate practices of support with clients. Behind

this concern is the fear of associating ageing with decay and vulnerability. The ambivalence is not completely removed through their actions of support.

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

Paula, volunteer, Field Maple.

2.1.2 Assisting independence

Clients define independence as a state of autonomy regardless of functional limitations. However, one is not able to enact such an identity unless supported by the community. This view was largely shared by staff and volunteers from the visiting scheme and the day centres as a form of justification of their actions of support.

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

Terry, 56 years old, volunteer, Tulip Tree

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

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

Paula, 48 years old, volunteer, Field Maple

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

Trevor, 26, visitor

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

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

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

Meg, 89 years old, client at Aspen Day Centre

Overall, clients perceive independence differently from staff members and volunteers. Clients see themselves *independent despite the presence of support,* whereas staff members and volunteers see the older adults as *independent via support*. This negotiation also has an impact upon people's well-being—the fact of seeing oneself as independent, although in need of assistance, brings security and a positive sense of identity. Furthermore, the idea of independence relates to their ability to decide on daily matters and use their minds to counterbalance physical limitations. Independence is not located in the body, but in the mind, that is, in people's conscious awareness of their reality and ability to make autonomous decisions.

Gains and losses in later life

Psychological well-being is also seen as the product of the interaction between gains and losses in old age. Participants highlight the complex interaction between emotional, physical and social aspects needed to promote wellness. In this context, they extend their concepts of well-being to comprise health and quality of life.

Beyond health, the physical body and quality of life, well-being is also related to social relationships. The presence of social support is a protective factor against isolation and deterioration. On the other hand, loneliness and social isolation are the main hindrances to participation in the community and receipt of adequate support.

1) Well-being involves extended health

Health status is highly valued among participants. In this case, well-being is possible due to a preserved health status. Nevertheless, participants stress that physical and cognitive limitations directly affect people's mobility and sense of autonomy in daily life; thus, preservation of health status is paramount. Similarly, studies on lay views of successful and active ageing point to a hegemonic representation of wellness as a preserved health status (Bowling, 2006; Jopp et al., 2015; Tate et al., 2013). In this context, as will be further explored below, representations of wellness in later life correspond to previous studies on health conceptions in later life (Flick, 2000; Flick at al., 2003; Herzlich, 1976).

R: What makes you or Beth feel well?...

P: Well, the only way I could answer that is that .... How would we feel happy? ... if Beth's[9] *condition just improved, which I know it …yeah so… well-being … it's health really.*

Sue, 50, family caregiver, Aspen

R: For you, what is well-being?

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

P2: And health.

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

Interaction between a client (Clara, 93) and her visitor (Diana, 73).

2) Well-being as a healthy lifestyle

Clients are more likely to define wellness as a product of their healthy behaviours during their lifespan. In fact, they attribute the responsibility for ageing well to themselves – that is to a healthy lifestyle. Keeping oneself cognitively and physically active, eating properly, sleeping well, exercising, and maintaining a stress-free life are considered adequate actions to age with quality. **In this case, elements of support may be overlooked as participants see wellness and health as their own responsibility.**

[9] Beth was diagnosed as having dementia. During the fieldwork, I was able to support her in the day centre. Her husband was the main caregiver. In fact, the day centre gives him relief two days a week from caring 24/7 for his wife. I observed that he is also active in the day centre, participating in activities and interacting with staff members and volunteers.

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

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

Betty, Aspen

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

Caroline, Tulip Tree

In the first account, going to the doctors is seen as a sign of illness rather than health prevention. The second client places the responsibility for living with quality only on herself, despite acknowledging the help provided by the day centre. Current ideologies associated with *healthy ageing* promote independent living as a way of reducing the burden of social and health care (Bowling & Dieppe 2005; Walker 2009). In Western societies, health and illness have been represented as a function of lifestyle (Flick, 2000; Murray, Pullman, & Rodgers, 2003). Therefore, they structure the way in which older individuals respond to health issues. In this case, these representations bring a moral orientation towards a healthy functioning and the construction of a collective identity, as discussed above (Marková 2011; Smith, 2003).

The idea of well-being as a healthy and individual lifestyle challenges the ethos of support within the day centre. This was particularly evident in the staff members and volunteers' views of clients' level of independence. Even though staff members draw boundaries on what they can provide as a voluntary organisation, they perceive their role as more vital than what is perceived by some clients. One of the day centres' drivers used the metaphor of *lifeline* to represent the support given to socially isolated individuals. In one of our meetings, Jack emphasised the benefit of the day centre in older adults' sense of wellness. "*So, it's really, really important that these day centres are kept open. It's not just a social thing. It really is* [a] *lifeline. It can be the only time they have contact with people"*.

This divergence in terms of responsibility for health and social needs could be explained by clients' identity work. The experience of illness, and cognitive and physical limitations may threaten their *active identities* as it demands further support and dependence. As a consequence, they seek to reaffirm an active and independent identity in later life. In this case, psychological well-being entails self-responsibility and protection for the self. Preserving autonomy constitutes a gain in later life, and might counterbalance their perceived loss in the physical domain.

