‘MALE MAGNETS’, ‘FIRECRACKERS’, AND ‘FUSSY ENGLISHMEN’: AN ETHNOGRAPHIC INVESTIGATION OF THE INFLUENCE OF GENDER NORMS ON WELL-BEING IN AN ENGLISH CARE HOME

By

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Declaration

I declare that this thesis is my original work and has not been submitted elsewhere for the award of a degree. Any sources used in this thesis have been appropriately acknowledged. I further declare that any contributions made by others to this work, including any joint authorship, have been clearly and fully acknowledged and disclosed in this thesis.

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Abstract

In the following study, I examine the experiences and dynamics of gender norms in an old age care home setting in England. The care home aims to provide comprehensive care to older adults, encompassing their physical, emotional, and social well-being. However, existing literature on old age care often overlooks the social and gendered dimensions of care, focusing primarily on the medical aspects of ageing. This research seeks to address this gap by delving into the intersection of gender constructs and the experiences of well-being and dignity among care home residents.

Drawing on theoretical frameworks such as Raewynn Connell's theory of gender and power, Julia Kristeva's theory of abjection, Erving Goffman's front-and-back stage, and Sara Ahmed's 'affective economies', I take a constructivist understanding of gender and age to shed light on the care home context's complex relationships and social dynamics. Ethnographic research conducted during the summer and autumn of 2021 provides a rich understanding of the daily life experiences and voices of old-age residents as well as care workers, uncovering the intricate ways in which gender and age intertwine to shape interactions and the expression of gender identities within the care home environment. This dissertation predominantly uses data in the form of field notes derived from participant observation with both care home residents and care workers, as well as some interviews with care home residents.

The main findings from this research highlight the impact of gender norms on the experiences of both residents and care workers, demonstrating that the care home environment can reproduce and intensify norms that limit and facilitate social interaction and this has a direct impact on social life and belonging in the care home. By exploring the intersection of age and gender, this study challenges reductionist attitudes towards older adults and offers valuable insights into future research on care and old age. I also highlight the ethical considerations involved in caring for older adults in residential settings. Through the study's findings, we gain a deeper understanding of the diverse experiences of care home residents and the implications of providing compassionate and inclusive care.

By bringing to light the interplay of age and gender constructs through a lens grounded in theoretical frameworks and ethnographic exploration, this research contributes to ongoing efforts toward a more holistic and compassionate approach to care for older adults. Findings from this study highlight the imperative to foster an inclusive and empathetic caregiving ethos that honours the diverse experiences of older adults, contributing to the ongoing dialogue on the social dynamics of care and the profound implications for the well-being and dignity of those residing in care homes. Due to its context-specific analysis of this particular care home, with the incorporation of detailed case studies, this study's unique contribution lies in offering a rich account of gender dynamics in caregiving within the care home setting. This study offers insight into the future benefits of ethnographic research in residential care settings, the beneficial relationship between humanised care and research ethics, as well as the symbiosis of 'caring care' and ethnographic methodology.

Table of Contents

List of Figures

“Old age is not a disease—it is strength and survivorship, triumph over all kinds of vicissitudes and disappointments, trials and illnesses.”

Maggie Kuhn, American activist and founder of the Gray Panthers

Figure 1. “George and Julia”, Author’s illustration

Chapter One: Introduction

It was a warm, misty evening, and I was sweating under my light rain jacket as I coasted into the back parking lot of Comfort Days[1], the North England care home where I had been living and conducting fieldwork over the summer. Without stopping, I leaned over and, while still moving forward on my bicycle, touched the fob in my pocket onto the keypad—a small trick I had learned over the past weeks of leaving the care home each evening to cycle and clear my head. A box of fish and chips rested against my back, radiating fryer warmth through my backpack. Though I swore I would stop eating fish and chips so often, it became a summer habit in this small town with limited options when I did fieldwork later than the onsite Comfort Days cafe was open. I coasted smoothly around the corner of the drive, nodding hello to a few staff members having their smoke break at the edge of the property. The new pavement of the parking lot was notably different from the town's patched and pot-holed roads, signifying the region's lack of recent public upkeep.

As I was locking my bike at the back of the building, Kate[2][3], a care worker with whom I had become familiar, came outside. I checked the time: 8:55 PM, just before the night shift. Kate seemed to have left her evening shift a few minutes early and looked upset.

“I never took my break, so they just told me to come out now, well—” Kate was fumbling for her keys, and her dog was waiting on its lead. Kate would often bring her dog to work with her, as

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[1] Fictionalised name to protect anonymity

[2] All names in this thesis are changed to protect anonymity.

[3] Please see Appendix 4 Participant Information Table for list of all participants’ pseudonyms.

he was small and well-mannered, and it made some of the residents happy to see him. This meant that Kate would have to mind her dog while performing her other duties, adding a bit more work, but she was happy to do it for the residents. I offered her some of my fish and chips, and she politely declined, but, taking a seat on the picnic table next to me, absentmindedly helped herself to some vinegar-dressed chips while 'ranting' about a resident, a man I will call George.

"He is a bottomless pit!" Kate was crying, but she wiped her few tears away aggressively and told me they were "just" tears of frustration. "I over-extend and over-extend, and someday I might just burn out." Kate was young but not the youngest of the carers. In her early 40s, she had worked in care for over a decade and had always lived in the town. She had a very kind and patient demeanour, and residents seemed to adore her. This was not the first time I talked with Kate as she "decompressed" [4] from a shift. She told me she was coming in more often as other care workers were ill, and Comfort Days struggled to keep staff for all shifts. After some more 'ranting', a few placations from myself, and a few more shared chips, Kate left in her small car, and I made my way upstairs to my guest room—an apartment fit like a hotel room with a bed, a kettle, and a private bathroom. The apartment, usually reserved for visiting families, had not been open for visitors since the beginning of the COVID-19 outbreak.

As I unlocked the door to the apartment, I glanced at a sign on the wall listing a helpline number for overwhelmed care staff. I wondered if they would offer anything more valuable to Kate than

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[4] Suggests the need for a transitional space in which the mind and body have to adjust in order to process experience from inside Comfort Days and neutralise it before re-entering the world outside.

my own feeble sympathies and understanding. I felt deflated in the face of Kate's frustrations, and in the face of George's "bottomless pit"—which was Kate's way of addressing his very real, and unmet need for attention and emotional care. I heard laughter from a "House" adjacent to my guest apartment, one of six large apartments within the care home that housed around ten residents each (more on the layout of the care home later). This House had a team of care workers who got along quite swimmingly. Sometimes care work looked so easy and natural, joyful even. But just as often it looked like Kate and George—a disconnect between receiving and giving, sometimes awkwardness, regret, or even despair.

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I came to Comfort Days as an outsider in all meanings of the word. Located in a small town in northern England, one which was so self-identified that care workers commuting just 10 minutes from a neighbouring town were sometimes lightly roasted for their differing accents (undetectable to my ears), Comfort Days housed residents from all over England and hired care workers from all over the UK and the world. I am American, and I am not a care worker, nor a resident. I am an early career researcher, a doctoral student, conducting ethnographic research at this care home. This study is part of a collaborative research project (more about this later on) to explore how gender impacts care services and to do so ethnographically. I come from a background in Psychology and Social Anthropology, and I feel a strong sense of duty to give voice to those who may often be overlooked. In this project, I want to develop a study that would consider and highlight the voices of old adults. However, to study care is to study relationships; care is not a simple, uni-directional exchange from care worker to care recipient.

Thus, the residents' experiences could not be separated from the care workers, managerial staff, family members, friends, and myself. Though taking place just after the most intense waves of COVID-19, when the residential care home was a site of extreme protection and separation, the lines of care were enmeshed, making it impossible to focus solely on one actor in this meshwork of care.

With this research, I aim to examine the experiences and dynamics of gender norms in this old age care home, which was designed to provide comprehensive care to older adults, encompassing their physical, emotional, and social well-being. However, existing literature often focuses on the medical aspects of old age, neglecting the social and gendered dimensions of care. Old age is often defined by physical and mental ailments associated with frailty and cognitive decline, leading to a medicalised narrative that overlooks the holistic needs of older adults. Residential care homes promise to provide full care under one roof, including physical, emotional, and social needs. Understanding the daily life experiences of residents and how they navigate their social relationships is critical to ensuring that care homes can fulfil this promise.

Taking into account the contexts that shape gender identities, such as regional cultural values and generational values, I aim to take a more nuanced look at care relations. Care acts range from bodywork such as bathing, support with exercise, feeding, and provision of medications to something much less easy to define but of equal importance to well-being, such as giving space to connect with others, validating one's feelings, or ensuring privacy. Gender impacts these relations, sometimes more explicitly, but always, it seems to sit there in some form, shaping how we relate to one another. Gender influences the assumptions formed around people’s desires and needs, which may cause residents to receive different care acts for different reasons. One woman’s hygiene is tended to more regularly because she is seen as a woman who holds value in her appearance. A man who served in the military is given more time in the library alone, perhaps because he is seen as a male figure needing autonomy. Gender roles are often reflected in the findings of this ethnography, especially in what people say, but when we take the time to observe how people act, this is not so simple. Care is not a one-size-fits-all process but a negotiation, a complex contract between the carer and the care recipient. Carer-resident relations nuance this dynamic, as do pervading stereotypes of older people as homogenous in their needs and priorities, thus sometimes not having a gender. Reductive views of gender identity risk the oversimplification of care strategies.

Here, I aim to fill this gap by exploring how gender constructs intersect with the experiences of well-being and dignity among residents in this care home. Drawing on theoretical frameworks including Raewynn Connell's theory of hegemonic masculinities, Julia Kristeva's theory of abjection, and Sara Ahmed’s affective economies, analysis of the data unearthed takes a constructivist understanding of gender and age to shed light on the complexities of relationships and social life within the care home context. Through ethnographic research conducted in the summer and autumn of 2021, the daily life experiences and voices of old-age residents are brought to the forefront, highlighting the ways in which gender and age intertwine to shape interactions and the expression of gender identities within the care home environment. By exploring the intersection of age and gender, I challenge reductionist attitudes towards older adults and provide valuable insights into person-centred research and the ethical considerations involved in caring for older adults in residential settings.

Through ethnographic methods, I will focus on the needs and demands being vocalised and demonstrated by the old adult care home residents and care home staff. I will examine how these demands are related to gender and age. The findings will discuss how gender and age continue to intersect to shape and influence identity formation throughout life, even in retirement and residential care. Through this study, I will provide insights into the methodological approaches and ethical considerations for person-centred research with older adults living in care settings.

Map to the Thesis

The structure of this thesis merges existing literature on care and on gender perspectives on ageing within the context of residential care provided by ethnographic findings. By incorporating social sciences, especially critical gender perspectives, into health and care research, a comprehensive lens is provided to explore intricate issues. This approach broadens the analysis to investigate the complex interplay of social, cultural, and psychological factors that profoundly influence care experiences. In presenting this thesis, I aim to convey a strategic rationale that prioritises clarity and coherence, establishes a narrative focus, and allocates sufficient space and significance for the stories and experiences central to this study.

Chapter 1: Introduction - Exploring Critical Gender Perspectives on Ageing in Care Research

In this thesis, I examine critical gender perspectives on ageing in the particular context of residential care. The introduction chapter lays the groundwork for the following dissertation. Following this 'map', I will provide a contextual backdrop that emphasises the significance and applicability (and absence) of critical gender perspectives within the field of ageing in care research. Furthermore, I clarify the research question and objectives guiding this project.

Chapter 2: Background

Within this chapter, I furnish a thorough background of the study, encompassing its rationale, challenges, setting, ethics, and literature to contextualise the study inquiry. These components form the bedrock upon which I build my research, providing essential context for understanding the study's scope and significance.

Chapter 3: engaging with the Literature

Within this chapter, I explore existing literature relating to care, ageing, and gender. Additionally, I present the theoretical frameworks that serve as the backbone of this study. Drawing from various established theories and frameworks, such as Connell's Theory of Gender & Power, Kristeva's Abjection, Ahmed’s Affective Economies, and the Humanisation of Care Framework, I weave together a comprehensive and multidimensional lens to analyse the data.

Chapter 4: An Ethnographic Methodology

Here, I will address the practical implications of conducting this research, including considerations of anti-oppressive ethnography, researcher reflexivity, and the situatedness of the researcher within the study context. Moreover, I outline the participant observation and interview methods, shedding light on the strategies employed to gather rich and meaningful data in the care home context.

Chapter 5: Ethnographic Findings & Analysis

This chapter constitutes the heart of the study, as I present the findings derived from the data analysis. Within the backdrop of ageing in North England's care setting, I delve into the themes of power and gender, critically questioning and examining these dynamics. The findings are structured into four sub-chapters: a chapter featuring three case studies that zoom in on individuals' experiences as they navigate living in the care home, another on social life and on meals and eating in the care home, and lastly, a chapter dedicated to social events that serves to consolidate the diverse themes and to more deeply explore the the dynamics of power and gender in care relations.

Chapter 6: Discussion and Conclusions

In this chapter, I engage in a comprehensive discussion of the implications arising from the study findings. I explore how my study contributes to the broader discourse on the humanisation of care, shedding light on its potential applications and transformative effects. Additionally, I critically reflect upon the limitations of our study and discuss the implications for further research, practice, and how this project points to policy implications.

Chapter 7: Final thoughts

Within this concluding chapter, I reflect on the study and its implications for the field of ageing in care research.

Context and Relevance to the Field

In the contemporary landscape of the United Kingdom's care sector, marked by a surging demand for long-term care fueled by demographic shifts, escalating healthcare costs, and the competition and marketisation that characterise a growing private care industry, a closer examination of a small care home assumes significance. This study is particularly relevant in light of the prevailing trend towards home-based care and the closure of many smaller independent care facilities. Even so, an estimated 421,100 people reside in care homes in the UK (AgeUK, 2018). An in-depth study facilitates the exploration of the challenges unique to these smaller setups, offering valuable insights into their constraints and opportunities, and aiding in crafting informed decisions to ensure the sustainability of care services.

However, the complexity of providing round-the-clock care, especially in the absence of a clear-cut "solution," remains a central conundrum (Cottell, 2017). The dynamic nature of caregiving demands, combined with evolving societal expectations and changing economic landscapes, poses significant challenges to developing care that meets residents' needs (Duffy et al., 2015). A notable disparity arises in the evolution of care practices and our understanding of what constitutes *good* care. While the demand for long-term care escalates, care worker turnover rates increase, austerity measures chip away at fraying social services, and care homes are painted as horror sites of bare-bones care, neglect, and potential abuse which have all been sources of scandal (Mulley, 2011; Humphries et al., 2016; Lloyd et al., 2014). The shifting dynamics in care provision necessitate a concurrent evolution in our understanding of quality care, encompassing not only the physical and medical aspects but also the emotional, social, and psychological dimensions crucial for the overall well-being of individuals in long-term care settings. The pursuit of excellence in long-term care requires not just a response to immediate challenges but an ongoing commitment to advancing our understanding of what defines quality care in a rapidly changing sociocultural and economic context. Recognising the multifaceted nature of the issue is the first step towards crafting holistic and adaptable solutions that can withstand the dynamic nature of the care sector.

Research Aim and Questions

The overarching aim of this study is to explore the experiences and dynamics of gender norms in an old age care home setting in the UK and their implications for residents' well-being. A focus on well-being will help think about what constitutes good care, as good care should foster experiences of well-being (Galvin & Todres, 2013). To make sense of gendered experiences of dignity and well-being, a critical gender framework offered by Raewynn Connell (2009) informs the design and analysis of my project, and the focus on well-being is underpinned and supported by a humanisation of care serves as a ‘value framework’ for this study, which, in very introductory terms, means that this study is guided by the notion that there are many interconnected dimensions of well-being which can range from being humanising or dehumanising, and that to capture the richness of experience requires holding the possibility for both while examining the lived experience—more on this in the next section (Todres et al., 2009).

Research Questions:

- What are residents' experiences and challenges with gendered expectations, roles, and practices within the care home?
- How do gender norms manifest and intersect among residents and staff in the care home; how do gender norms influence care interactions within the care home?
- What are the implications of the findings for care practice in caring for older adults in residential settings?

By focusing on the specific context of this care home, this research sheds light on issues of care that require a close look, such as the direct impact of changing care trends on elderly individuals and their families but also delves into more large-scale issues, such as the intricacies of the gendered and feminised care workforce, where women constitute approximately 82% of all care workers. Unpacking the challenges faced by these predominantly female care workers in terms of low-paid, low-status jobs, workload issues, and limited career development opportunities provides a better understanding of the complexities surrounding care provision. Moreover, a close look at care work exposes the cultural and social norms perpetuating the devaluation of care work, offering a foundation for challenging stereotypes and advocating for the recognition and equitable treatment of care workers. Ultimately, this research contributes vital information that can shape more targeted and effective policies, fostering a supportive environment for care providers and enhancing the overall quality of care in the UK.

Chapter Two: Background

A wide array of care services have been and are being designed to meet the new and dynamic needs of a growing population of old adults in need of care. There is research on these services (though one could argue still not enough), but there is even less research *with* care recipients. Research that centres the experiences and perceptions of care recipients, and in the case of this study, old age residential care recipients, needs to be much more deeply understood. Research *on* older adults can reproduce stereotypes of older adult care recipients. Many studies consider "the elderly" as objects of research rather than as people who mutually produce understandings of experience. To ensure that services meet the actual needs of this population, we need to understand the subjective experiences of ageing in residential care from the perspectives of care recipients.

With a particular focus on experiences and perceptions of dignity and well-being, I aim to contribute to the humanisation of the care field with the findings of this project, which is part of the INNOVATE DIGNITY Marie Skłodowska-Curie fellowship focused on the humanisation of care research with particular attention to older people (Galvin et al., 2013). Dignity and well-being are profoundly varied subjective phenomena that impact and shape our experiences across interpersonal, institutional, and societal contexts. The observation and consideration of these subjective phenomena, and the perspective that one's experience is relative and reflexive, invite the depth and flexibility offered by qualitative research methodology.

The goal of this study is to offer a deeper understanding of older adults' experiences and perceptions of dignity and well-being living in a residential care home, as well as to provide insight into the ethnographic, humanisation-based methods by which we can understand the intersubjective experience of residents of a residential care home.

Rationale

The development of care homes in the UK has led to a significant transformation of the care sector, with profound implications for care workers, care recipients, and the broader society. Despite the growing body of research on care work, there is limited understanding of how gender and relationship dynamics shape the provision and receipt of care services in care homes. Furthermore, existing studies have focused on care workers' or recipients' perspectives rather than examining their interactions and relationships.

The rationale for this study is multifaceted. Firstly, by investigating the relationship between gender, relationships, and care services, I seek to contribute to a richer understanding of the challenges and opportunities associated with care work in a private sector independent care home setting. Secondly, the study sheds light on the complex and dynamic interactions between care workers and recipients, which should be addressed in existing research. By examining the perspectives and experiences of both groups, the study aims to generate insights into how care work is negotiated and performed in practice and how broader social and cultural factors shape these practices.

Finally, the study has practical implications for the UK's design and delivery of care services. By identifying the strengths and limitations of current care practices, the study aims to inform the development of care services responsive to the diverse needs and experiences of care workers and care recipients. Furthermore, by highlighting the impact of gender and relationship dynamics on care work, the study aspires to contribute to broader debates on gender equality and social justice in the United Kingdom and beyond.

Rich and descriptive data generated by ethnographic research methods will be useful for understanding life in residential care better. The ethnography took place in a residential care facility located in northern England, which offers a continuum from independent living to end-of-life care. This qualitative research study is designed to deepen current understandings of how older adults living in residential care experience daily life: to find out what residents enjoy, whether they form new relationships in the facility, or prefer to be alone or with family. I aim to understand older adults' experiences of dignity and well-being. I would like to understand how older people experience their daily lives in the context of residential care. I want to know what residents in this space do daily and what they think about their experiences here. Through participant observation, conversations, and interviews, I want to ask residents what they think about their situation and to participate in and observe the normal day-to-day functioning of the community[5].

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[5] Data includes both residents' and staff experiences, as witnessed and told. Please see Appendix 4 Participant Information Table for list of all participants' pseudonyms.

Findings will contribute to our understanding of the lives and actual needs of people living in residential care by providing insight into the experiences and perceptions of older persons living in this environment. Since the data will be descriptive and qualitative, it will contribute to a discussion on care and develop a research methodology that promotes the consideration of care recipients. As produced by this study, new knowledge of issues that impact well-being in care may support a better understanding and application of novel research methods to engage with older people.

The Humanisation of Care as a Value Framework for This Study

This study contributes to the overarching goals of the Marie Curie Skłodowska Action (MSCA) INNOVATEDIGNITY Fellowship. This fellowship is an international program designed to train early-career scholars in care science, focusing on the experiential aspects of well-being and care for older individuals through qualitative research. Building upon the Humanisation of Care Framework (HCF), a theory-based model used to explore the experiential dimensions of well-being, I aim to critically examine the intricate and context-dependent understandings of well-being in the care context (Galvin & Todres, 2013). By applying the HCF, we can gain insights into how individuals' care experiences can either humanise or dehumanise them within the care setting. The framework is similar to Tom Kitwood's person-centred approach (1997). Still, it focuses on the phenomenological aspects of the caring experience and highlights the dimensions of well-being that stem from potentially humanising and dehumanising encounters.

Therefore, the HCF is a valuable framework for guiding qualitative research on care and well-being (Todres et al., 2009).

In the HCF, dimensions of well-being are interconnected and woven into the fabric of human experience. These dimensions include uniqueness/homogenisation, sense of place/dislocation, and agency/passivity. They form a spectrum, ranging from humanised experiences (agency) to less desirable ones (passivity). The humanised characteristics are considered "ideal" types, although they may not always be achievable or desirable in all care contexts. For instance, when examining uniqueness/homogenisation, "uniqueness" may not be the most desirable characteristic when adherence to hygiene protocols during the COVID-19 pandemic is required. In other words, the HCF enables us to explore different dimensions of care to better understand individuals' well-being experiences within their contexts and consider actions that may either promote or hinder their well-being.

The HCF provides a broader perspective on well-being that extends beyond the absence of illness, portraying care as a reflective process that occurs in relationships rather than a mere transaction. Furthermore, this approach allows us to view older adults as agential individuals rather than passive care recipients. Research on older adults often perpetuates homogenising stereotypes and overlooks the diverse and intertwined identities that shape their lives (Arber, 2002; Calasanti, Slevin, & King, 2006; Minkler, 1997). Adopting a humanisation of care perspective helps us delve into each individual's complex and nuanced aspects, placing older adults' experiences and perceptions at the centre (Cruikshank, 2008; Todres et al., 2009).

Situated ethics, also known as the ethics of humanisation of care, offers an alternative approach to procedural ethics by acknowledging caregiving practices' multifaceted and context-sensitive nature. While this approach may seem "messy," it is crucial to recognise that research can be integral to the care matrix. Understanding the contextual dimensions in which care is provided is essential for delivering humanised care that respects each individual's unique needs and preferences. By emphasising the importance of context in care, our ethnographic study aligns with an ethics of care and humanisation of care framework. This framework provides a valuable alternative to rigid ethical procedures, highlighting the significance of comprehending the individual's circumstances.

Consequently, an ontological thread connects the humanisation of care practices and the consent to participate in qualitative research. Both processes occur within relationships, representing reflexive interactions between individuals. Recognising the value of context in shaping lived experiences is central to understanding well-being within the context of care across various settings. This emphasis on context is foregrounded by an ethnographic methodology, which aids in comprehending and describing the relationship between individuals' subjective experiences and social structures.

I hope to contribute to research which challenges prevailing homogenised and homogenising understandings of what it means to be both an older adult and a recipient of care. While I realise that findings from this project represent one voice among many in the choir, I am excited to work on progressing the way we look at the human experience in old age and care.

Setting the Stage: Descriptions of the Care Home

Figure 2 Care Home PPE during Fieldwork

As I approached the modern building that housed the care home, "Comfort Days" on the outskirts of a small post-industrial town in northern England, its institutional nature was apparent before entering the property. The sleek design stuck out in the sea of brick houses characteristic of northern English towns. Some signs on the fence showed that the Care Quality Commission (CQC) awarded the care home a high-quality score.

Upon entering the building, I was whisked into an ante-room, given sanitiser and Personal Protective Equipment (PPE) and greeted by friendly staff members who exuded warmth and compassion. They took my bags, offering to store them behind the counter until I was shown my room. Their genuine smiles and willingness to engage in conversation added a touch of familiarity to the otherwise impersonal setting. Throughout the corridors, I could hear the gentle hum of chatter and occasional bursts of laughter between workers. The sterile atmosphere, though comforting in its cleanliness and sense of safety during COVID-19 (everyone in PPE and the floors shining from a recent mopping), conveyed efficiency and functionality rather than a sense of homeliness.

Moving through the care home, I observed that the layout emphasised efficiency and practicality. The building was organised in a structured manner, with clearly defined areas and purposeful spaces. While this design facilitated the smooth operation of daily routines and caregiving, it did little to evoke a sense of comfort or familiarity. The surroundings felt more akin to an institution rather than a place intended to replace the home for its elderly residents. There were some attempts to link the care home to the surrounding community. For example, the various rooms were named after local landmarks, illustrating the effort to connect the building with its local history.

Several communal areas within the main building aimed to foster social interaction and engagement. However, during my visit, these spaces were not in full use due to the COVID-19 restrictions. Upon entering the care home, you find yourself in a spacious reception area. The reception desk is always staffed by someone who, at least during my study, was there to help visitors to the designated visitation area or to instruct them to use the proper PPE after signing in. To the right of the reception, you'll notice the elevators and the back entrance to the main building, which leads to the independent living apartments. There is also an on-site hairdresser's salon, which takes residents on appointments. To the left is the Cafe, which is open and well-lit with round tables and a wall of windows.

Figure 3. The bistro decorated for Italian Night

On each end of the large reception area and cafe are the ‘Houses’. There are two Houses at each of the three levels of the main building. Each House accommodates 8-10 residents and provides a community within the more extensive care home.

Figure 4. Care home venue

On the second floor, you can find the gym. It is well-equipped, though during the time of the study was used to train CPR courses and store various things, as residents were not approved to use the gym facilities during COVID-19. Across from the gym is the "pub" venue which hosts various social events: dinners, viewings of movies or special televised events (such as the Olympics when I was living here), bingo, concerts, et cetera. And besides the venue is a small library room with a shelf of books, some armchairs and a fake fireplace roaring on an HD screen.

The building's layout prioritises functionality and efficiency, with clear divisions between different areas and purposeful spaces. The floors are kept clear and are either linoleum or carpeted with a firm, unfussy carpeting designed to avoid the chance of falls. There are handrails mounted along most walls. The lighting is bright, and most doors have clear signage in large font. Though the care home strives to create a nurturing environment, it is important to note that the challenges posed by its institutional nature take work to overcome. The design and structure, while organised and efficient, may still remind residents that they are in a space meant to replace the familiarity of home.

The staff's efforts to mitigate the impersonal atmosphere were evident during my first Together visit. Their presence brought life to the care home, injecting moments of joy and companionship into the residents' daily lives. While the building lacked the warmth of a traditional home, it was not a depressing environment. Instead, it stood as a testament to the care home's awkward negotiation of safety and protocol and human elements of care and home.

Challenges

Studying gender, relationships, and care services in a UK care home presents several challenges, mainly when using ethnographic methods such as participant observation and interviews. Some of these challenges include:

1.4.1 Access and Ethics

I will mention here briefly before delving into the ethics section below, which will go into detail on the way that the ethics application process, and my thinking around ethical research with older adults, some of whom cannot provide informed signed consent, has shaped this project profoundly, that one of the primary challenges of conducting an ethnographic study in a care home is gaining access to the setting and the participants. Care homes are highly regulated environments, and I need to obtain the proper clearance from multiple bodies, including the

Health Research Authority, the Faculty Ethics Committee, the MSCA Ethics Board, and the care home managers (Tauzer et al., 2023). Moreover, throughout the study, I negotiated with the care home staff and residents to obtain informed consent and ensure their participation does not compromise their privacy, dignity, or well-being. This requires careful planning, communication, negotiation, and sensitivity to the power dynamics and hierarchies within the care home.

1.4.2 Positionality and Reflexivity

Another challenge of conducting an ethnographic study is manageing my positionality and reflexivity. My gender, age, ethnicity, and other characteristics influence my interactions with the care workers and care recipients and affect the data I collect and analyse. This is not a challenge, per se, but it is a consideration and something I must remain aware of throughout this project. Moreover, my role as an outsider to the care home created tension or suspicion among the participants, who may perceive me as an interloper or a threat to their routines and relationships. I attempt to maintain an awareness of this by regularly reflecting on my positionality and establishing trust, rapport, and respect with the participants through ongoing communication and feedback.

1.4.3 Ethnographic Challenges

Finally, conducting an ethnographic study in a care home setting presents several methodological and practical challenges. These include the need to balance my role as an observer and a participant, negotiate the competing demands of data collection and analysis, and manage the emotional and physical demands of the fieldwork. I must develop various skills and strategies, such as active listening, note-taking, reflexivity, and self-care, to navigate these challenges and generate rich and meaningful data.

These challenges include gaining access, ensuring ethical conduct, manageing positionality and reflexivity, and addressing ethnographic research's methodological and practical challenges. Nevertheless, by being aware of these challenges and taking proactive steps to address them, I make every effort to generate valuable insights into the complexities of providing and receiving care in a gendered and relational context.

Ethics [6]

The focus of the following chapter is on the tensions between conducting ethnographic research, where a sense of ethics is bound up in every action, and the formalised ethics process put into place to protect research participants. I hope to offer a reflective account of a social scientist engaging in rigorous and ethically sound research in the qualitative health field. It is important to highlight the barriers to conducting research with older adults who live in residential care settings and who may lack the capacity to provide formalised consent to participate in research. This chapter is meant to pick at some interdisciplinary tensions, but it should be foregrounded that ethical considerations are vital and should always underpin every aspect of the research process.

Before detailing my own experiences with both formalised and situational ethics in this study, it is important to acknowledge that many researchers have been making efforts to better include the voices of older adults in research. The inclusion of older adults as co-designers has spurred methodological innovations in qualitative health research (Mulvale et al., 2019). Participatory methods such as workshops, focus groups, and community-based participatory research (CBPR) are increasingly employed to facilitate active involvement. These methods are adapted to accommodate the specific needs of older participants, ensuring that the process is inclusive and respectful of their capabilities. As one example, Kile (2021) described the use of photovoice and

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[6] This sub-chapter draws substantially from an article titled, "From Ethical Approval to an Ethics of Care: Considerations for the Inclusion of Older Adults in Ethnographic Research from the Perspective of a 'Humanisation of Care Framework'" published in The Journal of Ageing Studies (Tauzer et al., 2023) and has been reproduced here with the permission of the copyright holders.

storytelling as effective methods for engaging older adults in co-designing community health initiatives.

Despite the benefits, there are challenges to involving older adults in research. Barriers such as physical limitations, cognitive impairments, and technological challenges can hinder participation (Altawalbeh et al., 2020). Addressing these barriers requires thoughtful planning and resource allocation. Ethical considerations are paramount when involving older adults as co-designers. Issues of informed consent, confidentiality, and the respectful treatment of participants are critical. Researchers must ensure that the involvement of older adults is voluntary and that their contributions are valued and acknowledged appropriately (Rogers, 2023). Sustaining the involvement of older adults beyond the initial research phase and scaling participatory methods to larger populations are ongoing challenges. Long-term engagement strategies and the integration of participatory methods into standard research practices are necessary for sustained impact. In the following, I will explore my orientation toward these challenges in the development and planning of this study, and discuss the many possible co-benefits of research and care. I emphasize the relational aspects of developing rapport to ensure that research efforts remain ethically sound.

One pleasantly warm afternoon, I asked Theresa, a 75-year-old resident if she'd like to join me out on the balcony to get some fresh air. Theresa declined, explaining, “I just want to sit in silence–sometimes you think I’m dull but I am not, I like peace. They want me to be busy though. It is like in school. Sit straight, don’t speak! Sit and look busy and they don’t bother.”

Overhearing this from the kitchen, a care worker, Mary, explained, “Oh, she must be talking about her school days. She was quite a stern school teacher, weren’t you, [Theresa]?”

Theresa shrugged and gave a half-smile, and I wondered if this was what she really meant. It seemed an adequate, in fact quite eloquent, response to my invitation to socialise outside at that moment, rather than a musing about her past. Theresa is one of many participants of this study whom, when I assessed, I considered not having sufficient capacity to provide informed consent. Theresa was enrolled on the advice of her daughter, who felt that she would likely enjoy participation. Theresa is often social and philosophical, and she offers up her understanding of daily life in the care home. Other times, she is private and declines invitations to socialise. An important component of a qualitative event is that it is connected to other meanings, contexts, and events. This means that any singular moment or experience has an embeddedness which, even when not consciously recognised, exists implicitly (Merleau-Ponty, 1962). Thinking with this embeddedness, we can understand the small interaction with Theresa, where she communicated momentary dissent to participation. Consent, which occurs in moments and is shaped by context, occurs through interaction. And each interaction is a new assessment of consent, or, just as importantly, an opportunity for participants to communicate dissent.

As was often the case, especially during my early days of research, Mary offered a narrative as well. In providing Theresa’s backstory, Mary was giving some context which might enable further conversation between Theresa and me. Perhaps she was even apologising for Theresa’s refusal to join me, which may be viewed as rude–this already speaks to the limited rights care home residents may possess. Dissent, even to daily interactions outside of formal consent required for study participation, is viewed as poor manners or a lapse in judgement, rather than as a clear and justified communication of one's unwillingness to participate at a given moment.

These interactions were opportunities to strengthen rapport with staff, who often did not quite understand my role as an ethnographer while they tirelessly provided care work. The moments where staff or family members shared their knowledge were helpful: they are the experts in this space and they are sharing their expertise, helping me to become more of an insider over time. They are also expressing attitudes: one should not reject the invitation of another, the idea that residents' preferences are best understood in relation to their previous role as productive members of the workforce ("she was quite a stern school teacher"). Yet these instances, when staff would speak "for" residents, risk convoluting the dynamic, sometimes confusing residents, and detracting from a more intimate, present exchange where they are given the chance to decide if they want to participate, or not (Sunghee et al. 2015).

The formal ethics requirements to involve adults who cannot demonstrate the capacity to provide written consent as legally required by the Mental Capacity Act (including assessing the capacity to consent), can, in practice, contradict these moments of consent which emerge in real-life situations. As I assimilated to the care home, I experienced many challenging moments which called the consent procedure into question, where my interpretation was required to understand how to most ethically proceed with my inquiry, and where my positionality served as a starting point to make these decisions.

An ethnographic approach helps highlight the interpersonal dimension of care events and the qualitative, existential nature of well-being, but studies of this design often face significant gatekeeping at the ethics approval phase, far before ever setting foot in the care home space. Barriers to consent exist at the structural and institutional levels, through ageist attitudes towards all older adults, especially those who lack capacity, as well as at the interpersonal level, through power dynamics between care workers and care recipients.

The humanisation of care framework may help to think through the consent process and to highlight that consent is momentary and occurs in relationships. Potential barriers to conducting qualitative research with older adults who may lack the cognitive capacity to provide informed consent can exemplify the tension of procedural ethics with the subtler ethics which lie within interpersonal navigations both in care relationships and within the ethnographic approach to research. I will illustrate my use of process consent through some vignettes.

Situated ethics, or the ethics of the humanisation of care, presents an alternative approach to procedural ethics, one that acknowledges the complex and context-sensitive nature of caring practices. While this approach may be "messy," it is crucial to recognise that research can be a component of the care matrix. Understanding the context in which care is delivered is essential to providing humanised care that respects the individual's needs and preferences. By highlighting the contextual dimensions of care, we can demonstrate how our ethnography engages with an ethics of care and humanisation of care framework. This framework provides a useful alternative to the more fixed ethical procedures, emphasising the importance of understanding the unique circumstances of each individual.

Thus, there is an ontological thread that runs through the acts of humanisation of care practices, and consent to participate in qualitative research: it occurs in relationships, a reflexive event between individuals. The value of context in shaping one's lived experience is central to understanding well-being as it pertains to care across varied contexts. This is foregrounded by an ethnographic methodology, which helps us to understand and describe the relationship between people's subjective experiences and social structures.

Negotiated Process Consent

Care and caring are wrapped into consent: residents and staff navigated my presence as I became more of an insider in their daily lives, deciding where and how I fit. Not all participating residents lacked the capacity to provide written, informed consent, but a majority did. It was important to identify a consent procedure that would include all willing participants, regardless of their capacity to provide informed written consent. Approaching this study with the perspectives of the HCF and the imperative to be as inclusive as possible, the preliminary protocol asserted that process consent is the most suitable way to fairly engage a population in which many participants lack the capacity to provide informed, written consent. Negotiated process consent is not uncommon in the world of qualitative health research, and the value of this consent process has been written about by dementia researchers specifically, as it supports the inclusion of participants who may lack the capacity to provide informed, written consent (Dewing, 2008).

Obtaining informed consent is a crucial aspect of ensuring that potential participants' rights and autonomy are respected. However, in situations where a person's capacity to consent is impaired, such as in some cases of dementia, obtaining informed consent becomes more complex. The traditional model of informed consent may not apply to individuals with cognitive impairments, and it is essential to find alternative ways to include them in decision-making processes. In this context, the model of process consent developed by Dewing becomes particularly relevant. This model acknowledges that individuals with dementia may not be able to provide traditional forms of consent, but it aims to use all remaining capacities of the person to obtain their consent. This approach emphasises the importance of getting to know the person and understanding their preferences to ensure that their wishes and rights are respected. Process consent highlights the relational aspect of consent: it is not a one-off occurrence, but a process, which is regularly negotiated and communicated interpersonally (Grout, 2004).

In this consent process, the participant is repeatedly, through relations, either providing or declining consent to participate in the research. Negotiating consent requires moving beyond the signed document, even beyond the verbal “yes”, to reading for non-verbal signs of consent as expressed by the body. Consent as negotiated occurs within every interpersonal interaction

(Dewing, 2008). Process consent is a methodological tool of obtaining consent when the person with dementia has very limited capacity for informed consent, on the one hand, whereas informed consent using proxy (e.g., consultee, see below for explanation of this term) as the primary way of obtaining consent, followed by assent of the person with dementia as secondary to informed consent rather than the primary source for consent.

This process highlights that consent is not merely a one-off event, but that it is regularly negotiated through various forms of communication, whether this is verbally, through mood, or body language (Nolan, 2002). Perhaps even more importantly, especially as this project takes place in the private living spaces of participants, negotiated process consent allows saying no. Consent to participate in the project does not, and should not, mean that I have full, unlimited access to the lives of participants during the study. Negotiated process consent aligns with the ethos of the ethnographic approach, where consent occurs as the researcher and participant build a relationship (McKeown et al., 2010).

In the first application for ethical approval, I argued that I should employ process consent with every resident, regardless of their capacity, so that every potential participant could engage with the study in the same fashion[7]. The goal here was inclusion, and the argument hinged on the strength of the ethnographic process in establishing the level of rapport required for process consent. I explained that the recruitment process would begin the moment I arrived at the community, and data would only be collected once I could introduce myself, begin to embed

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[7] 'Consent as process' is typical of ethnographic works operating outside of medical contexts which may have more strict requirements to ‘protect’ potential interlocutors.

myself into the community and obtain consent. Furthermore, in a fluid and changing environment, signed consent forms may act as a barrier to participation (Boulton & Parker, 2007), and may bureaucratise the relationship between researcher and participant (Mapedzahama, 2017), thus harming rapport and stunting the natural flow of data (Wynn & Israel, 2018).