3) Life satisfaction as an indicator of well-being

Clients and volunteers also state that well-being is the result of feeling satisfied with their lives. Satisfaction with life in the present, past and with someone's social position also relates to this concept. It involves an important coping process for dealing with physical limitations and cognitive problems as well as life economic issues.

But to, to feel well is to just accept what comes along and deal with it, and if you take that attitude, you just get used to it, don't you? Mm. You get on with it.

Julia, 79, client, Field Maple

R: … What do you think is psychological well-being?

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

Teresa, 35, volunteer, Field Maple

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

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

Martha, 84, client, Tulip Tree

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

Sarah, 82, client, Field Maple

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

4) Well-being via family support

Well-being is also located in older adults' relationships with their families. Help with daily issues (shopping, finances, walking etc.) and emotional support are some of the outcomes of family involvement in later life.

R: What makes you feel well in your life?

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

Ashley, 65, client, Field Maple

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

Betty, 81, client, Aspen

Beyond daily support, family is regarded as an important part of older adults' identities. This representation was also shared by one family member, who highlighted the importance of family relationships in coping with memory problems.

So, I guess maintaining social contact, and maintaining contact with the distant relations that we do have, so supporting the family that does exist, because that's the link back to my Mum's childhood, so that's quite important.

Peter, 49, family member, Field Maple

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

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

R: Why do you think these are very important?

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

Helen, 82, Aspen Day Centre

Despite the absence of some family members due to demographic changes and loss of relatives, some clients perceived themselves as supported by family members. Distance was not enough to interfere in some participants' representations of family support. As a form of *social support by distance,* clients seem to represent their families as overseers.

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

Sally, 90, client, Aspen

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

5) Loneliness and social isolation in the community

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

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

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

Jess, 82, client, Aspen

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

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

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

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

Victoria, 66, client, Field Maple

Their views of the experience of loneliness holds a strong affective component, particularly related to their feelings of separation from the community. In fact, they regard experiencing loneliness and social isolation as more problematic than mental health problems or physical illnesses. Some organise their daily routines around socialise in different community spheres: *"Sometimes I go to exercise class on the Friday morning, and on Wednesday I go to church, and then after we have church, so we have coffee afterwards…"* (Felicity, client, Field Maple). Volunteers share this representation but with a less affective component, which is mainly due to their lack of personal experience with loneliness. On the contrary, they emphasise how a situation of isolation may increase vulnerability to other problems.

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

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

Sarah, 53, staff member, Tulip Tree.

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

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

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

Laura, 72, staff member, Field Maple

The experience of social detachment is the main hindrance to well-being as expressed above. The groups of clients and staff and volunteers differ in terms of how they see social detachment. Clients emphasise the detrimental character to their social identities and well-being caused by social detachment, whereas volunteers emphasise the vulnerability to physical, mental and social problems. The first group focuses on socialising and being part of the community, while the second stresses the need for care and support for the elderly. In this context, clients may refer to their need to be active and participative in the community, whereas volunteers and staff members stress how their help enable the clients to remain in the community.