This being my first experience applying for ethical approval both in a healthcare setting and in the UK, I relied on the expertise of my main supervisor, who is experienced in UK-specific ethical requirements for qualitative research in healthcare settings, to navigate the culture of the formalised ethics process. However, the ethics application justifying the use of process consent was not approved by the UK National Health Service Research Ethics Committee (REC)[8], which is responsible for studies taking place in care settings[9]. We were asked to include a version of signed consent or written advice for each enrolled participant and to only interview participants who demonstrate, through careful application of the MCA[10] indicators, the capacity to provide written, informed consent for themselves. Taking this feedback seriously, I re-designed the

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[8] NHS RECs are required to follow the legal framework of the Mental Capacity Act, it is not the REC with which I take issue, but the frictions that can result when applying an ethnographic logic to health-care research in the UK, especially when working with a population which may include those who demonstrate a lack of capacity to provide informed, written consent.

[9] In England and Wales, assessing mental capacity follows a careful process required when working with a population which includes, or may include, adults who demonstrate a lack of capacity to provide informed consent to participate in research. According to the Mental Capacity Act (MCA), all individuals must be assumed to possess capacity unless established otherwise. Establishing capacity was done by sharing the Participant Information Sheet with potential participants and then asking some questions about the study to gauge whether the information was retained, understood, and could be repeated back to me. Because I had yet to establish rapport with most residents, I triangulated with staff and family members when assessing capacity. All participants should be assessed in the same way, and no assumptions about capacity or lack thereof should be made before assessment. The Health Research Authority (HRA) outlines that in order to demonstrate capacity, one must be able to understand information relevant to make a decision, retain said information, use or weigh the information given, and finally, be able to communicate (by any means) a decision based on the provided information.

[10] Mental Capacity Act - Health Research Authority https://www.legislation.gov.uk/ukpga/2005/9/contents

consent process to include consultee advice for those residents who do not possess the capacity to consent to participate, and to require written informed consent for interviews, and from staff for observation. The strength of the participant observation design is not only that it enables one, but it requires one to move through the layers of familiarity slowly and with time. In seeking ethical approval for an ethnographic study in residential care during the pandemic, I gained useful insight on issues of gatekeeping and paternalism of older adults, issues which persist outside of this context.

Especially while issues of isolation and stigma facing older adults in residential care have been so recently highlighted by the COVID-19 pandemic, conversations on barriers to participation and inclusivity in research matter. There are issues with using consultee advice at a time when family and friends are not allowed to visit or spend time in the homes of residents. In my experience with recruitment, friends and family were glad to have a “fresh young face” to interact with their family members–highlighting the collective understanding of socialisation as an important component of well-being. However, I was gaining permission to access the care home at a time when many were not allowed or able to visit with their loved ones. Even with equal access to residents, there are tensions with consultee advice, e.g., the assumption that friends or family members may truly know what the person wants; or that some legal consultees may not have lived or been in close relations with their parents for a long time, therefore not knowing what they would like or want. In an example later on in this paper, there is a resident whose behaviour and preferences appeared different during the time of the study than was expected by both family and care staff. This demonstrates that consultee advice does not accommodate for the fact that preferences change.

Awareness of these tensions helps to further understand the impacts that protected care settings during the pandemic (and beyond) may have on the agency and rights of older adult residents, who are often viewed as static in identity. However, this process is constricted by the MCA's legal restrictions on involving only those who have written consultee's advice–especially when used with ‘vulnerable populations’. Though an integral aspect of safeguarding, the ethics review process risks reinforcing cultural stereotypes of older adults, as not able to make decisions and lacking agency, which contributes to the governance of this population. This is arguably as much a political act as one grounded in ethical concern (Stevenson et al., 2015). Consequently, the ethics review process can reinforce paternalistic attitudes towards older adults and can silence populations and individuals who do not demonstrate a specific ability to provide informed, written consent, and threaten to stymie research endeavours, preventing new research from ever taking place.

The process consent approach differs from the informed consent required by committees with the assessment of capacity on one occasion rather than as an ongoing process, which often ends up in excluding the person with dementia rather than using any form of remaining capacity to include them in research. Process consent is contingent on rapport, which was flagged by the committee as a potential area of concern for the study design, as rapport is not a quantifiable thing that I can present prior to my fieldwork period. You cannot ensure that rapport will build between myself and each resident and member of staff (and it did not), but the notion that rapport is a subtle art which will guide me through my research to engage with those who desire interaction was not well recognised by the REC at the time, and the focus was instead on the issue that rapport is not a one-off event (Bell, 2014).

In order to include residents who demonstrate lack of capacity to provide informed written consent in participant observation, we included consultee advice, which relies on the opinion of a close relative or friend to determine whether their friend or family member would likely participate in the study. The Mental Capacity Act defines consultees as those who would be most fit to give an opinion about the potential participant's willingness to participate in the study. Consultees do not provide consent on behalf of potential participants, but they provide advice, helping to include the potential participants wishes and preferences in the decision making process. The concept of negligible harm is important here, as consultees need to gauge, basically, whether their friends or family would want to sit and talk with me, or sit with me, in the care home, which is their home.

However, prioritising the opinions of close relatives or friends over those who interacted with residents more regularly was complicated during this pandemic period when many residents had not been able to have visitors for months. Staff helped me reach out to those who they understood to be the best likely consultee. Communication between residents and family was often facilitated by staff, not by me or by residents directly. Had family and friends been allowed to enter the separate sections of the care home housing groups of residents, I would have met with them, discussed my plan with the resident and their family member(s), the process of seeking advice on the behalf of resident participants would have been more relational, including people from many parts of the participants' lives.

Taking place in a private residential care home located in the United Kingdom, this ethnographic study took place throughout the spring and summer of 2021. I resided in a private on-site apartment in the care home for weeks at a time over the course of three months, making a few return visits thereafter. During these periods, I was in the care home 24 hours a day. The fact that I was residing in a care home during the COVID-19 pandemic, during an event which placed disproportionate pressure on this population through prolonged periods of isolation, increased (and often changing) regulations, and experiences of loss and illness, shaped this project from design to dissemination of findings. The design for this ethnographic study evolved with health and safety protocols as the care home adapted to public health concerns during the pandemic.

I was required to obtain informed, written consent for interviews with residents of the care home. Thus, this limited the number of interviewees to just three participating residents of the care home. Interviews are valuable – it is a different type of data source, and there is a sense of vulnerability and earnestness during these events. One interview gave a man a chance to speak about the challenges of caring for his wife who has dementia, and who was also a participant in this study. In another interview, I spoke with a retired nurse resident about her expert perspective on care, and how she felt her care was handled during the 2020 lockdowns, when, in a few months' span, her section of the care home lost seven residents to COVID-19. The third interview was with a man who was a temporary resident when his daughter, his primary care worker at home, would travel for work.

At first I was disappointed that I would not be able to conduct interviews with more residents. However, though the interview privileges a type of storytelling, it is not the only, or even best way to tell one's story. So much is said in observation and interaction as well, and this form of communication enabled those who were not ethically, legally, or perhaps cognitively capable of interviewing to share their experiences and what mattered to them. Ethnographic data is observational, documenting body language, how participants move through space, how they react to other people and non-human agents. This form of data collection is easily blurred into daily life: participants over time began to see me as a confidant as my role in the community grew more natural. It became more difficult to understand when a conversation was data or when it was a moment between friends. This poses complex ethical challenges, fusing the relationship between care and research, as will be detailed in the following case studies.

I participated in the daily life of the care home through care acts: making tea, helping residents make phone calls, reading mail, washing dishes and disinfecting surfaces, having a chat, listening to stressed staff talk about their shift, and much more. Care sat firmly at the centre of all these interactions, and care occurred between residents, staff, and me. The movement and messiness of the space meant that attention to body language, verbal cues, and having a sense of the norms of each section of the care home (for they varied greatly) was important to ensure that my presence was not intrusive or stressful for staff or residents.

Julia

The day after interviewing George, I sat with his wife, Julia, and we knitted together for a few hours, speaking about her experiences moving into the care home with her husband. Julia had been enrolled after consultation with her husband, who in addition to providing informed consent for himself, was enthusiastic about Julia's inclusion in the study. The day prior, I had complimented Julia on her cardigan. She said that she made it and then, "I make everything that I wear". I asked her if she'd like to show me how to knit, and we agreed to try it together the following evening.

"Well, I haven't done this in ages", she began slowly, clumsily looping the polyester pink yarn around two large knitting needles. She patiently explained to me how one would "cast on", but before too long, Julia was knitting expertly, and her instructions stopped, she focused on her job and began to speak openly about her life, telling me about her childhood and her training to become a teacher. Her chipped pink nail polish glittered as her knobby, stiff fingers moved quickly, wearing the memory of a lifetime of knitting. I paid close attention to what Julia was telling me, but I also knew that perhaps Julia was not fully aware of me, of my intention for being there. Eventually, a man yelled from his room and Julia's awareness came back into the room. I assured her that he was fine, and she shuddered, saying, "I wish they could do something about that racket. He is always yelling and I am worried nobody is there to help him". Then she looked around, and not seeing George, she asked after him. We started talking about how it feels to live in different rooms from her husband, and the conversation, becoming more related to my topic of inquiry, allowed me to reacquaint myself and my role to Julia.

The experience of sitting and having a chat over time allowed for interruptions, shifts in topic, reacquainting to the topic, and continuing to discuss matters outside of my inquiry in a way that felt less rigid, and more natural. During this time, Julia told me some things that I did not feel were appropriate to directly quote, so I did not capture Julia's verbal account exactly, as I would in an interview. Instead, I captured a feeling of the interaction, a sense of what Julia was expressing. Rather than gleaning the interaction from a singular perspective, I tried to capture the mood and feeling from the entire interaction, making my role clear where appropriate while also allowing for the spontaneity of our dynamic to play out (Pols, 2005).

Like my experience talking with Julia, many of the interactions in the care home were ambiguous, but by reading body language, and tone, and by carefully observing the 'natural' flow of care workers and residents, I etched myself into the daily life of this care home and gently and as transparently as possible. Though the process is complex, it upholds the values underpinning the HCF: that consent is an interpersonal process which occurs temporarily and can change across moments. In the following section, we will share some experiences of seeking consent throughout this research project to further explore the complexity of these interactions.

Eva

“It’s warm out there!” I greeted the room, which was buzzing with the sound of electric fans. It was a hot afternoon, and the windows were open to create a cross-breeze in the room. Eva was sitting in a chair in the dining room, dressed in her nightgown (someone explained that this was the only clothing item most residents owned thin enough to be appropriate for this weather). Positioned under a fan, Eva’s face was glistening and pale, and her soft white hair was wet on the edges, causing small curls to cling to her temples like wet leaves on a windshield . Mary, one of the care workers, continued to gently dampen Eva’s face with a cloth. “It certainly is, and this poor thing”, she said, turning to Eva, “we are simply not accustomed to this kind of heat, are we dear?” Eva sighed and raised her eyebrows in agreement. “Yes, it’s far too warm” I chimed in, hoping to join in the small talk. Eva looked away from me, frowning, and then to Mary. Since Eva appeared uncomfortable with my presence, I chose to sit in a chair a bit further away.

In this situation, I quickly understood my participation to be an imposition, as there were clear signs that Eva had felt a sense of discomfort with my voice and presence. Of course, a sweltering afternoon might be a particularly difficult time to engage with someone unfamiliar. I also wondered how it would feel to be sat in a thin nightgown, a logical response to staying cool in the heat, but not with much consideration for Eva’s feelings of privacy or dignity. Though Eva was in a common area used by all residents, staff, and anyone who entered the community, her clothing, and the activity of being given a washcloth, were private activities.

Following this event, it is important to explain that I did not observe Eva from a distance without her knowing. As I grew more used to each ‘community’ within the care home (a separate living quarter with its own common areas made up of about 10 residents and 3-4 staff at any given time), I grew better at focusing my observational eyes on those residents and staff who were willing to participate, and not observing the others, such as Eva in this instance. The households are open to any visitors and the common areas would often contain many different people, coming and going, and when I wasn’t on “data collection mode” I would still be around, interacting with people, from whom I did not have consent (or consultee advice), or, as in Eva’s case, were part of the study, but from whom I did not have present consent to observe for the purposes of data collection.

I had previously spent time with Eva and grew to understand that she often preferred my presence along with the company of other staff. Eva, who is non-verbal, and who has been living at this care home for four years, is a favourite resident among care workers, and they often explain things to me as they are helping her with mealtimes. Staff will explain how they read Eva’s face for signs of being hungry, or not interested in a certain dish. They explain how they might adapt the daily menu to a soft diet.

Whether or not these explanations bother Eva, I cannot readily discern. Staff do not speak about Eva in front of her, rather opting to speak in “we” (“we eat lots of tomato soup, don’t we?”). In this way, it did not feel voyeuristic when I participated and observed in her care. But there was a line drawn: I would not accompany Eva to her room or to other areas alone, which I might occasionally do with other residents, with whom I'd established a stronger rapport. I also would not often address her directly, sit too close to her, or even sit at the same table, depending on her mood. During my time in this section of the care home, Eva and I have exchanged the occasional smile, kind glance, or nod. But most of the time, we kept our distance. Through my time in her private living space, I placed myself gently at the periphery, mostly through observation, but also through participation, as Eva and her care workers navigated the presence of an outsider in Eva's home. Importantly, though a stronger rapport did not build during the study, Eva did not always dislike my presence, and in fact, she seemed quite calm and understanding when I would accompany her along with a member of staff. Had Eva consistently demonstrated discomfort with my presence, I would not have included her in the study, as was the case with some other residents. This is a very sensitive distinction which is subjective in nature. Here, I relied not only on my ability to 'read' Eva, but on the comfort and naturalness of staff with whom Eva had a more consistent rapport.

Over time, I became more familiar with residents' daily schedules, and would know when certain residents may be willing to spend time with me. Discerning consent was slightly more difficult with residents who preferred to stay in their room, as I would have to impose in order to gauge consent. I often did this by offering care staff to bring residents' their tea or coffee. This way, I would have a reason to knock and say hello but would also allow for residents to inform me that they would rather be alone, either verbally or through body language (or if they were sleeping, with a physical therapist, on the phone, or in the bathroom, et cetera).

Rebecca

Because she was comfortable with telling me when she did not want to participate, I felt confident that Rebecca's participation was consensual and I visited her whenever she said she was 'up for it'. Through staff, I learned that she did not marry, had no children, and her niece signed the consultee advice sheet, but this was about all that could be gleaned about her life before the care home. When she was in the mood for my visits, she would often tell me about the series she was watching at the time, an antique shopping competition. We would sometimes sit in silence for periods of time as she grew more engaged with her show.

My experiences with Rebecca help illustrate care work through ethnographic presence and sensibilities. She was not always an eager participant, but consent was there, subtly, in the interactions that we did have. This calls into question what a "good participant" may look like. Participation, and what defines "good" participation, could be seen as similar to well-being, which is outlined by the HCF as operating along several connected, but separate values, such as insiderness, uniqueness, and embodiment, running along a spectrum of humanisation-to-dehumanisation. The dimensional understanding may help us to complicate what it looks like to participate "well": remaining solitary, prioritising privacy, and dissenting to participation can be equally valuable to understanding the shape of experience in the care home. There was a slowness, a subtlety to the time I spent with Rebecca. Unlike some residents, who had a seemingly endless supply of opinions and stories to share about their experiences in the care home, Rebecca required patience, slowness. Then, sometimes, she would tell me about how it feels to be in her bed, hearing people out in the room but not knowing any of them, about not wanting to know them. Sometimes she would share her feelings of not wanting to be a part of the care home, that her bed-ridden state was physical, but her rejection of the care home was more than that, it was a choice. Her insiderness, keeping a sense of separation from the community in the care home, is where Rebecca seemed to find a sense of safety. “It will be good for her, having those chats, I’m glad that you go in”, one care worker told me, and another: “everyone enjoys a nice chat”. True, I reflected, but for Rebecca it seems somehow equally valuable to reject the invitation for a chat, to establish her right to a private life in a living situation as public as the care home. Through the slowness of our relationship, Rebecca showed me how she protects her sense of agency by having a boundaried relationship with care workers and with myself.

Rebecca’s case reminds us that advice given by staff members may not necessarily align with the desires of the resident. Although staff may have a closer relationship with Rebecca, this does not necessarily mean that they know all of Rebecca’s preferences or wishes. This raises the question of who is best suited to provide guidance in such situations, which is an issue with the viability of consultee advice (and the importance of this being advice, and not consent on the behalf of an individual). Rebecca’s case also highlights the empowering effect of active participation, particularly in situations where individuals feel trapped or powerless. By actively participating and expressing her thoughts and feelings, Rebecca can importantly enact her sense of agency and also contribute a valuable voice on how it feels to navigate a limited sense of agency in the care home.

The cross-disciplinarity of care work and research further structured how participants and I engaged in this study. These collaborative moments expose a multiplicity of interpretive lenses at play–carers offer their interpretations, first, as a supportive insiders' knowledge to help with my introduction to the field. Later, my interpretive lens, was shaped by not only the fact that I was new to the care home, but that I was using my time differently–instead of providing a set of care services for residents over an eight-hour-shift, I could come and go more flexibly, spending longer amounts of time simply 'being' with residents. This eventually meant that I held information that could only present itself slowly, information about mood, preferences, and subtler needs (like making a call or getting a new pillow) which sometimes would fall through the cracks in a busy day of care work.

My role, as a PhD student studying the care home, also meant that these collaborative moments could sometimes feel awkward, and my inquiry could be interpreted by some as criticism. Sometimes I would come into a community of the care home to see carers quickly get off their phones, or stop chatting casually with one another. Though care workers were given a participant information sheet detailing that their identities would be kept confidential, I worried that they felt they had to participate in the study to please management who had been a part of the recruitment process. There is no way to prevent the possibility of subtle coercion in this case, but I assured the care staff that I was interested in the daily life of the residents and my role was not to hawk over carers as they did their jobs, but that I hope to be "part of the furniture" (Draper, 2015, 39). My working-class background, and the fact that my mother had worked as a “lunch lady” in public schools, strengthened rapport between carers and myself, as a “trusted outsider” (Bucerius, 2013).

My ‘outsiderness’ shaped and guided many interactions around consent and intention. Throughout the study, my foreign identity was often brought to the forefront of interaction between residents, staff, and myself, and was instrumental in establishing consent. First, I am American in the United Kingdom during a time when so few outsiders made their way into the isolated care spaces. My clumsy, untrained hands would often give me away as someone who is not a regular member of staff. Even the way I prepared tea exposed me as an outsider; I steeped tea too long and added too little milk (“is this builder’s tea?” one resident joked). I re-introduced myself to residents, accepting “close-enough” titles, such as ‘nursing student’, ‘American girl who wants to talk to us about care’, ‘who wants to know how we like it here’, or sometimes just ‘the girl’ (which required some more information on my part). When necessary and appropriate, I would remind everyone of my role, and my goals in talking to them, and I used my role to help remind residents of why I’d want to ask them questions or sit with them while they lived out the details of their daily lives. Furthermore, my role as an outsider to the care home culture impacts not only possible rapport between residents, staff, and myself but also means that I may not always correctly read body language or cultural and social cues in the way they are intended by participants.

Throughout the study, I experienced a shift in my initial hierarchical positionality - a common feature of any research context - through a process of mutual accommodation. As we became accustomed to one another, the hierarchical and procedural form of seeking ethics became more entrenched, as I became a “guest of the guests” (Boccagni & Bonfanti, 2023). Additionally, vulnerability occurs and is experienced by everyone involved in the study–not only those lacking the capacity to consent–such as the vulnerability experienced by staff workers in relation to more privileged residents (Reed-Danahay, 2001). These observations highlight the significance of an ethnographic approach in healthcare research, which requires sensitivity to power dynamics and the complex dynamics of vulnerability in healthcare settings. This experience underscores the importance of process consent not only for individuals lacking capacity but also in any setting where a power dynamic exists between the researcher and participants.

Doing ethics is a messy process. It took time to build a sense of what consent, and just as importantly, dissent, looked like from each potential participant in this project. It took time to understand the general flow of the communities within this care home, each being quite different, and to gently find a space where I could fit in. Importantly, it took time to build trust. Relational ethnographic work requires a ‘caring for insiderness’ (Desmond, 2014; Todres et al., 2014). My positionality was both an asset to gaining information about this community and a barrier to understanding certain complex cultural cues. The interaction required to repeatedly assess consent, (an initial concern for the HRA ethics committee as being “overburdensome”), varies greatly from individual to individual and this sense for being a burden is developed over time and through rapport. Informing Julia that I am interested in her experiences for my study throughout our conversations looked different than my long afternoons spent with Rebecca, for instance.

The need for not just more, but deeper, explorations of the world of residential care for older adults is pointed to over and over (Westwood, 2014; Sandberg, 2013; Simpson et al., 2018; Cowdell, 2013). Yet, the struggle to represent the experiences and voices of participants who do not demonstrate capacity began the moment this project came into existence. This begs the question not only of representation, but the power structures which generate said representations (Marcus & Fischer, 1986). It describes the care home from within, experiencing along, which will help us to move beyond paternalistic views and treatment of older adult care recipients (Connor, 1989), and to engage with the lived experiences of residents. The phenomenological approach underlying the HCF is useful when engaging in such research. Even with consultee advice, I was still tuned into looking for signs that each participant wants to take part in the study (e.g. through body language and verbal expression). This relational approach to consent, bound up in the ethnographic design, is good practice and is informed by such a phenomenological approach to well-being and care.

Describing the way one might tread carefully through intersubjective events to best respect one’s wishes to consent or dissent to study participation is difficult to describe in an itemised formal ethics application, or to make sense of in a procedural fashion (Simpson, 2011; Fluehr-Lobban, 2003). The case studies presented in this paper show that there is scope for a different approach which is much more ethical and inclusive than can be fully accounted for in procedural ethics. There is no possibility that I could have described my experiences with Julia, Eva, or Rebecca before going into the care home and meeting them, or even to explain which percentage of residents would likely want to sit and have a chat with me on which days, or which times of the day the care home would be most active. Instead, ethically engaging with, including, or excluding potential participants was bound up in the care logic of the care home and relied on all actors to carefully negotiate our positions (Roger, 2023).

In a project which aims to highlight the stories of those living in this care home, how are these stories witnessed, gathered, and represented? The justification for this project existing at all is that older adults' experiences of care, and in this particular case, residential care, is underexplored, and tend to focus on the institutional failures over the lived experiences of older adult residents (Malta-Müller et al., 2020). It is not too bold to call this project one of anti-oppression, one which would do well engaging with ongoing debates in post-colonialism and disability studies–grappling with subjectivities and directly engaging with a 'politics of position' to highlight which voices are enabled to represent whose experiences (Rogers, 2023).

Consent, like care, is not an immutable thing, but it is a messy, nuanced process. Conducting research with the ethos of process consent, wherein one reads each situation for consent between individuals, allows for the inclusion of participants regardless of their capacity to provide informed consent. The methodological issues of engaging adults with varying capacities to participate in ethnographic research are supported by the philosophies of care and caring. Well-being, an existential, multi-faceted experience which occurs along varied, and sometimes even contradicting, characteristics, is supported in this process, a way to "care for insiderness" (Todres et al., 2014). The balance, for instance of privacy or solitude, for the chance to share one's experience and engage in research is a choice which is taken away by overly paternalistic ethics barriers. Research can be a component of the care matrix. The fact that engaging in research can improve mood and well-being among older adults has been explored (Butterworth, 2005; Grout, 2004). With process consent, consent is negotiated through the relationships built between researcher and participant, be it staff or care home residents. The strength of the ethnographic design parallels the humanisation of care framework: to de-centre the verbal interview as a story-source, to listen and observe for the embodied ways participants may communicate what matters to them, to "unmask the elderly mystique" (Carney & Grey, 2015). A consent process which adequately values and understands the complexities of ethnographic research in care home settings with older adults is a necessary next step in addressing our need for more inclusive research, and ultimately better care.

Accessing a bounded/protected location and people in the times of COVID

The residential care home presents an intriguing setting for an ethnographic study. The notion of the dwelling and its transformation within the care home (Ingold, 2005) provides fertile ground for investigating processes, customs, and collective experiences (Giddens, 1981). Institutional ethnography has been widely employed in healthcare research, ranging from studies in psychiatric hospitals (Goffman, 1961) to community clinics. These ethnographic projects, which aim to explore specific groups or cultures, invariably raise questions about boundaries (Candea, 2007). Since Rose Laub Coser's seminal work, "Life in the Ward" (1962), researchers have been eager to delve into the intricacies of institutional life through ethnographic approaches.

In her early exploration of hospitals, Laub Coser portrays them as "little islands," emphasising their foreignness and distinct cultural practices (1962:3). In contrast, Zaman's (2005) ethnography of a hospital in Bangladesh highlights how the borders of such institutions are constantly being reshaped and redefined by the individuals who enter and exit them. The notion of boundedness (Candea, 2007) and closed communities gives rise to discussions on power dynamics and access issues within disability and gerontological research. Gatekeeping, while essential, can also present challenges. The COVID-19 pandemic has intensified gatekeeping practices, reigniting debates around access in healthcare settings and shedding light on power dynamics during this challenging period. The residential care home, as an exclusive and exclusionary institution (Foucault, 1975), is subject to the biopower exerted on older adults, as critically examined by gerontologists and sociologists (Estes, 1979; Estes, Biggs &

Phillipson, 2003). Accessing this community poses politically charged obstacles intertwined with notions of paternalism and assumptions about the agency of older adults.

Practical and material considerations are at play, given that my field site is a residential facility for older people, making it essential to ensure the safety of participants, staff, and myself. The pandemic has introduced unique challenges for conducting embedded research in this community. Residents are more isolated, care staff are likely under increased stress, and my own isolation is amplified. The data collected during this heightened stress and safety concerns will inevitably differ from what would have been obtained under normal circumstances. The COVID-19 safety regulations have demonstrated the permeability and negotiability of these institutions (Armstrong & Klostermann, 2023). Logistically, ethnographic research has become more challenging due to restrictions that impede the traditional notion of "being there," requiring the ethnographer to navigate access and safety in new and different ways.

The design of this project necessitated more extended periods of embedded fieldwork with fewer breaks or shorter periods spread over an extended timeframe, as dictated by the limitations imposed by the pandemic (Tauzer, 2023). Negotiating access to the field was an ongoing process, though I received little to no pushback from the care home itself, the ethics process and the consideration of family members and friends who have limited access to their loved ones living in the care home during data collection.

Various adaptations have been proposed to continue ethnographic research during the pandemic, such as digital ethnography or "ethnography from home" (Góralska, 2020), as well as patchwork ethnography (Gökçe et al., 2020). These adaptations aim to reflect the realities of our lives shaped by evolving restrictions on social interactions and the increasing role of digital platforms. Embracing the concept of boundless locations in the research design (Candea, 2007) or adopting a multi-sited ethnography approach (Marcus, 1995) helped me think about how I accommodated the temporal and spatial fluctuations inherent in this project. Even when physically present in the field, the research is likely to exist in an unbounded and liminal state (Turner, 1977), as I traverse between the field and home while encountering tightening barriers and gatekeepers seeking to safeguard the care facility's residents.

Chapter Three: Engaging with the Literature

> "Since it is the Other within us who is old, it is natural that the revelation of our age should come to us from outside — from others. We do not accept it willingly."
>
> Simone de Beauvoir, The Coming of Age

> "The trouble is, old age is not interesting until one gets there. It's a foreign country with an unknown language to the young and even to the middle-aged"
>
> May Sarton, The House by the Sea

A prevailing dehumanising attitude towards older adults impacts not only the provision of services but also shapes our social imagination to such an extent that data collection often fails to consider older people altogether. Existing care research on older people often peripheralises gender identity in its analysis (Calasanti, Slevin & King, 2006; Clarke & Bennett, 2013), desexualises older individuals (Calasanti & King, 2005; Gott, 2005; Heaphy, 2007; Simpson et al., 2018), and promotes a decline narrative that flattens older adults' perspectives on subjective experience (Davis, Grant & Rowland, 1990). Without a better understanding of existing conceptual approaches, these issues may be replicated in future research. For this reason, I will review how we grapple with gender and ageing in conceptual literature to identify empirical work that addresses or complicates how we look at gender and ageing in care. The following is an overview of existing literature that looks at old age and gender as intersecting categories to explore the potential for a gender approach to deepen existing understandings of old age care. This review is meant to first map out conceptual approaches to ageing and gender and then look more closely at how these attitudes, genealogies, and positions inform current research.

Because gender is a contested concept with many theoretical approaches and genealogies, and this review is structured with the hope to engage not only with existing research on gender but the varied ways in which old age and gender intersect, this review will be organised in two stages. This two-part design of this review is inspired by a similar format conducted on ageing and social exclusion (Walsh, Scharf & Keating, 2017). However, in this review, rather than synthesising existing frameworks to guide domain-based reviews, I first conduct a loose overview to build a map of conceptual and theoretical framings of the interaction between gender and ageing. This method attempts to establish a footing in this interdisciplinary field and engage varied modes of operationalising the slippery concept of gender. Since age and social location research is spread across multiple disciplines and can contradict gerontology, a broader overview is a reasonable starting point for this review. Once this map has been sketched, I approach empirical peer-reviewed literature to examine how existing research in the care field fits within the identified conceptual frameworks. I have selected this two-tiered process to help give shape and transparency to the amorphous nature of gender in research and the layered complexities of combining gender and ageing. This design is an asset in etching out a map of the trends and findings for this nebulous and interdisciplinary topic.

This literature review section presents a review of international literature focusing on gender and old age. Stage one involved a loose sociological review of varied approaches to understanding gender identity in old age: identifying conceptual understandings, critical debates, and critical themes of the discussion of age and gender interdisciplinarity. Stage two involved conducting overviews each of the conceptual themes highlighted in the first stage (five in total) with a particular (though still quite broad) focus on care contexts and recent empirical research considering older adults' experiences and perceptions. Reviewing existing literature on gender and ageing, this chapter calls for centring conceptual themes in making sense of the experiences specific to ageing individuals in future care research. Using dated sources in my literature review serves to underscore the enduring nature of certain issues within care research on older people. By referencing older literature, I aim to demonstrate that these themes have persisted over time without significant progress or evolution in the discourse. This approach allows me to highlight the longstanding nature of issues such as the marginalisation of gender identity, the desexualization of older individuals, and the promotion of a decline narrative.

My introduction to issues of old age injustice began in the academic sense over a decade before embarking on this doctoral project. As a first-year psychology major, intending to take the science courses required for admission to medical school, I wandered into a class in the biology department titled “Healthcare Inequalities”, led by Dr Andrea Steiner, who would, over the following four years, become my main supervisor and the inspiration to delve into the specificities of age-based discrimination in the US healthcare system. Among peers discovering Marxism, racial injustice, anarchist cooperative movements, and environmental rights, my focus seemed strange, perhaps a bit mild in comparison. But for me, the angry words of age activists–Barbara MacDonald (2001), May Sarton (1970; 1988; etc.), and Maggie Kuhn, as examples–burned with the passionate rage, embodied inquiry, and reflective honesty that I craved as a young adult mapping out and making sense of her world. The injustices faced by the old could not be parsed out from other issues of social injustice.

It bears noting that my orientation to studying healthcare (injustices) occurred in my home country, the United States. However, even in these early days of studying “critical social gerontology” relating to the specificities of the crumbling US healthcare system, it was made apparent that much of the interdisciplinary thinking on old age and, specifically, social gerontology, occurs trans-Atlantically. Writers such as Carroll Estes, Margaret Minkler, and Stephen Katz, to name a few, introduced me to the concept of old age as an intersectional aspect of social location. Biggs and Philipson, in the United Kingdom, were often in conversation with these North American writers. Molly Andrews led the way in lifecourse perspectives and the use of narrative to delve deeply into the lived experience of old age. Thus began my quilt of social gerontologists, who would follow me through my Masters' studies in Anthropology, and on into this current work, to which I will now turn my undivided focus.

For stage one of this review, I review literature that relates to the conceptual framework of gender and age with looser inclusion/exclusion criteria. I include literature from any date and include dissertations as well as peer-reviewed publications. This path is woven as I gather and search for trends and themes in this interdisciplinary area of focus. I focus particularly on how gender is used in research on ageing and unearth some subthemes which will help guide the second stage of the review. Search keywords to guide the first stage of the review were derived from the established literature on gender and old age. Keywords relating to the topic of gender included: gender; men and women; gender identity. Keywords relating to ageing and older people included: ag(e)ing; older persons; older adults; seniors; elderly; elders; senior citizens.

For stage two, my search is more systematic, and is presented as an overview of the literature with a sociological leaning. I focus on current research that deals with age and gender in care, with stricter inclusion/exclusion criteria. I used AgeLine (EBSCO); ScienceDirect; Scopus; Google Scholar, Google Books, and PsycINFO. The inclusion criteria were as follows: (1) literature since 2011 (the past decade); (2) academic, peer-reviewed journal articles, books, and research reports that present original work; and (3) empirical, qualitative studies which focused on the experiences and perceptions of recipients of care. Initially, I limited my review to studies which take place in residential care but found this too limiting. Any literature on care, in any capacity, was considered for this review. I decided to exclude literature that focused on the experience of carers—this limited my findings significantly, but without this limitation, the review would be dominated by studies on the experiences and perceptions of carers rather than care recipients, or those who expect to need care in older age.

Stage one identified five conceptual domains: lifecourse, intersectionality, embodiment, performativity, and sexuality/sexual identity or orientation. Stage-two domain-specific keywords were generated after domains were identified in stage one and are presented with the stage-two findings. I conducted overviews of care literature using these five domains. Using findings from these overviews, bookended by critical conceptual reviews, this literature review presents a unique approach to understanding the complex and under-researched world of gender and ageing in care.

The purpose of this first section is to overview discussions, debates, and critiques on gender and old age on a conceptual level. This overview is purposefully and necessarily, broad and interdisciplinary. My goal here is not to overwhelm with an eclectic breadth of literature but to establish a collection of the central critiques and shortcomings wrapped into how we study the intersections of gender and old age. As a starting point, I will overview the development of critical gerontology and its somewhat stunted communication with feminist literature. Ageing occurs in context and intersects with other identities across the lifecourse. The way social categories interact and influence the ways we age has been explored by the field of social gerontology: the study of the psychological, biological and social analyses of ageing in a social context (Longino & Powell, 2002). It is important when looking at gender to be wary of the epistemological trappings that can reproduce and promote hegemonic attitudes; in care research, this may be doubly so, since we must grapple with trends to over-medicalise and homogenise older bodies (Sandberg, 2013). It is also important to note that theorising about experiences of ageing has *mainly* been conducted by the 'ageing enterprise' (Estes 1998; Gubrium & Wallace, 1990) and not by older people themselves, except some influential autobiographical texts (Davies, 1989; Macdonald, 1983; Sarton, 1970).

Critical social gerontology is the study of age within society and the ways in which age serves as a point of identity on political, social, and individual levels (Estes, 1999). Critical gerontology, which often takes a political and economic stance on ageing, posits that ageing cannot be separated from a socio-economic matrix which positions different individuals to age differently. This perspective focuses on inequalities in old age and operates in the critique of previous perspectives on ageing which homogenised and simplified the aged population (Phillipson, 1982). Foucauldian perspectives on biopower, feminist perspectives on gender-based disparities in agency and ‘the feminisation of ageing’ (Minkler, 1996) have been useful in understanding ageing as a social process. Social and critical gerontologists have identified the impact of gender in old age in many areas of life such as retirement (Minkler, 1990), housing needs (Svihula & Estes, 2008), and access and utilisation of services (Biggs, 1999; Estes, 1998; Laliberte, 2014). Critical gerontology has identified that a pervasive neoliberal logic of productivity in old age may promote a binary when understanding ageing: either one is successful (a productive, consuming subject), or one is sickly, weak, and frail (Calasanti & Slevin 2006; Estes, Biggs & Phillipson 2003). Critical gerontologists have coined the term “the feminisation of ageing” (Estes, 1998; Mujahid, 2008) to describe the phenomenon of women living longer and in relative positions of less economic and social power than men (Hess, 2018; Byles et al., 2010; Tuohy & Cooney, 2019). The invisibility and mistreatment of older women in a patriarchal context have been written about across a variety of contexts and have been rigorously explored, especially in second-wave feminism (de Beauvoir, 1996; Frieden, 1994; Greer, 1991; MacDonald & Rich, 1991; Steinem, 1995). That disproportionate dependence that older women have on the state is a product of societal values and economic structures (Minkler, 1996), and the contradictory demands for women to spend more time providing informal care services (Wilson-Ford, 1990) are recognised as some of the most salient factors that create a gendered pattern of dependence in old age. Since critical gerontology takes a largely socioeconomic lens on issues of ageing, the experiences of individuals with regard to their intersecting identities in old age can be under-explored by this perspective (Hulko 2002).

The ‘feminisation of ageing’ is used widely to frame and justify inclusion criteria for health and policy research (Davidson, DiGiacomo, & McGrath, 2011). Scholars from public policy, social work, sociology, and feminist studies apply a gender lens to ageing studies (Clarke & Bennett, 2013; Song & Kong, 2015; Tuohy & Cooney, 2019; Winterich, 2007), and the ‘double jeopardy thesis’ of age and gender has been used to argue that older women are often at a necessarily more disadvantaged position in old age (Chappell & Havens, 1980; Chepngeno-Langat & Hosegood, 2013; Ferraro & Farmer, 1996; McKay, 2005). The term double jeopardy is used primarily in policy research to describe the combined disadvantages that individuals coming from certain categories may face, such as being old and being a woman (Liska Belgrave et al, 1993).

These issues and patterns are important to consider, but framing all research in this way risks silencing varied experiences of ageing and reproducing a binary understanding of gender. In reaction to this “operational essentialism”[11], critics of this perspective argue that a ‘double jeopardy thesis’ promotes a “misery lens” by which we examine older women (Ovrebo and Minkler, 1993). That is, the view that all older women must necessarily live at a disadvantage to men threatens to reproduce assumptions of autonomy and agency. Furthermore, critics of the ‘double jeopardy’ perspective posit that this framing of older women’s experiences replicates and strengthens simplified and wholly negative understandings of what it means to age as a woman, thus bolstering sexist stereotypes of ageing women (Ovrebo and Minkler, 1993).

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[11] Operational essentialism of gender has been defended as a method to promote equality for women - the operational aspect of gender which is used in policy and public health promotion (Spivak, 1985)

These categories are a fact of our current society and must be considered when evaluating how gendered identities impact ageing. However, we run into an epistemological conundrum if by researching gender and power, we in turn reinforce a pervasive gender binary. There are indeed sociological categories of gender that adhere to binary and heteronormative understandings, which act upon individuals throughout the lifecourse to position us differently. A lifecourse perspective helps us to look at how social location impacts the ways we age narrative studies look at the lifecourse perspective as a mode to centre the individual's life experience in our analyses of ageing in context (Woodward, 2006). Thus, it should be useful to operationalise the lifecourse as a conceptual framing to look at differences in old age.

Feminist gerontology has responded to the conceptual issue of gender by engaging more directly with the complex and multi-faceted nature of identity. Expanding on Bytheway's earlier definition of ageism, feminist gerontologists aim to take a more holistic view of the individual and to engage with subjectivity and identity. Feminist gerontology views gender as a relational construct that provides women and men with advantages and disadvantages throughout the lifecourse. Feminists pursue a holistic view of people's lives, emphasising strengths, oppression, differences, and abilities; analysing old age more inclusively; and advocating social change to reduce inequities (Hooyman et al. 2002: 10).