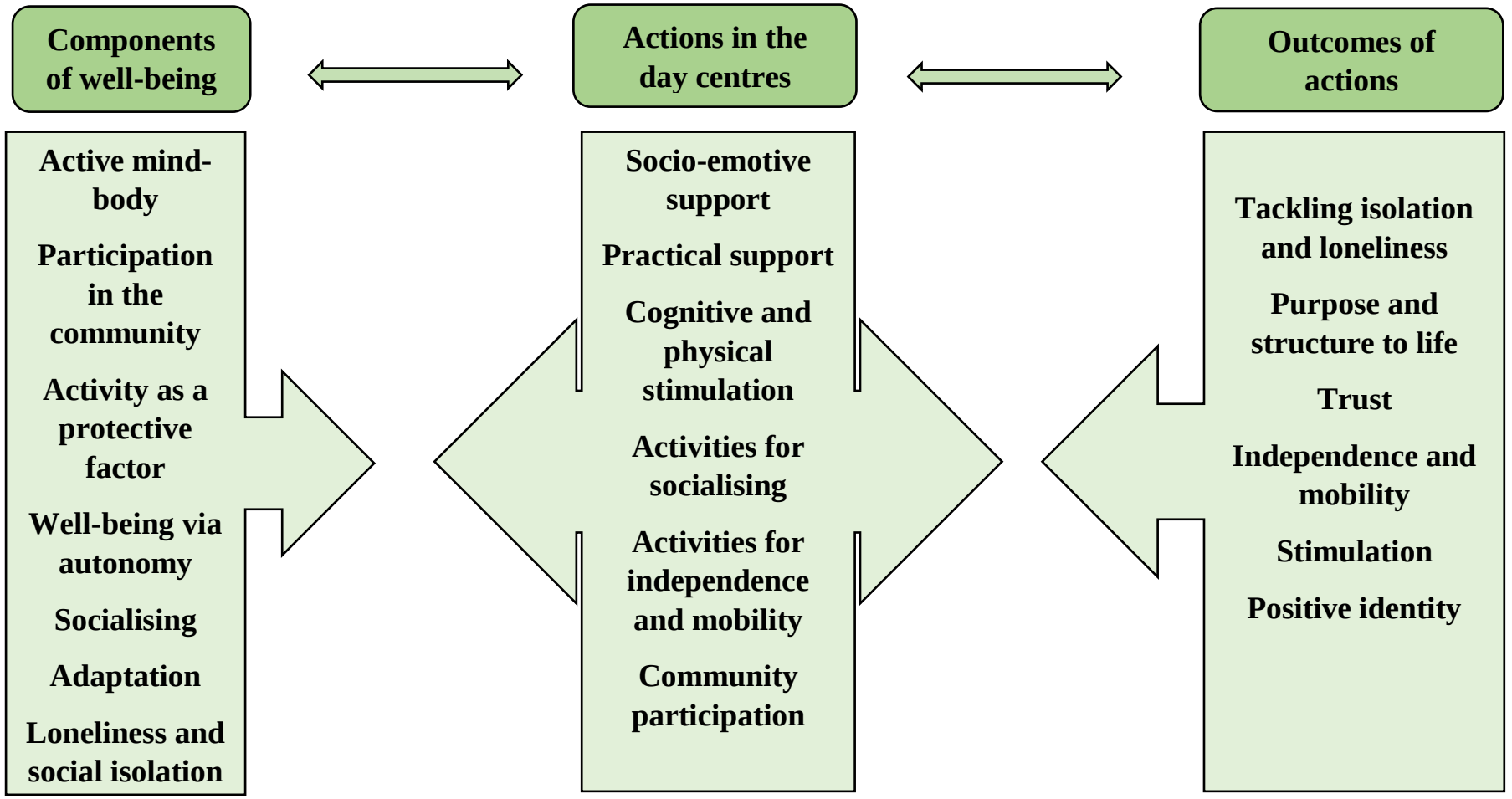
Promoting well-being being in the day centres

In the next sections, I will present how he day centre is engaged in promoting well-being in later life. According to clients, family members and volunteers, promotion of well-being is either within or *for* the community. Two types of support were evident: *socio-emotive support & practical support*[10].

The first set of actions emphasise socialising and human interaction in service provision. **Participants regarded the day centre as a space for socially rewarding interactions, whereas peer support was the main factor to promote group cohesion and wellness among frail, socially detached and at times stigmatised older adults.** Secondly, **well-being promotion involves the awareness and management of needs**. Actions that foster mobility, sense of independence, and an active identity are the focus of support in the day centres. To promote this, the staff members and volunteers position themselves as reliable sources of support, enabling family members and caregivers to rely on their services. The next diagram represents graphically participants' views of support in the day centre and the outcomes of such actions.

[10] These categories resemble some of the main types of social support functions according to the specialised literature (Cohen & Wills, 1985; Rodrigues, Gierveld, & Buz, 2014; Thoits, 2011). However, they bear contextual meanings that go beyond social scientific understandings of social support. In fact, they are personal and institutional ways of preserving the project of wellness in later life.

Figure 2. Project of well-being promotion in the day centres



1) Socio-emotive support via the day centres

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

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

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

Grace, 80, client, Aspen

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

Fieldwork note, Week 4, 12.03.2014, Aspen

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

Theresa, 44, staff member, Field Maple

Staff members and volunteers emphasised **the role of community in protecting the elderly against psychological deterioration and social isolation** (Knight & Ricciardelli, 2003; Ryff, 1989). As discussed by Thoit (1985), social-psychological processes mediate the way in which psychological well-being is affected by support. In this context, the development of a sense of belonging via the assimilation and enactment of specific identities correspond to a possible positive outcome of socialising in the day centres (Cobb, 1976; Thoit, 1985, 2011).

One important outcome comes from participants' involvement in the day centres: **a stronger sense of belonging** via the participation in a mutual project of support where one "belongs to a network of communication and mutual obligation" (Cobb, 1976, p. 300).

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

Mike, 53, staff member, Aspen

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

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

Paul, 80, client, Aspen Day Centre

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

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

Megan, 89, client, Field Maple

In the day centres, I highlight **two ways through which the day centres promote well-being:**

- **Providing peer support;**

- **Promoting structure and purpose in life**

1.1) Peer support via the day centres

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

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

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

Sally, 82, client, Aspen

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

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

Anna, 82, client, Field Maple

Peer support helps older adults to deal with the stigma associated with physical and cognitive limitations and 'not being productive' with age (Ekerdt 1986; Sánchez & Hatton-Yeo 2012; Walker 2009; Walker 2002).