Lifecourse Perspective on Ageing & Gender

When gender is applied as a variable, this implies an inherent and consistent difference, which fuels the "othering" of women compared to the normative male experience (Hochschild 1978;

Matthews 1979). Gender-as-variable work also operates under a binary assumption of gender which has and continues to be problematised as erasing the existence of individuals who live outside of this dogmatic binary framing of gender. The lifecourse perspective on ageing is a theoretical framework that examines how individuals develop and change over their lifetimes, particularly focusing on ageing and the processes that occur as people grow older. This perspective emphasises the dynamic interaction between historical, social, and cultural factors across the entire lifespan. Taking a lifecourse perspective on ageing may help to map differences among ageing individuals without promoting overly prescriptive understandings of what ageing looks and feels like for older adults based on gender identity alone. A lifecourse perspective on ageing can help to understand the way different individuals age differently and to engage with gender as an analytical tool rather than as a variable that necessarily positions older women to age at a disadvantage to older men.

Exploring the lifecourse domain revealed a smaller volume of literature than anticipated (n=457), and only 12 of these studies proved relevant for this review. While there were some studies centred on older women in this category, many of them were quantitative, emphasising risk and frailty. Qualitative studies that did exist primarily explored the experiences of family care workers and centred on risk factors. Surprisingly, there was a dearth of literature concerning the lifecourse experiences of LGBT elders. These themes were predominantly heteronormative, with a greater emphasis on women than men. This highlights the necessity of considering the perspectives of older adults themselves when utilising the lifecourse framework to gain a deeper understanding of ageing and care.

Regarding the literature on the lifecourse perspective, gender identity was mainly taken into account when discussing familial structure. For instance, studies examined the experiences of older widows (Isherwood, King & Luszcz, 2017), voluntarily childless older men and women (Warren & Pals, 2013; Allen & Wiles, 2013), single older women (Timonen & Doyle, 2014; Reilly, Hafford-Letchfield & Lambert, 2020), and men and women living alone (Timonen & Doyle, 2014). Frazer, Cleary & Oyebode (2011) interviewed women with dementia who lived alone, delving into the liminal aspect of their experiences as they faced uncertainty about maintaining their independence. Hafford-Letchfield et al. (2017) explored the links between relationship status and well-being among older women living alone in old age in the UK, but this survey data calls for more in-depth qualitative research on the topic.

The lifecourse perspective literature also proved valuable when examining adults who aged with specific diagnoses, such as HIV (Cahill & Valadéz, 2013; Wallach & Brotman, 2013). However, these studies primarily focused on men and stigma, neglecting a deeper gender analysis. Sleep issues in older women were found to be less correlated with medical or physiological factors and more associated with familial and caregiving responsibilities throughout their lives (Walker et al., 2012). Reduced cooking activity among women in later life was not attributed to disengagement but rather to new forms of engagement with others, such as using formal meal services or dining out with family, indicating continued change and growth throughout the lifespan (Lane et al., 2014). Other themes explored included choices or lack thereof regarding location and place in late life (Van der Pers, Kibele & Mulder, 2015; Stones & Gullifer, 2016), loneliness and community engagement among LGBT elders (Hughes, 2016), loneliness and activity among older men in Wales (Milligan et al., 2015), as well as agency (Pirhonen & Pietilå, 2018) and positive ageing (Stenner, McFarquhar & Bowling, 2011) concerning the lifecourse. Overall, studies within this domain predominantly adopted a "gender-as-variable" approach and did not utilise gender as an analytical tool. Surprisingly, even studies focusing on married couples often failed to consider gender, with keywords related to gender, men, or women absent from their abstracts. Furthermore, literature from this domain frequently relied on heteronormative assumptions.

Gender and Age as Intersectionality

Intersectionality and performance in gerontological research appears to draw many recent studies (Ferrer et al., 2017; Nikander, 2009; Previtali & Spedale, 2021; Syed, 2023). Within dementia research, some care literature utilises intersectionality as a conceptual framework to challenge the objectification of older adults in care studies and to gain deeper insights into their care experiences (Hulko, 2009). This approach aligns with a person-centred interpretation of care (Kitwood, 1997), which emphasises the individual receiving care. The intersectionality lens has been particularly developed in studies on selfhood in dementia and late old age (Sabat & Harre, 1992). Wendy Hulko's ethnographic research with adults with dementia in Toronto attempts to operationalise intersectionality by examining class dynamics, individuals' priorities, and strategies as they navigate changes in cognitive capacity (Hulko, 2010).

When viewed as a social category, old age does not simply compound oppression but generates a distinct array of challenges and positionalities (Calasanti & King, 2015). An intersectional approach helps illuminate the structural and personal interplay between gender and age. Intersectionality, as a concept and analytical framework, has been explored in various contexts. Initially introduced by Kimberlé Crenshaw (1991) in a legal context, intersectionality has since proliferated in the social sciences as a means to analyse and conceptualise the multifaceted nature of identity categories. The idea of intersectionality existed intuitively before it was formally coined, with a complex history involving multiple scholars and actors (Yuval-Davis, 2011). While some argue that intersectionality is only applicable when discussing the experiences of black women, I acknowledge its widespread usage and find it useful to include when searching for literature on identity and ageing.

In an analysis of how a person-centred approach to care may contribute to the re-gendering of individuals with dementia, Sandberg (2018) contends that unquestioningly locating one's continuity of self solely within gender expression risks reinforcing normative gender attitudes and overlooking the structural power disparities perpetuated by a gender binary. If adults are re-gendered to promote continuity, feminist critiques may become obscured in favour of preserving a simplistic notion of self and identity within the context of care provision. Without a more intersectional understanding of care in old age, studies run the risk of homogenising and oversimplifying the experiences of care recipients (Kontos & Marten, 2013). Adopting an intersectional perspective can aid in comprehending how individuals are positioned along multiple identity dimensions and offer a valuable approach to understanding the ageing process. Furthermore, this approach can help emphasise the need for transdisciplinary approaches to understanding, as argued by Phillipson (2015) who suggests that critical race studies would benefit from incorporating a gerontological perspective on the experiences of older adults.

When age was considered as an intersecting factor, the focus primarily revolved around middle age, examining income as a determinant of well-being. The majority of research utilising the term 'intersectionality' originated from Canada and the United States. However, gender often received minimal attention in these studies or was treated as an 'other' aspect of identity alongside racial, class, and other social distinctions among older individuals (Buch, 2015). An intersectional approach played a central role in a US-based survey that explored the priorities, concerns, and recommendations regarding ageing and health of black lesbian women aged 41 to 91 (Seelman, Adams & Poteat, 2017). Additionally, an examination of self-reported health identified the interactive impact of race, gender, and socioeconomic status on individuals' perceptions of their health and well-being (Brown et al., 2016). A study conducted in Switzerland, focusing on differences in hospital stays, revealed that women tend to have longer stays, and this disparity is influenced by social factors such as income level, marital status, and social resources (Hedinger et al., 2015). Socioeconomic status and familial ties were also identified as significant factors impacting gender and retirement mobility (Xu & Wang, 2019). In Barbados, it was found that lower-income older adults were more likely to rely on care provided by their adult children. Gender emerged as a crucial determinant of economic independence in old age, emphasising the importance of economic status and familial connections in shaping outcomes (Quashie, 2015). In a case study involving a transgender older individual receiving care, it was recognised that further research is needed to understand how the lifecourse influences the ageing experiences of adults from diverse backgrounds (Carroll, 2017). Notably, the literature in this domain is relatively recent, suggesting the emerging nature of intersectionality as a concept for comprehending difference and identity throughout the lifecourse.

Embodiment and Gender

Critics in social gerontology strongly emphasise the neglect of the ageing body in gerontological studies (Twigg 2004; Gilleard & Higgs 2011). They argue that, from a sociological perspective, old age is overly medicalised and all too often associated with a narrative of decline (Phillipson & Walker, 1996). Examining the homogenisation and control of older bodies, critics highlight how we actively marginalise them (Katz, 1996). Consequently, gerontology has rejected the inclusion of the body, paralleling feminist research, which shifted towards social constructionism to comprehend identity and disassociate it from corporeal references. However, over the past decades, there has been a more vital call to reconsider the body as an important site for identity and meaning-making in old age (Twigg, 2004). Authors, influenced by postmodernism, have increasingly framed the ageing body as a cultural construction that both shapes and is shaped by one's social reality (Katz, 1996; Woodward, 1999). The body is a fundamental aspect of ageing, and it would be unrealistic and limiting to overlook its significance. The management of the body in care work has often been analysed through a Foucauldian lens, exploring concepts such as the professional gaze, power dynamics, and the notion of "docile bodies." While these frameworks help us understand these systems, there is a risk of perpetuating a medicalised and detached understanding of one's lived experience. Twigg (2004) expresses concerns about the excessive reliance on Foucault's theories to interpret the experiences of ageing bodies needing care.

Furthermore, feminist research has been criticised for neglecting the ageing body, but many authors argue that prioritising the ageing body can help counteract its invisibility in other fields (Segal, 2013; Cruikshank, 2003). When ageing adults are asked about their bodies, it challenges our assumption that ageing is inherently traumatic or alienating due to our youth-centric values (Arber & Ginn, 1995). Exploring the body becomes crucial in understanding how culture shapes gendered experiences of the self. Gullette (1997) posits that culture plays a significant role in ageing, reading our bodies as scripts of irrelevance and stigma. By focusing on embodiment, we can better comprehend intersectionality, including how bodies are racialised throughout the lifespan (Rajan-Rankin, 2018). Cultural influences such as consumer culture, technology-mediated self-monitoring, and the performance of youth have all been examined for their impact on ageing and the body.

As described in the conceptual overview of embodiment, research in this domain was largely focused on cultural aspects of gender expression, maintaining youth, and experiencing ageing as bodily change. Interestingly, some papers did not mention gender in their keywords or abstracts but did include gender analysis in their findings (Ward & Holland, 2011). In others, rich first-person data on the body and meaning-making in old age is central, but gender is not included in the title, abstract, or keywords (Thomas et al., 2014). Some studies included gender in the keywords and abstract and offered insight into embodied ageing. Still, the analysis was not there, and gender was understood as a 'covariate' to be accounted for to produce accurate data (Robertson et al., 2015).

Commonly, the body was described as a site of resilience and as a tool for navigating care needs to others—framing experiences of resilience among older adults with dementia in residential care (Newman et al., 2019), older adults and their families as they navigate inter-team care services (Dahlke et al., 2018), and how autonomy links to the body and life story of the older adult care recipient (Dahler, 2018). In studies which highlight resilience, gender is not used as an analytical tool but instead mentioned as a factor of one's bodily reality, looking at embodiment and lacking an in-depth account of gender while claiming to consider gender identity (Ben Mortenson et al., 2012).

Studies which used gender beyond a surface level mostly focused on youth culture and consumerism as forms of maintaining one's gender identity. Examples of this category include: women in hospices in Spain expressed more concern about the appearance of bodily decline than men (Hilário, 2016), the materiality of clothes and implications on care and performance of gender (Twigg & Buse, 2013; 2018), gender performativity through hair care (Ward, Campbell & Keady, 2016). Linking bodily experience to meaning-making and planning for older age among the younger-old (Cranciun & Flick, 2014; 2015), oral health as 'doing' family, and gender and age intersections to this aspect of well being and generativity/influence on one's kin (Emily Kettle et al., 2019), women's experience with well-being transitioning to extra-care housing (Shaw et al., 2016), ageing women's mental health and social engagement (Sabik, 2017), class and status and how this plays out on the body and performance in residential care socialisation (Brossard, 2016), and home-making as dwelling in a precarious body (de Jonge et al., 2011) continue in this vein. These approaches invoke gender as a factor in ageing settings, but do not interrogate binary understandings and stereotypes.

Another common theme was the ageing body as a site to perceive oneself: self-perception and internalised age stereotypes (Sargent-Cox & Anstey, 2015) or perceived uselessness (Zhao et al., 2017). Looking at what older people think others think of them through a survey across the EU, gender is identified but only as a variable to organising findings (Vauclair et al., 2018), negotiating sameness and difference in community care (Oliver et al., 2018). Mental health and income level, including gender considerations on masculinity (Fernández-Niño et al., 2014). In a case study on one informant's narrative of her own ageing body (Mercado Thornton, 2015), the ageing body was framed from a materialist standpoint, looking at the decline in terms of labour and productivity. Still, gender was not used in the analysis. The 'fourth age' was not commonly included in this domain. In a US survey on sexual body image and age, the upper age limit was just 68 (Montemurro & Gillen, 2013). I found a study looking at embodiment and identity in dementia, but not until the end of the paper is gender mentioned as an element of bodily identity (Kontos & Martin, 2013).

Overall, studies in this domain provided rich accounts of ageing, often finding that one’s bodily identity contradicts pervasive views of decline/negativity associated with the ageing body. Regarding care context, this domain reached literature that explored social and cultural aspects of vulnerability and resilience, relation to others, and meaning-making. Gender as anything more than a variable/descriptor was not as common across studies. When used analytically, gender was majorly used to explore gendered tactics/strategies to ‘maintain’ appearance or to discuss women’s disproportionate concern with appearance concerning youth culture. Overall, including the ageing body in gerontological research and considering gender as a crucial analytical lens can provide textured accounts of ageing experiences (Mercado Thornton, 2015). Understanding the intersectionality of gender, age, and other social categories can shed light on how culture, social norms, and power dynamics shape the embodied experiences of older adults. By acknowledging and exploring the significance of the ageing body, we can gain a deeper understanding of the complexities of ageing and work towards promoting more inclusive and holistic approaches to gerontology.

Performativity

“The effect of gender is produced through the stylization of the body and, hence, must be understood as the mundane way in which bodily gestures, movements, and styles of various kinds constitute the illusion of an abiding gendered self. This formulation moves the conception of gender off the ground of a substantial model of identity to one that requires a conception of gender as a constituted social temporality.” (Butler, 1990).

Gender performativity, as conceptualised by Judith Butler, highlights the role of repetitive ritualisation of gendered behaviours in reinforcing and developing our gender identities (Butler, 1990). This perspective challenges the notion of gender as a fixed and inherent identity, instead emphasising its constitution through individual, social, and cultural practices. In the context of ageing, examining the interplay between gender performativity and the ageing process sheds light on how gendered identities are shaped and negotiated in later life. This section explores the construction of gender performativity concerning ageing, specifically focusing on the femme culture and middle-aged women's experiences navigating their gendered identities into old age. The notion of gender performativity emphasises that gender identities are not predetermined but are continually constructed through bodily gestures, movements, and styles (Butler, 1990). As individuals repeatedly engage in gendered behaviours, they create the illusion of an abiding gendered self. This framework enables us to explore how gender performativity intersects with the ageing process and shapes experiences of gender in later life. In gender performativity and ageing, discussions often revolve around the concept of "femme culture" and its significance in understanding the construction of gender-performative subjects as they age. Scholars have examined how the internalisation of beauty culture influences the formation and expression of femininity within the context of ageing (Walker, 2001). The negotiation of gendered identities by middle-aged women becomes particularly salient as they navigate societal expectations, cultural norms, and personal experiences of ageing.

Studies have explored the intricate relationship between gender performativity, ageing, and the construction of the femme identity. Segal (2007) delves into the discourse of ageing and its connections to Medusa's curse, highlighting the cultural and societal pressures women face as they age. The concept of being forever young, ingrained in beauty culture, shapes the experiences of ageing women and influences their perceptions of self-worth and desirability.

By examining gender performativity in the context of ageing, researchers aim to deconstruct gender types and expand our understanding of diverse gender identities beyond traditional binaries.

Gender performativity, as theorised by Judith Butler, offers a framework to understand how gender identities are continually constructed through the repetitive ritualization of gendered behaviours. When applied to the context of ageing, gender performativity sheds light on the complexities of gendered experiences in later life. The examination of gender performativity concerning ageing often focuses on the construction of the femme identity, particularly among middle-aged women navigating their gendered identities into old age.

The interplay between gender performativity, ageing, and the internalisation of beauty culture reveals the influence of societal expectations and cultural norms on the experiences of ageing individuals. By interrogating the performativity of gender in the ageing process, researchers aim to challenge fixed notions of gender identity and recognise the fluidity and diversity of gender expressions. This expanded understanding of gender performativity in later life contributes to a more comprehensive exploration of ageing and gender within social gerontology.

Sexuality, Sexual Identity, and Gender

Gender and sexuality are inseparable social categories; one cannot consider gender without sexuality, and vice versa (Westwood, 2014). engaging with sexuality helps to understand gender importance and to undo the homogenisation of older adults, which is pervasive societally and in research. Older adults are often treated as non-sexual (Bauer et al., 2007). According to Ward et al. (2010: 12), where there is funding to explore sexuality in this population, it tends to focus ‘on (mainly men’s) sexual health with less information available on older bisexual and lesbian women’, leading to erasure of experience.

Exploring sexuality in the context of ageing also provides insights into older adults' care and interpersonal strategies. Toni Calasanti has extensively studied the interplay between gender, sexuality, and ageing, examining topics such as caregiving, labour, retirement, and inequality in old age (Calasanti, 2008; Calasanti & King, 2015; Calasanti, Slevin, & King, 2006). Although not solely focused on care provision, Calasanti's work explores how gender identity shapes our experiences of ageing and impacts the quality of life in retirement (Calasanti & Slevin, 2007). Within gerontology, scholars have examined how gender and sexuality sociologically position individuals to age differently within care systems. Price (2008: 1344) argues that "for older gay men and lesbians, dementia may become the hub around which other intersections of identity turn, rendering ineffective the privilege and carefully constructed coping mechanisms associated with their other social identities." Understanding sexual identity is particularly important in residential care, as these facilities are often heteronormative, leading to potential challenges for lesbian, gay, and bisexual individuals (Guasp, 2011).

The literature on gender and sexuality in old age, particularly in residential care, has predominantly focused on care workers' attitudes rather than residents' experiences and perceptions. Studies often mention sexuality without directly engaging with its implications for older adults, perpetuating the marginalisation of these individuals. Furthermore, research tends to rely on survey data and larger sample sizes, which limits the depth of gender analysis and overlooks the oldest old and recipients of full-time care (Villar et al., 2015; Gleibs et al., 2011; Heaphy et al., 2003; Boyle, 2013a, 2013b, 2013c, 2013d; Freak-Poli, 2020).

To challenge homogenous understandings of older adults and explore the complex interrelation of gender and sexuality in old age, further research is needed. By delving deeper into the implications of gender and sexuality, researchers can contribute to a more inclusive and nuanced understanding of this population. Additionally, addressing the experiences and needs of the oldest and individuals receiving full-time care is essential for developing comprehensive and meaningful support systems.

Literature Review Discussion

This literature review was a creative attempt to address an ongoing concern with a lack of research on ageing and gender. In the first phase of this review, I overviewed literature to identify conceptual themes about gender and how these are situated within “ageing studies”, an interdisciplinary project. In the second phase, I used four conceptual domains to search recent, empirical research to discover how and if these domains are being operationalised to understand the experience of older care recipients. Findings generally support that these domains can be useful in understanding how difference and identity matter in later life, but underscore that considerable overlap exists and that they may more usefully operate in combination.

This literature review has some limitations which require discussion. My identification of keywords was guided by findings from a literature search involving high subjectivity. This method risks leading the thematic overviews in directions that may not reflect other ongoing trends in the literature. Using “intersectionality” or even “embodiment” as a conceptual keyword for this search may be limited because some studies conducting an intersectional analysis might not use this term. Finally, I could only review literature produced or translated into English. My use of the ‘snowball effect’ in the conceptual overview meant that overlooking some literature could be possible. Much of the literature used to frame and explore possible conceptual themes is notably dated - this may be due to the divestment of interest in the field of ageing.

Limitations considered in this review were able to point to and highlight many trends that haunt the fields of “ageing studies'', and to prioritise a review of literature which leans on empirical, qualitative findings, which may be peripheralised in other reviews on old age, gender, and care. The interdisciplinary nature of this project is a strength—no one domain addresses all of the concerns and considerations brought up in this review. The width and breadth of topics covered in a review on “care research” was another interesting finding. Care with and among older adults can touch many aspects of life. Living well, belonging to particular identities and communities, manageing symptoms, and grappling with new and changing dependencies and needs means that care can come in many shapes and forms. When looking at gender, age, and care, there is a diverse, interdisciplinary body of literature. The diversity and breadth of this review can be seen as a limiting factor, but it is equally a strength: we need interdisciplinary and collaborative perspectives and angles to continue understanding what it means to live well in old age.

There are significant and valid critiques of each of the conceptual domains identified in this review, but when combined or put into communication, they may more successfully examine the meanings and priorities of older adults in care research. As an approach, intersectionality has been critiqued for its complexity, the futility of an endless "et cetera'' of identity (Butler, 1990), and the intangibility with which it can practically be operationalised in research (Hulko, 2002). While these critiques are valid, an intersectional approach strongly responds to the burden of homogeneity that continues to trap ageing research. Areas of research that tend towards an intersectional perspective on identity and selfhood in old age intersect with embodiment (Furman, 1999; Gilleard, 2002), narrative studies (Charon, 2006), and the lifecourse perspective (Laz, 2003). Meanwhile, viewing the ageing body as a cultural site can downplay physiological realities to such an extent that some authors have cautioned that these perspectives may lean towards a cartesian dualism (Kontos, 1990; Gibson, 2000). A lifecourse perspective may 'lock older people, especially older women, into rigid gender roles, which may be contrary to their wishes at that stage in life'. (Hulko, 2004: 103). Moving beyond seeing one's gender as an expression of a previous self can be aided by looking at embodied experience and considering an intersectional framing of experience and social location.

Looking at gendered patterns of experiences helps to promote a humanised understanding of the well-being of older adults by reversing the tendency to de-sexualise and de-gender older bodies (Gilleard, 2002) both in research and in healthcare practice (Furman, 1999; Jackson & Scott, 2001; Laz, 2003; Winterich, 2007). Existing literature on age and gender tends to rely on a rhetoric of dependence and bolsters heteronormative cultural values. Care literature continues to contribute to a gender-as-variable trend and does not use the complexity an intersectional analysis offers to understand individuals' experiences. This review helps direct gender-in-care research to centre an in-depth understanding of the way individuals experience care in old age, thus informing more comprehensive and effective modes of care for older people.

These conceptual domains will be important in analysing subjective and intersubjective experiences within a care home context. In the design of this review, many issues came to awareness: a lack of research with older adults, a lack of work that centres care recipients' experiences, and over-simplified views of gender, to name a few. In placing these frameworks in communication, I argue that taking an approach that intentionally and carefully combines conceptual areas may be useful to highlight the experiences of selfhood throughout old age, keeping in mind the strengths that each conceptual domain may offer.

Theoretical Frameworks

In addition to introducing the theory selected to make sense of the data for this study, this chapter serves as an exploration of the rationale behind my decision to adopt a multidimensional approach, aiming to shed light on how the amalgamation of diverse theoretical lenses contributes to a fuller understanding of the complexities of this subject matter. This “theoretical sensitivity” supports that using multiple theories allows researchers to explore the complexity of social phenomena more thoroughly and to develop a richer understanding of their research topics (Charmaz, 2014). This approach aligns with the idea that social reality is multifaceted and that no single theory can fully capture its complexity. Each framework selected offers a distinct perspective, honing in on particular facets of the phenomena under investigation.

By embracing a range of theories, I hope to expose the intricate connections between emotions, societal expectations, physical spaces, and the quest for dignified care. Care homes are intricate ecosystems shaped by a symphony of personal experiences, cultural influences, power dynamics, and historical contexts. Acknowledging the complexity of this environment, I have chosen to adopt a multidimensional approach. This flexibility allows us to adapt our analysis to the unique aspects of each case, enriching our understanding without oversimplifying the complexities of the care environment. This approach not only aligns with established qualitative research methodology but also embodies a commitment to robust and comprehensive analysis. By incorporating insights from multiple theories, we not only enhance the depth of our exploration but also ensure that our findings are firmly grounded in the complex realities of care home environments.

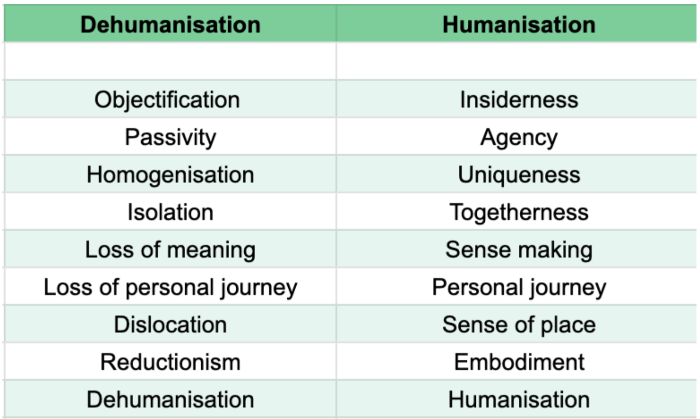
Each theoretical framework possesses a unique lens that illuminates specific facets of my research questions. By weaving together these perspectives, I uncover hidden interconnections and dependencies that might remain concealed otherwise. The exploration of affective economies through Ahmed's insights, the scrutiny of gender norms through Connell's theories, and the examination of humanisation guided by Todres and Galvin's framework all combine to enhance my insights. This collective approach reveals patterns and narratives that would elude me if I were to rely on a single theoretical framework. Rather than isolating these theoretical frameworks, I approach them as tools that contribute harmoniously to my analytical toolkit, helping to make meanings of the data. I intend not to pit one against the other but to blend their diverse strengths into a coherent narrative. I envision a narrative that interweaves these frameworks, upholding the significance of each while fostering a collaborative synergy that enriches my understanding of the landscape of the care home environment.

I will delve into each selected theoretical framework in the following sections, illuminating its unique merits and demonstrating its applicability to my research themes. This chapter aims to establish a sturdy foundation for the following empirical chapters, underscoring why the fusion of multiple frameworks is pivotal in my quest for a richer and more comprehensive grasp of the intricate dynamics within care homes.

The Humanisation of Care Framework

As previously discussed, my findings are contextualised within the context of dignity and well-being in care settings, utilising the humanisation of care framework (Todres et al., 2009). The framing of care and the perspective on caring are pivotal, as they directly influence policy formulation and regulations governing care provision. Consequently, our philosophy of care significantly impacts the quality of life experienced by both care workers and care recipients. This project is intricately woven with the aspiration to bolster and deepen a lifeworld-oriented approach to care. This perspective, rooted in phenomenological and existential philosophies of the self and personhood, represents a cornerstone within the field of caring sciences (Todres et al., 2002).

Within the spectrum of intersubjectivity, the potential for humanisation or dehumanisation emerges. Humanisation—embracing a specific viewpoint that explores the essence of being human—constitutes an invaluable concept for analysing dignity and well-being. It has found application in various studies concerning care (Galvin et al., 2018; Galvin & Todres, 2012; Hemingway, 2011). The tension between the lived experiences of patients and service users and the culture and practices of healthcare has been the focus of humanised care theorists (Galvin & Todres, 2013). Elucidating this complex interplay, Todres et al. (2009) offer a theoretical framework presenting eight dimensions of humanisation and eight dimensions of dehumanisation:



Dehumanisation	Humanisation
Objectification	Insiderness
Passivity	Agency
Homogenisation	Uniqueness
Isolation	Togetherness
Loss of meaning	Sense making
Loss of personal journey	Personal journey
Dislocation	Sense of place
Reductionism	Embodiment
Dehumanisation	Humanisation

Table 1 Eight Dimensions of Humanisation and Dehumanisation

This framework facilitates an intricate understanding of wellness and care by embracing multiple interwoven dimensions of human experience. Such a perspective aids in comprehending subjective concepts like well-being and dignity in diverse contexts. The spectrum spanning from humanising to dehumanising across these eight dimensions becomes the foundation for the methodology and analysis of this research endeavour. It is crucial to acknowledge that these "bipolar terms suggest possibilities along a spectrum that has to be considered in context" (Todres et al., 2009, 69). The attributes of humanisation are presented as "ideal" types, acknowledging that their attainment or desirability hinges on the nature of care provided. Todres et al. (2009) aptly illustrate this complexity, particularly concerning individuals in intensive care requiring highly technological definitions and treatments for their bodily functioning.

Centring a Gender Analysis: Connell's Gender and Power

The understanding of gender as not solely an individual experience but also deeply shaped by societal factors suggests that relational gender theory may offer a more effective lens than categorical frameworks (Connell, 2012). This perspective, as elucidated by Connell, conceptualises gender as a multidimensional process entrenched within a complex network of institutions (Connell, 2012). While this discussion primarily centres on interpersonal relationships, it is crucial to recognise the role of labour and power in comprehending gender dynamics. Cathexis, which plays a central role in social interactions, extends beyond sexual contexts to encompass meaningful relationships as perceived by participants. Raewynn Connell's (1987) framework assists in understanding the gendered experiences of dignity and well-being by enabling the mapping of gendered practices and dynamics at both interpersonal and institutional levels. These pillars—division of power, division of labour, and cathexis—intersect and mutually inform one another, necessitating a holistic perspective on the diverse ways in which gender identity shapes our lived experiences. These pillars operate synergistically to construct gender roles that perpetuate inequities (Wingood & DiClemente, 2001). The gender and power framework proves valuable in examining the myriad ways in which gender norms influence and disrupt individuals' experiences, particularly in the context of care homes for older adults.

At the societal level, gender structures are embedded deeply, altering slowly over time. At the institutional level, evident in care homes, these structures interact with lifecourse positions shaped by external societal and cultural elements. Division of labour offers insights into retiring from gendered work and economic productivity implications. Division of power clarifies authority and governance linked to gender. Applying these concepts illuminates cultural implications, variations in pension, and attitudes toward formal and informal care.

Lastly, cathexis aids in analysing power and labour's interpersonal unfolding. In the context of intimacy within care facilities, existing work often maintains heteronormative assumptions, overlooking emotional intimacy. Cathexis unveils emotional connections, promoting a more humanised approach to care. Overall, this framework enriches understanding of gender's role in the care home.

Connell’s framework can help us centre gender in our care exploration in the following ways:

- Gendered Emotional Labour: Connell's theory of gender and power can help explore how traditional gender roles influence the distribution of emotional labour within care homes. Caregiving tasks and emotional responsibilities are often divided along gender lines, with women expected to provide more emotional support and nurturing care. At the same time, men might be assigned tasks considered less emotionally demanding. This gendered division of emotional labour can impact the affective economies within the care home and shape the quality of interactions between carers and care recipients.

- Intersectionality of Care Worker Identities: Connell's theory emphasises the importance of intersectionality, which considers how multiple social identities intersect to shape individuals' experiences. Gender norms interact with other factors, such as race, class, and age among carers and care recipients. This intersectional analysis can reveal complex dynamics contributing to the affective economies within the care home, highlighting how different power structures intersect and influence emotional interactions.

- Power Dynamics and Emotional Expression: Connell's theory offers insights into power dynamics and how they influence emotional expression. Gender norms might affect care workers' and care recipients' freedom to express certain emotions. For example, traditional masculinity norms could discourage male carers from openly expressing vulnerability or nurturing emotions, while female carers might face pressure always to be emotionally available. Analysing these power dynamics can shed light on how affective economies are shaped by and contribute to reinforcing gender norms.

- Agency and Resistance: Connell's theory also considers how individuals negotiate and resist dominant power structures. Care workers and care recipients navigate gendered expectations and norms within the care home setting. Some care workers might challenge traditional gender roles by engaging in emotional caregiving regardless of gender identity, while care recipients might resist imposed gendered expressions of emotion. Analysing these instances of agency and resistance can provide a richer understanding of how affective economies are negotiated and potentially transformed.

Affective Economies of Care: Cathexis, Abjection, and the Front-and-Back Stage

In this section, I delve into the interrelation between cathexis, abjection, and affective economies, and how these concepts contribute to understanding the ways norms and values can shape our intersubjective experiences, and how gender norms specifically may impact the experience of caregiving and receiving in the context of “Comfort Days”. These theoretical frameworks collectively provide a comprehensive framework to discuss how gender norms impact the complexities of care relations in a care home.

Ahmed’s Affective Economies

At the core of our exploration is Ahmed's concept of affective economies. As introduced by Sara Ahmed (2004), affective economies encompass the intricate and dynamic ways emotions circulate, shape, and structure social and cultural spaces. Emotions are not confined to individual experiences; they are collectively produced and shared, influencing interactions, behaviours, and power dynamics within society. Affective economies underscore the distribution of emotions in social spaces. They will thus be a valuable framework to map the affective quality of the experiences and interactions of care workers and care recipients in the care home setting. In this study, where spaces were defined and often acted upon by the individual participants (e.g., the care home was a closed community, and within this closed community were several smaller and arguably more closed communities). By integrating Ahmed's framework, we gain insights into the transformative potential of emotions and how they move through the spaces and confines of the care home. I selected Ahmed to engage with topics of intersubjectivity because this framework has a spatial element, helping to “see” the way intersubjective eddies may ripple and burst against the parameters of the care home space, which care home researchers have aptly argued serves as a Foucauldian “heterotopia”, a space which is neither (Sayers & Brunton, 2019). Heterotopias are characterised by their capacity to hold multiple meanings and functions simultaneously (Foucault, 1986). The care home serves as a space of care, residence, community, and institutionalisation. This complexity can generate intricate affective economies, where emotions are layered and interwoven across different aspects of the care home experience.

Through Ahmed's lens, we seek to comprehend the influence of empathetic engagement and its potential for either humanising or dehumanising, care acts within the care home space. Additionally, a focus on the emotional elements of care helps to problematise a tendency to prioritise efficiency, standardised protocols, and task-oriented caregiving over emotional engagement. These approaches can lead to a "dehumanisation" of care, where care workers may feel pressured to follow strict procedures at the expense of building meaningful relationships with care recipients. This perspective highlights a potential tension between emotional engagement and institutional demands for efficiency.

Cathexis: Emotional Bonds and Attachments in Care

While initially focused on intimate relationships, Connell's concept of cathexis offers a broader interpretation that encompasses any meaningful connection. Cathexis involves emotional investment and attachment, shaping power dynamics in relationships. In the care context, it is vital to residents' well-being through their connections with care workers, peers, and family members. By examining cathexis, we gain insights into power dynamics, emotional connections, and the quality of care within care homes. As Connell argues, Cathexis is shaped and influenced by gender norms and our relationship to them. Positive cathexis fosters an environment of trust, empathy, and respect, enhancing well-being. Conversely, negative cathexes can lead to isolation and frustration. Recognising the significance of cathexis prompts us to create inclusive environments that prioritise empathy, respect, and meaningful engagement, thus improving the overall care experience for older adults.

Abjection: Challenging Norms and Identity in Care

In conversation with cathexis is Kristeva's concept of abjection, which highlights the rejection of elements deemed "other" or "different" (Kristeva, 1984). Building upon the psychoanalytic framework developed by Julia Kristeva, abjection refers to the psychological discomfort and repulsion experienced when encountering something that disrupts established boundaries, norms, or identity categories. Within care homes, abjection emerges when individuals resist societal expectations and stereotypes.

Abjection, as elucidated by Kristeva, is a complex interplay between the self and the Other, manifesting as a visceral reaction to what is considered outside the bounds of acceptability. This concept becomes a lens through which we can explore experiences of disgust or repulsion in care relationships. The discomfort associated with abjection may lead to the avoidance of care or, at the very least, impact the extent to which carers are willing or able to engage with the social reality of care recipients (Johansson & Holmes, 2022; Holmes et al., 2006). Challenging traditional gender roles or expectations may lead to exclusion or marginalisation, and abjection can help us explore how interruptions in the “clean” or “pure” ideas of gender norms may lead to moments of confusion or repulsion. In the context of care, abjection has been explored in nursing research to understand how interpersonal disgust can serve as a “rite of passage” for nurses providing bodily care (Montgomery, 2014).

Incorporating abjection into social care discussions reveals the influence of identity and power dynamics. Abjection prompts us to go beyond the institutional constraints that may hinder care's emotional and relational aspects, and question the interpersonal elements as well (Rudge & Holmes, 2010). Kristeva's theory of abjection provides a profound theoretical foundation for understanding the emotional complexities involved in care relationships, pushing us to navigate the intricate interplay between the self and the Other. Through abjection, we not only explore the discomforting aspects of care but also uncover transformative potential in gender and sexuality discussions within care home environments. The application of Kristeva's abjection broadens our understanding of the intricate dynamics at play in care relationships, emphasising the need for sensitivity to the psychological nuances involved in the provision and reception of care.

Integration of Cathexis and Abjection

Cathexis and abjection are interconnected concepts that explore power dynamics, identity, and emotional investments within the care context. While negative cathexis and abjection may involve negative emotions, they have distinct theoretical origins and implications. Negative cathexis entails investing emotional energy in something that triggers negative or aversive feelings. Rooted in psychoanalytic theory, it relates to emotions like disgust, fear, anger, or discomfort. Negative cathexis shapes thoughts, behaviours, and attitudes, focusing on allocating mental and emotional resources to something disliked.

Meanwhile, abjection refers to emotional responses when confronting elements that disrupt boundaries between oneself and what's considered "other." It generates unease and repulsion in response to things challenging normalcy. Abjection encompasses emotions, bodily sensations, and psychological reactions. It pertains to transgressive experiences that threaten identity and cleanliness. While negative cathexis focuses on emotional investment in the disliked, abjection deals with emotional reactions to challenges to identity and norms. Integrating both concepts enriches the understanding of complex emotional dynamics within care settings. Abjection's disruption of cathexis prompts critical reflection and new emotional investments, particularly when confronting losses of autonomy or resisting labels as "other."

Applying these concepts to gender norms highlights how emotional energy is invested in adhering to or resisting these norms. Affinity towards gender norms stems from conformity, fostering emotional bonds with socially accepted roles. Conversely, repulsion arises from discomfort, leading to emotional distancing. Positive cathexis aligning with norms enhances affective economies, while abjection can occur when norms challenge autonomy, prompting reevaluation and transformation. Furthermore, the negotiation between affinity and repulsion towards gender norms is influenced by intersecting identities like race, age, and culture. The interplay of cathexis and abjection within these dynamics shapes emotional responses. The negotiation between these emotions provides insights into gender norm dynamics and affective economies. Integrating cathexis and abjection enhances our comprehension of affective dynamics, power relations, and transformation possibilities within care settings. The application of these concepts to gender norms underscores their role in shaping emotions and interactions, ultimately contributing to a deeper understanding of the care environment.

Goffman's Front and Back Stage

Erving Goffman's concept of "frontstage" and "backstage" is a framework used to understand the presentation of self in social interactions (1961). Goffman's work is especially valuable for comprehending the complex interplay of roles, performances, and impressions in various social settings, including the care home environment. Goffman's front-stage and backstage concepts offer further insights into care dynamics in the care home. The frontstage represents the public and visible realm of social interactions, where individuals present a carefully constructed image of themselves to others. This is where individuals enact roles, adhere to social norms, and engage in performances designed to meet societal expectations. Frontstage behaviour is often characterised by a heightened awareness of one's presentation, as individuals strive to maintain a positive self-image and uphold the desired identity in the eyes of others.

In the care home context, care workers and care recipients interact with each other and staff, visitors, and other residents within the front stage. Care workers might adopt nurturing roles, displaying empathy and professionalism, while care recipients might emphasise their need for assistance and gratitude. These performances are influenced by the care workers' and care recipients' perceptions of what is expected in the care home environment. The backstage, on the other hand, refers to the private and less visible sphere where individuals can relax, let down their guard, and temporarily suspend their frontstage performances. It's a space characterised by more authentic and unfiltered self-expression, as individuals are not constrained by the need to conform to societal norms. In the backstage, individuals can be themselves, share emotions, and engage in behaviours that might not align with their frontstage persona. These “unmanaged spaces” are the places where care workers can engage in these backstage behaviours (Bolton, 2005).