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

Hannah, 89, client, Aspen

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

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

George, 68, client, Tulip Tree

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

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

Claire, 89, volunteer, Field Maple

R: How do you think society sees the elderly?

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

Gail, 83, client, Field Maple

1.2) Promoting structure and purpose in life

Attending a day centre brings purpose and structure to someone's life, and helps in coping with unstructured elements (which cause isolation and loneliness). Clients highlight the importance of a structured routine to keep themselves active. Socialising enables a sustained routine which brings purpose and scaffolding to cope with mobility and cognitive problems.

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

Sarah, 82, client, Field Maple

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

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

Kevin, 68, client, Tulip Tree

Tulip Tree was characterised by a stronger emphasis on conducting activities with the purpose of promoting meaning and structure to older adults' lives. Puzzles, memory games, chair exercises, wrist-band exercises were repeatedly conducted during a common day in that day centre.

2) Practical support via the day centres

Well-being promotion is also enacted through practical help with daily needs. Day centres were not only viewed as spaces where socialising was the main vector of wellness. Staff members and volunteers adapt their actions in the course of social interactions to deal with complex needs in the community. In so doing, they also represent well-being promotion within the course of actions which enable older adults to *live in the community*.

Instrumental support constitutes the provision of practical help such as financial assistance, management of daily tasks and provision of material aids (Cohen & Willis, 1985). In this context, *preventative services* are put into practice in the daily routine of day centres: services, activities and advice to prevent deterioration and promote independent living.

R: Is it a purpose of this day centre also to promote independence to them?
P: Yes, yes, to keep people able to live in their own home. So, they don't have to move to a residential home. I mean, Julie is another example, she was very lonely, didn't want to carry on living when her husband died, but she's come here, made friends, comes twice a week, and it's made all the difference in the world.
Martha, 60, staff member, Tulip Tree

Promotion of functionality and independence has become a mainstream international policy target (EU, 2012; WHO, 2002). Moreover, **current shifts in community care have placed voluntary organisations as strategic partners of health and social care commissioners (DoH, 2001; JSNA, 2012).** The recognition of extended needs in later life such as management of domestic tasks, shopping and house cleaning has called to psychosocial interventions in the community (JSNA, 2012). In this context, "care by the community", becomes a normative pattern of well-being promotion (Brown, 2010).

The day centre is perceived as a space of support network where staff members and volunteers oversee clients' needs and act to support them in different areas: social care, advocacy, information on different services, etc. **As such, staff members and**

volunteers anchor their practices of support within the framework of family care. In so doing, they legitimise their practices and define the day centre as a secure harbour for family members and clients to receive adequate support and advocacy.

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

Mike, 56, volunteer, Tulip Tree

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

Luke, 65, client, Field Maple

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

Olga, 89, client, Field Maple

Clients feel more comfortable to receive support if they perceive the day centre as their family. Peer groups and staff members/volunteers are then represented as the symbolic substitutes of family care. In this case, clients not only subscribe to a specific social position of receiving support, but also cope with limited social interaction and support on a daily basis (Hazan, 1994).

Promoting well-being via the visiting scheme

The visiting scheme represents an important strategy to address social isolation and loneliness. In my initial interactions with volunteers and clients, I noticed that social interaction and company were the main purposes of this scheme[11]. More isolated individuals and people with mobility problems were the main clientele of this service. However, this social ethos was not stable across time. **Participants' narratives revealed that *time progression* and *the acknowledgement of different needs* had an impact upon their views of support via the visiting scheme.**[12]

Figure 3 highlights how volunteers changed their views about the visiting scheme over time: initially, their actions of support focused solely on providing social interaction (A). Nevertheless, with the time progression in their relationships, **visitors were confronted by numerous issues presented by clients: help with shopping, mobility problems, frailty, information on services, etc.** These contextual aspects had an impact upon the way in which they provided support to older adults. They realise the need to promote practical help with daily issues (B)

[11] During the process of acquiring consent for the interviews, I also shadowed some volunteers when they visited their clients. This enabled me to grasp the context of interaction between clients and visitors.
[12] Data from this section covers mainly my interactions with visitors. Most of the clients who receive visits were unable to be interviewed. Frailty was the main reason for their refusal to participate in the interviews.