Within the care home, the backstage might manifest in the private rooms of residents, staff break areas, or even in the informal interactions that occur away from the visitors' gaze. Residents and care recipients may feel less pressure to conform to their assigned roles, allowing for more genuine emotional exchanges and expressions. The interplay between front-stage and backstage in the care home setting is crucial for understanding the affective economies at play. Care workers often navigate the emotional labour of manageing their emotions and maintaining a professional demeanour in front of residents and visitors (frontstage) while seeking emotional release and support in private spaces (backstage). Similarly, care recipients might perform frontstage to cope with the expectations of being a care recipient while seeking genuine connections and understanding with care workers in more intimate settings (backstage).

The care home can be seen as a unique heterotopia, where the boundaries between frontstage and backstage can become blurred due to the personal nature of caregiving and the proximity of residents and care workers. This blurring of boundaries adds complexity to the emotional dynamics as care workers and care recipients navigate the roles they are expected to play and the more authentic connections they seek to establish. Incorporating Goffman's front-stage and backstage concepts enriches your exploration of affective economies by highlighting the tension between public performances and private emotional experiences. This framework helps uncover how emotions are managed, expressed, and negotiated within the care home setting, shedding light on the multifaceted nature of caregiving relationships. The front stage involves public caregiving performances, while the backstage represents private spaces of authenticity (Goffman, 1961). Integrating these concepts, we explore how care workers manage emotions and empathy in caregiving.

Chapter Four: An Ethnographic Approach

As covered in the previous chapter on the theory undergirding my investigation, I take a constructivist and relational approach to gender, acknowledging that individuals' experiences are intertwined with institutional frameworks and broader sociocultural and historical contexts. How can we explore such a complex and multi-faceted phenomenon? The ethnographic approach, informally defined as spending time observing and ‘getting to know’ the contextual nuances of residents’ and staff’ experiences and their intersections with factors such as culture and gender, will give rise to the data for this project. At the heart of this methodology lies the exploration of context, encompassing historical and cultural dimensions while embracing a profound appreciation for relativism. It recognises the importance of understanding the emic perspective, whereby one attempts to understand individuals' viewpoints within their cultural frameworks.

In the background section, I discussed that this study was born as a piece of a larger research project designed to deepen our understanding of the world of old-age care across various European contexts. My project, number 13 of 15 individual projects, was designed before I was appointed as the researcher. Before my perspective gave flavour to this investigation, it was already tasked with 1. looking at gender and age and 2. doing so in an ethnographic fashion. The choice to use ethnography as a methodology is based on its ability to uncover patterns and processes that other methods, like surveys or interviews, may overlook. By immersing myself in the residential care home through participant observation, I can better understand the residents' experiences and perspectives on dignity and well-being.

The ethnographic methodology is rooted in anthropology, a discipline dedicated to comprehending and articulating the intricate interplay between individuals' subjective experiences and the broader social structures that shape their lives. Today, ethnographic field methods are used in various disciplines, such as the caring sciences, as is the case with this study (Kiefer, 2006). I endeavour to incorporate narratives, stories, and representations, aiming to identify and explore any contradictions between the lived and represented cultures within the residential care facility (Shapira, 2000). This dynamic process involves observing and interpreting various forms of expression, including oral communication, behaviour, interaction, body language, atmosphere, and pertinent quotations from observed situations (McGranahan 2018).

One becomes the investigation tool in ethnography (Turner, 2000). One’s biases and preferences shape how you move through your ‘field site’. In this project, I established rapport with particular residents and members of staff, and this guided my inquiry. For example, I had experience caring for my grandmother at home before she moved into a private care home in her final few years of life. I came to this project with ideas about the choices families may make, the sacrifices residents may experience, and what might constitute a good or bad experience in care. By acknowledging that assumptions and values shape perceptions and interpretations, I maintain a reflexive stance to mitigate potential biases as in the analysis of the collected data (Clifford & Marcus, 1986). In the ethnographic approach, this is not a detriment but an opportunity to deepen reflection and be transparent about how an interpersonal approach will shape the findings (more on reflexivity later). Thus, in this research design the “tool” or location of data is often in the interpersonal relationship (Whyte, 1999).

Another important aspect of the ethnographic approach is the time spent in the field. By spending time with a community and getting to know people, you can begin to view the norms and rules that shape that community's everyday experiences. Thus, there is a hybrid identity of being both an insider and an outsider (Hastrup, 2004). The meaning-making we engage in daily necessarily becomes a ‘given’. Being an outsider, you see these taken-for-granted meanings and stories we tell to make sense of our world as something novel. Then, once you become integrated into the community, gaining an emic perspective (never entirely integrated, but at least in the sense of becoming more familiar with what is expected and what is said about the norms), contradictions emerge (Coffey, 2021). We move out to existing theory, other cases, and examples to engage in the etic perspective (Geertz date). What can we learn about how people live in this community and what stories they share to make sense of their lives? This is the heart of the ethnographic approach.

Interpretivist/hermeneutic underpinnings

I adopt an interpretive perspective drawing on hermeneutics as a philosophical foundation to explore the intricate meanings and interpretations older adults in a residential care home attribute to their lived experiences (Ricoeur, 1976, 1984). Ricoeur's hermeneutical approach combines phenomenology, examining experience, with the interpretation of texts and representations of experience, offering valuable insights for nurse researchers (Charalambous, 2008).

Ricoeur serves as a bridge between phenomenology and hermeneutics, focusing on understanding written texts as the primary goal of hermeneutics. His theory of interpretation encompasses language, reflection, understanding, and the self, which, when merged with critical hermeneutics, facilitates gaining fresh insights and understanding from texts through critical interpretation.

According to Ricoeur, ordinary language is meant for communication, while scientific language is used for argumentation. Both types of language are essential for fully grasping the meaning of a text (Ricoeur, 1976). The advantage of this movement between understanding and explanation is that it allows me to blend both types of language, resulting in rich and comprehensive descriptions of the phenomena being studied. In ethnographic research, the “raw data”, primarily, in this project, field notes, is never completely raw, but it is already “partially cooked” (Madden 2017). Ricoeur talks about a movement between parts and whole of a text which is helpful as we analyse and try to understand text (specific interviews in relation to all of the collected data and also try to comprehend the text in relation to context).

Ricoeur emphasises that language is more than just a system; it expresses our experiences and enables us to grasp our existence and engagement with the world. Language holds centrality in our lives as it reflects our impressions and experiences, shaping how we comprehend situations.

In this research project, I consider both the experiences shared by the residents and staff and my own observations. I highly value language and expression as they reveal lived experiences and the interpreted world. The process of fixing language through writing offers independence and distance from the original situation, supporting analysis and interpretation of the phenomena under investigation (Ricoeur, 1984). To gain a comprehensive understanding of residents' meaningful experiences, I combine participant observation and interviews. Participant observation provides insight into the context of patients' lives, their interactions, and responses to health services. Interviews offer a deeper understanding through the participants' stories.

Ricoeur's work connects phenomenology and hermeneutics, underscoring the significance of language in comprehending lived experiences. Employing a hermeneutic approach, I aim to delve beyond surface-level descriptions and uncover the layers of meaning in the residents' experiences. By embracing an interpretive process that considers their cultural and historical backgrounds, as well as individual perspectives and interpretations, I seek to understand how experiences are influenced by broader social and cultural contexts.

In this context, language plays a crucial role in the investigation. As a researcher, I use language to explore and understand new ideas. This happens as I interpret the data during its generation. So, I constantly switch between understanding the language and using it to explain what I have discovered.

This approach also requires me to adhere to reflexivity in this process. My interpretations and biases can influence the understanding and interpretation of the data. Through ongoing reflection and self-awareness, I strive to navigate the complexities of interpretation and minimise potential distortions or misunderstandings. Overall, the hermeneutic approach provides a framework for me to interpret and understand the experiences of older adults in the residential care home. It allows me to uncover the layers of meaning and significance attributed to these experiences, shedding light on the interplay between the subjective and the contextual factors that shape their well-being and dignity. Ricoeur suggests that preconceptions can still play a role in interpretation, but they should not dictate understanding before engaging with the text or data (Ricoeur, 1976). Instead, researchers need to qualify their preconceptions through the process of interpretation, which involves continuously checking and validating their understanding in light of the text (field notes, interviews) being used as data for the study.

To sum it up once more, ethnographic data is descriptive and relies on detailed observation and interpretation over an extended period. By living in the care home and becoming familiar with its culture, I can provide a rich description of the community and better understand its norms, values, and rituals. It is important to actively engage in ongoing discussions on care and contribute to the field. The findings will enhance an understanding of lifeworld-led care and the humanisation of care theory. Although the depth of description may limit generalisability, it provides valuable insights into the experiential aspects of ageing and well-being in the residential care setting. By employing this methodology, I endeavour to provide a textured understanding of the lives, experiences, and gendered impacts on well-being and dignity among residents in a residential care facility. The interpretive/hermeneutic approach, with its steadfast focus on context, reflexivity, and the exploration of subjective experiences, serves as an invaluable framework for this pursuit.

Anti-Oppressive Ethnography

I am in the ever more common position of using ethnographic field methods outside of anthropology. Ethnography has come to mean many things - almost an over-utilised term and has been picked up in areas outside of academia, such as marketing research. In the ethnography's trans-disciplinary—and trans-academic—usage, the ethnographer must be strict about using the term. Traditionally, the ethnographer goes somewhere far away to discover something new, exotic—somewhere 'other' (Ahmad, 1997; Scott, 1992). The risk that ethnography others or exoticises cultures not native to the ethnographer are a critique which has long followed various approaches to ethnographic research design (Elie, 2006). Even with post-colonial adjustments to problematise and complicate the self/other divide and to call attention to the exotic Self (Gupta & Ferguson, 1997; Ergun & Erdemir, 2010), ethnography is an act which seeks to define a group or culture to be studied, an act which can disempower if not carefully designed.

The design and implementation of this project are in conversation with this tendency and the traditional anthropological design of 'the Other' in a few ways. One, I hope that with a focus on subjectivity and humanisation practices, this project will be anti-oppressive, reflexive, and useful to the research participants, thus operating in defence of ethnography's potential to contribute meaningful data in a contemporary, interdisciplinary project. Second, I intend to consider the notion of ‘other’ throughout the study's design, implementation, and analysis phases to understand how we tend to conceive of the aged individual and the recipient of care as such. It may also be necessary to note my status as an early career academic.

The methodology is inherently intertwined with politics, encompassing specific values and perspectives that necessitate subjective positioning (Young & Ackerman, 2001). In light of this, my research will adopt a synthesis of critical and feminist approaches to ethnography, aiming to address the complex issue of "othering" and align with the collective objectives of the (MSCA) INNOVATE DIGNITY Fellowship. Critical and feminist ethnographic literature has long grappled with the power dynamics and exploitative aspects inherent in ethnographic inquiry (Elie, 2006), including the historical marginalisation and "othering" of women within ethnographic research (Mies, 1996). In this research, I seek to critically examine and challenge the tendency to "other" certain cultures or social groups by incorporating critical perspectives. It acknowledges the need to deconstruct prevailing assumptions and stereotypes, particularly concerning the experiences of marginalised individuals and communities. This critical lens allows for exploring power dynamics, structural inequalities, and potential exploitation within the research process.

Additionally, by embracing feminist methodologies, I aim to highlight and address gendered power dynamics within the context of ethnographic research. Recognising the historical exclusion of women's voices and experiences in ethnographic studies, I strive to ensure the inclusion and empowerment of women as active participants in shaping the research process and interpreting their narratives. This will not be a matter of sampling in a care home, as women make up a majority of care workers, and women make up a larger portion of care home residents. Instead, this will mean that in my data collection and analysis, I will be keenly aware of the patriarchal framings, which may peripheralise certain perspectives, stories, and experiences.

Wuest (1995: 129, cited in Hulko, 2002) provides three guiding principles of feminist research, which I hope will guide the design and implementation of this project:

1. Knowledge produced by the research should be useful for the participants
2. The research method should not be oppressive
3. The research method should be reflexive

Following these guiding principles, I will overview the possibilities and challenges of taking a feminist approach to this ethnographic research project.

The project must be useful: Ethnographic Outsiderness in health research

Orienting the field of health sciences and the caring sciences network to which this project contributes has required a level of un-learning around ethnographic research and subsequent re-orienting around interdisciplinary inquiry. In the healthcare field, along with the power dynamics and gatekeepers specific to this arena, come new challenges and obstacles to consider. Hemmings (2005) argues that healthcare and medicine need to receive more support from social scientists; lack of insight offered by qualitative and social inquiry into care services leads to disastrous and harmful outcomes (Fadiman, 1998) and health disparities and outcomes of care have been shown to mirror issues of social inequalities (Rogers & Kelly, 2011). Thus, applying a social analysis to care is both necessary and ethical.

The ethnographic methodology offers researchers a unique opportunity to immerse themselves in the naturalistic setting of care work, facilitating a deep understanding of the contextual factors shaping care delivery. This holistic perspective is invaluable for discerning the intricate interplay of social, cultural, and organisational elements that influence care practices and experiences. By engaging in prolonged fieldwork and participant observation, ethnographers can capture the subtleties of everyday care practices and interactions, shedding light on the nuances of how care is enacted, negotiated, and experienced by both providers and recipients (Holloway, 2005). Through this lens, researchers can uncover hidden power dynamics within care settings, exploring issues of hierarchy, authority, and control that may impact care relationships and decision-making processes, uncovering what matters to residents (Galvin et al., 2020).

Moreover, ethnographic research has the potential to promote person-centred care by amplifying the voices and perspectives of care recipients. By listening attentively to the narratives and experiences of individuals receiving care, researchers can gain insight into their unique needs, preferences, and priorities. This understanding lays the groundwork for the development of more responsive and tailored care approaches that prioritise the dignity and agency of care recipients (Gavin et al., 2020). Noticing what matters can be subtle:

It was late in the evening and everyone had gone to bed. I was having a cup of tea and chatting with some care workers when I noticed that Rachel (pseudonym) was leaving her room. Rachel is a resident whose carers often prompt her to leave her room to have meals with everyone else, so I was surprised to see her coming out into the common area of the household so late in the evening of her own accord. I looked at Lucy (pseudonym, care worker) and nodded towards Rachel, silently alerting her that she was up and about so late in the evening. Instead of going to help Rachel, Lucy smiled and explained, ‘She comes out on her own after everyone’s gone to bed. She’ll go through some mail by the lamp in silence for a while. I think she feels a sense of relief as if, finally, everyone has left her house for the day and she can relax. I love to see her relaxed and comfortable in her home like that.

I share this scenario to help highlight the value of an outsider's perspective in identifying new insights into the care relationship. I better understood Rachel’s possible experience and feelings about the care home environment by asking the care worker to explain Rachel's behaviour. This illustrates the importance of approaching care relationships with a critical and open-minded perspective. Care workers may become entrenched in their routines and ways of thinking and miss essential details in their residents' behaviour and emotions. Bringing an outsider's perspective can highlight these nuances and bring new insights, as well as uncovering expertise.

Furthermore, this scenario also reveals the importance of creating a culture in the care home environment that fosters well-being and comfort for the residents. Lucy recognised that Rachel felt a sense of relief and relaxation when everyone had gone to bed, and she could have some quiet time alone. This demonstrates the value of understanding and responding to the unique needs and preferences of each resident in the care home rather than treating everyone the same. In conclusion, this scenario emphasises the importance of being attuned to the subtleties of the care relationship and the value of bringing in an outsider's perspective to gain new insights. It also highlights the importance of creating a care home environment that fosters a sense of well-being and comfort for each resident and tailoring care to meet each individual's unique needs and preferences.

The logistics of conducting effective ethnographic research in a residential care setting depend on my ability to establish rapport and engage appropriately with the community being researched. I have the support of a qualified and experienced supervisory team, which includes two nurses who have experience working both directly and in research with older people, who have overseen my research and supported my work throughout the planning, research, and analysis phases of this project. I will approach this project with as much preparation and rigour as possible to conduct proper research and ensure I have done everything I can to approach this community respectfully and minimise any potential harm.

With the legal and ethical regulations associated with accessing recipients of care in their residence, accessing this community during a pandemic which has been demonstrated as putting older adults at particular risk has been a significant barrier to this project. Between the time required to acquire ethical approval, the shifting demands on healthcare staff, the needs of the residential community itself, and my timeline and planning, there have been many variables shaping the possibility of this project. Because this is a protected community, I have been required to advocate for the potential benefits that this project may offer to participants to provide an ethical justification for conducting this research project:

- The study is likely to yield findings which may be used to improve the lives of residents now and in the future.
- I represent an added resource to enable residents to engage in meaningful activities through fieldwork, which took place in a time when social activity has been significantly reduced due to COVID-19.
- My participation in social activities during the fieldwork period may be of staff assistance, who will also be participants in this research project.
- Contributing perspectives and experiences to this project may feel good: participants may enjoy discussing their values/meaning-making

Far before I began ‘proving’ my usefulness as an individual researcher, the fellowship of which this project is a component was required to navigate the gatekeeping of the European Commission—seeking and receiving approval for funding and support to engage in a collective project on qualitative research on care and well-being among older adults speaks to the institutional value placed on better understanding our care systems for older adults. This is a systemic issue which requires collective action. In less protected communities and different circumstances, it may not be a requirement to explicitly brainstorm potential benefits to research to justify the risk of being there and collecting data. I am glad that I was asked to provide these potential benefits, and I think that considering potential mutual benefits is an essential component of any research design.

Furthermore, ethnographic insights can inform practical interventions and policy initiatives in care work. By providing rich and nuanced accounts of care provision, ethnographic research equips stakeholders with evidence-based recommendations for improving care quality and effectiveness. From identifying areas for improvement to developing best practices and advocating for policy changes, ethnographic findings have the potential to drive positive transformations in care delivery practices and policies, ultimately enhancing the well-being of both care providers and recipients alike.

Anti-oppressive Ethnography - critical & feminist influences

During the study, I encountered various challenges and concerns related to ethnographic methodology. Navigating these complexities required a thoughtful approach, particularly in light of the sensitive nature of the research topic. One of the foremost challenges I grappled with was acknowledging and critically reflecting on my own biases and positionality. Recognising the potential for ageism and other biases to influence the research process, I endeavoured to actively challenge these perspectives. This involved seeking out and valuing the perspectives of older individuals themselves, allowing their voices to shape and inform the research. It is important, also, to avoid ‘navel-gazing’, and make the study overly-focused on my own reactions and attitudes (Holt, 2003).

However, reflection is crucial, not just in the analysis and writing stages, but throughout the entire research process. Creating a safe and respectful research environment emerged as a paramount concern. I was acutely aware of the power dynamics inherent in the researcher-participant relationship and took deliberate steps to mitigate any potential for exploitation. Establishing clear boundaries, adhering to ethical guidelines, and prioritising informed consent were foundational principles guiding my interactions with participants. Moreover, actively involving participants in the research process was essential to maintaining an ethical approach. By soliciting their input and feedback, I sought to ensure that their voices were not only heard but also actively incorporated into the research findings.

Navigating these challenges required humility and a willingness to continually reflect on and refine my approach. While striving to uphold the principles of ethical research, I remained cognisant of the inherent complexities and limitations of the ethnographic methodology. By embracing a reflexive stance and remaining open to feedback, I aimed to navigate these challenges with integrity and sensitivity. A feminist methodology also emphasises valuing diverse perspectives and experiences. I used inclusive language, asked open-ended questions, and remained sensitive to cultural backgrounds and values. Additionally, I employed an anti-oppressive approach to participation by using process consent, particularly for older adults with varying cognitive capacities. This person-centred approach aimed to reduce barriers to participation and ensure inclusivity for all willing participants.

Reflexivity and situatedness of the researcher

> All researchers should be explicit about the politics of their research, as it is more logical to accept our subjectivity, our emotions and our socially grounded positions than to assume that some of us can rise above them (Ramazanoglu, 1992: 211).

Ethnographic research inherently offers partial and incomplete truths, a perspective acknowledged and resisted by those who value clear verification standards (Clifford, 1986: 7). Embracing this partiality allows for representational tact in ethnography. In line with feminist research praxis, I will approach my study reflexively and acknowledge my subjectivity (Ramazanoglu, 1992). This stance challenges traditional positivist views and emphasises the researcher's role and subjectivity throughout knowledge-making (Kirby & McKenna, 1989; Lather, 1991; Ramazanoglu, 1992). It promotes an empathetic understanding of subjective experiences by prioritising researching with participants rather than researching on them (Lather, 1991).

As I embark on my ethnographic study in a working-class town in North England, I recognise the complex layers of my identity and experiences that inform my engagement with the research setting. Coming from a rural area affected by economic decline, I understand the socio-economic challenges faced by communities undergoing industry shifts. This shared economic context enables me to contextualise and empathise with the complexities of the local landscape. Recognising power dynamics and potential insider/outsider tensions, it is the goal to approach the research site with humility, acknowledging and interrogating biases. My white, American background may influence my interactions with staff and residents, and I am committed to reflexivity in navigating these dynamics. I am looking at old age as a young person who has not yet experienced old age. Understanding the community's economic context and its resonance with my upbringing enables me to grasp the nuances of collective experiences and aspirations.

Within the care home, I observe the intricate interactions among staff, residents, and management, each with unique perspectives and motivations. Navigating these complexities requires an acute awareness of power dynamics, cultural expectations, and individual experiences. Throughout I strive to create spaces for genuine engagement and dialogue, valuing the voices and stories of the residents and staff who have graciously welcomed me into their lives. By fostering trust, actively listening, and acknowledging the diversity of experiences within the care home, I aim to co-create knowledge that challenges prevailing narratives and sheds light on the complexities of care and ageing.

As a feminist researcher, I examine how gender shapes the dynamics and experiences within the care home. By critically exploring gendered divisions of labour, power differentials, and lived experiences, I aim to identify gender hierarchies, advocate for equity, and amplify marginalised voices within care contexts. This lens allows for a more comprehensive understanding of care, gender, and the socio-cultural fabric of the working-class community. Drawing from my positionality as a working-class American woman, a first-generation university student, and a feminist researcher, I embark on this ethnographic inquiry committed to understanding and advocating for the diverse experiences and needs within the care home environment. Through collaboration, empathy, and an intersectional lens, I seek to generate knowledge that captures the realities of care in the working-class town and contributes to broader discussions on gender, power, and transformative care practices in society. Maintaining transparency, reflexivity, and acknowledging the situated nature of knowledge will guide me in conducting this research and ensuring accurate and descriptive reflections throughout the process.

Field Methods

As a participant observer in the field, I actively engaged in social activities within the care home setting, such as cooking, crafting, and attending various community events (Spradley, 1980). Participating in these social activities allowed me to observe and study the social interactions among residents, which provided valuable insights into their everyday lives and experiences. It also played a crucial role in establishing rapport with the participants and the staff as I became more integrated into the community (DeWalt & DeWalt, 2010).

While I did not participate in any clinical activities, my involvement in the social aspects of the care home allowed me to develop a deeper understanding of the social dynamics and relationships within the community. This immersion in the day-to-day life of the care home helped me gain a more complete perspective on the experiences of the individuals involved.

I diligently took field notes throughout my fieldwork to document my observations, interactions, and reflections (Emerson et al., 2011). These field notes were valuable for analysing and interpreting the data collected during my research. They also facilitated the examination of how my role as a researcher was being "naturalised" within the care home community, shedding light on the evolving dynamics and my positionality as an insider.

Participant Observation and Interview Methods

I employed participant observation as the primary data collection method to uncover the patterns, rhythms, and processes that might have eluded other research approaches, such as surveys or interviews alone. The success of this endeavour relied on my ability to establish rapport and respectfully engage with the community under study. Building on my prior training in ethnographic research methodology and experience working with adults in a clinical research setting, I am adequately prepared for the task. However, I also recognised the importance of continuous learning and sought guidance from my experienced supervisory team, who provided valuable insights based on their expertise in ethnographic research. To further enhance my understanding of researching adults with cognitive impairment, I attended a three-day training course on 'Ethics in Dementia Research' at Leuven University.

I prioritised meticulous preparation before commencing the research period at BCU and the host organisation. This included conducting a thorough risk assessment and undergoing a DBS check to ensure the safety and integrity of the research process. Throughout the project, I benefited from the guidance and support of my knowledgeable supervisory team, including two experienced nurses with expertise in working directly with older individuals and conducting research in this context. By approaching this project with careful planning and a commitment to rigorous research, I aimed to minimise potential harm and respectfully engage with the community.

Immersing myself in the field, I planned to spend a substantial amount of time at the residential care facility–engaging in ethnographic research necessitates a significant investment of time within the field site (Savage, 2000). Fortunately, I was offered the opportunity to reside in a private abode on the premises, allowing me to gain insights during regular hours, evenings, and weekends. The study was conducted at a not-for-profit provider of care housing in northern England. This care home was designed to cater to the changing needs of ageing adults, promoting a sense of community within and beyond the Houses which is where residents primarily spend time. The integration of community establishments such as cafes, hairdressers, and gyms aimed to foster connections between residents and the surrounding neighbourhood. Individuals could live independently or as couples, with various housing arrangements available. The research specifically focused on a residential care facility in North England, housing around 100 residents in a combination of independent-living apartments and households.

Participant recruitment was facilitated through collaboration with the residential care facility's gatekeepers. After engaging in discussions with the chief executive, a plan for my participant observation was established to foster trust and ongoing participation. Introducing myself to the community involved gradual integration, including community-wide announcements and communication through residents' meetings and newsletters. This ensured that the managers and the care staff were aware of my presence, allowing for rapport-building and transparent communication of my research intentions.

I employed a combination of observational and interview-based data collection methods to capture a comprehensive understanding of the community. I primarily focused on participant observation within selected households through purposive sampling while engaging with residents in apartments and community establishments such as the bistro, gym, or tea room. This design was influenced by the layout and structure of the care home, enabling me to explore the spatial and temporal dynamics that shaped notions of home and community.

All participants in the study met the age requirements, and inclusion was based on their willingness to participate. It was clear to residents that their decision to participate or withdraw would not impact the quality of care they received or their engagement in social events. Conversations and interviews served as valuable supplements to the observational data. I adopted an open-ended approach during the interviews, encourageing participants to share their perspectives on their social lives and interpersonal relationships within the residence. I remained mindful of the sensitive nature of specific topics, such as loneliness, depression, and isolation, respecting each participant's comfort level in discussing such matters.

Conducting research within people's homes requires careful ethical considerations, which I'll discuss in further depth in the following section. I maintained ongoing communication with staff and residents to ensure minimal disruption to their daily routines and to address any signs of distress or agitation. Collaboration with the residence's management allowed me to participate in low-risk social events without hindering the natural flow of community life. Transparency was upheld as I shared my schedule with staff and residents, clarifying my intentions and whereabouts. In adherence to safeguarding principles, I received comprehensive training to effectively respond to any instances of abuse, harm, or neglect that might come to light during the research. I was well-versed in the relevant legislation, including the Human Rights Act and the Mental Capacity Act, which underscored the importance of upholding the rights and well-being of every individual involved.

Reflexive Journal

Taking daily field notes, coding, and writing memos on recurring themes helped structure my inquiry. It provided the opportunity to maintain a reflective voice in my analysis (DeVault, 1990), and to engage with an iterative framework of analysis (Srivastava & Hopwood, 2009). A practical and measurable way I accounted for my subjective experience was through the reflexive journal (Kirby & McKenna, 1989). This provided a space to unpack assumptions, reactions, and reflections that I brought to the project and attempt to account for my 'conceptual baggage' (Hulko, 2002). My reflective journal started from the onset of this project, and I found it helpful to track my development of this project and react to/account for the unforeseen changes throughout my first year as a doctoral candidate in 2020. The research process was a journey during which I immersed myself as well as I could into the dynamic community of the residential care facility, humbly seeking to unveil the subtle intricacies and hidden dynamics that shape residents' experiences.

Chapter Five: Ethnographic Findings

In combing through my field notes, I found many stories worth highlighting, and I wanted to write in a way that allowed these 'stories', these vignettes, to shine[12]. The process of merging my data with theory was not just a sequential step but an integral aspect of my methodological approach, guided by the principles of constant comparison. This involved continually revisiting my field notes, identifying recurring patterns, and integrating relevant theoretical frameworks that provided depth and insight into the observed phenomena. The selection of theoretical frameworks, such as Connell's Gender and Power, Ahmed's Affective Economies, the Humanisation of Care Framework, and Kristeva's concept of abjection, was not arbitrary but based on their applicability to the nuances of care relationships within the care home setting. These theoretical lenses illuminated the emotional intricacies and power dynamics at play, allowing for a multifaceted understanding of the care dynamics within the context studied.

I do not wish to prematurely muddy the waters with my interpretation and analysis, but rather to provide large pieces of text that showcase what happened - what was said, done, or not said, not done to represent residents' experiences best. But the act of representation is slippery. Many residents' experiences are challenging to describe in one "clean" moment. Not every significant event I witnessed occurred in a narrative story arc. And my bias is already wrapped into the notes from my research: in the act of searching, observing, and participating, I was already making choices of what to pay attention to, who to hear, to witness. This was based on rapport, participants' capacity to communicate with me, my capacity to receive what was being

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[12] Please see Appendix 4 Participant Information Table for list of all participants' pseudonyms.

communicated well, and of course, on being in the right place at the right time.

In Chapter 5, my aim was to strike a delicate balance between the ‘unfiltered’ narratives and the analytical interpretation. The aim was to refrain from prematurely shaping the reader's understanding and instead allow the presented stories, or vignettes, to organically convey their essence. However, I am cognisant of the inherent challenge in faithfully representing residents' experiences, as not every significant event neatly fits into a narrative structure. The intricate nature of these experiences necessitates a multifaceted approach, akin to the layered methodologies often employed in ethnographic studies.

In recognition of this complexity, Chapter 5 will feature ongoing discussions woven throughout, providing continual insights and interpretations. This iterative process will foster increased flexibility for deeper exploration in Chapter 6. By adopting this methodological stance, I aim to enrich the clarity and coherence of the final analysis, ensuring a robust and comprehensive examination of the care relationships within the care home. This approach will extend across the subsequent sections and into the following discussion chapter, aligning with the iterative and reflexive nature inherent in ethnographic inquiry.

Section 1: Case Studies

This first section presents three case studies, each showcasing the experiences of people living their lives in the care home setting—George and Julia, a couple, and two single residents, Orla and William. I have chosen these cases due to the extensive time spent researching and interacting with these individuals, as well as the valuable data they shared which directly addresses the guiding questions of this study. The choice to present these case studies as a central piece of the study is rooted in anti-oppressive ethnography principles and feminist methodology, both of which advocate for centering the voices and experiences of marginalised individuals. I aim to critically examine the intersecting systems of oppression that shape the experiences individuals living in care homes by challenging and complicating dominant narratives and stereotypes surrounding ageing and care provision. This methodology prioritises the agency and autonomy of care home residents, acknowledging their lived experiences as valuable sources of knowledge. Through constant comparison and reflexivity, I navigate the complexities of power relations within the care home, ensuring that my research remains ethically grounded and socially just.

In adopting a feminist methodology, I acknowledge the importance of situated knowledge and standpoint theory in understanding the experiences of care home residents. By centering the perspectives of these individuals, I not only highlight the structural constraints they face but also give space to illustrate their perspective of how they navigate the care home environment. This approach underscores the importance of intersectionality in understanding the unique challenges of individuals within the broader context of institutionalised care. Ultimately, through the synthesis of theory and lived experiences, an anti-oppressive ethnographic approach aims to challenge hegemonic narratives surrounding ageing and care, while advocating for more inclusive and equitable practices within the care home setting.

Section 2: Social Life in the Care Home

The next section delves into social life and food practices within the care home, employing the framework of affective economies to scrutinise the underlying structure. Building upon examining explicit gender norms, I delve into the concepts of cathexis and abjection, focusing specifically on their manifestation during social events and meals. This chapter aims to unveil the implicit ways in which gender norms shape interactions within the care home environment, particularly within the affective dimensions of food-related experiences.

To better understand the intricate social dynamics, I draw upon Goffman's front and backstage concepts in this section. By integrating insights gained from preceding chapters, I explore how facilitated interactions, e.g. planned social events such as coffee and cake, bingo, or holiday parties, within the care home operate in conjunction with previously examined issues. This approach provides a deeper understanding of the overall care home experience, shedding light on the various ways in which social life and gender dynamics intersect.

Section 3: Looking at Power & Gender in the Care Home

In the final section of this empirical data chapter, I delve into the dynamics of power and gender within the care home setting, primarily drawing on Connell's framework. The main objective of this chapter is to provide a comprehensive contextual understanding of the operations of gender and power in the care home environment. This analysis revolves around the concepts of cathexis, aligned with Connell's ideas, and Kristeva's notion of abjection.

I investigate how individuals react to and challenge societal gender norms, blurring the lines between gender expectations. Moreover, I highlight how individuals are either drawn towards or repulsed by the gender norms imposed upon them, ultimately impacting their experiences and identities.

Through the organisation of these empirical chapters, my goal is to comprehensively show and analyse power, gender, cathexis, abjection, and their interplay within the care home setting. By drawing on established theoretical frameworks and utilising case studies and observations, I strive to provide a nuanced and insightful exploration of the complex dynamics shaping the lives of residents and staff in the care home environment.

Section One: Three Case Studies

This section presents three case studies that explore the experiences of four residents–one married couple, a man, and a woman. Case studies are a common method used in ethnographic research, which involves studying a particular group or individual to provide rich insights into the experiences and perspectives of individuals within a particular community or setting. The case studies were selected based on their ability to provide a rich and diverse perspective on how different individuals navigate their lives in a care home setting.

By highlighting the following three case studies, the aim is to offer a more layered and detailed account of the social and cultural dynamics at play within the care home. I also want to show my own process and subjective orientation to the care home environment. I provide notes from my reflective journal and explain my reactions and choices made while engaging with these people's lives. Sometimes this may look like an intervention of something dangerous or upsetting, other times it comes as a reflection after witnessing something. In some instances, I cite literature to show how some of the events and experiences I witness may relate to trends in care. I also point to how some of these findings "brush against" the theoretical framework I use for this study. A deeper analysis and discussion will follow the case studies.

The process of selecting informants for ethnographic studies is influenced by my subjective experience of the care home and the residents. First, my biases and assumptions may shaped my perceptions of who might be considered a significant informant. Establishing rapport with the participants was a critical component of the selection process, as it was important to gain their trust and build a relationship over time. This was achieved through ongoing engagement and interaction, allowing me to better understand the participants' experiences, perspectives, and values.

The selection of these cases was also informed by an intersectional analysis, which considered factors such as age, gender, ethnicity, class, and disability (Christiansen &Qvotrup Jensen, 2012). This allowed for a more complex understanding of the participants' experiences and helped to highlight the ways in which different forms of oppression and marginalisation intersect and interact to shape their lives. Each case study presents a unique and compelling perspective on the experiences of old adults in a care home setting. Through a detailed exploration of their daily lives, relationships, and interactions with care workers and other residents, these case studies provide a rich and nuanced understanding of the challenges and opportunities in care homes and how individuals navigate these complex environments.

In this chapter, I'll be diving into the individual experiences within a care home, connecting these personal narratives to broader literature. The goal is to uncover deeper insights into caregiving dynamics, power structures, and societal expectations. Each case study acts as a lens for examining wider themes in the context of care, and I will integrate insights from existing literature to offer a comprehensive perspective. This approach is grounded in the understanding that individual stories are intricately linked to broader socio-cultural, gendered, and psychological contexts (Ramazanoglu & Holland, 2000). By connecting specific case studies to wider scholarly discussions, we aim to contribute to a more comprehensive understanding of caregiving within residential settings.

Case I: George & Julia

Figure 7 George and Julia

Before I met George and Julia, I had heard a lot about them. These were the only residents I was told about before coming to stay at the care home. In a meeting to orient me to the social activities at the care home before my fieldwork started, the current activities coordinator[13] told me that they are married and, with a slight chuckle, added that they often get into fights and require some support with the emotional demands of their marriage. She explained that George is "'still with it', mentally speaking", while his wife has advancing dementia which both find very difficult to navigate. George enrolled himself and then acted as a consultee to advise Julia's enrollment in the study. Until recently, George and Julia lived in another downstairs community in the care home but were moved[14] upstairs to a community that housed a few

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[13] The Activities Coordinator later left the position without any notice and has since cut contact with everyone from the care home–probably due to burnout.

[14] This was not the choice of George and Julia, but of the care home staff who felt George needed more socialisation.

single male residents who staff hoped might keep George company. They were described as a "lively couple" and attended the social activities organised by the care home, perhaps the most of all residents. A few days later, I met George and Julia for the first time. Lucy, a care worker who agreed to show me the household, introduced me to George and Julia sitting at a table in the dining area.

George was bald and was wearing a blue cardigan and wool trousers. He had wide hips and large hands, but he looked quite small, as if his body were attached to the skeleton of a much larger man (later, I would see old photos of George and Julia, confirming that they were both much larger in the past). George wore glasses and hearing aids, and a Zimmer frame was parked next to his seat. His clothing was stained and unkempt–some egg yolk on the front of his sweater, and his undershirt was sticking out the bottom, not tucked into his trousers. There were a few coffee or tea stains on his khaki trousers. He was sitting on a cushion - a small piece of egg carton foam covered in stains from food. He smiled up at me and said hello in a high-pitched chirp. Next to him, Julia was wearing a clean, ironed dress and a pink sweater. She looked very tidy. Her lower legs were red and swollen, which caused her socks to hug her ankles tightly, and the pink velcro slippers she wore were strapped tight around her swollen feet, the velcro clinging desperately to keep them closed. Julia's white hair was styled in a short bob, a bit unbrushed but still clean and looked recently cut. She held her eyes closed, both hands gripping the cane she had balanced against her knees. She opened her eyes and nodded hello with a frown before closing them again. Lucy explained that George and Julia moved into this household last week from a flat downstairs. I asked George if I may join them, and he said, “Please!” and gestured for me to take a chair. I introduced myself, and George said, “Oh right, you’re the student”. I showed him the Participant Information Sheet and began to explain a bit about the study, and he waved it away and said, “Yes, I read that. I will help you. What do you want to know about us?”

The staff who had introduced me to the residents was correct, George was gifted with the art of chat. George wanted to hear much about America (“Tell us about America” became one of George’s catchphrases over the following months). He told me he and Julia travelled on a tour bus from Montreal to Philadelphia. He told me about their sights on the trip and that they had also been to Switzerland and France. George asked a lot of questions and shared a lot about his experiences: his job as a business owner, he and his wife’s involvement in the church, the community of friends they had “back home”. His eyes grew wide when he got excited. He would mumble and speak quickly but was a very animated and engaged speaker. He laughed at jokes and would make many of his own.

Julia sat beside him the whole while, frowning with her eyes closed. At one point, Julia was asked if she would like anything else for breakfast, her bowl of corn cereal sitting untouched in front of her, and she declined. Instead, she pointed to George and explained to Lucy, who was in the nearby kitchen, that he was “rather wicked, and I am quite cross with him. We’ve had a fall-out, and I just can not understand why he’d do something so cruel to me”. Lucy turned to me and explained that George woke up later than usual today, and Julia could not find him, and she grew slightly confused. Lucy told me that George and Julia slept in adjacent rooms and would meet for breakfast in the morning, ending their days sitting together on the sofa watching television after dinner. As Lucy explained this to me, she used a loud, slow voice, petting Julia's shoulder and winking at George. Though explaining their "normal" daily routine to me, she included George and Julia in the description, "is not that right?" or "sometimes we just have an off day, don't we". I clumsily engaged in Lucy's triangulation–thanking her for the information, while looking to George for confirmation (Julia's eyes were still shut tight, ignoring us all). This was a balancing act with which I would come familiar over the next months, it felt strange, but not unkind. A sort of dance through many intentional and polite gestures, an awareness of differing moods, a negotiation. It felt akin to getting through an awkward dinner party.