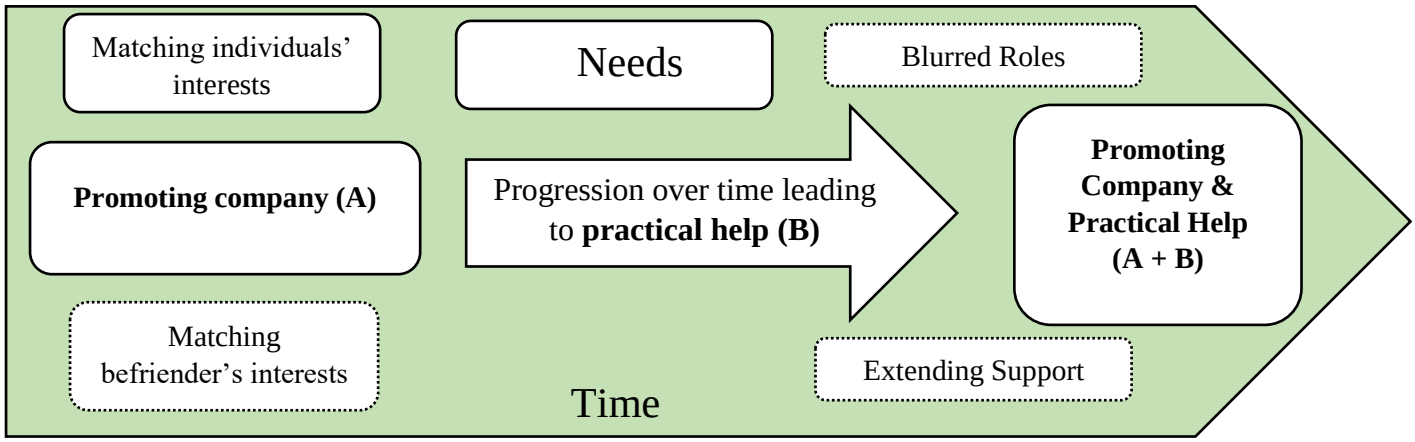


Figure 3. Progression of the project of well-being promotion over time.

1) Visits to promote human interaction

Evidence suggests that educational and group activities are more efficient to tackle social isolation and loneliness than one-to-one support (Cattan et al. 2005). Nevertheless, in-depth research is yet to cover how home visits in the community benefit older adults (Cattan, et. al., 2005). **In this study, clients acknowledge the value of socialising via the visiting scheme.** Their focus is on the relationships developed through the visits. In some way, visits are reliable *social spaces* where human contact happens.

So, I know that having a regular visit from someone each week, mhm, who is just there to talk, and just to chat, and for him to you know, to reminisce…

Toby, 94, client, Visiting Scheme

Visitors regard the visiting scheme as a unique strategy to address older adults' main problems: social isolation and loneliness. They applied different metaphors to make sense

of their role as befrienders such as *springboard to talk* (alleviate concerns) / *scaffold to socialise* (promoting confidence to engagement in social life). In this context, volunteers define their roles as mediators of company. Initially, they differentiate themselves from health and social care service providers and embraced the guidelines of listening and talking during the visits. In this context, the purpose of the visiting scheme is to provide "*contact, to be dealing with someone who is pretty lonely, who doesn't see anybody other than a nurse or whatever*" (Max, visitor). On one level, this social orientation was largely shared amongst the volunteers.

But, as a volunteer we, we don't do anything carewise, our role is just to be friend…"
Hannah, 59, Visitor

My role is, erm, to provide company, I think…
David, 80, Visitor

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

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

Edward, 66, visitor

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

Charles, 68, visitor

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

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

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

Esther, 64, Visitor

Over time, the visitors extend their scope of care to adapt to clients' needs. What starts with a clear social focus, extends to practical support.

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

Social roles become less defined in the visiting scheme. In fact, the passage of time challenges their initial conceptions of well-being promotion via social relationships. **Time is a key element** in participants' representations of social support via the visiting scheme. It facilitates changes in the social roles of clients and volunteers, and, Therefore, presents a challenge to volunteers.

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

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

Sarah, 26, visitor

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

study, users of a visiting scheme placed value on the “extra” work done by volunteers in the progression of their friendship.

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

P: We are more of friends, definitely friends. I see her once a week as for this organisation, but I can see her other times during the week as a friend. It is not bound to just my 'want'. I can go out and take her out, but it's not gonna be this organisation's thing, because then you get into all these comfort and safety situations, or you know. So, as I just get to make a point of, OK, if I go out and we go for a coffee or something, that's not gonna be [via] *this organisation, that's gonna be as a friend.*

Helen, 64, visitor

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

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

Daniel, 68, visitor

3) Practical support via the visiting scheme

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

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

Danielle, 26, visitor

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

Martha, 68, visitor

Concerns with clients' needs are partially related to age-related issues.

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

Volunteers also see themselves as reliable sources of support. Similar to day centre volunteers, they regard the visiting scheme as an adequate space for community help. In this way, the organisation seems to adopt an *ad hoc* approach. However, volunteers report that daily issues such as mobility problems, health needs and house chores should be discussed with staff members, particularly visiting supervisors. They report the need of improving advice and communication about service provision in the community. They constantly adapt to deal with different demands of personal and closer social contacts. Furthermore, they maintain socialising as an important domain of social support within this needs-oriented project.