Julia was now looking around and said to nobody in particular, she felt "very queer" being here. Lucy sympathised, petting Julia's shoulder and telling Julia that she knows it must be hard to get used to a new House but that they were glad she was here. Lucy noticed that George was listening intently, and she patted his arm, adding, "But he's a handsome man, eh", to which Julia responded, still looking off into the distance, "Well, he is certainly bald!" and she closed her eyes and crossed her arms again. Lucy removed Julia's untouched bowl of cereal, now a soggy grey paste, and George asked her if he could have poached eggs. George was on a soft diet, he explained to me, and he was not supposed to eat any foods that, "require much chewing". Some minutes later, the carer brought George a bowl of chopped poached eggs, and she brought Julia poached egg on toast, offering that she just try. Julia asked George where two people were (I could not hear the names), and he impatiently said, “They’re dead!” and then mouthed to me “She’s confused”, with wide eyes and a shrug.

Navigating George and Julia’s different needs will become a common occurrence I witness in the following months of fieldwork. Every care worker has their own style of mitigating the couples’ different needs (they are two people, after all). Still, the goal is the same–to validate and support each of them despite their very different needs and perspectives. George often advocated for Julia, calling a care worker over to get her a blanket, asking for someone to talk to her when she was upset, or asking me to do a knitting lesson with her. George strategised his own incapability of caring directly for his wife by asking for things on her behalf. On the other hand, Julia did not appear to be equally concerned with George’s needs. While Julia expressed more psychic pain regularly, George was quite physically unwell: he often complained of horrendous pain in his back and “bum”. He carries around a grimy little cushion to soften the various surfaces that host his body throughout the day. He constantly winced from the pain when we would talk, and he told me that it was very depressing to feel so hopeless in his own body: “Nothing can be done; they said so. I just have it like this now”.

George frequently exhibited anxiety when Julia expressed distress, particularly when she disclosed details about their shared life that he preferred to keep private. On one occasion, she seemed fixated on a memory involving the theft of their money, asking, "Well, who were those men, those who took our money…" In response, George promptly hushed her and shifted the conversation. A few days later, he confided in me, revealing that they had been victims of fraud.

Someone posing as a church representative had deceived them, leading to the theft of some money.

The following week, George, looking visibly upset, greeted me at the entrance of the House. He shared that they had a heated argument that day, and he felt lost dealing with Julia's unpredictable mood swings. Such complaints are often dismissed, with responses like, "Husbands… can not live with them, can not live without them!" as Lucy once quipped to a distressed Julia. Another time, she remarked, "Well, I know you bicker, but you've been together a whole lifetime; I think that's something to be proud of!"

In my reflections, I noted:

This got me thinking about how a long-lasting relationship can sometimes become more of a marker of time than a dynamic contract between two loving individuals. The celebration of longevity can obscure the fact that it's an ongoing negotiation between two people rather than a fixed entity.

On another occasion, Julia playfully took George's Zimmer frame, causing him anxiety. When he asked for it back, she retorted haughtily, "What? So you can be the only one using it? That's hardly fair." During my training on moving and handling, I learned that altering someone's walking support can be legally considered elder abuse. The nurse conducting the training shared an incident where she stacked zimmer frames against a wall with the intention to tidy up the room. However, she was promptly informed that it was illegal and unsafe, instructed to return each person's zimmer frame immediately. While Julia may not have intended to neglect or isolate George, it prompted me to consider the seriousness of abuse and the importance of understanding context. When viewed through cultural stereotypes, issues of abuse might be downplayed. Reporting Julia's behaviour as domestic abuse does not appear to be a reasonable solution. Instead, there could be an option to formally document and observe such interpersonal dynamics among residents, reducing the likelihood of issues getting lost amid the responsibilities of care workers.

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Julia told me that she had knit this beautiful cardigan that she was wearing. I asked her if she wanted to teach me to knit, and she agreed. This plan made George very happy (“We old people can teach you things, too!”), and he has been asking when we plan to knit since.

One evening, when Julia was in a good mood I asked if she would give me a knitting lesson. She and George were sitting in their usual spot on a sofa under blankets. She was holding George’s hand and joking with him. When Julia was happy, it was infectious - she would have a silly grin and loved teasing everyone. I came to say hello, and they told me about Greg, the young carer, who did some pushups for George earlier (“The man’s an athlete!”)

I asked Julia if she wanted to give me a knitting lesson. “Yes, alright. We can see if I remember.” There was a basket of acrylic yarn and knitting needles in the household, and I went to get it.

Julia picked through the yarn and needles, explaining that we should find a thick, big needle for beginners.

Figure 8 Julia's knitting

She started knitting, showing me how to cast on. “Pearl, pearl!” jokes George, and she elbowed him jokingly back (“He’s always trying to mix me up…”). Eventually, Julia stopped explaining things to me and started knitting faster, now focused. She told me that her sister, Edith, knit her wedding veil. She tells me that her mother taught them both to knit as girls, and they made their own clothes before leaving school.

While knitting, Julia spoke calmly and fluidly, sharing her memories of being a girl.

For about 20 uninterrupted minutes, Julia told me about her brother's fish business, her and George's experiences at the church, and their friends in Scotland. Her face looked calm, and her focus did not leave her knitting. Eventually, she explained, "So this is...this would be the sort of edge of a sweater. If you wanted to knit further, we would connect this bit, you see its width, not length...we'd connect this to a larger pattern". She handed me the knitting, and I tucked it back into the basket and told her we could hold onto it for our next lesson.

All the while Julia had been giving me my lesson, George often peered over and smiled, looking relaxed and occasionally gazing at Julia with a look of admiration. I noticed that while Julia was busy knitting and talking, George's body relaxed; he leant back into the sofa watching his program, occasionally chiming in with a joke. When we stopped the lesson, he looked at me and held his hands together as if to pray: "Please do that with her again. A lot! Please."

While I cleaned up the knitting, Greg dimmed the lights and drew the curtains. Julia and George sat together quietly on the sofa. I sat near them in a chair, not speaking either. Our programme, Summer Watch, came on (we had been watching it together every evening that week). Besides George occasionally asking me to clarify what was happening, the sitting room was quiet; the mood was calm. On the programme, a man in Scotland hiked around. Julia said, "Oh, you have to see Scotland. We will take you. We go in the camper van occasionally. Oh, do take our number, and we will arrange something. You can come to Manchester and stay with us". George looked silently bewildered at this, throwing his hands up behind her and mouthing "NO" to me, but Julia was calm and happy, and he did not protest. When the program was nearing its end, Greg came in and said, “Are we getting ready for bed?” George became cross and said “No. Can not you see that we are enjoying this programme with our American friend?!” he gestured at Julia who was sitting cosily under the blanket. Greg nodded and headed off to help someone else. “He always does this”, explains George, “and just you wait...when I go to use the toilet, he follows me, catches me in my room and has me get into my pyjamas”. I nodded, not sure what to say. Eventually, George did need the toilet, and as predicted, Greg followed him slowly down the hallway.

Ten minutes later, George returned in his pyjamas, shrugging at me. He smiled and rolled his eyes. So much is met with complete awareness on his part that the care workers are not fully respecting his wishes or desires. As I gathered my things, Heather, a young carer, asked if they were ready for bed. “No, just a little bit longer,” said George. He and Julia got cosy on the sofa, sitting together for a little longer.

Interview with George

I asked George if he would be willing to interview for my project the day prior. When I came to meet him, he was sitting on the sofa, waiting. He looked up at me expectantly - “Are we ready?” I said yes and asked if he would mind coming to his room, where it was quieter “Go with it” he agreed.

I had been in George’s room once before when I helped him get to his bathroom. The room was empty and undecorated, with a few framed photos on the dresser and belongings on the desk (electric shaver, magazines). He showed me a photo of him and Julia standing in a city street “That’s when we went to the opera!” They looked young, Julia almost unrecognisable, much heavier and with thick brown curly hair. “Wow, look at you both,” I said, pausing at the photo. George told me that Julia had lost weight, “she is not eating”. I ask him if he is worried about her eating. “She just gets too upset. She allows herself to - she does not know what she needs anymore. (shrugs) I can not worry too much about that” He carefully backs up to his mattress and plops down on the edge of his bed and I sit across from him on his desk chair.

> J: *So [George], my first question is about when you moved to [Together]. Do you remember when you and [Julia] moved here?*
>
> G: *Got to think...yeah I’ll think in a minute. Silence...*
>
> J: *Was it a few years ago?*
>
> G: *Three years ago.*
>
> *J: Three years ago, okay. And when you first moved here, you first lived downstairs, right?*

G: Yes, downstairs, below in the other one.

J: Did you and [Julia] already have separate rooms, or did that happen later?

G: Yes, we had separate rooms from the beginning.

J: And how did it feel to live in separate rooms?

G: A bit strange. Well, we stayed together for a bit at the start. But eventually, I started...I could not sleep. I could not get comfortable, so they asked if I wanted my own bed. My own room. I said go with it.

J: When you shared a room, did -

G: They put two of these (pats bed) together - they sorted it for us. But then we went to our own rooms. I think they had the extra [mattress]. (shrugs)

J: Did you decide to move here, or was there a situation that prompted the move into [Together]?

G: There was a situation. We were both going well. I had a fall and had to go to hospital. So. She kept saying she was dizzy. She was dizzy, so I didn't want to leave her alone. So *she came with us to the hospital. We could not leave her at home, and I wasn't doing well. I didn't know what to do, so they did it.*

J: Do you mean your godchildren?

G: Yes - they decided we should come here. They sorted it for us.

J: And that's a bit far, from [town 45 minutes away] to [this town].

G: I'd say it is! (Smiling)

J: How have you found it, living over here?

G: I haven't really been out. I don't know the town. I haven't seen anything...I don't walk so well, you see. And she...she would not know. We stay here.

J: Well, and in this year everyone is staying home, everywhere. (I point to my mask)

G: Right. I forget (laughs)

J: About the pandemic, do you mean?

G: Yes, well. I follow the news, I know it is happening, but I don't think about it. It's all normal for in here, really.

J: Okay. I'd like to talk a bit about what is working living here, and then about what is not working so well, if that's alright, [George]?

G: Yes, that's alright. My godchildren. They can come on Saturdays. They help us with everything. My phone, it needs a new SIM card in it. They haven't sorted that yet...I can not call everyone I know.

J: Yes, I remember that you need help with this. It must feel isolating not to be able to call people.

G: Yes. Isolating, very much, so yeah.

J: Will they let you use the phone here?

G: Yes, they let me. But then I have to wait for someone to come.

J: I imagine that's not easy.

G: I feel helpless. It's easier to talk about what is not working, not what is working. (Long Pause). I can not help her the way I'd like-

George gestures behind him at the wall connecting to Julia's room. Silence. His eyes are moist, and he slouches a bit.

G: Can we move on, please?

J: Yes, of course. What about friendships? Have you made any friends while living here?

G: Here? (he gestures to the hallway, looking surprised with eyebrows raised) *I just know people, can not say they're friends.*

J: Hm, you're still relatively new to this house. But downstairs, you lived there for two years.

G: Yes, but that's the same, really. I just know people. Not friends.

J: And what about the staff?

Silence - then looks to the door. George said quietly: *can they hear this?*

J: No. We are far down the hall.

George glanced out the door then continued: Okay, well, they always say 'later, later'. They don't want to talk to me. So you have to wait a lot. I get very tired of waiting. They have these buttons (gestures to the emergency alarm button on his wall), but that's not for...most things. Only falls.

J: Yes, I see. My impression is, and please correct me if I'm wrong, that you have help for emergencies, but it's more difficult for staff to find the time if you want something. Like your whiskers... (I am referring to his desire to get help with a shave. He has mentioned his whiskers to me many times)

G: That's right. I can not get help with shaving very often. And I grow long whiskers. I have fallen about...10 times. They find me. I have this (gestures to the emergency button on his neck). That's good. I don't worry to be left. But ten times, I have been down there. Terrible.

J: I'm really glad that you've gotten help when you have fallen. Would you say that you feel safe here?

G: Yes. (answers confidently and immediately) *Sometimes I nearly fall out of bed. I know they will help me. I almost fall out of here, gestures to bed. I wish I had a larger one.*

J: I was with you a few days ago, and we did ask the staff about the bed. (Julia has a larger bed) *They said they could order a larger mattress if you'd like.*

G: Can they? I want them to. Will you ask?

J: Yes, we can go together to ask if you want. [George], I just wanted to discuss one more thing, if you're still comfortable sitting there?

G: Go with it.

J: This question is about this last year during the lockdown. I'd just like to ask a bit about your experience of the lockdowns.

G: I just cope with it. I go with it. I can see my godson more now. During the lockdown, they can not come. Still, just once sometimes. They live close. I am glad we can see them now.

J: And yesterday, you went to the hospital by ambulance instead of car...

G: No, taxi. A big taxi van. It wasn't good. They strapped me in my chair. The bumpy ride hurt my bum.

> *J: I’m sorry to hear that. You mentioned that your grandson could take you to your eye appointments before the lockdown.*
>
> *G: Yes, that’s right. Now we have this bumpy ride that they arrange. I was scared to go without [Julia]. They put a needle into my eye, you know. It’s terrible. And the taxi goes bump bump bump. Really hurts my bum, that.*

[George Interview - 2 June 2021]

After this, the interview derailed into George discussing the ride yesterday. I thanked him and let him know that I had stopped recording. I felt moved by George’s offering of something honest and sincere, which appeared to be painful for him, and hopefully a bit cathartic. He asked if I could help him shave. He had an electric shaver in a drawer in his desk; when I opened the drawer to find it, it slid easily to the front, the drawer’s emptiness causing the thing to thud and echo. George did not have many belongings. I agreed to “spot” George but saw that he could not get to his beard behind his ears and under his jaw. I took the shaver and slowly, gently buzzed the white whiskers. I felt nervous initially, not wanting to hurt George, but he moved his neck slowly to angle his bony face towards the electric razor. George turned his head compliantly, thanking me when I had finished.

Getting his needs met was a constant struggle for George. For example, during a social dinner event, George expressed a preference for a glass of red wine. He politely asked Cara, a care worker from his House, to fetch him one. However, another carer from a different House took the initiative to bring George a pint of beer while Cara was on her way. When George pointed out the mistake, the care worker cringed, suggesting, "But it’s a pub night; you don’t want a nice cold pint?" This scenario repeated twice more with different care workers overseeing the pub night. It took three corrections before George finally received the desired glass of wine. Despite his apparent annoyance while correcting the staff, he displayed a contented demeanour as he sipped and smiled upon receiving the correct beverage–so many slights to George’s individual preferences are met with his sense of humour and willingness to “just go with it” (his words).

This incident raises the possibility that the carers made assumptions about George's preferences based on stereotypes associated with his gender and possibly his working-class background. It appears that they may not have fully considered his tastes and desires. This situation highlights how hegemonic masculinity and class stereotypes can inadvertently influence assumptions and actions towards individuals, even within the supposedly neutral and considerate environment of a care home setting. It emphasises the importance of recognising and respecting individual preferences and avoiding generalisations based on gender and social background.

Stereotypes not only influence the types of care acts that may be most likely offered to George but also contribute to a perception of abjection towards him and his care needs. I contend that George's inability to conform to traditional ideals regarding what a man of his age and background should require, and how care for an 87-year-old white Englishman should be administered, exacerbates this sense of marginalisation. In the thesis introduction, Kate, a care worker who, based on my observations and impressions, displays a dedicated commitment to care work, characterises George and his needs as a "bottomless pit."

Contrary to this characterisation, my observations of George reveal a desire to maintain personal grooming, spend quality time with his wife in the communal areas of the House, and have his individual preferences acknowledged. These preferences include wanting a glass of merlot during "pub night" or enjoying the occasional listening session of ABBA–nothing too wild. George's specific needs and desires hardly appear to be a bottomless pit of demands. But they sit just outside of the 'script' that makes care work efficient, a script which relies on a very narrow set of norms to make sense of a person's needs. A care home aims to offer full care, from existential to medical care, which is an enormous promise.

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The Halloween party was the first event since the onset of the pandemic allowing for a mixture of residents from different communities. The dining area was decorated with orange and black streamers and paper masks. Fabric leaves and electric tea light candles decorated the tables. Julia did not want to come down, so George was seated with Max and Lucas. George put a paper cat mask on and grinned at me. When my attention was not sufficient, he began calling out to passing care workers: "Look! Look, I'm a cat!". Everyone was busy sorting the meals and drinks, and George was largely ignored. It was raining and already dark out, and I was anxious to get to the train station on time. But, though I intended to stop by the event for some quick goodbyes, it quickly got busy: helping arrange a meal for a woman who had arrived late, helping kitchen staff carry plates and drinks, and asking the kitchen staff for some thickener for George's chocolate milk. I lost track of time and realised that I had to leave immediately, or I would be stuck for some hours waiting for the next connection back to Birmingham. I rapidly said goodbye to the table. Max and Lucas bid me polite farewells. I stopped to say goodbye to George, who seemed a bit down despite his silly cat mask antics. Maybe because Julia did not feel up to joining: I do not know, I did not have the time to ask him how he was feeling. He teared up, saying, "Please come back soon!". I assured him I would, feeling guilty about ejecting myself from the party with such urgency. I left with the sickening mixture of urgency to detach and guilt of turning your back on someone who just wants a bit more care and time.

The next time I returned to the care home, George had passed away. He died in the hospital in ''February or March'' (as estimated by Jodie—so many changes here and so fast that death dates are quickly misplaced). As I entered the care home, everyone told me about George, from the receptionist to a woman from administration whom I had befriended to the care staff in the household. Everyone knew we had had a nice rapport and spent much time together. The last time I saw George, he cried as I left the dinner table, and I promised him I would come back; it *would not be the last time we see each other*. What a foolish promise. When I came into the household, Jodie, the young woman who worked in the kitchen, told me that when Julia asked after him, they had been telling her that George was gone for the day.

Julia had been wandering the hallways. Instead of her cane, she was now using a Zimmer frame. Her feet and ankles were more swollen than before, and the skin on her lower legs was scabbed and infected. Her shoes were very tight, and her steps looked pained. Her lone silhouette appeared smaller now, her rounded shoulders bonier, and her hair softer and whiter. I wondered if she had lost much weight or just appeared more robust next to her thin George, with his hunched-over posture making him much shorter than Julia. Every hour that afternoon, Julia wandered back and forth along the long hallway, alone and searching.

Today she was looking for her bathing suit. She was somewhere in a memory—telling me about the swimming pool near her family's home. We walked slowly along the hallway. She checked the doors, looking for something, but I could not tell what. She tried to open the door to the household, which remains locked, and she muttered: "Tried that one before; they must not want me to go in there". I wondered if "they" refers to staff or her parents. Whoever they are, she knows somebody else has the final say about where she can go and when. She told me a story about being three years old and too proud to cross the street with her older sister, so she approached a police officer and grabbed his hand for help crossing the street. She laughed when telling me it was a lovely memory that made her smile. She told me this story six times today, pointing at the large photo of downtown as a reference to explain her family's pub on the corner across from the sweets shop. She seemed jolly, reliving this place in her mind—being a child living above her parents' public house. She recounted being the younger sister to her beloved older sister Edith, this topic teetering between nostalgia and agitation as she grew anxious that Edith had not been around. "Well, it's only Monday. She might turn up yet", encouraged Sam. I remember all the times George would grow upset at Julia's inability, or unwillingness, to understand that her sister passed away last winter. He would remind her harshly: “She’s dead”—just like that. Julia would get upset with him, thinking it was some cruel joke, or sometimes she would understand he was serious and cry about her sister’s death, the information as new as if it had just happened. I wonder if it is easier for Julia now without the need to sync her reality with George’s.

I had not heard her talk much about George, except once when a new resident, bald and tall like her late husband, walked past, and she called for him, laughing and saying that he always walks right past her, that he never remembers where he is going. “That’s not [George], darling”, Sam gently corrected, and Julia did not seem bothered by this: “Oh, yes, you’re right. Well, they have the same head shape”. She then returned to telling me the policeman story. After dinner, Julia ate a cornetto cone. She admired her ice cream with a small, satisfied smile, twisting the cone, kicking her feet happily, lost in the bliss of this dessert. “That is just…perfect ice cream”, she mused to herself when she finished.

This afternoon spent with Julia, as she navigates her newfound status as a widow, is a specific snapshot that does not capture the entirety of her experience in coping with the loss of her husband. It's crucial to clarify that this vignette does not suggest that Julia is "better off" without him. However, delving into the complex matrix of care that enveloped George and Julia within the confines of this care home, there emerges a theme that speaks to the tension between maintaining a fixed identity and embracing the flexibility needed to let go and seek a renewed sense of presence.

Much like George, whose experience was hindered by the constraints of pressure to adhere to a fixed gender identity, Julia, too, seems to grapple with the challenge of breaking free from a linear narrative of her life. The narrative encompasses not just the recent loss of her husband but also resurfaces memories of the loss of her sister and the broader context of her and George's social life in their hometown, as well as their physical connection with their church community. This observation highlights the intricate dynamics of identity, loss, and the struggle for a sense of presence within the framework of care and support provided in the care home setting.

Case II: William

William was a retired engineer from Manchester who had moved into the independent living apartments in the care home with his wife a few years ago. After she passed away, and since his Alzheimer's began to advance, he moved into a room in the household. Staff informed me, in addition to memory loss and reduced mobility (he was able to get around with a Zimmer frame), that William has depression and tends to isolate. William was a tall, serious man who could be found in his room most of the time. His room was kept tidy and had a handful of personal touches: a radio sat on his chest of drawers, some unhung paintings leaned against the wall by his bed, and a handsome portrait of him and his late wife sat on his wardrobe. There were also clinical elements to his room: a pile of adult diapers stacked unceremoniously on a desk by the bathroom, medications assembled in loose organisation, safety rails fastened to the walls, the large bright SOS button near his bed. William would move from his bed to the chair in the morning, where he would remain for most of the day, even for meals, where he'd hunch forward and use the storage compartment of his Zimmer frame as a small table. William's room looked out on the quietest and most peaceful side of the property, a small grassy side-yard that went unused. He would gaze out of this window for hours, sometimes watching squirrels, other times seemingly lost in thought.

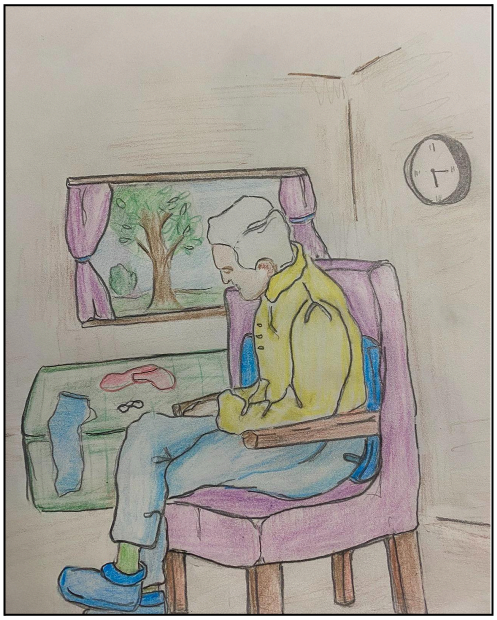

Figure 9 Sketch of William sitting in his room, field notes

William was familiar with the staff, often greeting everyone with a friendly hello and even giving some of the young girls nicknames. "Pocket rocket", he called Cara, a young care worker with whom he'd had a solid rapport. "Pocket rocket, huh? Has he always called you that?" I once asked Cara, thinking that the slightly flirtatious nature of the nickname might bother her. But Cara grinned and told me she was glad he had a nickname for her. "He is a flirty old man". She explained that, even though he does not remember her name most days, the nickname shows her that he knows her and has come to expect her to bring him his tea and medication every day she is working.

I think of the training about sexual harassment I had the month before when the nurse giving the training told us about a young carer who would wear tight trousers to work, the skinny jeans fashionable at the time. When a resident, “got a bit handsy and grabbed her bum”, she reported it to management. The nurse explained that though ideally, these instances would not happen at all, there is “*only so much you can expect”* from certain individuals with reduced impulse control. The girl was encouraged to wear clothing that would not so easily reveal her figure and to approach the man in a way that would not give him access to grabbing her. Practically, dressing in a way which is appropriate for the demands of care work does make sense. When I worked as a mental health staff in a psychiatric institution, the list of recommendations was extensive: one should not wear a ponytail, it is too easy to yank, and no dangling jewellery or loose straps for the same reason. Avoid wearing t-shirts with images or words that may trigger delusional thinking. Plain, modest clothing is best. I remember this scared me at first, it made it seem likely that I would be grabbed and attacked every day on the job. But over time, I came to understand that though none of the residents were violent with me, the preventative measures were as much for their benefit and safety as they were for mine - if a resident were to attack a member of staff they could be sent to a higher security institution where their quality of life was likely to decrease immensely. Preventative before punitive action was the goal. But is the message that young women should not make themselves sexually appealing to old men the same as this—sexual assault is posed as a vocational risk. Through these trainings, where we are instructed on how to be less likely to be assaulted, there is an acceptance that rape culture may not translate within the walls of a care home, where agency is questioned.

Perhaps it can be both a practical adaptation to the specific potential risks of caring for adults who *may* lack impulse control (Wilkins 2015) or who perhaps have a history of sexual assault (Teaster 2007), and also yet another signal that this population is somehow viewed and treated as ‘other’, perceived existing outside of the norms of society. Inadequate training and administrative complications are cited as the most common reason behind underreporting of instances of sexual assault in care homes (Smith et al., 2018), but there is a cultural aspect at play which may underpin these systemic shortcomings. The complacency with sexually predatory behaviour reaffirms that the residents are removed from and no longer require the same socialisation standards as those active members of society[15]. It implies that to be a care home resident is to lack accountability for your actions. It is the medicalisation (impulse control being impacted by cognitive disorders in old age) of misogyny and predation.

Part of this erasure of accountability means that residents may be treated as not quite a full people. To call William’s use of a somewhat demeaning nickname sexist is not to say that he is somehow morally corrupt or less deserving of the best possible care at every moment. It just

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[15] Though one should be sceptical about the idea that sexuality is neutralised in the 'normal' society. In many, if not most, environments, women (and men–to an extent) would have to think about the sexualised perception of their appearance and behaviour, and branding these contexts as 'abnormal' in comparison to the sterilised imaginary 'normality' is dubious.The removal of residents from their native environment and subsequent placement in the total institution may be the reason that the reproduction of this behaviour becomes socially problematic and a narrative around these behaviours becomes responsibility of the institution: there is a decision to 'fix' his behaviour to their ethical standards through discipline, or let him be and manage these occurrences in other ways, such as wardrobe choices among carers.

means he is a complex human being who is a product of societal patterning. As a personality, William is polite, kind, and funny. I enjoyed the time I spent talking with him in his room, even though he does drop many hints that the sexist tint to his behaviour is not just a product of becoming the cliched "dirty old man" in his old age, but it is likely a much more consistent part of his identity. Once, he explained to me, quite proudly, that he had the pick of a few secretaries at his work before eventually deciding to marry his late wife. He explained that she was not necessarily the prettiest nor the best cook ("truthfully, her cooking was mediocre at best") but that he felt she would make a nice housewife. I set aside my contempt for how William discussed women because I wanted to learn more.

But was I holding him accountable? Was I, in turn, dehumanising him as an old man who lacks the ability to be more discerning, a passive "product of his time"?

(Reflective Journal)

William had a few adult children who lived nearby. Like many other residents, he moved away from the northern Manchester neighbourhood that he had called home for most of his life to this small town because it allowed his children to visit him more easily. When I first came to the care home, visits were still quite limited due to the COVID-19 pandemic. Residents' families and friends could call to book a time for an hour visit (they were never strictly timed, but this was a way to ensure that many residents could have visits in a day) and come to sit in a small sitting area in the reception of the care home. This sitting area was not particularly private nor conducive to much more than having a small chat over a cup of tea. Between a nearby son and daughter, William had bimonthly visits. I never accompanied William on these visits—he preferred a quick escort downstairs and then to be left alone with his visitors, understandably.

Once, William sat with his daughter in the common area until quite late, after dinner, which was not usual for residents as it conflicted with dinner and post-dinner preparations for bedtime.

> *At around 8 pm, Greg (a young male carer new to the caregiving profession) went down to get William who had been visiting with his daughter. When they returned, William walked into the sitting room, where we watched TV. He was glowing, with bright eyes and a big smile. He wore a nice button-up shirt, and a box of cigars and a ginger cake sat on his walker tray. He was standing tall and waved at Sam and I. "Well, good evening ladies!" Sam asked if he'd like to go to his room (his usual choice) or join us in the living room. He responded, "Oh, I'll join the people" in a cheerful voice. He sat near me in a chair. I asked him about his visit, and he told me that he saw his granddaughter as well, who is 21 years old. "We sat out in that little garden in the front. There are some chairs there, and a table. And well I had one of these", he winked and opened a box to show me 8 cigars still inside. "Special occasions, these. Granddad's cigars".*
>
> *William looked around, waving at Sarah, who politely smiled and nodded, and then he looked at George & Julia, sitting under a shared blanket on the sofa. I see him look at Julia, still sitting with her arms crossed, frowning. "Hello," he said loudly in their direction, but they either didn't hear or didn't register that he was addressing them. As I*

sit between William and the couple, I relay the message, telling George that William has just returned from a visit with his daughter. "Oh," George raised his eyebrows and nodded. Then, in a hushed voice, George asked, "Who is that?". I explained that we played dominoes with William just yesterday and that he lives in this household. "No, that wasn't him…" George said sceptically. "It is, you are housemates. I can introduce you again if you'd like". George shook his head and sat back on the sofa, looking at the TV.

Greg approached William and loudly said, "You haven't had your dinner! You should have some food, won't you eat something?" William declined, looking at me quickly, and Greg continued, "Oh, come on, just a bit of food, it will be good for you. You need to eat..". After this, Greg winked at me, and I think that William noticed. "No," repeated William firmly, frowning now. He sat back in his chair, his posture changing as he slumped forward and looked at the TV. I watched as his facial expression faded from the bravado he wore when he returned to something which could probably be most accurately described as dejection. He looked over at Julia again, a sort of nervous glance.

Despite his refusal, Greg brought William a large slice of cake with whipped cream. "there you go, a nice piece of cake". The plate sat untouched next to William as he sank into his chair and watched TV silently. I looked at the cheerful cigar box, now sitting underneath his untouched cake and looking a bit cartoonish with its bright colours, like a cruel reminder of the contrast between William's life among family and friends and his

> *life as a resident in the household. William says loudly, to nobody in particular, "I'm an old, decrepit man", which Julia heard from across the room and chimed in, "Oh tell me about it!" with a small laugh, her eyes still closed, hand resting gently on George's forearm. William sat quietly for a few more minutes and then got up to leave, removing the plate with the untouched cake from his Zimmer frame and setting it on the table next to his chair. He slowly shuffled down the hall to his room without saying good night. "We need to get you your PM medications, sweetheart", reminds Juliette, who is busy entering updates on the computer. "Okay, well you know where I'll be", replies William without stopping.*
>
> *(Fieldnotes, 2/6/2021)*

William's body language showed how much confidence he lost in a matter of minutes of being back in the household. He entered appearing happy and assured, but once he re-assimilated into the household all of that was quickly lost, and he shrunk, visibly, into his 'role', which he understood as a "decrepit old man".

> *Tonight I had a long chat with William in his room, during which Larry brings in dinner. Seeing the plate of food, William says "What the hell is that?!" It's some mashed potatoes, a bit of boiled green beans, and "mince and onion"—honestly, it does not look*

very appetising. Larry looks very annoyed, closing his eyes while sighing, then putting on a 'patient' voice and telling William to try it ("You might like it!" patronising).

When Larry leaves, agreeing to make William a sausage sandwich instead (visibly irritated by his facial expression and the brisk pace of his walk out of the room), William apologises to me: "I am sorry. I don't mean to be...fussy. I am fussy, I suppose. But I am used to food that… I can not pretend to like this". I reassure him, "I can not force myself to eat things I don't find appetising either", and he asks me if I think this is an "Englishman phenomenon".

Me: Do you mean, is this pickiness specific to English men?

William: Yes, fussiness. They're not like this in the wild, wild west surely...

Me: I think it is universal to want to eat food you enjoy.

William smiles: Just so long as I am not giving my people a bad image…

Me: Are you worried about making a bad impression?

William: No, well. I am not used to my life being…(he gestures at me and out the door-presumably towards staff)

Me: Does it make you uncomfortable that I am here?

William: Nooo no, no. No, not only you. I just. It is not my own…(he trails off into silence)

Me: Your own private space?

William: Yes. But mmm...I can not ..

William trails off. He was gesturing with his hands, and his hand now hangs, frozen in the air. He slowly lowers it, looking off into the distance. We sit like this in silence for a few moments. William looks at me and smiles. I think he's forgotten what he was going to tell me. We change the topic and make small talk until his sandwich arrives, I leave so he can eat in peace.

(Fieldnotes, 30/6/2021)

William was caught in a difficult situation–to appear masculine, as he said himself, "They're not like this in the wild wild west", which means being tough and masculine, or to get his desires met, for a dinner he would enjoy. He shows awareness that he is "picky" and expresses some shame about this. Yet, despite the hit to his masculinity, he does ask for a different meal and explains that he cannot force himself to eat something that he does not find appetising. Thus, desire competes with his ideal of masculinity, and he accepts that his behaviour does not uphold his own expectations for this, but interestingly, he makes it about culture. English masculinity versus more rugged American masculinity, specifically, adding, “I don’t want to give my people a bad image”. If I weren’t there watching, I wonder if he would have demanded a different meal and felt no shame about it. If so, this discomfort seems more about how he might be perceived as less masculine.

This came up again a few days later when I sat with a few residents during lunch. Having recently returned from a visit, William joined us in the dining room. Again, he did not like the food offered, and Lucy fixed him a sandwich instead. “We men sure are fussy, aren’t we?” He said to her, and she agreed, saying that her husband never wants what she cooks, and she says too bad! The residents at the table laugh at the idea of a wife and husband bickering over dinner—a familiar cultural trope.

Giving up these tropes is common between carers and residents and seems to say: “See? We are all the same here. We all have the same experiences”. And often, they fall along gendered lines, especially among heteronormative lines. But what happens when these tropes become lived events, not just imagined scenarios, such as a male resident having “the hots for” (carer’s words) a female resident? Towards the end of my stay, William started to take an interest in another resident, Susan, who has advanced dementia and does not speak very often. Susan has very friendly and bright eyes, and she often holds your gaze and likes to hold the hand of the person sitting near her. She used to live in the apartments and staff have told me that she used to be a very “festive and generous” woman who would buy jewellery for all of the staff and who was very sociable and involved in the community. A few months ago, Susan suddenly remembered the name of one of the kitchen staff and called her name across the bistro. A few carers told me about this occurrence and said they teared up because they “miss her very much”. One said: “She’s still in there, somewhere…” Because of how they remember her, the staff are very attentive towards Susan’s clothing, hair, and makeup and she is always very well groomed. She is one of the few residents who go to the hairdresser weekly to get her hair cleaned and styled.

Lately, William has taken an interest in Susan. I first noticed when they were sitting together at lunch. Susan had grabbed William's hand, which took him by surprise at first, but he allowed it, and they sat holding hands. Lucy noticed and waggled her eyebrows at me, whispering: “Ooh look at the new romance..” A few days later, at a cafe event, which Susan always attends, William came as well. This surprised me because he never agrees to attend the events outside the household. As a carer helped him sit across from Susan, she said “Now look, this is not a candle-lit dinner for two, you hear?” She and another carer giggled. William didn’t respond. I imagine that making light of his desire could be quite embarrassing for William.

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> *The next day, I walk into the living room to see Wiliam sitting on the sofa (strange, he is never out of his room during the day, only occasionally in the evening), and Susan is*

sitting next to him in a recliner chair, in her usual spot. They're holding hands. I see Lucy (carer) watching carefully while she chops vegetables at the counter. William slowly works his hand up Susan's arm, caressing her, and he gets near her breast. I feel panic! I don't know exactly what to do, but I tense up, ready to intervene. Lucy walks over and casually says, "Oh [William], did you drop something? Don't worry, dear, I can help you", and she moves his hand away, pulling a blanket over Susan. Again, his hand slowly moves up Susan's arm. I look at Susan's face, unsure if she minds or is uncomfortable. She is smiling, looking at William. Again, when his hand gets above Susan's elbow, Lucy comes back around, "Oh [William], are you helping Susan cover herself up with the blanket? Thank you but we are here to help her with that. You just relax", she again tucks the blanket over Susan's torso and arms.

I quietly ask Lucy in the kitchen how long this has been happening. She tells me that it's been just recently. And then, "It's always her. Every time there is funny business, it's [Susan] involved. She's a male magnet…"

(Fieldnotes, 21/7/2021)

Victims of resident-to-resident sexual abuse are more likely to be older (Teaster, 2003), widowed or single, and have some physical or cognitive disability. Deeming her a 'male magnet' demonstrates some ignorance of the statistical likelihood for Susan to become a victim or an unwillingness to “call it like it is”. The impulse to sweeten the narrative around certain events (“my husband is fussy too”) is common in residential care (Kittay, 1999). This can arise from a variety of factors, including a desire to preserve the dignity and self-esteem of the care recipient, to shield them from the harsh realities of their situation, or to alleviate the care worker's own discomfort with difficult circumstances. It can also help carers avoid losing empathy for residents who may behave in ways which are difficult to accept, or to diffuse tension between parties (Bei et al., 2022)

A while later, Linda (care worker) brought tea around to the residents. William glanced at me a few times. He called Lucy over, sitting at the counter watching over Susan, and said “I think someone’s forgotten to put sweetener in” (He always takes his tea, no milk, two sweeteners, and I have never seen Linda mix this up!) Lucy took his cup and walked back into the kitchen corner to the cupboard. While she was gone, he grabbed Susan’s arm, this time a bit faster and more robust. Susan, not expecting this, slumped sideways. I stirred, unsure how to best intervene. My heart, I noticed, was racing a bit, and I felt a surge of adrenaline. Again, William glanced at me. I am sure he knew I saw his tea-trick, and he paused, looking at me.

Before I said anything, Linda said, “[William], sir, I’m sorry but that will not do. You will hurt her back if she's pulled all sideways like that”. She squats to be eye level with William and continued, “You can hold hands, I think that's lovely! But you can not be pulling her like that. What are you up to, anyway?” He shook his head as if to say nothing, and he went back to holding Susan’s hand.

I think about how Lucy handled the situation differently than Linda had—that her passive hinting helped stop William without shaming him, but he didn’t stop pulling at Susan's arm until Linda spoke to him directly, addressing his behaviour in a calm yet firm way. Lucy remained subtle, avoiding any direct communication with William or assumptions about his intentions. Meanwhile, Linda ‘levelled’ with William, and this is when he stopped pulling on Susan (at least for the time being). Lucy is a young woman while Linda is middle-aged. This may say something about the power afforded to women within hegemonic masculinity: older women tend to be less sexualised and thus may feel more comfortable addressing potentially predatory behaviours. Linda has much more experience in residential care, and she may know that direct communication is more effective and more respectful of William. Pretending to not know what he’s doing ignores that William is acting autonomously and devises a strategy to shirk off surveillance so that he can act as he wants. Gauging consent and facilitating appropriate sexual or romantic behaviour between residents is complicated, and watching the different ways in which Linda and Lucy attempted to confront William’s advances towards Susan may in part be due to training, but I’m certain that their instinct also comes from the lived expertise of being a woman in a culture where unwanted advances are commonplace and where to move through the world as a non-cis-male you are likely to develop a strategy to avoid or escape these behaviours.

Later that evening, in my room, I thought about my own bodily response to watching William grabbing at Susan, and I wrote in my journal:

I honestly don't know how I would have dealt with that situation had I been alone with them. I felt worried for [Susan], but I also felt some kind of pity for [William], that to attempt to access intimacy he had to try to distract the women in the kitchen and had to grab at a woman who, though engaging in some friendly behaviour such as hand holding and smiling, did not seem to understand [William]'s intentions. The entire situation left me feeling sad.

(Reflexive journal, 21/7/2021)

Discomfort with his role as a care recipient in a care home runs through many of William's experiences, and this discomfort is often navigated, understood, regulated, and sometimes made starker by masculinity. For example, when feeling shame about struggling to accept the care home menu, William explains his role as a care recipient as less of a man, forfeiting some of his ideals around masculinity to ask for what he needs and wants. In another case, his attempt to seek intimacy with another resident who appeared to lack the capacity or awareness to consent made carers question his masculinity by openly joking about his behaviour. It is often treated as funny or even cute when old people demonstrate romantic or sexual desire. Under this infantilising humour may be a feeling of repulsion and abjection from the carers. This repulsion is bound up in ageist attitudes which de-sexualise the elderly, which can be not only humiliating for William but potentially dangerous for Susan if the situation is not recognised for the intrusion that it is. Similarly, William's perceived failure to adhere to a masculine ideal seems to incite feelings of self-disgust. Even in my own reflections, I say that I have felt some kind of repulsion about the situation between William and Susan. Yes, to witness someone potentially victimising another person will likely waken feelings of disgust or shock in any situation, but it seemed to have a particular flavour of repulsion that this was happening in a care home where a widower was making advances on a woman with whom he'd never had a conversation and whose name he did not know.

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The last time I sat with William, I had dropped in to say goodbye before leaving. We looked at old photos of Piccadilly Gardens on my phone from "before they messed it all up". William fondly told me about the many times he'd go to meet his friends on a weekend in front of the Woolworth's department store. I asked him if he ever missed going to Manchester. "Those days are…that's done. I am here", he shrugs. I wince a bit, realising that my question was a bit insensitive. However, William didn't seem to mind the question, and he continued telling me about Woolworth's fire and how ugly they made Piccadilly Gardens. Before I left, he showed me some new CDs his son had brought. I noted that one of his paintings, previously propped against the wall by his bed, was hung behind him. He tried to tell me why he owned that particular painting, but it was difficult for him to complete his sentences, so we left that story untold. I thought about how gently William allowed the past to slip away, how peaceful he seemed about it.

The next time I came to visit, William had passed away. In my reflections, I wrote:

Before anyone told me about his death, I saw William's portrait on the mantle (where they display every resident after they pass away) and my heart sank. I had so many questions I wanted to ask him. The last time we spoke, we sat together in his room as he intelligently mused about his experience with memory loss. He told me that he has always relied on his intellect, mind, as an engineer, and just as a personality - he lived in his head. "I am sick of living up here!" he said with a smile. He said that he was trying to live in his body more ("though that has its own aches and pains"), and he was listening to jazz as a way to reduce anxiety over his inability to remember, to connect thoughts, an idea, I think, which his son offered up. I grew quite fond of William, and he was one of the people I was looking forward to meeting again on this visit. I wish I had come back to see him sooner…I hope he passed gently.

(Reflexive journal, 15/6/2022)

Our short relationship was a mere moment in William's decades of different experiences: one small snapshot from the last summer of his life. A snapshot heavily shaped by our identities, which bellowed loudly in the chasm separating our lives: I am a researcher, a younger woman, an American from a rural, working-class background, and he, the one being researched, a widower, a retired engineer, and Englishman from upper-middle-class Manchester, a man with some views on women with which I wholeheartedly disagree. Yet, there was a relationship that I like to think was authentic in its small way that existed beyond those categories. When getting to know William, I found something elegant about how he would look directly at the memory loss, reduced mobility, and brain fog he described increasingly experiencing at the end of his life. He seemed to treat his ageing process as a curiosity, to find something meaningful in his condition. He would say that he was learning not to rely so much on his mind, to instead relax into daydreaming, watching television, or hearing jazz music. William seemed to lose confidence in his capacity to show up, as he had known himself for the majority of his life, to resist moving forward into a new form of masculinity. It's tempting to wonder if it could be said that William's discomfort came more from being a man than from being old. Of course, it's impossible to isolate the two; they inform one another inextricably. However the task of clinging to the ideals of being perceived as masculine weighed heavily on William's interactive life in the care home. Furthermore, the problem was not only about how William thought he should be but also how he could *practise* himself. There is no neutral correct way to practise oneself, to exercise agency; he tried to find a way to do it that was meaningful to him. If not masculinity, there would be another repressed mode of behaviour, so the problem is not masculinity as such. Still, the way it can intersect with the conditions and context of the care home renders William's identity unstable and abject. Through various situations, William oscillated from the confident man who gave young carers nicknames and enjoyed a cigar with his family on a summer evening to the 'decrepit old man' who sat, bored and stifled, in the care home household.

Case III: Orla

I first met Orla outside one evening, locking my bicycle up in the care home's garden. Orla had a stern-looking face, peering up at me from her wheelchair. She had bright short white hair, wore a dark wool coat, and had a thin blanket covering her legs. Orla’s clothing and combed hair looked well-kept, and, despite her initial sternness, she had twinkling, inquisitive eyes. A care worker from Orla’s community, Sarah, introduced us politely: “Have you two met? I think Jayme will come to spend some time with us in a few weeks”. I stood and chatted with the two in a small shed next to the bicycle racks. We all gazed at the parking lot, watching the asphalt slowly grow darker with the gentle summer rain.

Both Orla and Sarah were smoking cigarettes. Orla sat in her wheelchair with her blanket over her lap while Sarah sat on a short, plastic footstool next to Orla. The stool height positioned Sarah’s head to reach Orla’s shoulder. This may be one of the few instances in which Orla, who always used a wheelchair, sat higher than those around her. I usually detest the smell of cigarette smoke, but here it felt comforting—somehow juxtaposing the clinical smell of the cleaning products and latex gloves that filled the care home. Orla joked, “We are the rebellious students”, and both laughed. Orla looked calm as she flicked the ash from her cigarette, Sarah sitting at her side. I noticed that Orla appeared to possess an air of confidence which stood out as unusual for a resident. She was also one of the few residents of the communities that I would ever see outside past dark.

Before meeting Orla, I saw her from the window of my own apartment, which faced the back garden, as various care workers would push her out to the little shed, Orla holding their little plastic smoking stool on her lap. Orla would later become one of just three residents who provided informed written consent to participate in the study. I eventually inducted Orla into my study when I came to her House, which houses quite a few non-verbal residents who require higher levels of care. This community became a personal favourite, as the staff are lovely, and there is a harmonious, inclusive atmosphere. Meals are often friendly, the staff are very respectful to all residents, and it was explained to me that though this community houses a majority of residents who are nonverbal and require a high level of daily care, Orla is probably best suited for this household, as she likes to be left alone. Described to me as "cagey" by Sarah, Orla never attended the social events put on by the care home. Orla promised me an interview early on but avoided the subject whenever I would bring it up to her until I eventually gave up on the idea.

Orla is an Irish immigrant, a retired nurse, a widow, a mother of two adult sons and a grandmother of one young boy. After immigrating in the 1950s, Orla lived and worked in a small neighbouring town which, in the 1950s, was a thriving industrial town known for being a major centre for textile production. The 1950s was also a time of significant social change in England, with the end of World War II and the introduction of the National Health Service (NHS) and the welfare state. Many people from Commonwealth countries came to England during this period to help rebuild the country and fill labour shortages in industries like manufacturing and healthcare. The 1950s was a time of increased immigration from Ireland to England, as many

Irish people sought work and better living conditions (Maye-Banbury, 2016). The Irish community in the region was particularly strong during this period, which is how Orla came to move to England with the encouragement of her aunt who had known others who moved there. During the 1940s and 1950s, there was a shortage of nurses in the UK's National Health Service (NHS), and the government actively recruited nurses from overseas to work in the NHS.

This led to an influx of Irish nurses to the UK, including Orla. However, despite being welcomed by the state for their English language and cultural similarities, Irish immigrants generally faced discrimination and hostility in the UK during this period. Orla told me she remembers people moving away from her on public transport and women at work treating herself and Irish colleagues as “less than others”. Irish immigrants were often seen as a threat to British jobs and culture and were subject to discrimination in employment and housing. Despite these challenges, many Irish immigrants, including nurses like Orla, were able to build successful lives in the UK, and many stayed past retirement. I asked Orla if she had made friends with other Irish nurses, but she said she married quickly and did not spend much energy socialising. She maintains contact with family in Ireland and is one of the few family members who left to find work elsewhere.

Orla's Irish Catholic identity shapes her experiences and interactions within the care home, which intersects with other aspects of her identity, such as her gender and age. Orla took a liking to me, which gave me a welcome sense of belonging, especially in the early days of fieldwork. I shared a bit about my own Irish Catholic grandmother, and Orla may have initially found a connection with me through our shared heritage. “She’s a good Catholic girl, helping with the dishes”, she’d sometimes note as I stood at the sink to help wash cups. When she said this, I felt slightly uncomfortable, both at being called ‘girl’ as a woman in my 30s and cringing at memories of my Catholic father growing weary of my tomboy behaviour and commanding me to behave ‘more ladylike’—memories of gender norms which jumped up at the mention of being a “good catholic girl”. But Orla was producing her ideals around the intersection of gender and religious or cultural background, placing me in her context and bringing me into her sense of the world. Orla’s rapport with me speaks to how residents connect with care workers based on these personal elements, and these connections affect their experiences in the care home[16].

Orla’s sense of humour had been apparent since our first meeting:

> *me: We met last month before I came into your household. I was unlocking my bike out back; you were smoking...*
>
> *Orla: I remember! I remembered hearing you are American. And wondering why you’d be here. (laughs)*
>
> *me: You’re the only person I have met out back. Do other residents smoke?*
>
> *Orla: You know what, Jayme? It is just me! I’m the only smoker in the building…*

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[16] In fact, as I will mention again, my outsiderness was often used as a source of connection with other residents, some of whom moved just 20 km to live in the care home. This raises the question of who is deemed “insider” in a community built up of people from many diverse backgrounds.

me: Do you smoke often?

Orla: No. Just before breakfast. And then after. And before dinner, usually. Then in the afternoon. Well, and before tea. And then a few more times in the evening. Breaks up the day a little. I do it for something to do. It's something to go and do and get some fresh air..

I smile: Yes, cigarettes are a great way to get fresh air. (maybe this was rude! But Orla has a sense of humour and reminds me of my Irish Catholic grandma..so I assume I know how to make the appropriate level of a friendly jab.)

Orla: (laughs) Well, no. But I can not stop everything. I have to keep doing some of the things that…(trails off into silence) the things that give me life. Otherwise, it's just...this (gestures again to the room).

me: Well, I like your little smoking shed.

Orla: We call it the rabbit hutch (both laugh).

[Fieldnotes 21/6/2021]

The carers seem quite fond of Orla and will take turns going with her down to smoke. I have noticed that they will offer the chance to one another ("You seem tired, do you want to take a break, go down to the hutch?") Some of the carers smoke themselves, and thus time their smoking breaks with Orla's. She carries a little stool on her lap when she goes down as the carer pushes her into her chair. The carer will sit on the stool beside her in the rabbit hutch. From the widow, it looks sweet, two women hunched over in a tiny house. They often discuss their plan with Orla, including her in the decision process (e.g., not talking over her as if she is not there: "I can go down in 10 minutes, Orla, does that work?") I imagine that this activity helps Orla feel some amount of agency, and as she said it gives her something to do and breaks up the days. Additionally, the act of smoking as care, and synching their smoking habit with Orla's, adds a texture to Orla's care plan.

The little tweaks to Orla's care set her apart from most other residents in this household. The staff say that Orla is "very set in her ways". They tell me that she is not interested in the care home's social events and prefers to be in her room on her iPad[17], smoking, or sitting in the dining room. They never prompt her to attend anything, as I have seen them do with other residents. Orla has a silver tea set which staff always prepare for her, and she does not have much of an appetite, usually preferring a simpler meal than whatever has been prepared, often just toast and beans. The care workers never prompt her to eat more or eat differently than she prefers.

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[17] Orla is one of the only residents I meet who has use of social media. Social media has been shown to improve mental well-being among older adults experiencing isolation associated with social distancing (Brook & Clark, 2020).

> *It’s lunchtime on Household 3. Everyone is eating, and aside from some chatter between Orla and me, it is quiet. The janitor and a woman in charge of finance came into the household to look at the dishwasher. They addressed a staff member and stood near the dining room tables while residents ate. They went over to the kitchen for a while to speak and then when they left- they nodded to me and said thank you to the room generally with a wave. Orla waved towards me and said “You see, this is something I have an issue with. They don't say hello. And I find it quite rude for people to enter the house without saying hello. Even residents who may not speak... should receive a hello. At the very least. It’s just bad manners.” I agreed, “Yes and it’s your home”, - “well exactly. Exactly. It’s our home, and they shouldn’t come in, especially during mealtime, and not address us as people”.*
>
> *[Fieldnotes]*

Later, I heard Orla passionately relaying the story to a staff member. Orla demonstrates effective communication in expressing her needs within the care setting. She employs humour as a communicative tool, playfully saying things like, “I thought you might be tempted by the exciting offer to take me to the toilet” or urging action with a humorous tone, such as, “Stop talking so much and do your job—now take me to the loo.” This approach not only communicates her requests but also adds a lighthearted element to potentially sensitive situations, fostering a positive and engaging interaction with the staff.

In addition to her use of humour, Orla interjects in conversations, occasionally correcting staff grammar or chuckling at their remarks. Interestingly, she does not seem to expect a direct response or interaction from the speaker. Instead, her interjections appear more like reactions to a radio show, where the enjoyment comes from participating in the conversation without necessarily seeking engagement or acknowledgement.

Orla's communication style not only serves as a means to convey her needs effectively but also adds a distinctive and engaging element to her interactions with staff. This sophisticated approach to communication reflects her ability to navigate social exchanges with a touch of humour and a unique interaction style.

Orla's primary source of social interaction seems to be with the care staff, revealing a connection built on effective communication and shared moments of humour. However, her living situation presents an interesting contrast. Orla shares the house with another resident named Danielle. Initially, the care home's plan was for Orla and Danielle to be companions. They both moved from Ireland to the region at the same time and age, with the hope that they would click and keep each other company. Unfortunately, it turned out quite differently, as they can not stand each other and maintain a noticeable distance. I remember one instance when I excused myself from Orla's company to greet Danielle, and she humorously quipped, "You better bring a cushion to sit on; that woman can talk…." This remark highlighted the strained relationship between Orla and Danielle.

I also faced challenges connecting with Danielle. Despite being a staff favourite due to her passion for Manchester United, which adds a lively touch to social events, some aspects of Danielle's behaviour create complications. Her occasional racist comments and expressed trust issues with women, stating, "Men are honest. Women can not be trusted," contribute to the intricate social dynamics within our shared living space. This adds a layer of complexity to the varied and, at times, conflicting interpersonal relationships in our care home setting.

During a visit several months later, I was delighted to witness a positive change in Orla's routine. She had started going out with her sons since the care home had "opened up." Excitedly, she shared details about a charity walk she participated in a nearby town, emphasising that her sons had pushed her wheelchair throughout the entire event. This experience showcased Orla's proactive approach to meeting her physical care needs at the care home while actively seeking connection and socialisation through her family and friends outside its confines.

Orla's ability to maintain connections and engage in activities beyond the care home demonstrates the importance of personal agency in seeking social interaction and fulfilment, even in the context of a care facility. Her experience highlights the potential for residents to strike a balance between receiving necessary care within the care home and maintaining meaningful connections with their broader social circles if their circumstances allow. In the case of George and Julia, and of William, this was not possible, either due to having outlived important connections, or for being relocated to access residential care, and thus alienated from the surrounding community.

Section Two: Social Life in the Care Home

During my time at the care home, even amidst heightened health concerns and limited social interactions, the staff made sure to organise one or two care home-wide social events each day. These gatherings usually took the form of a mid-morning coffee hour or an afternoon tea time. Occasionally, there were exercise classes or games like bingo. Now and then, we would have a special event, such as an outdoor concert, a multi-day summer Olympic games event, or a group gathering to watch an important televised event, like the 2020 Olympics. These social events were typically held in the venue or the cafe and involved one to four members of a household. It took me a little while to notice that the small group of regular attendees tended to be the only residents interested in participating. On average, daily events attracted anywhere from two to eight residents.

Over my stay, the regulations changed, and events were opened up to include multiple Houses at a time. This would allow members from different Houses to interact with one another. However, unless heavily encouraged and facilitated by staff, resident interactions between Houses were limited. Here is an example of such an event from my field notes:

During the coffee hour, a quiet atmosphere filled the room. Rachel sat with her hands folded in her lap, gazing out the window at the rain. The care worker, attempting to initiate conversation, remarked, "Look, Rachel, she has a lovely sweater on. Julia knits, don't you, Julia?" Julia responded modestly, muttering something about her knitting skills being a thing of the past, "a lifetime ago." Rachel remained silent but turned to observe Julia and her sweater.

This afternoon, House 1 was invited to a tea event. I accompanied Kelsey downstairs, joining another household in the bistro. Max, Kelsey, Julia, George, and Susan participated in the activity. The bistro staff beautifully arranged the table with delicate saucers, tea plates, and tiered cake trays. Each resident was given a choice between tea and a latte, accompanied by a *cupcake and a slice of lemon cake. Unanimously, everyone opted for the lattes. I sat beside Kelsey, who appeared content, while Susan quietly savoured her treats, wearing a smile.*

As we settled into our seats, another group from House 4 joined us, mingling with our House. Max and Julia engaged in conversation with a lively woman. Max, visibly elated from his recent outing, smiled throughout the event. Julia, on the other hand, insisted on dividing her cupcake into thirteen slices so that she could share with everyone, despite our explanations that each person had their cake. George, understanding her tendency to stress over sharing, discreetly moved her cake aside. Julia expressed her happiness and commented on the delightful weather.

Approximately twenty-five minutes into the event, Susan dozed off, prompting me to call for care staff to assist her back to the household. Hearing this, Max also expressed his desire to return home. A care worker asked if I could stay with Julia and George and accompany them when they were ready to leave. Kelsey, too, decided it was time to go home. I remained with Julia and George, periodically waking George as he unintentionally fell asleep with coffee in his mouth. Julia reflected on the social dynamics, remarking, "They seem a bit awkward, unused to socialising, don't they?" She said that it is important to see "how honest the children are". George mouths "confused", but I think I know what she means.

When we got up to leave, Julia holding my hand and using her cane to walk, and George shuffling ahead of us with his Zimmer frame, Julia gasps and hits George's shoulder: "You didn't pay!" He assured her it had been sorted.

In this example, we see how a simple tea event can have different impacts on residents. It showcases the challenges of providing person-centred care, where understanding each resident's unique needs and preferences is crucial for their well-being and engagement. The concept of front stage and backstage, as explored by Erving Goffman, is evident. During the coffee hour and tea event, residents engage in social interactions on the front stage, facilitated by the care worker. Julia's knitting skills and Rachel's previous experience with knitting are brought up as topics of conversation, representing their roles and identities in this front stage performance. However, in the backstage, Rachel's lack of response suggests a more withdrawn state of mind. The need for care staff support becomes apparent when Susan falls asleep, requiring their backstage intervention. In several instances, I have observed care staff socially "propping" residents up to meet the social expectations set by an event (e.g., trying to start a conversation between Julia and Sarah). Meanwhile, Julia shares her observations and musings about the social dynamics and the honesty of children, which is the perspective she shares with trusted individuals outside of the main social event.

Furthermore, Connell's concepts of power and gender also help to make sense of the dynamics of this event. The care worker holds a position of power as they initiate and facilitate conversations, exerting influence over the social dynamics on the front stage. Care staff's involvement in manageing unexpected situations, like Susan falling asleep, highlights their power in providing necessary care and support[18]. The conversation revolving around knitting and Julia's former skills exemplify gendered stereotypes associated with traditional feminine activities. The participation of Susan, Rachel, and Julia in the tea event reflects gendered roles and expectations within the care home context. Additionally, Connell's framework considers how gender norms influence the roles individuals occupy within institutions. Therefore, the care worker's role in initiating and maintaining social interactions may be influenced by gendered expectations associated with caregiving and nurturing roles, as suggested in the passage.

An Evening at 'Home'

My intention with this section is to show the way social life typically played out in the House common area during the evening, after dinner and before bedtime, when residents would be encouraged to sit together in the sitting room, usually watching some television. I witnessed that the evening social hour would serve a few purposes: the care home identified that

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[18] This reflects Connell's notion of power as not only hierarchical but also relational, with individuals exerting influence over social dynamics.

socialisation is important for residents’ holistic well-being, care workers would be busy doing one-on-one evening care tasks (more clinically focused care, or changing into pyjamas, medications, et cetera) with individual residents in their rooms and it was more convenient, and more secure, to encourage residents to wait together, and culturally, sitting and watching some television in a sitting room gave a sense of normality, and perhaps continuity. What I witnessed, however, was minimal interaction between residents. A few, namely George and Julia, would use the sitting room to socialise, but most would avoid it altogether, or tolerate the occasion based on care worker encouragement or invitation. The following details one of my early evenings with the first House with which I spent time, “House 1”.

When I entered House 1 that evening, the residents were finishing their dinner, or as they called it, “tea”. Susan and Lisa, two residents who had a nice rapport, sat at a table in the dining room, engaged in conversation and appeared content. Kate and Lucy, two of the care workers on shift, were at the adjacent table, occupied with charts while having their dinner. Due to the pandemic, care workers were no longer allowed to dine together with the residents. Kate's dog was present, sleeping at her feet. In the living room, George, Julia, William, and Sarah were present. George seemed a bit frustrated because he could not hear William and Julia, who were sitting on the sofa together. When I offered to help George move closer, he declined, stating that he was comfortable where he was: “Just go with it”. Sarah sat in an armchair, frequently glancing towards Larry in the kitchen. I inquired if she needed anything, to which she replied, "No dear, I'm just being nosey." George and Sarah had finished their dinners, but Julia was still eating her sandwich and crisps. William's plate remained untouched. Julia expressed concern to

Lucy about William's lack of eating, pointing at him and exclaiming, "He hasn't touched his meal!" Lucy reassured her that William would eat when he was ready.

Larry, a young male carer from London who was encouraged to take a job in care work to gain acceptance to a Master's program in Sociology, was also worried about William's lack of food intake. He checked the residents' daily intake on the electric medical system–software on iPads and phones that the care workers use to log medications, food, liquid intake as well as other clinical elements of care provision–and decided to offer rice pudding as a dessert to increase their calorie intake. Everyone accepted the offer, except for William who still did not touch his food. Later, Larry offered William hot chocolate and cake. By the end of the evening, William managed to eat half of his cake. Julia was disturbed by this, stating, "He's not eaten anything! I just feel really sorry for him."

While everyone was having their pudding, I took the opportunity to greet Max, who was reclining in his lounge chair in his room, the door open. He was watching Star Trek and having a glass of wine. I had seen him earlier during a visit downstairs and asked how it went. He was delighted and pointed to a photo of his granddaughter, sharing that she had visited with her dad that day. He proudly mentioned that she was 12 years old and doing well in school. Max's room was full of personal items–family photos adorning the shelves and a heart hanging from the mirror reading, "Love you to the moon and back."

Max's room felt more like a home compared to other rooms, as he utilised the space for rehabilitation to eventually leave the care home. It was intriguing to observe the varying atmospheres in different rooms, ranging from homely to clinical. For example, William's room had minimal furnishings with only one painting. Additionally, some rooms felt like common areas where residents spent most of their time, while others felt more private. I noted that I would not enter Susan's room to speak with her since she was usually in the common area throughout the day. I asked Max if he wanted to join us in the sitting room, and he shook his head vigorously as if to say: absolutely not. “I’m happy here”, he gestured to his room.

Tonight I was told that a new resident just arrived at the household - an English man who had been living in Spain for several years before returning to England due to the need for additional support. He was flown in and had to undergo a 10-day quarantine in his room. Upon his arrival, he brought along unmarked medications or medications labelled only in Spanish, without any dosage or instructions. Kate took on the task of deciphering the medication details and began making calls to gather support. She mentioned that she needed to consult with the nurse to seek assistance and also tried to reach the on-call GP. As a result, only two staff members were available for the evening medication administration and helping residents change and prepare for bed. In the meantime, I offered to stay in the living room and keep the residents company while the staff carried out their caregiving duties.

It was a sunny evening, and the sunset poured in through the windows in the dining room. It was gorgeous and bright in the space, and I noted this to the residents. There’s a balcony but I have not yet seen it being used. I wondered how long residents have gone without being outside. I asked Lucy if anyone goes outside and she told me that Sarah has in the past, but not recently. I asked George if he ever goes outside and he said no, the air is too chilly and he prefers to be in. In the living room, Julia attempted to communicate with George, but he struggled to hear her. He asked me to act as a translator, relaying a few of Julia's messages to him. Julia expressed her concern about when they would return home, fearing they were overstaying and being impolite. George assured her that everything was fine, and Julia appeared satisfied with his response, reclining back on the sofa.

Sarah excused herself to use the restroom, which seemed to worry Julia. Throughout the evening, Julia displayed a certain level of anxiety, persistently expressing her worries about William and his untouched dinner. She held the belief that Sarah and William were married and repeatedly inquired about the whereabouts of their spouses. The staff members responded with statements like "they aren't here" or "they've passed away," causing William to visibly flinch at times. The staff members faced challenges in determining when to correct residents and when to allow for "untrue" statements. During training, they were instructed not to correct residents, but this could become complicated in social scenarios where multiple individuals held varying beliefs. Inevitably, someone's truth would be negated.

At one point, Lisa approached Sarah, greeting her and taking a seat next to her on a stool. They held hands and shared giggles. Lisa mentioned that she was waiting for her mother to come and pick her up, prompting Sarah to inquire about her whereabouts. Lisa proceeded to describe, in great detail, the directions to her childhood home. Shortly afterwards, Julia asked Sarah if she needed any help getting home, to which Sarah sternly replied, "No, I live here, and I have lived here for 3 years."

It was fascinating to observe how residents interacted with one another and responded differently depending on the circumstances. Sarah, for instance, seemed inclined to go along with Lisa's ideas while simultaneously correcting or avoiding Julia. This disparity in rapport appeared to be more about the feelings involved rather than the actual words exchanged. Lisa tended to be easygoing and inclusive, especially when discussing her mother or reminiscing about her childhood home. In contrast, Julia tended to exert control over others. This behaviour occasionally put off other residents as it generated a sense of anxiety and intensity.

Susan had retired to bed, so everyone remaining in the common area had gathered in the living room. Julia and William occupied the sofas, both appearing quite sleepy. Sarah settled into a chair, also displaying signs of drowsiness. However, Lisa seemed unusually restless, wearing a frown and expressing concern that her mother might be worried. I sensed that she could sense the difference in the atmosphere tonight and was seeking the presence of Kate, who was still busy sorting out the correct medication instructions for the new resident. Meanwhile, Larry and Lucy went into individual rooms, assisting the residents with their bedtime preparations. Eventually, Larry asked George to accompany him to George’s room for help changing into his pyjamas. Upon returning, George winced, sharing his struggles with nerve pain in his lower back. He lamented the lack of access to in-person medical attention, as telehealth appointments were the only option available. He expressed dissatisfaction with the effectiveness of the cream he was using, stating, "It makes me sad, enduring so much pain." George mentioned having an upcoming appointment for his eyes, where he would receive an injection. He described it as an awful experience, adding with a touch of sadness, "I don't recommend growing old; it's about as fun as a needle in your eye." He referred to himself as a "soft man," although Julia overheard this and laughed, contradicting his self-perception. Julia appeared anxious, so I approached her and initiated a conversation about knitting. I asked if she could teach me, and she laughed, agreeing but explaining that it was too late for that night. This interaction seemed to bring joy to George, who informed the staff multiple times that his wife would be "teaching our American friend how to knit!" He found solace in witnessing Julia in her role as a teacher once again.

Lucy, the lead care worker, came over and took a seat beside me, emitting a sigh of weariness. She disclosed her plans to transfer to the bistro soon, having served as a care staff member in the household for an impressive nine years. Lucy's mother had multiple sclerosis, and she had been her full-time care worker, receiving payment since she was sixteen. After her mother's passing, she began working at this care home when it was owned by another company. Being a care worker had been her lifelong occupation. She expressed her fatigue, particularly amplified in the past year, and her desire for a change. She hoped that transitioning to the bistro would offer a shift in pace and intensity while allowing her to continue utilising her interpersonal skills and maintaining daily interactions with the residents. Lucy emphasised the busyness of their environment and expressed gratitude for my presence, as the staff often lacked the time for extended conversations, especially on evenings like this one, with unexpected occurrences.

Lucy checked something on her phone, prompting Julia to inquire, "Do you think you could survive without that thing? Very queer, those! I don't think you could go without it anymore." Lucy ignored Julia.

I informed George of the score, unfortunately revealing that his team had lost. He shrugged and uttered, "Win some, lose some," accepting the outcome. He then expressed his gratitude for my presence, remarking, "You have made my day, just being here, hanging out with us elderly people."

As George dozed off in his chair, Julia playfully woke him, exclaiming, "George, you are asleep! How rude! You can not sleep here." Unaware of her words, he continued to slumber.
The night staff arrived, signalling the end of my shift. I bid everyone good night. Julia became teary-eyed and requested that I accompany her upstairs. She tightly held my hand, tearfully expressing her love before shedding a few tears. This emotional display provided insight into her anxiety and heightened emotional state, particularly considering her recent loss of her sister. Kate pulled me aside and thanked me for staying, saying she did not know what they would have done without me. There is such a heavy load on the care staff!

Leaving, I pondered how to contribute to the care home community. Having spent five days in the household, I started noticing intriguing patterns. The experience was strange—both heavy and light. I continued to wonder about William not eating, contemplating whether it stemmed from insecurity about his motor skills or if he had forgotten how to eat. The lack of direct access to care plans made me feel awkward, observing and talking to residents but unable to provide more direct support. This brought attention to the distinction between 'expert' clinical care and intuitive, spontaneous care.

Residents seemed to crave conversation, but carers were often too busy. Reflecting on the staff's hard work, I realised the lack of opportunities to pause and process recent events. The house had lost seven residents in 2021, and some had lost family members, yet daily life didn't necessarily reflect this. I wondered about the countless moments of dignity and humanity residents expressed daily. Although residents were beginning to visit friends and family once a week, I questioned if this could compensate for what they had been through. The departure of some of the best and most experienced staff due to burnout added to the complex dynamics within the care home. From my reflective journal, that night, I write:

I also think about how it will be difficult to leave this household. Julia and George are going through a lot right now and they appear to need some extra support. It feels a bit unfair to support them for a few weeks and then leave, creating perhaps a pattern or dependency just to cut it. However I hope that in this few-week period, I am helping a bit with Julia's bereavement. George has a lot to manage with his wife's dementia and his physical well-being. I also think about the residents with whom I have spent less time (Susan, Lisa). Maybe I should even out the time I spend interacting with residents, but it's also a natural process to see who wants to talk to me and who in the household is interacting.

When reworking my field notes to write this section I find it very interesting how familiarity makes certain details 'invisible'. After months of spending time with this House, I ceased to notice the specific dynamics of individuals, after learning more about William's depression I stopped finding it strange when he refused meals. I stopped asking about the balcony. In fact, by the end of my time in House 1, I stopped noticing the balcony. It became a sort of non-space. This phenomenon underscores the transformative power of habituation and the gradual normalisation of once-noteworthy aspects within a familiar environment. As a participant-observer, the evolution of my perception towards these elements within House 1 serves as a poignant reminder of how extended exposure can render certain details 'invisible,' a process that warrants thoughtful consideration in the context of ethnographic research.

Luis, the resident who came from Spain that night, and who later enrolled in the study, was the first resident to engage with the balcony, which excited and enlivened care workers, who had also begun to ignore the potential for the balcony to add quality of life to the House. Luis initially demonstrated a keen interest in gardening, earning admiration from the staff. They expressed delight in his dedication, with one care worker mentioning her fondness for him and even offering to bring compost from her garden. During my interactions with Luis, he shared his passion for rejuvenating the neglected balcony garden, emphasising his long-standing affinity for spending time outdoors. The staff appreciated the revitalising impact he brought to the household. However, over subsequent visits, it became evident that Luis' enthusiasm for gardening waned, culminating in an observation where he spent an entire afternoon in his room with the door closed.

At a social dinner event, encouraged by care staff, Luis appeared fatigued and less engaged than before. When asked about the garden, he expressed a lack of progress, mentioning that there wasn't much happening with the plants. Contrary to his previous vibrant demeanour, Luis revealed a shift in preference, opting to watch films alone in his room instead of tending to the garden. When questioned about his apparent loss of interest, he admitted, "They said they'd bring soil, but I didn't have enough, and it's...it's easier this way."

While contextual factors and the passage of time could influence Luis' change in mood, his acknowledgement that gardening had become less natural and convenient suggested a more deliberate shift in his activities.

Food & Eating in the Care Home

Food and meals emerged as a central theme in this study, highlighting their multifaceted role in residents' lives at the care home. Beyond serving as a basic source of nutrition, food carries significance in providing cultural identity and preserving heritage. However, within the care home environment, meals often took on a medicalised and impersonal nature. Despite this, they presented an opportunity for residents to share their culture and establish social connections. Food acted as a dual-purpose entity, serving both as a unifying element and a potential site for control, order, rebellion, empowerment, or disempowerment. The process of preparing and cleaning up around meals became integral to care workers' daily routines, offering structure to the residents' lives (Lowndes et al., 2018)

The tension between institutional and interpersonal care was palpable in the serving and consumption of food. This tension is reflected in Gilleard and Higgs's (2015) observation that much of the literature on ageing emphasises the productive potential of older adults rather than acknowledging their lived experiences as desiring, performing, and resisting bodies. This quote prompts a consideration of how the older adults in the study negotiate their bodily ageing within the specific social context of the care home.

The social and cultural dimensions of bodily ageing become apparent in the observations related to food, meals, and eating. The act of food consumption, or resistance to it, places the body at the centre, often rendered passive. Moving beyond a corporeal understanding of ageing, Gilleard and Higgs (2015) propose viewing the ageing body as a social actant—an entity with the agency that shapes and is shaped by its social surroundings. This perspective challenges the notion of the ageing body as a passive object, highlighting its active role in social interactions and cultural norms. Alternatively, considering ageing as an embodiment underscores the ageing body as a co-constructor of its own identity. Here, the ageing body is not merely a physical entity but a dynamic embodiment shaped by multiple social, cultural, and historical forces. This perspective enriches our understanding of how the ageing body contributes to and is shaped by broader cultural and historical narratives surrounding ageing and old adults. Expanding further, acknowledging the body as a social actant and a vehicle of social agency emphasises its active role in shaping broader social norms and attitudes (Haraway). This perspective underscores the reciprocal relationship between the ageing body and the social forces that influence it.

A meal with Susan

Kate asks me if I can sit with Susan, who is having her dinner. I sit down and greet Susan, seated at her usual spot, alone at a round dining room table near the kitchen counter. Unlike the others, adorned with a royal purple cloth, this table is bald shiny laminate, since Susan often spills food and staff has grown weary of changing it after every meal. Susan is agitated, looking around with wide eyes, and she grabs my arm hard, her nails pressing into my skin. Susan's thin, dyed-red hair has been recently curled, with lots of hairspray holding it in place. She is wearing, as usual, a nice bright pink top with pearls, deep pink lipstick, and rouge. She smiles at me, and I carefully remove her hand from my arm. Her gold and beaded bracelets jingle as I carefully set *her hand down. Susan has beautiful, bright eyes, and she sometimes looks like she remembers who I am, a sort of wide, surprised expression, fading to relief and then wide again.*

Whenever I sit with Susan, we hold so much eye contact that it is nearly uncomfortable, and there is a lot of touching and grabbing, as if she is searching for who I am. For a moment, now and then, she gasps, and her smile deepens, and I wonder who she might remember in the lines of my face. I feel inconvenienced by the masks in these situations, as Susan often looks deep into my eyes, her eyebrows furrowed with anxiety. I want to smile, to potentially ease her mind for a moment. Susan often starts talking, “You know - !” or “Well, I’ll say..” and trails off. These short conversational starts happen repeatedly, and she often seems so impassioned by whatever she is going to say that I hold my breath and wait, captured each time by her energy and intensity. Impatience is an element of this dynamic, the experience of summoning patience with Susan’s tempo was, in my experience, a care act (Roitenberg, 2021).

Today is my task to help Susan finish her meal, which carers have previously demonstrated by guiding her hands to her utensil, verbally reminding her about the food, and simply sitting there, keeping her company so she does not have to eat alone. I help cut the food into smaller pieces and talk a bit about the meal—it is a mash with ham and gravy and some boiled broccoli. I wonder if this resembles a meal Susan would have prepared for herself. It does not look very appetising to me, the ham is so pink. But I do not say that. Instead, I say, “Would you like some mash with a bit of ham? does not that sound nice?” The words feel a bit foreign coming out of my mouth. I had previously felt sceptical of care workers saying similar things about similar *meals. But the silence feels uncomfortable, and I feel the urge to vocalise what we are doing so that I am not silently shovelling food into Susan's mouth or guiding her hand to do the same. I hope that I might help her remember the food, and understand what we are doing here together, and words are, at least for myself, a guiding lantern. It takes Susan a long time to eat, sometimes she uses the spoon, sometimes her fingers, and she allows me to lift bites to her mouth.*

We take many breaks. Susan drinks some juice, which is always offered during meals to increase caloric intake. We smile at one another, she gasps and has the revelatory expression of recognising an old friend for a moment. We repeat. We sat there together for about an hour, making eye contact, smiling, some bits of conversation, and lots of trailing off. I genuinely like Susan, and I don't feel particularly bothered by the task of keeping her company, but even so, I feel myself summoning patience for the task. It is slow, and loops around repetitive words, actions, and feelings—it feels like we are trapped in a time loop. I notice that I feel a sense of accomplishment when Susan manages to eat more, not only for her well-being (of course this), but also because I know we are closer to finishing the meal and that this means we can move on…to what exactly? I am careful not to rush her due to my impatience with the tempo.

Eventually, Susan's mostly cleared plate (she wasn't interested in the broccoli) is whisked away by a watchful staff member when she has no interest in the remaining bites. I hear, "She ate the dinner and a cup of juice as well", for the logging. There are bits of food around Susan's place, and I wipe them up with her napkin. I ask if she enjoyed her dinner, and Susan smiles. When the *ice cream comes, plunked down softly by a silent, smiling carer, Susan cleans her bowl in a few minutes, entirely focused on her spoon and bowl.*

Kate comes over and greets us, and thanks me for sitting with Susan, noting that the ice cream went by much more quickly than the dinner and adding that at this age, any calories are good calories, and they're just glad to get her to eat enough food in the day. Kate lightly pats Susan's shoulder as she explains this, and Susan smiles a bit, saying, "Oh, hello!" Susan has some ice cream on her hands, and I wipe them with a napkin. Kate gently wipes Susan's mouth and hands with a warm, damp cloth and asks if she'd like to go to watch some tele while unlocking her chair and moving her toward the living room area.

I think about this phrase: *any calories are good calories*, and how it was used last week by Evan when he was prompting residents to eat some pudding or some hot cocoa with whipped cream. Sarah was surprised at the offer, asking, "Not for me, why?" and Evan pressed on, saying, "Oh it might be nice a little hot chocolate with some cream on top." Evan often prompted residents to eat something sweet, with whipped cream added on top, as he checked the caloric intake for each resident in the evenings. The notion that any calories are good seems to say that older bodies, and sick bodies, are somehow other bodies which thrive on different subsistence. Sugar is notably not a healthy form of calories, but it is featured in many of the meals I witnessed at the care home. William is diabetic and takes his tea with two alternative sweeteners, but he, too, is offered cakes at night. I am no dietician, but I once asked Evan how William can have coconut cake with cream, yet he is not allowed sugar in his tea. “Oh, he can have some! And he hasn’t eaten much at all today. He wasn’t pleased with the options for dinner”.