SUMMARY OF TAKE HOME MESSAGES

- Voluntary organisations hold a strategic position of supporting lonely and socially isolated older adults. This study shows evidence of how clients assess positively the support they receive from a charity. Well-being is manifest in their positive views of social support.
- This study brings evidence of how different groups interact to promote wellness, and how their views are shared and compared. Previous studies have only mentioned specific groups involved in social support.
- Well-being in later life is not only attached to positive emotions. Housing, socialising, social support, health, and lifestyle are all components involved in clients' views of well-being. Therefore, well-being is multifaceted and complex.
- The day centres and the visiting scheme promote well-being via two broad actions of support: socio-emotive support and practical (or instrumental) support. Both strategies are deemed efficient and relevant for clients, staff members, and volunteers.
- Clients stress the value of the social support provided in the day centres. They highlighted the benefits of peer support to their health and well-being. **Peer support is regarded as one of the main actions to promote a sense of well-being amongst clients.** It raises the need to develop actions that promote a sense of belonging and acceptance in this organisation. Validation therapy is one possible intervention to supplement the social support provided by staff members and volunteers. It consists of several 'verbal and nonverbal communication techniques specifically designed to stimulate communication and

to tune in to and empathically validate the communications of an elderly person [particularly] with dementia' (Toseland et al., 1997, p.33).

- Research has shown some evidence of the relationship between validation therapy, social contact, and psychological well-being in people with dementia (Neal & Wright, 2003). This is particularly relevant in the context of this study as staff members and volunteers highlighted the increasing number of clients with dementia. More information about validation therapy and research can be found at https://vfvalidation.org/ and http://www.nhs.uk/Conditions/dementia-guide/Pages/dementia-treatment.aspx. However, it is important to mention that there is not enough evidence about the efficacy of this sort of therapy. **From clients' views in this study, peer support and the acknowledgement of their value and voice amongst their peers constitute positive outcomes of coming to a day centre.**
- In the visiting scheme, volunteers reported the need to talk more about the evolving needs of their clients. They highlighted the value of this scheme to tackle social isolation and promoting wellness. They also emphasised that the visits not only promote company but also help clients to deal with different issues (shops, information, house chores, etc.). Consequently, they discussed the need to re-evaluate their role as volunteers.

BIBLIOGRAPHY

Adams, R. G., Blieszner, R., & de Vries, B. (2000). Definitions of friendship in the third age: Age, gender, and study location effects. *Journal of Aging Studies*, *14*(1), 117–133. http://doi.org/10.1016/S0890-4065(00)80019-5

Adams, R. G., Blieszner, R., & de Vries, B. (2000). Definitions of friendship in the third age: Age, gender, and study location effects. *Journal of Aging Studies*, *14*(1), 117–133. http://doi.org/10.1016/S0890-4065(00)80019-5

Andrews, G. J., Gavin, N., Begley, S., & Brodie, D. (2003). Assisting friendships, combating loneliness: users views on a befriending scheme. *Ageing and Society*, *23*(3), 349–362. http://doi.org/10.1017/S0144686X03001156

Banister, P., Burman, E., Taylor, M., Tindall, C. & Parker, I. (1994) *Qualitative Methods in Psychology: A research guide*. Buckingham: Open University Press.

Baum, F. (1999). Social capital: is it good for your health? Issues for a public health agenda. *Epidemiology Community Health*, *53*, 195–196. http://doi.org/10.1136/jech.53.4.195

Bowling, A. (2006). Lay perceptions of successful ageing: Findings from a national survey of middle aged and older adults in Britain. *European Journal of Ageing*, *3*(3), 123–136. http://doi.org/10.1007/s10433-006-0032-2

Bowling, A. (2008). Enhancing later life: how older people perceive active ageing? *Aging & Mental Health*, *12*(3), 293–301. http://doi.org/10.1080/13607860802120979

Bowling, A., & Dieppe, P. (2005). What is successful ageing and who should define it? *British Medical Journal*, *331*(7531), 1548–1551. http://doi.org/10.1136/bmj.331.7531.1548

Brewer, J. (2000). *Ethnography*. McGraw-Hill Education (UK).

Brown, K. (2010). Community vulnerable adults (2nd ed.). Exceter: Learning Matters.

Cambridge County Council. (2012). *Cambridgeshire Joint Strategic Needs Assessment JSNA Older People Services and Financial Review*. Cambridge. Retrieved from http://www.cambridgeshireinsight.org.uk/currentreports/jsna-older-peoples-services-and-financial-review

Campbell, C., & Jovchelovitch, S. (2000). Health, community and development : towards a social psychology of participation. *Journal of Community & Applied Social Psychology*, (10), 255–270. http://doi.org/10.1002/1099-1298(200007/08)10

Chiripanhura, B. (2010). Measures of economic activity and their implications for societal well-being. *Economic and Labour Market Review*, *4*(7), 56–65. http://doi.org/10.1057/elmr.2010.97

Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine*, *38*(5), 300–314. http://doi.org/10.1097/00006842-197609000-00003

Cohen, I. (2003). Introduction. In I. Cohen (Ed.), *Schizophrenia into later life* (pp. xiii–xx). Washington, DC: American Psychiatric Publishing.

Cohen, S., & Wills, T. a. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, *98*(2), 310–357. http://doi.org/10.1037/0033-2909.98.2.310

Cromby, J. (2011). The Greatest Gift? Happiness, Governance and Psychology. *Social and Personality Psychology Compass*, *5*(11), 840–852. http://doi.org/10.1111/j.1751-9004.2011.00398.x

Cummings, S. M., & Kropf, N. P. (2009). Formal and informal support for older adults with severe mental illness. *Aging & Mental Health*, *13*(4), 619–627. http://doi.org/10.1080/13607860902774451

Dewing, J. (2007). Participatory research: A method for process consent with persons who have dementia. *Dementia*, *6*(1), 11–25. http://doi.org/10.1177/1471301207075625

DoH. (2001). *National service framework for older people*. London. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf

European Union. (2012). *The 2012 Ageing Report*. *European Commission* (Vol. 2012). Brussels.http://ec.europa.eu/economy_finance/publications/european_economy/2011/pdf/ee-2011-4_en.pdf

Flick, U. (2000). Qualitative Inquiries into Social Representations of Health. *Journal of Health Psychology*, *5*(3), 315–324. http://doi.org/10.1177/135910530000500303

Flick, U., Fischer, C., Neuber, A., Schwartz, F. W., & Walter, U. (2003). Health in the context of growing old: social representations of health. *Journal of Health Psychology*, *8*(5), 539–556. http://doi.org/10.1177/13591053030085006

Foster, J. L. (2001). The social representations of mental illness held by clients of the mental health services. Unpublished PhD, University of Cambridge.

Foster, J. L. H. (2003a). Beyond otherness: controllability and location in mental health service clients' representations of mental health problems. *Journal of Health Psychology*, *8*(5), 632–44. http://doi.org/10.1177/13591053030085012

Foster, J. L. H. (2003b). Representational Projects and Interacting Forms of Knowledge. *Journal for the Theory of Social Behaviour*, *33*(3), 231–244+347. http://doi.org/10.1111/1468-5914.00216

Foster, L., & Walker, A. (2015). Active and Successful Aging: A European Policy Perspective. *The Gerontologist*, *55*(1), 83–90. http://doi.org/10.1093/geront/gnu028

Frawley, A. (2015). Happiness Research: A Review of Critiques. *Sociology Compass*, *9*(1), 62–77. http://doi.org/10.1111/soc4.12236

Friese, S. (2014). *Qualitative data analysis with ATLAS. ti*. London: Sage Publications.

Hahn, J., & Oishi, S. (2006). Psychological needs and emotional well-being in older and younger Koreans and Americans. *Personality and Individual Differences*, (40), 689–698. http://doi.org/10.1017/CBO9781107415324.004

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice*. Routledge.

Hazan, H. (1994). *Old Age: Constructions and Deconstructions*. Cambridge: Cambridge University Press.

Herzlich, C. (1973). *Health and Illness: a social psychological analysis*. London: European Association of Experimental Social Psychology.

Hilton, C. (2005). The origins of old age psychiatry in Britain in the 1940s. History of Psychiatry, 16(3), 267–289. doi:10.1177/0957154X05050075.

Jopp, D. S., Wozniak, D., Damarin, A. K., De Feo, M., Jung, S., & Jeswani, S. (2015). How could lay perspectives on successful aging complement scientific theory? Findings from a U.S. and a German life-span sample. *Gerontologist*, *55*(1), 91–106. http://doi.org/10.1093/geront/gnu059

Jovchelovitch, S. (2012). Narrative, Memory and Social Representations: A Conversation Between History and Social Psychology. *Integrative Psychological and Behavioral Science 46*(4), 440-456. http://doi.org/10.1007/s12124-012-9217-8

Kildal, N., & Nilssen, L. (2013). Ageing policy ideas in the field of health and long-term care. Comparing the EU, the OECD and the WHO. In: R. Ervik & T. S. Lindén (Eds). *The making of ageing policy. Theory and practice in Europe.* (pp. 53-77). Cheltenham: Edward Elgar Publishing Limited.

Knight, T., & Ricciardelli, L. A. (2003). Successful Aging: Perceptions of Adults Aged Between 70 and 101 Years. *J. Aging and Human Development*, *56*(3), 223–245. http://doi.org/10.2190/CG1A-4Y73-WEW8-44QY

Langan, D., & Morton, M. (2009). Reflecting on community/academic `collaboration': The challenge of `doing' feminist participatory action research. *Action Research*, *7*(2), 165–184. http://doi.org/10.1177/1476750309103261

MacKean, R., & Abbott-Chapman, J. (2012). Older people's perceived health and wellbeing: The contribution of peer-run community-based organisations. *Health Sociology Review*, *21*(1), 47–57. http://doi.org/10.5172/hesr.2012.21.1.47

Marková, I. (2011). Ethics in the theory of social representations. *Papers on social representations*, 22, 4.1-4.8.