As was illustrated in the previous chapter, William is vocal about his food preferences, which can sometimes irritate staff, and he notices himself as an inconvenience (“I’m a burden”, he once explicitly said after refusing a meal of curry). He often opts for a ham and cheese sandwich, often the final resort when residents aren’t interested in the meals. Also, for those not in sync with meal times—like Lisa when she was on medication that made her sleep through most meals. Watching Lisa, set up with a late-night dinner box of a sandwich, crisps, and some fresh fruit, tucked in with a tray on the sofa, felt different from William in a similar position, sitting rigidly, eyeing his sandwich suspiciously after being through an emotional debate over the hot dinner options for that evening. Unlike Lisa, who accepted her dinner gratefully, William’s sandwich acknowledges a battle lost or won, but not in the way he’d hoped. A subtle deflation of his attempt to command his environment or just to ask for something that felt like home.

Flexibility is something that the household scale allows for, at least marginally: food is stored on-site, and fixing an impromptu meal is only a matter of popping into the refrigerator and getting a bit creative with the ingredients on hand. In these moments, where flexibility and adaptation are required from both the resident and the care staff, care can take a more organic form. The institutional form is softened to something more organic, more human-shaped. “We all work with what we’ve got, don’t we?” Kate once asked Julia as she fixed her late-night snack. That *we* felt genuine, something stronger and more improvised about that collective sense of survival together. Otherwise, when seen as a request to do extra work, care acts may elicit a colder response, as I saw with Evan and William when William sent his dinner back for a sandwich.

Preference and Norms: "You just sit there and eat your soup"

Jean is a relatively new resident, having moved into the care home just last month because she has family nearby. She is a tall woman, and she stands up straight and walks quickly. She was a schoolteacher and possessed a teacher-like authority. She is southern—her accent stands out, and the staff sometimes repeats how she pronounces some words out of amusement. One staff member, Kevin, explained to me that she is 'posh', with a grimace. Jean is an intelligent, curious person and she often asks many questions. She seems to be quite confident, and wants to understand how to live among the other residents: she asks where people are when they're away on appointments, she tries to help herself with the things she needs, and she asks staff questions about the schedule. Jean carries a purse (indicating that she may not yet feel at home). She often misplaces her purse, and many of my early interactions with Jean have taken place while helping her find it. She does not remain in her room, and will sometimes lay on the sofa and take a nap, kicking off her shoes and slinging her feet up on the arm of the sofa. Something is charming about these naps, they cause the sitting room to appear like a room in a real home, especially in the week I first meet Jean, when there is a summer thunder and rain storm, and residents are huddled around the TV to watch the 2020 Olympics.

Today Hannah made turnip soup for lunch. Edith wanted sugar in her soup. She was quite clear that it was sugar she wanted, but the staff collectively did not think this was normal, and they didn't accept her preference:

Hannah guided Edith over to a setting for lunch: "Here you are, love, I made you some nice soup". A steaming bowl was waiting for Edith. It was a rainy afternoon, and soup seemed a very appropriate, cosy lunch.

Edith sat down and looked at her soup: "Sugar. I need a bit".

Keith: No, that's soup! You want salt.

Edith: No I don't. Oh, not a lot! I just want a little sugar here.

Keith: (brings over salt) here, you want this.

Edith: Is this sugar?

Keith and Leah: yes! That's sugar.

Edith pours some salt into her palm and licks her finger to taste - "no, that is salt! I know what salt is. I want sugar. Just a bit."

Keith brings the sugar over, shows her, and says "THIS?"

Edith nods and takes the canister. She is not given a spoon, so she looks around, grabbing the lid of the sugar container to try to scoop a bit out.

Keith: No no no silly, that's not right. You don't put sugar in soup.

Keith takes away the sugar. Edith finishes her soup silently.

Moments later, Edith wants a napkin. She gets up to grab the paper towel roll from the kitchen counter. Leah comes over and says in a scolding, but kind tone "Edith...just ask for what you want and I'll bring it to you". Leah hands Edith the napkins. Edith says thank you and takes them back, but notices there are more than she wants/needs, so she comes back to hand the extras back. Leah says "Edith, just leave them at the table, we'll take care of it. You just sit there and eat your soup".

Preference and taste are negotiated situationally. It is seen as something quite normal, useful even, in establishing rapport and engaging care which is customised to each resident. Knowing who likes vinegar with their chips, for example, is seen as a charming, even enjoyable, aspect of living in a community, a step in building familiarity. When preference contradicts a sense of what is normal (sugar in soup), this is met with scepticism or even discomfort. The emotional reaction to expectations being unmet, surprise, or contradiction at the site of a meal evokes the cultural value held in the meal. The ordered meal relates to all the other ordered systems which are associated with it. Kristeva's theory of abjection may be useful to further understand the interactions between Jean and the staff regarding her desire for sugar in her soup. Kristeva's theory posits that abjection refers to the separation of the self from things that are considered taboo or unacceptable by society. In this case, sugar in soup may be considered abject by the staff, as it goes against their cultural norms and expectations. However, Jean's persistence in asking for sugar highlights the potential for subversion of societal norms and the power of individual agency. Jean's desire for sugar in her soup challenges the staff's cultural expectations and forces them to confront the abject, while the staff's refusal to give Jean sugar in her soup can be seen as an attempt to enforce societal norms and avoid the abject. The staff's insistence that Edith wants salt, despite her clear request for sugar, can be interpreted as an attempt to normalise her desire and make it more acceptable within their cultural framework. The staff's reaction to Jean's request for sugar also demonstrates how abjection can be enforced through social interactions. Keith's dismissive and condescending tone towards Jean, as well as his attempt to take the sugar away from her, highlights the power dynamics at play in this situation. Additionally, the staff's response to Jean's request for a napkin can be seen as an attempt to maintain social order and avoid the abject. Leah's scolding tone towards Jean suggests a desire to control her behaviour and prevent her from engaging in actions that may be seen as unacceptable or abject. Overall, the interactions between Jean and the staff demonstrate some of the complex ways in which societal norms and expectations are enforced and challenged. Kristeva's theory of abjection provides a useful lens for analysing the power dynamics at play in this situation and how individual agency can subvert cultural expectations.

Clinical and Cultural Adjustments to Meals

Leah is a young carer in her late 20s who has been working for this care home for 10 years. She prefers working in the kitchen and says she is skilled at preparing food for residents on a soft food diet.

"The trick is, you have to make it look like something you might eat", she explains, focusing on a cheese sandwich made of two crustless rectangles of white bread sandwiching a small mountain of white grated cheddar. She is misting the sandwich with a spray bottle of water until it is saturated. "Want to try?", she grins at me. I shake my head. Leah explains that she takes pride in helping residents eat well. She tells me she is periodically asked to make soft diet sample dishes when new staff are being trained. "We are asked to try them, you know…we should all eat what we feed everyone". Leah grimaces and laughs: "You should see the girls' faces! Uuuuhh!"

I have seen Leah pay careful attention when providing meals many times. Ruby, a temporary resident, told me that she felt very cared for when Leah explained how she plans to adapt each meal to her soft food diet before serving her and again when she delivers the meal to Ruby in her room. (“She takes care, says, today we blended the vegetables into a stew and layered it here with a mash…it does not [come as] such [a] mystery”) Ruby usually lives in her house alone and has a few carers come in to deliver food and heat her meals when she is there. I met Ruby once in the summer and again while she was on another temporary fall stay. In the summer, she reported feeling very happy with the care at home, but later, in the summer, she complained that carers only quickly discussed the food, and she felt again that she may as well have been at home: “They come and go, in and out, not much visiting, aside from checking on my food. Well, they’re busy, I know that..”

In this scenario, Leah's role as a carer can be seen as maintaining order and control within the care home. Her focus on providing meals that are visually appealing and nutritious for residents on a soft food diet demonstrates a commitment to upholding the norms and expectations of the care home community. However, Ruby's complaint that carers only quickly discuss the food and do not engage in meaningful visits with her suggests that there may be a sense of disconnection or separation between residents and carers. From a Kristevan perspective, this sense of disconnection or separation can be seen as a form of abjection, as Ruby may feel cast out or excluded from the larger social order of the care home. Similarly, Leah's role as a carer may be seen as one of enforcing the boundaries of the care home community by maintaining the cleanliness, hygiene, and dietary standards that are expected of her. This can be seen as a form of abjection, as it involves identifying and expelling certain elements seen as impure or disruptive to the social order.

Aside from soft and liquid diets which are medically necessitated, there are daily meal rituals adjusted for each resident. The flexibility depends on if carers have the time to cater to unique requests if one's habit is contextualised in the care home if it helps carers ensure everyone is eating enough. Though many residents eat the daily menu without much issue, there are of course customisations. A few examples of standing customisations or rituals to residents' mealtimes:

Orla uses her own silver tea set, which staff always prepare for her just so she is set for one at her table. She has little appetite, usually preferring a simpler meal than whatever has been prepared (e.g., toast and beans). She rarely eats the hot menu, except fish and chips, on Fridays. The care staff never prompted Orla to eat more or eat differently than she prefers. As a sort of second breakfast (after an early morning bowl of cereal) George often eats four poached eggs in a bowl. He would often quietly ask me if it was greedy to eat four eggs. I once asked him why he feels greedy, and he replied simply, and with a shrug: "It's a lot of eggs. But they say yes!". Meanwhile, Max always takes his meals alone at his recliner chair in his room, both lunch and dinner, accompanied by a glass of red wine, which he stores in his room. He rarely finishes his plate. He tells me that he does not like the food very much.

Luis stores bone broth packets in his room, fixing himself a broth in a little styrofoam cup with hot water from his bathroom sink. His daughter sends him these packets. He says it's for his health. While William often prefers to eat in solitude. He takes a long time to eat, sometimes forgetting how. He benefits from occasional help from care staff but says he prefers to be alone so that he can focus. He sits in his chair, using his Zimmer frame as a table. Eating appears to be a laborious task for William, also because the Zimmer frame table is quite low and does not allow for clumsiness—the slightest mistake may result in a glass of juice upturned on the carpet. He claims to be fussy and often opts for a sandwich instead of the hot menu. He tells me that his wife always cooked for him and that she was not a particularly skilled cook.

Then there is Theresa, who always sits near Matthew during meals. Matthew often thinks he is at a restaurant with his wife (who lives at home) and asks, "Did we get the check, dear?". Theresa will steal a peck on the cheek meant for Matthew's wife. This imposter game plays out most days. Meanwhile, Julia refuses to eat on "bad days" when her mood is low. She reports feeling "too upset" and finding it difficult to swallow. She is often bothered by others not eating simultaneously and always bothered when I am not eating. She finds her husband's soft food diet "queer", often picking at his food with her fork. Julia says she is not a fussy eater and likes "all English food". She usually sits with George, who always eats. Across all of these examples, we can see that meals are a site for individual preferences to be catered to, where care work can be personalised and adapted.

"Well, at least we've had a nice cup of tea!"

During group events, food is often at the centre of the conversation. It is a convenient topic, it engages with tactile and sensory experiences as well, and it can be an easy topic for those who do not have the confidence or apparent capacity to discuss more abstract concepts. It’s something that anyone can participate in: we all eat, and you don’t need to have much in common to discuss food. In other words, food is often a perfect topic for small talk. Most social events involve providing a hot beverage and a small sweet snack. Aside from the daily coffee club, held in the care home cafe, and the afternoon tea events, the activities are also very tea-and-coffee-centred. The activity itself often appears secondary.

We are a small group of five huddled at a large, kidney-shaped table, and the bingo game is falling flat. Barry, a temporary resident here on respite while his wife is away, is engaged, but most are not paying attention. Jeanette is trying hard to engage everyone in the conversation. She puts on some Elvis and dances, wiggling in her chair and smiling. “[George], don’t you want to dance?” But now he’s a bit preoccupied: Julia is upset with George, having thought the room was his newsstand until he tells her he does not own it and they have moved from their home. Her feelings hurt, and she sits tensely with her eyes closed. Exasperated with his wife, George says, “Well, this was a bust”, shrugging. Jeanette hears this, and says: “Well, at least we’ve had a nice cup of tea!”

Offered as a platitude, Jeanette’s response also highlights the cultural value of sharing a cup of tea as the central force of social activity. As an outsider, I quickly learned the power of a cup of tea, and tea brewing became my favourite ritual in the household. It is an immediate source of comfort, a small nudge of care, which you can offer nearly anyone at any time. I quickly learned that when someone is upset, it is almost always appropriate and welcome to fix a cup of tea.

Learning everyone's preferences is a small gesture of care. I sometimes learned the way a resident takes their tea before I memorised their name–definitely before getting to know them personally. Nearly an initiation process, memorising the various tea configurations served as a kind of map for each household: no milk, two sweeteners for William, lots of sugar for Julia, no sugar but plenty of milk for George, not too hot, in a large, heavy brown mug. Lisa will have one lump, one small splash of milk, and preferably in one of the pretty tea cups, always with a saucer… At first, carers would confirm that I knew how each resident likes their tea. Eventually, they stopped checking. I'd assimilated (I take my tea one milk, one sugar), at least insofar as the tea provision was concerned.

I enjoyed fixing beverages for residents. It was an easy way to feel useful, to do something in the name of care. It was a small gesture of respect to remember how one takes their tea, a tangible offering. A hot cup of tea bought time: a reason to visit with some of the quieter residents, to knock on their door and have a few minutes of conversation. It's how I got to "chin wagging" with William, how I could try to comfort Julia when she became upset or offer George some moments of peace when he was trying to calm an upset Julia. I think of Silvia, who at 104 years old, sees the benefit of the care home:

"You're new here. You can just sit by me, and they'll bring you a coffee and a biscuit. You don't have to pay for anything—just for the hairdresser downstairs" pulls out her wallet and shows me—empty. Silvia looks up at me with wide eyes, waggling her eyebrows, looking as if she's let me in on her little trick.

Silvia often asked for biscuits and coffee, waving me to her chair. She didn’t always want company or to chat, but she seemed comforted knowing someone was there, waiting for her to waive them and ask for her coffee.

“The boundary between meals and drinks has meaning”, explains Mary Douglas[19], who, in an exhaustive attempt to etch the coding of meals, argues that there is an intimacy hierarchy: those who share meals share drinks, but those who share drinks, do not necessarily share meals. Those who share tea do not necessarily share soft-food dinners.

The interruptions of COVID-specific health guidelines punctuated meals, shaping and starkening the divide between care receiving and care provision. Carers were not allowed to eat at the same tables as residents, diminishing the household's sense of collectivity. I eventually stopped eating my meals during mealtimes, as it brought on confusion and frustration for me to eat at my table. It was easier to not eat and to be with the residents while they had their meals. Meal times were a structuring force, helping make sense and order of the days, the waiting, and preparing just as important as the eating, then the cleaning. The washing up after a meal signifies that rest is deserved (for residents at least). The focus on maintaining cleanliness, hygiene, and dietary standards can be seen as a form of abjection, as it involves identifying and expelling certain elements seen as impure or disruptive to the social order. The sense of disconnection or separation between carers and residents can also be seen as a form of

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[19] Douglas, M. (1972). Deciphering a Meal. *Daedalus*, *101*(1), 61–81.

abjection, as it involves excluding or casting certain individuals from the larger social order of the care home.

Mealtime can be understood through social relations, mutual recognition, and the shared care experience. Leah's focus on preparing visually appealing and nutritious meals for residents on a soft food diet reflects her commitment to upholding the norms and expectations of the care home community. Her concern for the residents' well-being demonstrates her investment in the shared care experience, highlighting the importance of social relations and mutual recognition in the care home environment. However, Ruby's complaint about the lack of meaningful visits with carers suggests a potential sense of disconnection or separation between residents and carers, which can be seen as a form of abjection.

The daily meal rituals of residents, such as Orla's use of her own silver tea set, George's preference for four poached eggs, and Max's habit of taking his meals alone in his room with a glass of wine, can also be seen as forms of individual expression within the shared experience of care. These rituals reflect the residents' autonomy and personal agency in the care home environment, highlighting the importance of mutual recognition and respect between carers and residents. Care is, argues Nigel Rapport, to ensure that one’s ‘personal preserve’ stays intact, that, for residents’ autonomy is not infringed: that so far as possible, and for as long as possible, the elderly individual maintains not only his or her abiding authorship of over his or her life-project(s) but also authority, determining the course of that life and the trajectory of its becoming” (Rapport, 2018).

Overall, Ahmed’s “Affective Economies” provides a useful framework for understanding the complex social relations and shared experience of care within the care home environment. The data suggest that focusing on mutual recognition, social connection, and individual agency can help promote community and belonging among residents and carers. Meanwhile, Kristeva's theory of abjection could complicate, or add texture to Ahmed's framework by adding a layer of analysis that focuses on how individuals and groups are excluded and marginalised within the care home community. How people make you feel matters. This intersubjectivity positions different residents to receive different levels of and forms of care, based on preferences, norms, and biases that eddy between the care worker and resident.

Kristeva's theory of abjection highlights how this order and control can result in the exclusion of certain individuals and groups from the larger social order of the care home. For example, Ruby's complaint that carers only quickly discuss the food and do not engage in meaningful visits with her could be seen as a form of abjection, as she may feel cast out or excluded from the larger social order of the care home. Similarly, Max's preference for eating alone in his room with a glass of wine could be seen as a form of abjection, as he may feel that he is not fully included in the communal meals and social interactions in the care home. Additionally, Kristeva's theory of abjection emphasises how social norms and boundaries are enforced through the exclusion and rejection of certain individuals and groups, which is then reinforced over time. Leah's role as a carer, for example, can be seen as one of enforcing the boundaries of the care home community by maintaining the cleanliness, hygiene, and dietary standards that are expected of her. However, this enforcement of boundaries can also result in the exclusion of certain individuals or groups who do not conform to these standards, such as Max who rarely finishes his plate and complains that he does not like the food very much. Or the dismissal of certain preferences, such as a bit of sugar in soup.

Overall, Kristeva's theory of abjection can add a critical perspective to the theme of food and eating in the care home by highlighting how the maintenance of order and control within the care home can result in the exclusion of certain individuals and groups from the larger social order.

Kristeva's theory of abjection helps to highlight how the unique mealtime practices of the residents in a care home can be seen as deviations from the normative expectations of communal meal experiences, but also how these practices are tolerated and accommodated to varying degrees. That, “modernity can allow others into its community of strangers as long as they give up the signs of their concrete difference”, (Ahmed, in Chanter & Ziarek, 2005, 98). Max's practice of taking his meals alone in his room and Luis's use of bone broth packets from his daughter are also forms of abjection that deviate from the communal meal experience provided by the care home. That they are both single men may play into the tolerance of these deviations from the expected mealtime behaviour. Theresa and Matthew's restaurant roleplay during meals and Julia's refusal to eat on "bad days" also represent abjection, as they deviate from the normative expectations of behaviour during mealtimes in a care home setting.

Section Three: Power & Gender in the Care Home

Power dynamics in caregiving are influenced by various factors, including gender norms and societal structures. Within these macrostructures is a reproduction of traditional gender roles, with women and their work in caregiving often being subordinated (Johnson, 2023). This culture perpetuates inequities in power between men and women, as highlighted by the theory of gender and power. The sexual division of power reinforces these inequities and is sustained through social mechanisms, such as the abuse of authority and control in relationships (referred to as 'power over').

In the care home, the concept of power takes on a complex nature. Despite their crucial role, carers often lack job status and autonomy empowerment. This lack of power was particularly evident when vaccines were made mandatory. One carer expressed frustration, stating, "I can barely live on this paycheck, and I can't even decide what goes in my body." As a result of such imbalances, many carers across the country chose to leave their jobs in response to the mandate. There is an inherent tension between the subordination of gender and the power dynamics between carers and care recipients. Carers generally possess power over residents, often influenced by surveillance measures to enhance safety. For example, using digital records to monitor food and drink intake may pressure carers to encourage residents to consume high-calorie desserts in the evenings. This power dynamic is enforced by higher authorities such as management, governmental guidelines, and Care Quality Commission ratings, and it trickles down to impact the relationships between carers and care recipients.

“This is not...it is not home, is it?”

The following is a conversation with a temporary resident, Joan, whose husband passed away and has since had a progressive amount of home care to stay in her house. By leaving the full conversation intact, the nuances of Joan's worries and the way she intertwines them throughout our discussion are highlighted. This approach allows readers to observe how Joan navigates her concerns and relates various subtle details of care as she contemplates whether to continue living at home or to transition to a care home setting. Joan is childless and has a niece who helps her with her affairs. Joan’s dilemma, whether to remain at home with home care support or to move into the care home permanently, touches on many themes and issues people face when entering residential care. Joan's story relates to power and gender dynamics in the context of her decision-making about residing in a care home. The narrative Joan provides sheds light on the intricate interplay of power and gender roles (Connell, 1987). Joan's dilemma involves her negotiation of power dynamics in her relationship with her niece, who plays a pivotal role in organising her care. The gendered expectations and responsibilities within the family structure, as seen through Joan's reliance on her niece, add depth to the exploration of power dynamics. Furthermore, Joan's expression of independence and the social aspects of the care home raises questions about how gendered expectations influence choices regarding living arrangements for older individuals. This inclusion serves to illuminate the nuanced ways in which power and gender intersect in the decision-making processes of elderly individuals in care contexts.

This afternoon I went to say hello to House 3. This House has a few empty rooms and is thus the household which receives the most temporary residents who come to stay for a few days to a few weeks' time. I expected to see some new faces and hopefully some old ones. Walking down the hallway toward the common area, I passed a few rooms. I saw a new resident in bed sleeping on the left, and on the right, I was surprised to see Joan sitting in an armchair gazing out the window.

Joan had been here during the summer for a few weeks after a short stay at the hospital. She is a 95-year-old woman who lives alone at her home in [the town] with the support of meal delivery services and daily home care visits. Her husband passed away two years ago, and she has been navigating care with the help of a social worker and a niece who lives nearby.

I pop my head in and say hello, and she ushers me in. Her room is empty of decorations as she is only here temporarily. There are a few dishes on the desk. The TV is playing women's football, muted.

I greet her: Hello Joan! I didn't expect to see you here. Do you care for a chat?

Yes, dear, come in, here you can… (pats at the chair at the desk). I pull out the chair and sit in front of her. I see that she has a half-finished plate of lunch.

Me: Are you finished eating? I can come back when you're done with lunch..

Joan: No, no I could not finish all of that. It was lovely though, those girls, they always make sure that my meals are tasty. They always come in and tell me how they plan to prepare my dish, and then it is not just... Well, I know they put in an effort. Lovely girls..

Joan is on a soft-food diet, and her meals are usually blended or finely chopped which can be unsightly. She has praised the kitchen staff for being mindful of letting her know what she's eating and paying attention to the seasoning and texture.

Joan: Have you eaten?

Me: Yes - thank you. I just came for the weekend and didn't expect to see you today. I'm very glad, but is everything alright?

Joan: Oh yes. Well, I was back in the hospital, something with my stomach. I have been here a few days…

Me: Ah, I'm sorry to hear

Joan: That's alright, I'm feeling better. (gestures at a plate of food)

Me: When we met in July, you were here for the first time for a few weeks, right?

Joan: Yes dear, yes that's right. Two weeks. And you! Well, you just come and go as you please, do you? (said playfully)

Me: (her asking me about my whereabouts gives me the opportunity to re-introduce the study and my role) Yes, I am a student, a researcher and was staying here over the summer talking to residents and seeing how the care home is. I am doing a research project on daily life in this care home. Do you remember that we signed a form for you to participate?

Joan: Yes.. you are from America, is that right? The nursing student.

Me: (I don't correct her because she's accurate enough) Yes, so now I'm back, just to say hello and see how things have been going. And you and I have had some wonderful chats, so I am happy to speak to you again as part of my project. Is that alright?

Joan nods.

Me: So you're feeling better now? That's good.

Joan: Yes, yes better, well the thing is… she has to arrange things a few weeks out, maybe a week..

Me: Who does?

Joan: My niece has to book the carers you see? Some of them don't have their own car, they share rides or something, and it takes some days for [niece] to organise everyone.

Me: The home carers?

Joan: yes, they come, and on Mondays and Wednesdays I prepare the washing, I get the laundry ready for them. One comes at breakfast, and one comes at lunch, and they put in and then take out.

Me: A good system!

Joan: (Laughs), yes well, I like to help to set it up. It keeps me (points at her head)

Me: it keeps you active, and involved?

Joan: Yes. It's my house, I should do what I can...

Me: So now you must let your niece know when you want to go home.

Joan: Yes, but well. I should think about whether I should go there or stay.

Me: You're deciding if you will stay here?

Joan: Yes, I think [niece] is getting older, and it's a lot to manage… (Joan's speech is slower, more thoughtful and she is wringing her hands. She's frowning and looking down)

Me: That must be a tough decision to think about.

Joan (Looks at me) Yes. (a few seconds pass) Well, they live here, don't they? (gestures towards the common area, I think referring to the permanent residents). In the morning they come in to help me, and I think they're surprised to find me dressed and ready. I go in there (gestures towards the bathroom) and I get my clothes and then I come sit here. I am dressed and ready for the day. I think they are surprised when they come to help me.

Me: You think the carers here–they're surprised at your independence?

Joan: Independence! (she claps and her eyes light up) That's the word. Yes, that's it. I need to walk… my knees…I have to use these (patting her knee) Well, I go for a walk *sometimes, nothing much, just out to the reception room, and sometimes they look, they are not well. I am quite fortunate, to be (points at her head)*

I nod. Joan continues: Well, yes I help the carers at home. I get the things prepared for them, the laundry, cleaning...I think it helps. But now, I am not sure. I think [niece] is getting older, she has her own affairs...do you - is your mother alright?

Me: Yes, she's in her 50's and fortunately quite healthy, it will be a while until we need to make these decisions. But everyone must make them at some point, don't they?

Joan: (nodding) That's right. [My husband] was fit as a fiddle...he died, you know.

Me: I remember hearing about him this summer... sounds like he was a great man. Did he live at home until the end of his life?

Joan: No - the Hospital.

Me: But before he went to the hospital, he was at home?

Joan: Yes...yes well we could not drive. We didn't use the car, but we managed ok. We lived well. Comfortable. [Niece] was good in school, she passed the certificates for two universities - and she said well [they are] too expensive. [Husband] said that if she can *work as hard and do well, we can pay her way. We did - we paid it all. She went to university…*

Me: That's wonderful. What did she study?

Joan: Banking (Smiles, looks at me)

Me: Wow. And how lovely that you've taken care of her.

Joan: Thank you! (she says proudly, with a big smile) But she is getting older now...I should decide. By tomorrow. Maybe the next day…(wringing hands)

Me: Has someone asked you to make this decision, [Joan]?

Joan: No, no. But with the time we need to arrange everything, well it has got me thinking.

Me: You mentioned independence before, are you worried about losing independence here?

Joan: Not really... As I say, I can dress, care for myself in the ways I need...but…(pauses for a few seconds) This is not...it is not home, is it?...

They say you can have visitors but (her voice cracks a bit) Joan turns to gaze out the window.

We sit silently for about 30 seconds. Joan is wringing her hands nervously, looking off in the distance, thinking. She looks very worried, frowning with a furrowed brow.

Because I have spoken with Joan before and am familiar with her communication style, I expect she will share more if I wait for her to speak rather than ask a new question. She is a reflective woman who tends to elaborate, or sometimes repeat, information that she finds important.

Joan suddenly breaks the silence: the carers at home are too short.

Me: You mean they don't stay for very long?

Joan: No - in and out. They are very busy, I understand that, but it is so short. Then I sat again. They come, they're nice really, but yes it's just...short. (She shrugs)

Me: Would a possible benefit of living here be that you have more company throughout the days?

Joan: Of course, and the girls are lovely, they come in to see me. [male carer] always says 'hello gorgeous!' (smiles)

Me: And do you go out to the common area to meet other residents?

Joan: No. I don't really...I don't know them. It's not...

Me: What do you mean?

Joan: We don't talk. (her tone is a bit shorter, and she waves her hand dismissively. I can sense that she is not interested in discussing peer relationships here)

A carer comes in to take the dishes, apologising for interrupting and asking Joan if she's had enough. Joan apologises for being unable to finish her lunch. "s'alright, love. It was a pretty large portion, wasn't it?" As the carer leaves she says loudly to another carer "she did well - she ate about half, but it was a lot there on the plate". If Joan is bothered by this, she does not show it.

Joan turns to me: So anyway, I have to decide.

Me: I'm sure it is difficult…

> *Joan: Yes, it is.*
>
> *Me: Have you spoken to your niece?*
>
> *Joan: [Niece]? Yes, and the social worker. She is also short sometimes...I think she's probably very busy. (Joan looks very concerned, brow furrowed and a deep frown. She's looking at me. She gives me a small smile, her hands still wringing, and she looks very sad…)*

The narrative provided by Joan offers valuable insights into the experiences of older individuals within institutional settings. Joan has the financial capacity to choose whether to stay at home, hire carers to help her, or pay to live in the care home. She has a family member who helps her with her affairs and a social worker to support her. She also expresses loneliness, isolation, and a sense of fear for the unknown of her future. She highlights the social element of the care home, that she may have more interaction here but does not want to lose the independence of living at home.

Joan's mention of her niece's role in arranging carers and her concerns about her niece's ability to manage her affairs highlights the significance of familial support networks in caregiving and decision-making processes. This aspect underscores the broader theme of gender roles and responsibilities within care homes, where familial relationships and gendered expectations play influential roles.

Moreover, Joan's discussion of her interactions with carers and her perception of their limited availability emphasises the importance of social connections and companionship for care home residents. Loneliness and isolation emerge as common concerns, underscoring the need to consider the social dimensions and the quality of interpersonal relationships within these institutional settings.

Joan's expressed desire to maintain her independence and her hesitation about leaving her home reveal the complex interplay between autonomy, identity, and the concept of "home" for older adults in care. Overall, this glimpse into the dynamics of the care home experience from Joan's perspective addresses issues of gender, family dynamics, social connections, autonomy, and the search for a sense of belonging and familiarity.

As Joan grapples with the decision of whether to stay in the care home or continue receiving support at her own residence, her narrative illuminates the intricate dynamics of familial relationships, power, and gender roles within the context of care. Now, shifting our focus to another resident, Silvia, we encounter a vibrant personality who, at 103 years old, brings humour and liveliness to the care home environment. At 103 years old, Silvia is funny - vulgar, quick-witted, and outgoing. Some care workers refer to her as “firecracker”. Posted on the door to her room is a large photo of herself edited to look like an old western wanted poster, reading “WANTED” and featuring her portrait in sepia behind jail bars. I have heard a lot about Silvia before having met her due to the humorous anecdotes she provides staff.

> *I sit with Silvia for the morning, making small talk (truly, it's very difficult for me to understand most of what she says, but she asks me if I have children, am married et cetera) she tells me about working in the factory, about her son who is 80. "You're new here. You can just sit by me, and they'll bring you a coffee and a biscuit. You don't have to pay for anything - just for the hairdresser downstairs" Silvia pulls her wallet out of the bag, fastened to her zimmer frame, and shows me - empty.*

Silvia worked in the textile industry, and she has had a "long, hard life". She often seems to welcome the support of staff, asking for extra cookies or chocolates. She appears to ease into the culture of the care home quite comfortably. She is always in the common sitting room during the day, plays dominoes with staff, and will sit and chat with almost anyone who passes her recliner.

> *Jen, the only carer Silvia will call by name, brings Silvia some chocolates. "They have gin in them," she says loudly, as Silvia is nearly deaf. Silvia replies, "JIM?! I DON'T KNOW HIM!" the carer laughs and opens some of the chocolate with Silvia and eats it with her. They sit laughing and joking together for a while.*

Silvia is a working-class woman from the local region. She does not have 'power' in terms of economic status or hegemonic gender identity, but her capacity to speak the local slang, and be lovable by staff (many of whom are from similar backgrounds) does give her the power to strategise her care in a way that works well for her. But she also expresses a sense of fear and isolation.

> *I get up momentarily to help hand out tea, and she says, "I like you being here. Please don't leave me". A bit later, she says: "I am old. The doctor looked at me here (gestures to stomach). I just don't want to die!" She says in a near cry, grasping my hand. And, "My mom and sister died - now it is only me. I'm the only one left"*

Silvia lacks traditional sources of power such as economic status or conforming to hegemonic gender identities. However, her ability to connect through local slang and endear herself to staff, many of whom share similar backgrounds, empowers her to strategise her care effectively. Despite this apparent agency, Silvia also reveals a profound sense of fear and isolation. During moments of vulnerability, she expresses a plea for companionship, voicing her concern about mortality, especially after the doctor's examination. In a poignant revelation, she shares the loneliness of losing her mother and sister, leaving her as the sole survivor in her family. Silvia's narrative paints a complex picture of empowerment and vulnerability intertwined in the fabric of her ageing experience.

As we engage with the diverse experiences of residents in the care home, we encounter varying perceptions of agency and control. Lucinda, with her keen observations of the bustling intersection from her room, shares an intriguing perspective on privacy and the gaze of others. Yet, her narrative also unveils a sense of detachment, as she speculates about items in her room being strategically placed by an unseen authority. This notion of an external influence shaping residents' lives echoes in other residents' comments, like Orla's nonchalant remark about the purpose of a projector in the dining room. These narratives collectively shed light on a prevailing belief among some residents—a belief in a mysterious "they" who, intentionally or not, govern certain aspects of their lives within the care home.

> *Today, Lucinda is sitting in her chair, looking out the window. She has curlers in her hair and is wrapped in an oversized robe. We look out the window, and she explains that she loves her view (she's in a street-facing room on the front corner of the building and oversees a busy intersection). "I can see everyone, but they can not see me. I don't have to worry that they will think I am strange". I ask why they would think she's strange and she replies "Well, just an old woman watching them...it's a bit strange, no?" I say that I like to watch people too and agree that it is an interesting view. She says she likes to watch the children come home from school and to watch the buses. We sit and comment on various things that we see for a while.*
>
> *I gesture at her hair and tell her I haven't seen curlers in a long time. "Yes, they're old-fashioned, probably", she says. She pats her head and asks if I can help her remove them. I take them out, and she asks for a comb. After combing her hair, which is now voluminous, I ask if she'd like to see herself in a hand mirror. "What for? I don't need to see. Do I? Well (pats head), does it look strange?" I say no, it looks nice. And she settles back into her chair, looking at me like I have just said the most bizarre thing in the world.*

She shows me her purse, a small leather bag filled to the brim with receipts, papers, and other things. "You can tell it's a gorgeous bag, good stitching, it will outlast me".

Lucinda has some photos on her desk, presumably of family. I point them out, asking about the people in the photos. She only seems to recognise the photo of her and her husband. She tells me his name and a bit about their wedding. I ask about the other photos of the children and she tells me, "oh well they must have put them in here, you know, the people who own the place. They are...for decoration probably. To liven the place up!" (indicating that she does not feel the space is her own)

There is a TV there near the photos we are looking at, and she says

Lucinda "I don't know what that is"

Jayme "It's a television. Do you ever watch television in your room"

Lucinda "No, not that. It is not a television (laughs at me). They probably put that in here to–I don't know. Watch over me so I don't fall, must be."

Jayme: "You haven't used that before?"

> *Lucinda “No. No, I have not seen it. We could ask them about it. They probably installed it”*

Lucinda says, “*They* probably installed it” indicating that she is aware someone is watching her, and making decisions for her. Similarly, a few weeks later, there is a large projector in the dining room and Orla, who has never expressed any ‘paranoid’ thinking, says, “Oh maybe that is a thingy to watch that we are being COVID-10 safe in here”. The casual tone with which she explained it surprised me, and I think further illustrates the tendency for residents to assume that there is a “they” shaping their lives, that to live in the care home is to give away a certain level of freedom and right to information about what is going on.

The care sector is characterised as a gendered sector often labelled as "unskilled," leading to liability issues and increased surveillance of carers. Even in pre-pandemic years, the sector experiences a high turnover rate. Carers face pressure to perform emotional labour beyond the tangible requirements of their job, which can ultimately result in burnout. The capacity to provide emotional labour is finite, while the demand for it seems endless. Kate, whom I introduced earlier, exemplifies this situation as her generosity with time and emotional energy puts her at risk of burnout.

The concept of labour as self-management introduces complexities to the notion of care being a unidirectional act from care worker to care recipient. Self-management practices may be imposed differently on residents based on their gender identities. For example, women may be expected to engage in a certain level of self-care to demonstrate being a "good resident," while men may be expected to be useful or autonomous in different ways. This may look like a resident disengaging from regular activity to maintain an image of autonomy, such as with William, a man who is developing Alzheimer's and who has expressed feeling ashamed of his change in the ability to eat:

> *I drop a tea by William's room, who is sitting in his chair. I say hello, and come in for a minute. "No TV or music, eh?" he says no, that he needs quiet because he is "working on thinking". He tells me that he has been diagnosed with Alzheimer's and says that the hardest part is being aware that his thinking is not the same, which can be very frustrating. ("I have lived by my mind, by my thinking. I can not live in that anymore"; "I get lost sometimes")*
>
> *Lunch is almost ready, and I ask him if he prefers to have lunch in the dining room or in his room (he is always in his room), "I notice that you often eat in your room". William explains that he often eats in privacy because he can focus better on himself and gets embarrassed. He said: "You have to choose between doing it well, or being with others". He said, "it can be lonely, but I can not do it well". I ask "You don't want to make mistakes in front of others?" to which he replies, "Yes exactly".*
>
> *I ask him if he'd like me to stay with him while he has lunch, and he says he does not mind. When the food comes, he does not touch it...so I offer to go for a while and come back to bring him a hot tea, and he begins eating when I'm out of the room.*

William cares about appearing together and does not want people to see him forgetting how to eat. He has told me that he feels disturbed by the changes in his cognition.

During the lockdowns of the COVID-19 pandemic, family members were not able to enter the households. When regulations loosened, families could come into the household and support these tasks, adding value to residents’, carers’, and families’ residential care experience.

> *This afternoon, Lisa’s daughter is in the household. She speaks warmly, familiar with the staff on duty today. She has come in because she is worried about Lisa, who has been prescribed antibiotics for a recent chest infection, making her very drowsy. Lisa hasn’t been well enough to make her regular visits.*
>
> *Lisa’s daughter brought in some fresh flowers and a box of new shirts for her mother and told carers that the shirts must be ironed or she won't wear them. “I can do it!” She then removes an ironing board and begins ironing her mother’s shirts. It’s a lovely scene, with Lisa’s daughter doing domestic chores, making it look more like a home. Lisa is dosing in a chair nearby, unaware that her daughter has visited. Her daughter comments that the board could use more padding “This thing is a bit ragged - do you use this?”.*
>
> *Eventually, Lisa wakes up and says she needs to use the toilet. She looks down the hall and smiles, her eyes set on her daughter standing at the ironing board, busy ironing her*

> *shirts. She points, smiling with surprise, and the care staff says "Yeah, that's your daughter! She's here!". Lisa goes to her room to use the toilet, and her daughter wraps up the ironing and joins her, the two stay in the room to visit for a while. I see them sitting together at the window, laughing, the new shirts laid out neatly on Lisa's bed.*

Tasks can help make one's experience more natural and can give value and purpose to one's role in the care home space.