Matzke, S. (2011). 2012 European year for active ageing. *Gerontechnology*, *10*(1). http://doi.org/10.4017/gt.2011.10.01.014.00

Morant, N. (2006). Social representations and professional knowledge: the representation of mental illness among mental health practitioners. *The British Journal of Social Psychology / the British Psychological Society*, *45*(Pt 4), 817–838. http://doi.org/10.1348/014466605x81036

Moreira, R. M., Boery, E. N., De Oliveira, D. C., Sales, Z. N., Boery, R. N. S. de O., Teixeira, J. R. B., … Mussi, F. C. (2015). Social representations of adolescents on quality of life: structurally-based study. *Ciência & Saúde Coletiva*, *20*(1), 49–56. http://doi.org/10.1590/1413-81232014201.20342013

Murray, M., Pullman, D., & Rodgers, T. H. (2003). Social representations of health and illness among baby-boomers in eastern Canada. *Journal of Health Psychology*, *8*(5), 485–499. http://doi.org/10.1177/13591053030085002

Neal, M. & Wright, B. (2003). Validation therapy for dementia. *Cochrane Database Syst Rev. (3)*, CD001394.

Nocon, A., & Pearson, M. (2000). The roles of friends and neighbours in providing support for older people. *Ageing and Society*, *20*(3), 341–367. http://doi.org/10.1017/S0144686X99007771

Pickard, L. (2012). Substitution between formal and informal care: a “natural experiment” in social policy in Britain between 1985 and 2000. *Ageing and Society*, *32*(7), 1147–1175. http://doi.org/10.1017/S0144686X11000833

Qualls, S. H., & Zarit, S. H. (Eds.). (2009). *Aging families and caregiving*(Vol. 3). John Wiley & Sons.

Rodrigues, M. M. S., De Jong Gierveld, J., & Buz, J. (2014). Loneliness and the exchange of social support among older adults in Spain and the Netherlands. *Ageing & Society*, *34*(2), 330–354. http://doi.org/doi:10.1017/S0144686X12000839

Ryff, C. D. (1989a). Beyond Ponce de Leon and Life Satisfaction: New Directions in Quest of Successful Ageing. *International Journal of Behavioral Development*, *12*(1), 35–55. http://doi.org/10.1177/016502548901200102

Ryff, C. D., & Keyes, C. L. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, *69*(4), 719–727. http://doi.org/10.1037/0022-3514.69.4.719

Smith, C. (2003). *Moral, believing animals: Human personhood and culture*. Oxford University Press.

Stoltz, P., Willman, A., & Udén, G. (2006). The meaning of support as narrated by family carers who care for a senior relative at home. Qualitative Health Research, 16, 594-610. doi:10.1177/1049732305285729.

Tate, R. B., Swift, A. U., & Bayomi, D. J. (2013). Older Men ’ S Lay Definitions of Successful Aging Over Time : the Manitoba Follow-Up Study *, *76*(4), 297–322.

Thoits, P. A. (1985). Social Support and Psychological Well-Being: Theoretical Possibilities. In I. G. Sarason & B. R. Sarason (Eds.), Social Support: Theory, Research and Applications (pp. 51–72). Dordrecht: Martinus Nijhoff Publishers.

Thoits, P. A. (2011). and Support to Physical and Mental Health, *52*(2), 145–161. http://doi.org/10.1177/0022146510395592

Thomas, J., & Evans, J. (2010). There’s More to Life than GDP but How Can We Measure It? *Economic & Labour Market Review*, *4*(9), 29–36. http://doi.org/10.1057/elmr.2010.127

Toseland, R.W. et al., 1997. The impact of validation group therapy on nursing home residents with dementia. *The Journal of Applied Gerontology*, 16(1), pp.31–50.

Vaillant, G. E. (1990). Avoiding negative life outcomes: Evidence from a forty-five year study. *Baltes, Paul B (Eds.). Successful Aging Perspectives from the Behavioral Sciences* (pp. 332–358). Cambridge: Cambridge University Press

Walker, A. (2009). Commentary: the emergence and application of active aging in Europe. *Journal of Aging & Social Policy*, *21*(1), 75–93. http://doi.org/10.1080/08959420802529986

Walker, A., & Foster, L. (2013). Active ageing: rhetoric, theory and practice. In R. Ervik & T. S. Lindén (Eds.), *The making of ageing policy: theory and practice in Europe* (pp. 27–52). Cheltenham: Edward Elgar Publishing Limited.

Ward, L., Barnes, M., & Gahagan, B. (2012). *Well-being in old age: findings from participatory Report*. *University of Brighton and Age Concern Brighton, Hove and*

Portslade. Brighton and Hove.

WHO. (2002). Active Ageing: A Policy Framework. *The Aging Male*, *5*(1), 1–37. http://doi.org/10.1080/713604647

Zani, B. (1995). The Mentally Ill Person and Others: Social Representations and Interactive Strategies. In Marková, I & Farr, R (Eds), Representations of Health, Illness and Handicap (pp. 145-162). Switzerland: Harwood Academic Publishers.