> *It's about 9:30 PM, Household 2 is quiet. The lights are dimmed, and there is a calm evening energy. I am talking to Vivian, who shows me photos of her dog on her phone.*
>
> *Rachel comes out of her room and sits on a chair in the corner. She takes her mail from her walker and looks through her letters. Rachel is often withdrawn at meals, and does not seem to engage with staff or residents. Tonight she looks more natural: her posture is relaxed, and she wears a calm, focused expression on her face as she sorts her mail.*
>
> *Vivian sees that I'm watching Rachel, and she explains "Oh yes, she only comes out of her shell late at night when everyone is in bed. She feels relief, as if finally all of these pesky guests have left her house and she can unwind for the day".*

Whether true or not, I like Vivian’s explanation for Rachel’s nighttime ritual. There is a low lamp on, and the space feels quite home-like. Rachel, who often appears shy and anxious, looks purposeful, focused, and relaxed.

Emotional labour, intricately woven into every facet of care work, plays a pivotal role in shaping the dynamics of the care relationship. Defined as the concerted effort invested in manageing emotions, both one's own and those of others, emotional labour takes centre stage in residential care work (Lopez, 2006). An illustrative example unfolds in the pairing of Kim and Krys, where emotional intelligence and an understanding of residents' needs create a harmonious care relationship.

> *Kim is a small, energetic middle-aged woman who manages the medications. She is very talkative and friendly, and I immediately liked her. She has a very positive communication style with residents and is always busy, but her work seems very efficient and thorough.*
>
> *This afternoon, Kim offers, “I’m going to go feed Krys if you’d like to join me”. I do, I haven’t met Krys yet. We go into Krys’ room. Krys is a young-looking black woman with big, searching eyes. Her hair is tied into braids, and she is wearing a clean white nightgown, lying in a bed angled up slightly so she can comfortably look forward. A knit blanket covers her feet. She has photos of her family in her room, some stuffed animals and decorational figurines on the shelves, a map of Jamaica and a few paintings on the walls.*

Kim explains that Krys communicates with her eyes and the movement of a hand, so I make sure to stand in Krys' line of vision, and Kim introduces me, speaking into Krys' ear. I smile and wave hello. I look for a sign of permission on her face, but I'm not sure.

Kim explains that she will give Krys a dose of paracetamol, water, and her lunch and gets busy administering the liquids through Krys' feeding tube. Kim loudly and clearly explains each step to Krys ("Now I'm going to give you some water, love") and explains that they measure everything out to the mL. As she helps Krys, she pats her hand and uses a very kind voice. "She is very hydrated, we are happy about that, her skin is so lovely - not dry at all, this gives me a bit of pride that we can keep her doing as well as possible", then turning to Krys, "aren't we darling". Kim gently pets Krys' arm. Krys has a small tear at her eye, which Kim dabs. Kim explains that Krys is very religious - Jehovah's Witness - and that it is very important for her to watch the services. She says Krys' family streams them for her on her iPad weekly. She has also contacted her family via the iPad during COVID. "Krys misses her family, it's been hard in the lockdowns, hasn't it?" Krys looks down and away from us. Kim says that Krys has a sister who lives nearby and calls Krys daily.

Kim explains that Krys will move her left hand if she feels uncomfortable and that she constantly watches her hand while feeding and administering Krys' medications. After a few focused minutes, she says "Ok, all done. We will be back later, dear", with a pat on

> *Krys' arm. I say "Goodbye, it was nice to meet you", before leaving her line of sight & hoping so much that I haven't made her feel uncomfortable by being there.*
>
> *Out in the hall, I ask how long Krys has been here. "About a year. She has MS and was in a previous place, they were administering the foods and liquids really quickly, making her sick, I think infection. She was in very poor condition when she came here. She had a seizure and lost what was left of her functioning. We obviously want to care for everyone well, but her story breaks my heart, so I take great pride in giving her the best possible care".*
>
> *I ask Kim how long she's worked in care. "Years. I watched my father-in-law receive horrendous care from in-home workers. Once a woman came and made him undress without a curtain, then snapped at him to hurry up because she hadn't had breakfast yet. I told her to get her things, have her breakfast and not return. That indignity made me realise that care is something I want to do. Now it is my life. Everything else falls into the background. Being a carer defines everything I am".*

Kim has a praxis of care which she finds empowering, this helps her to make sense of her role. Kim's approach to emotional labour is evident in her positive communication style, friendliness, and attentiveness towards the residents. She demonstrates an understanding of Krys' needs, such as positioning herself in Krys' line of vision to facilitate communication. Kim's ability to effectively communicate with Krys through her limited means of expression, along with her gentle and kind gestures, exemplifies her skill in emotional labour. Kim's dedication to providing quality care is highlighted by her thoroughness and efficiency in administering medications and feeding Krys. Her use of a positive tone, verbal reassurance, and physical touch demonstrates her commitment to creating a caring and supportive environment for Krys. Kim's pride in ensuring Krys' hydration and overall well-being reflects her emotional investment in the residents' welfare, emphasising the emotional labour involved in care work.

Additionally, Kim's understanding of Krys' religious beliefs and the importance of watching religious services showcases her attentiveness to the individual preferences and needs of the residents. This understanding and accommodation contribute to the emotional connection between Kim and Krys, as well as the empowerment that Kim derives from her role as a care worker. Kim's personal narrative reveals her motivation for pursuing a career in care work, stemming from a negative experience her father-in-law had with inadequate care. This experience propelled her to become a care worker and defined her identity. Kim's praxis of care, the integration of theory and practice, empowers her and helps her find meaning in her role as a care worker.

The analysis of Kim's case emphasises the significance of emotional labour in care work and its influence on the care relationship. Kim's compassionate approach, attentiveness to individual needs, and personal investment in providing the best possible care contribute to her sense of empowerment and fulfilment in her role as a care worker. Furthermore, the meaning Kim attributes to her role helps her to “find dignity in dirty work”, to take a narrative of purpose in a realm of work which is often defined by exploitation (Stacey, 2005).

Another compelling facet of care motivation emerges through the presence of a favourite resident—Lisa. She is from [the town] and speaks like a local, often making carers laugh. She is funny and often acts very soft and gentle, speaking in a soft voice, playing with the baby dolls, and asking about her mom. She has a cute smile and is often polite and grateful to the staff for helping her. Lisa's popularity serves as a motivating force, fostering a sense of joy and fulfilment among the care team as they engage in providing assistance and companionship. Her preferences also make sense to the staff; they can understand an older woman wanting to wear her pearls and dress well. Lisa also has four daughters who are very involved in her care and follow up often to ensure Lisa has what she needs.

> *It’s around 8 AM, and the carers are in rooms helping residents get dressed. Lisa comes out in her nightgown. I say good morning, and she says hello and takes my hand. I ask if she’d like some breakfast and she nods. I lead her to a dining table and bring her tea and juice. She says thank you, still quite drowsy and begins to drink her tea. Emma comes out and asks her if she’d like toast and a banana and starts preparing this for Lisa.*
>
> *Lucy approaches Lisa with a smile, singing “Good morning, darling!”. Tousling Lisa’s hair, she adds, “You’re due for a hair appointment today, love”. Lucy wraps a blanket around Lisa’s shoulders. Lisa smiles and says something I can not hear, and Lucy laughs.*

> *Lisa is still having breakfast in the dining room, and I refresh her tea. She is talking lightly about her mother, pointing out the window and smiling. I clear her plate, and she thanks me.*
>
> *Lisa goes to her room to dress with Lucy, Diane is working on the computer, and Emma is preparing lunch - crisps, cold cuts, and sausage rolls. Emma, Diane, and I chat lightly while the household is quiet, with only G&J and Susan in the living room.*
>
> *Lucy comes out laughing saying that Lisa wanted to sunbathe. I look, and she's sitting in a chair in a little sunlight in the corner of her room with her eyes closed. Lucy tells me that she will get her up for lunch later, and then she has an appointment at the hairdresser.*
>
> *After lunch, Lucy gets Lisa ready for her appointment, applying lipstick and spraying Lisa with perfume ("She likes to look presentable, she's quite vain, really!" with a small laugh and a smile). Lisa says she wants a different sweater, and Lucy obliges, smiling and patiently helping her select a different one.*

In stark contrast to the uplifting stories of care motivation and favoured residents, the reality for someone like George reveals a different facet of the care home environment. George, struggling with everyday tasks like shaving and facing challenges with personal care, stands as a poignant example. Despite his evident need for assistance, he often finds himself overlooked or met with reluctance from the care team.

George's experience highlights a crucial aspect of care dynamics — the vulnerability of those who may not fit the mould of a 'favourite patient’ (or, in this context, ‘favourite resident’) (Lee et al., 2016) His dependence on care contrasts sharply with his emotional resilience, as he shoulders the majority of the emotional labour needed to support his partner, Julia. This narrative underscores the complexities within the care home, where varying degrees of support and attention shape residents' experiences, revealing a spectrum of care that extends beyond the stories of cherished favourites.

Amidst the variety of care relationships, a subtle but significant pattern emerges — instances where care workers unintentionally "talk over" residents. The demands of caregiving tasks sometimes overshadow the experience of residents. In these moments, the focus shifts primarily to the practicalities of care, potentially neglecting the individual's unique journey and perspective. This subtle phenomenon hints at the challenges inherent in balancing the functional aspects of care with the deeply personal and subjective experiences of those being cared for.

> *It’s late, around 8 pm, and the only resident in the reception room is Silvia, who is wincing. She waves me over and explains that her feet are itching very badly. She tells me that it hurts. I ask Vivian, who is busy with medications if there is something I can do*

> *to help Silvia. She shows me a cream that Silvia can use, and I kneel in front of Silvia and take off her slippers and socks. I put some cream on her feet. Silvia allows me to put her socks back over her lotioned feet, and I pat them gently to reduce the itching. Silvia mouths "Thank you", still wincing.*
>
> *Vivian comes over and explains: "All old skin gets so dry. You get to an age where it is incurable. Sometimes the residents find a cream that seems to work, then they get more from the doctor, and it stops working. There is no miracle cure. And sometimes She (points to Silvia) gets bad dry skin on her back. Very bad" Silvia is listening, frowning. I can not tell how much she understood, but I feel awkward talking about her body in front of her as if she is not there.*

Sometimes this talk-over can be explicitly shaming and inappropriate, which shocked me to learn that is quite common:

> *The janitor greets Silvia and has a chat with her - telling her about her family and her work as a cleaner. Silvia asks her for a coffee and some cookies, which the janitor gets from Marcus. Silvia goes back to sleep. The janitor comes to chat with Marcus, Theresa and me and says she would not want to do care work, but she loves talking to the residents. "I could not do the diapers. I can do babies, but I can not deal with adults". "Oh, you'd get used to it. They're just big children," says Marcus in front of Theresa. If*

> *Theresa notices, she does not show it, but I wince at this being said about her in front of her.*

The interaction involving the janitor, Marcus, Theresa, and myself offers a rich context for examining gender norms and age dynamics within the care home. Marcus's comment characterising the residents as "just big children" reflects a perception associating vulnerability and dependency with childishness. This aligns with Connell's theory of hegemonic masculinities, reinforcing the traditional division of caregiving labour along gender lines. In contrast, the janitor's statement about being unable to handle adults, specifically their needs for diaper changes, hints at a potential experience of abjection, in line with Kristeva's theory. This emphasises the discomfort or repulsion associated with certain aspects of care work, particularly intimate care for older adults (Twigg, 2011).

Moreover, the exchange highlights the significance of social connections and conversations within the care home. The janitor's engagement with Silvia's request for coffee and cookies exemplifies the creation of meaningful interpersonal connections beyond formal care duties. The conversation among the janitor, Marcus, Theresa, and myself also illustrates the social dynamics within the care home, reflecting Goffman's theory of dramaturgy. Marcus's comment, perhaps unintentional, can be viewed as a performance of a specific role and assumption about the residents, while the narrator's wince signals an awareness of the potential impact on Theresa's feelings and dignity.

Finally, the janitor's statement about enjoying talking to the residents emphasises the affective labour involved in creating meaningful social interactions and emotional connections. This aligns with Ahmed's theory of affective economies, underscoring the importance of social engagement for both residents and staff members. Overall, this analysis highlights the intricate interplay of gender norms, age, social interactions, and affective dynamics within the care home, emphasising the performative nature of gender roles as discussed by Butler's theory of gender performativity.

Shifting to the Theory of Gender and Power, cathexis refers to the social norms and affective attachments dictating how men and women should express their sexuality and adhere to traditional gender roles. This influence extends to intimate interpersonal relations and the emotional energy attached to objects or desires. When considering desire and abjection in discussing intimacy, this layer helps us comprehend the complexity of the sexual division of power at the interpersonal level and may illuminate how societal gender norms differ on an institutional level within the care setting. Examining how subordination of residents/recipients to care providers complicates gender divisions in the care home space, the layer of cathexis becomes crucial. As repression and desire are no longer solely in the control of the individual, shaped by ageist attitudes towards the ability of these individuals to experience desire and repression, interpreting gender expression for these individuals becomes more nuanced. This layer deepens our understanding of how gender norms manifest institutionally within the care home context, reflecting the intricate dynamics of power, desire, and gender expression at play.

Theresa is 62, and she appears quite young. She wears long and straight hair, and often wears blue jeans and sandal shoes. There is something about those shoes - they are the kind you might wear to the beach and are nearly the opposite in function and practicality from the often-worn orthopaedic sneakers or velcro-on slippers seen on her peers' feet. Theresa is often very helpful and curious with staff, offering to wipe counters and verbally checking on residents with a quick, "You okay?". She seems to, particularly like Matthew, the only resident she knows by name (an absolute rarity between residents). Matthew often needs some support finding his room in the household. I have seen Theresa help Matthew several times, sometimes holding his hand as she walks him to his door. I have seen her sit near him at the end of meals, where sometimes he thinks she is his wife and kisses her on the cheek:

> *Theresa has been finished with lunch for about 30 minutes. She is wandering around, commenting on various things in the room. I asked her if she wanted to play cards, but she declined. I notice that she keeps looking over at Matthew, who is slowly having his meal. After he finishes, Theresa goes to sit next to him. "Darling, I think we should pay," I hear him tell her. She leans towards him, and he gives her a kiss on the cheek. "Nice, that was," he says cheerfully, about the meal. She coos at him, saying something quietly that I can not hear. They sit together for a while, smiling and talking.*

Marcus, the kitchen staff, has warned me that they need some 'supervision' because they have been found in a room together undressing. ("He has a wife, but thinks sometimes that she (pointing at Theresa) is his wife. He has whipped out his willie. We just have to keep an eye on it”.)

> *Today, Theresa and Matthew are sitting together at a table after breakfast while Marcus prepares lunch in the kitchen. Theresa asks if Matthew is cold, seeing that his arms are crossed over his chest. Matthew says yes he is cold. I hear this, and I fetch him a jumper and he puts it on, with a bit of help from Theresa and myself. He is concerned with straightening his collar. I say it looks smart and he smiles.*
>
> *He has a runny nose and walks to get tissues from the counter - something I have seen him do for himself many times. Marcus says “What do you want? '' in an impatient voice. Matthew says he needs a ‘hankie’. “We haven't got any hankies in the kitchen” Marcus scoffs, and then, “Here, have one of them” hands a piece of paper towel.*
>
> *Matthew takes the napkin, walks away, and walks towards another resident's room. Marcus says loudly “That’s not your room!” Theresa hears Marcus and gets up to help Matthew. She holds his hand and asks where he wants to go. “No! You cannot go in the room together!” Marcus yells. “You” - he points to Matthew. “Get your hands off of there!” Matthew’s hands are near his trouser buttons. I think he needs to use the toilet. “You” he points to Theresa “get away from him and come sit down” he points to her chair. Theresa looks confused, still holding Matthew's hand. I feel compelled to intervene,*

> *so I offer to help Matthew find his room "You need to use the toilet?" I show Matthew where his room is, and he uses the bathroom.*

Theresa returns to sit at the table looking tense. I try to engage her, but she does not want to talk. For the rest of the meal, Theresa is not speaking to anyone or responding much to the staff. She wants to take lunch in her room today. One carer explains that she will go through phases where she just wants to be alone. I wonder if her interaction with Marcus and Matthew, where Marcus reprimanded her for trying to help Matthew, has anything to do with this.

Marcus took Matthew's words literally, saying they do not have 'hankies' rather than assessing his needs and why he might be at the counter. He appeared to already be frustrated with Matthew and to already assume that the situation would escalate, rather than waiting to see that Theresa may just be helping her housemate. Gender norms influence power dynamics, emotional connections, and performative aspects within the care home. The incident exemplifies how implicit gender norms shape interactions and perceptions, impacting caregiving dynamics and emotional relationships among residents and staff. The integrated approach provides a richer understanding of the complex interplay between gender norms and other social factors in the care home setting. Examining gender dynamics in the care home through Connell's power and gender framework reveals how gender norms influence power dynamics, labour distribution, and emotional connections. Implicit and ingrained gender norms shape interactions, influencing task allocation, decision-making, and perceptions of authority.

Extending Connell's framework, exploring cathexis and abjection through Kristeva's theories deepens our understanding of how gender norms are influenced by societal expectations. Gender norms create pressures for conformity, evident in practices like maintaining cleanliness during meals, upholding societal norms related to femininity and caregiving. Simultaneously, residents' unique meal rituals challenge traditional gender norms, expressing individual autonomy. Examining affective economies and the implicit ways explicit gender norms shape interactions highlights the emotional dimensions of gender in the care home. Applying Goffman's front stage and backstage concept, gender norms play a crucial role in understanding the performance of gender in the care home. Front-stage interactions reflect and reinforce gender norms, aligning with traditional roles. Backstage interactions reveal negotiation and potentially subversive aspects where individuals may challenge or deviate from expected gendered behaviours.

This chapter has presented several descriptive accounts making up the daily goings-on of Comfort Days. This is to understand the multifaceted dynamics that shape the lives of both residents and care workers. From witnessing the heartfelt commitment of care workers like Kim, who invest emotional labour into their roles, to empathising with the trials faced by residents such as Silvia, George, and Lucinda, whose narratives convey a blend of vulnerability and resilience. Throughout this exploration, I've observed how gender norms and age dynamics manifest, as evidenced by moments like Marcus's patronising remark about older adult care recipients being no different than young children. These instances have provided glimpses into broader societal constructs, power dynamics, and the delicate equilibrium between dependency and agency within the care home. Reflecting on these narratives, it becomes evident that each contributes uniquely to the meshwork of caregiving dynamics in this care home. These stories, whether inspiring or challenging, underscore the importance of fostering a care environment that transcends mere routine, acknowledging and validating the distinct experience of each resident.

Chapter 6: Discussion and Conclusion

As I explore the experiences of care workers residents and care workers, my aim is to offer a deeper understanding of the lived realities within the care home, and to explore the implications of these findings on the future of care work. In this pursuit, I have drawn upon theoretical foundations from various scholars such as Julia Kristeva, Raewynn Connell, Sara Ahmed and Erving Goffman to make sense of the data. These frameworks, spanning abjection, cathexis, and front-stage and backstage behaviours, provide a comprehensive lens through which to analyse the power structures, gender norms, and emotional intricacies embedded within this care home environment. Beyond the theoretical, this discussion embraces a commitment to ethnographic thinking, recognising the value of immersing myself in the daily lives of care workers and residents to provide rich data. Ethnographic inquiry adds depth to this exploration, allowing me to uncover subtleties, cultural variations, and the often unspoken everyday rituals that shape the experiences of those involved in care work.

Before overviewing the various pathways of theoretical interpretation of the findings, I would like to offer a reflection on care, in the first section of this discussion chapter, “Caring Care”. As I navigate the complexities of care work, the concept of "Caring Care" emerges as a guiding light, helping to keep a focus on care relations central in my analysis. Rooted in the humanised care value framework, "Caring Care" serves as a beacon, reminding me of the intrinsic worth and dignity of every individual involved in the caregiving process. Through the lens of "Caring Care," I approach my research with a sense of empathy and compassion, recognising the importance of fostering genuine human connections amidst the institutionalised routines of care provision.

This value framework guides my interactions with both care workers and residents, encourageing me to listen attentively to their stories, concerns, and aspirations.

In applying theoretical frameworks such as Kristeva's abjection, Connell's cathexis, Ahmed's Affective Economies, and Goffman's front-stage and backstage concepts, "Caring Care" serves as a touchstone, grounding my analysis in the lived experiences of those involved in caregiving. Each theoretical lens is interrogated through the lens of "Caring Care," allowing me to critically examine how power structures, gender norms, and emotional landscapes intersect with the fundamental principles of compassionate care. Moreover, "Caring Care" facilitates an insightful look at care relations, encompassing not only the practical tasks and routines of caregiving but also the emotional labour and affective exchanges that underpin meaningful caregiving relationships. This perspective aligns closely with the humanised care value framework, which emphasises the importance of recognising and respecting the unique needs and preferences of care recipients. By integrating the concept of "Caring Care" into my analysis, I ensure that the study remains firmly rooted in a human-centred approach to care provision.

With this foundation in place, I will then move onto the integration of theory with findings. Through ongoing interactions and observations, I sought to grasp the nuances of everyday life within the care home, allowing themes and patterns to emerge organically from the data. Rather than applying preconceived theoretical frameworks during analysis, I maintained a reflexive stance, allowing insights to arise from the various ethnographic encounters. This iterative process enabled a deep understanding of the social dynamics and cultural nuances within the care home, rooted in the lived experiences of those involved. Employing a hermeneutical approach, the theories emerged from the data, and as I analysed, I engaged in a reflective dialogue between theory and the data. This interpretive process allowed me to delve deeper into the meanings and implications underlying the phenomena I encountered within the care home setting. As I navigated the complexities of care work, I found that theoretical frameworks served as useful tools to make sense of and organise data, while also being continually reinterpreted in light of the empirical evidence. For example, Kristeva's concept of abjection provided a framework through which to understand the marginalisation and stigmatisation experienced by George. Through this lens, I was able to discern moments of subtle exclusion or devaluation experienced by George as instances of abjection. Similarly, Connell's theory of cathexis offered insights into how dominant forms of masculinity shape interactions and power dynamics within the care home, such as when William gives his young carer the nickname “pocket rocket”. By applying this theoretical lens, I could unpack the gendered dynamics at play and identify instances where traditional notions of masculinity or femininity influenced caregiving practices. Ahmed's concept of affective economies provided a framework for describing how emotional exchanges occur within the care home environment. This theoretical lens allowed me to make sense of the emotional labour involved in caregiving and recognise the significance of affective relations in shaping the experiences of both care workers and residents. And finally, Goffman's concepts of front-stage and backstage behaviours further enriched my understanding of the performative aspects of caregiving roles. By making sense of the interactions I observed within the care home with this theoretical framework, I could discern how care workers managed their presentation of self in different contexts, balancing the demands of professionalism with the need for emotional authenticity.

However, it is crucial to recognise that theory alone can not fully capture the complexity of the care home environment. Rather, theory serves as a tool for interpretation and reflection, guiding my understanding and sense-making of the empirical data. This hermeneutical approach allows for a dialogue between theory and practice, enriching both my analysis and my understanding of the lived realities within the care home. Considering this, I have included a section on the ethnographic contributions and considerations yielded by this study, focusing on the similarities between care work and ethnography.

Finally, I will conclude this discussion chapter by offering a comprehensive overview of the strengths and limitations of this study, while also discussing potential implications for further research, practice, and policy development. By situating this project within broader debates and arguments surrounding residential care work, this discussion will underscore the significance of this study's contributions to the ongoing discourse on old age care.

“Caring Care”

Understanding the intricacies of identity and gender norms within the context of care work is a complex endeavour. While strict adherence to norms might limit the dynamic sense of identity, norms can serve as valuable tools for meaning-making and communication, particularly in the care home environment where alternative forms of identity expression may be limited by social isolation. In this context, residents are tasked with forging new relationships within a living space that might not entirely encompass the complexity of their lives. Within the framework of humanised care, it becomes imperative to explore how care workers approach gender norms to provide individualised care. Earlier in this dissertation, the literature review illustrated that an increasing number of scholars argue that old age has for too long belonged to the ‘etcetera’ in intersecting positions (Freixas et al., 2012). Instead, old age should be brought to the fore by developing more critical perspectives in gerontology (Calasanti, 2010; Ferrer et al., 2017; Torres, 2015). Paying attention to the situatedness and everyday performances of older adults contributes to the development of “caring care” which sees the individual and meets them as a human being (Galvin & Todres, 2013). In essence, "caring care" within the Humanisation of Care Theory can be understood as care that is imbued with qualities of empathy, compassion, and respect, and that prioritises the well-being and dignity of the individual receiving care. "Caring care" further reinforces the focus on individual experiences and the situatedness of older adults in the world of care research. In other words, matters of identity are matters of care.

My experience provided abundant instances of caring care. The way Linda transparently detailed her expert strategies to transform meals into soft food diets for residents with the enthusiasm of a chef, or how Julia, holding my hand tight, invited me to come with her to Scotland next summer, weaving her cherished memories with our newly found rapport, or when Susy communicates every move she makes as she provides care to immobile and non-verbal Krys, while watching Krys' left eye for the blink that signifies discomfort; when Edna comforted a crying Julia, telling me, "I don't know her, but I think she could be my friend". This is referred to as "caring care", and it occurred between care workers and residents, between workers, residents and myself, and between residents. And for every example I have of "caring care", I have another for the opposite.

"Caring care" permeates the task-based efficiency of institutional care, amidst the meticulous documentation of daily activities like calorie intake, bowel movements, and appointments. However, not everything that gets documented and filed into one's care package embodies the essence of "caring care." Often, it's the quiet, subtle acts that hum in the background of task-based care that truly encapsulate compassionate caregiving. The constructs that society imposes, labelling individuals as "sassy old ladies" or "fussy old men," prove to be shallow and limiting in moments of genuine interpersonal connection, where individual nuances are not only acknowledged but genuinely cared for.

In these moments of human-to-human interaction, the identities that typically facilitate ease in navigating the world may lose their significance. The currency of these identities fades as individuals engage in the interchange of "caring care," where authenticity and empathy take precedence over societal norms and expectations.

It is tempting to dwell in a realm of “shoulds,” discussing the ideal methods of administering care. However, a central finding of this study is that care work is inherently messy. It often demands immediate action, which prompts individuals to navigate their own norms and values, resulting in the subjective treatment of others. Concepts such as abjection and cathexis, or front-stage and backstage care, provide a framework to explore these messy relational dynamics, offering a vocabulary to articulate the slippery nature of interpersonal relations.

In the next section, I will reintroduce the theoretical frameworks selected to make sense of the study's findings. I will provide an overview of the diverse ways in which I observed and participated in acts of care among residents and care workers. By revisiting these theories, I aim to shed light on the complex interplay of power structures, gender norms, and emotional dynamics within the care home environment.

Integration of Theories with Findings

The integration of theoretical frameworks plays a pivotal role in illuminating the complexities that underlie gender norms, power structures, and emotional landscapes within the care home setting. These theoretical foundations were carefully selected based on their relevance to understanding the nuances of caregiving dynamics and were identified during the data collection and analysis stages, as the data reflected the need to construct a multi-faceted theoretical system to explain various elements which make up or deny “caring care”.

In this section, I intertwine the theoretical foundations of Kristeva's abjection, Connell's cathexis, Ahmed’s Affective Economies, and Goffman's front-stage and backstage concepts with the empirical findings derived from extensive research within the care home setting. By weaving together these theoretical perspectives with real-life experiences, I aim to provide a comprehensive analysis that captures the intricate interplay of factors shaping the caregiving environment.

Here I present a very brief review of the theories I employed to think through the findings:

Abjection Julia Kristeva	Kristeva's notion of abjection serves as a lens through which to understand the affective and psychological dimensions of gender dynamics. By exploring the ways individuals react to societal norms, I uncover layers of emotional responses that shape interactions within the care home.
Power & Gender Raewynn Connell	Connell's exploration of power and gender dynamics directs attention to the intricate interplay within societal structures, transcending explicit actions and institutional roles. Through the lens of power and gender, the nuanced relationships and influences in various social contexts come to the forefront, shaping the dynamics within homes, workplaces, and broader societal frameworks.
Affective Economies Sarah Ahmed	Affective economies, as conceptualised by Sara Ahmed, delve into the ways in which emotions circulate within social spaces. It goes beyond individual experiences of emotions to explore how feelings are not only personal but also have broader social implications. Within the care home setting, this framework allows us to unravel the emotional bonds, resistances, and responses to societal norms that are embedded in caregiving interactions.
Front-Stage & Backstage Erving Goffman	Goffman's concepts of front-stage and backstage behaviour guide the analysis of caregiving as an intricate interpersonal navigation. By understanding the alternation between public performance and the private preservation of dignity, I unveil the performative aspects of gender within the social life of the care home.

Figure 10 - A brief overview of theoretical frameworks

Drawing from a wealth of qualitative data and participant observations, the integration of these theoretical frameworks with the empirical findings brings to light an understanding of care dynamics within the care home. The application of Kristeva's abjection reveals unexpected layers in daily interactions. For instance, during mealtime observations, seemingly routine practices carry emotional weight, reflecting the residents' negotiations with societal norms regarding ageing and food-related behaviours. Connell's concept of cathexis emerges vividly in the narratives of care workers who, beyond their prescribed roles, display a deep emotional commitment to the well-being of the residents. These emotional investments shape the quality of care provided, emphasising the human side of caregiving.

Goffman's front-stage and backstage concepts come to life as care workers navigate the delicate balance between public expectations and private interactions. These observations underscore the performative nature of caregiving, where the reinforcement or challenging of gender norms becomes a subtle, daily occurrence. The synthesis of theoretical frameworks with empirical findings not only enriches the analysis but also offers profound insights into the intricate interplay of power, gender, and emotion within the care home. This integration forms the foundation for a more comprehensive understanding that extends beyond the theoretical realm, contributing to the ongoing dialogue on the complexities of care dynamics.

By integrating theories like Connell's power and gender, Kristeva's abjection, Ahmed’s affective economies, and Goffman's front stage and backstage, I have aimed for a comprehensive analysis while embracing the ‘messiness’ of the lived experience. This approach encourages an exploration of how emotions shape both care workers and care recipients, unveiling the inherent emotional labour in caregiving and the crucial role of emotional connections in shaping relationships. Simultaneously, affective economies shed light on the circulation of emotions within social and cultural contexts. In this care home environment, they reveal emotional bonds and resistances, providing insights into how residents and staff navigate or challenge the influence of norms on care. Through this lens, we uncover a spectrum of responses to the interplay of gender and old age, exposing emotional attachments that both reinforce established norms and challenge prevailing narratives.

Let us explore this with some examples. First, I would like to consider William's experiences being redirected. The adherence to William's masculinity was evident in Lucy's direct engagement with William's intentions. Unlike other care workers who ignored or dismissed his advances towards Susan, Lucy openly acknowledged his intentions and advised him to cease such behaviour. She also provided suggestions for possible and appropriate forms of physical touch. While some may see this as patronising (I certainly did at first), this instance demonstrated one of the few occasions where William's masculine identity was acknowledged and preserved. In contrast, we encounter Theresa, who received chastisement for entering Matthew's room. She intended to assist him, yet she was reprimanded for being in the presence of a male resident who was perceived as posing a threat. This act, justified by care worker Joshua as a means of "protecting" her from potential advances, ultimately resulted in shaming and erasing her individuality and caring nature, casting her solely as a victim of male advances. This is an example of how, as Ahmed argues, the affective economy works to maintain order. Within the care home, emotions circulate to contribute to the construction and maintenance of the social order (Ahmed 2014). The intersection of old age, gender, and sexuality leads to "shortcuts" in interpreting intention. These are not merely isolated events, but they are reinforcing a script by which care workers and residents order themselves. William knew to be sneaky, that perhaps Lucy would see his behaviour as something that could be avoided or ignored. Linda pierced through that veil:

[Linda] squats to be eye level with William and continues, "You can hold hands, I think that's lovely! But you can not be pulling her like that. What are you up to, anyway?"

In a sense, William may have been counting on the abjection of his sexuality, to be ignored and pushed out of sight due to a general discomfort with old-age desire (Calasanti, 2001). However, Linda took the time to witness and observe William. She knew his tendencies and she faced him as an individual, a man with autonomy over his actions. She was able to simultaneously protect Susan while also treating William like a full person. Conversely, Theresa was shut down in her attempt to help her housemate and was scolded like a child. This humiliation was a result of the care worker basing assumptions on the emotional reaction to a man and woman engaging in a form of intimacy. Rather than investigate and understand, he applied a punitive approach to control. The contrast between Lucy's acknowledgement of William's intentions and the reprimand that Theresa faced for assisting Matthew highlights the intersectionality of old age, gender, and sexuality in shaping perceptions and reactions. The example of Linda's interaction with William further emphasises the significance of individualised care and understanding in navigating the complexities of residents' needs and desires. Moreover, this scenario highlights the challenges faced by carers who must make split-second decisions in such situations, often without the opportunity for reflection or discussion afterwards. The absence of spaces for reflection and dialogue among carers perpetuates missed opportunities for learning and growth in providing sensitive care.

Theoretical frameworks provide a lens to uncover the spectrum of responses to societal norms. Whether reinforcing established gender norms or challenging prevailing narratives, residents and care workers navigate a diverse terrain of emotional investments that shape the social fabric of care homes. The application of affective economies brings attention to emotional bonds and resistances within the care home. Insights gleaned from participant interactions highlight how residents and staff navigate or challenge gender norms, offering a glimpse into the emotional intricacies that characterise the caregiving environment.

Affective economies reveal motivations and dynamics underlying diverse reactions to societal norms associated with ageing. This framework moves beyond simplistic acceptance or rejection binaries, providing insight into the multifaceted responses to societal expectations, especially concerning gender and old age. Exploring the emotional terrain surrounding gender norms uncovers the profound emotional investments that both perpetuate and contest prevailing norms. This exploration reshapes our perception of care, emphasising the deeply human endeavour intertwined with emotional bonds and commitments.

By examining the interplay of identity and gender norms, a more comprehensive exploration unfolds. The experiences of residents and care workers are situated within the broader context of the care home, revealing how individual identities intersect with and shape the gender dynamics that permeate everyday interactions. Connell's emphasis on cathexis directs attention to the emotional labour inherent in caregiving. Beyond explicit actions and institutional roles, the love and dedication embedded in care emerge as pivotal components, influencing the intricate dance between care workers and residents.

Belonging within “Comfort Days” entails the ability to express oneself through attire, grooming, and recognition in a manner that encompasses the acknowledgement of our gender identity

(Streeter et al., 2020). The attention and care given to Lisa, as seen in the assistance with her appearance before every visit, exemplifies the care workers' commitment to upholding her femininity and ensuring she presents herself in a "presentable" manner. On the opposite end of the spectrum, we have George, who preferred wine during a pub night but was repeatedly questioned about his choice and offered beer instead, and thus "corrected" George into a different presentation at the pub night. Through these observations, it becomes apparent that certain care acts reinforce gender norms by validating and preserving individuals' gender identities, while others involve attempts to mould or suppress their behaviour to conform to societal expectations. This dynamic demonstrates the complex interplay between the caregiving environment, gender norms, and the recognition or erasure of individuality.

The integration of Kristeva's abjection, affective economies, and Goffman's front-stage and backstage concepts provides a comprehensive understanding of the interplay between power, gender, cathexis, and abjection in the care home. This multi-theoretical approach reveals nuanced aspects of gender dynamics within the care home, emphasising the importance of embracing diverse frameworks to fully comprehend complex social phenomena. Affective economies offer insight into the emotional terrain surrounding gender norms in care homes, moving beyond a simplistic acceptance or rejection binary–this can help explore how the assumptions and attitudes we have around gender norms circulate through the care home to form rituals and habits. The difference in reaction to William and Theresa described above is a salient example of this. The inclusion of affective economies in the broader social and cultural contexts of care homes provides a more complex view of emotional bonds and resistances, uncovering complex responses to societal norms.

Goffman's front stage and backstage concept enriches the analysis by shedding light on the performative aspects of gender in the care home's social life. Care workers navigate gender norms along a spectrum, from adhering to traditional ideas to actively challenging them. This spectrum illuminates various caregiving styles and emphasises the human side of caregiving. It is essential to avoid oversimplification and instead offer this spectrum as an exploration of the multifaceted nature of caregiving, where actions may simultaneously conform to and challenge norms, delving into the complexities of providing care. Think again of George, who was repeatedly offered a pint of beer despite his requests for wine. To the care worker, this was the image of good care: an old man sitting in the care home pub with his pint. To George, this was a denial of his individuality.

In contrast, thinking through Orla’s experience with these frameworks, we can see examples of “caring care” in action. For example, Orla's interactions with the carers in the context of smoking breaks in the rabbit hutch reveal emotional dimensions. The act of smoking, often considered a social activity, takes on a specific meaning within this caregiving context. It becomes a shared experience, a moment of connection between Orla and the carers, shedding light on the affective and psychological dimensions of their relationship. By synchronising their smoking breaks with Orla's, the carers challenge societal norms that might stigmatise or isolate individuals engaged in smoking. This shared activity becomes a way to subvert potential feelings of abjection that Orla might experience due to societal attitudes towards smoking or age-related activities, not to mention the complexity of a care act being something unhealthy for the body.

The carers' actions, particularly the consideration of Orla's preferences and the inclusion of her in decision-making, align with Connell's concept of cathexis (Connell, 1987). There is a sense of love and dedication inherent in the way they time their breaks with Orla's, ensuring she has agency in her choices. This goes beyond explicit caregiving actions and institutional roles, emphasising a deeper emotional connection. The carers' approach, involving Orla in the decision process and respecting her preferences, reflects an acknowledgement of her agency. This moves beyond a one-size-fits-all approach to caregiving.

The synchronised smoking breaks and the shared activity of sitting in the rabbit hutch contribute to the affective economies within the care home. Emotional investments are at play, shaping the social fabric of Orla's care environment. The act of smoking becomes a textured element of Orla's care plan, adding layers of meaning to the caregiving interactions. The emotional bonds formed during these smoking breaks circulate within the social context of the care home. It creates a unique emotional landscape that sets Orla apart from other residents, emphasising the importance of understanding diverse reactions to societal norms. Furthermore, the smoking breaks in the rabbit hutch can be seen as a backstage activity, a private moment between Orla and the carers. From the widow's perspective, it may look sweet, but it is a performative aspect of caregiving that occurs away from the public eye. This aligns with Goffman's concept of front-stage and backstage behaviour.

The private setting of the rabbit hutch allows for the preservation of Orla's dignity. The carers engage with her in a more intimate space, avoiding talking over her and respecting her presence. This reflects an understanding of the performative nature of caregiving, alternating between public and private interactions. In summary, Orla’s case exemplifies how caregiving interactions, particularly around shared activities like smoking breaks, are imbued with emotional significance. The frameworks of abjection, cathexis, affective economies, and front-stage/backstage behaviour provide lenses to understand the nuanced dynamics and how Orla's care plan is uniquely shaped by emotional investments and performative aspects of caregiving.

The everyday ritual of Orla’s smoking breaks can be contrasted with William's evening with his daughter, which was a rare moment of emotional significance for William, marked by his glowing demeanour and the special box of cigars sitting on his zimmer frame, an artefact of his selfhood. However, the subsequent interaction between William and Greg introduced a shift in emotions, particularly as William faced pressure to conform to institutional norms, evident in the insistence on having dinner and the unwanted offering of cake. The pressure to conform to care norms is evident in Greg's insistence on William having dinner despite his refusal. The act of bringing a large slice of cake, despite William's declining appetite, reflected a societal expectation of caregiving that did not align with William's preferences or needs at the moment, thus illustrating the conflict between task-oriented care and “caring care”. Of course, task-oriented care is important, but when care workers are encouraged to mark off their caregiving duties on an iPad, lots can be missed.

William's glowing demeanour after the visit with his daughter exemplified the love and dedication inherent in familial relationships, which he was so often missing in the care home. However, the shift in his posture and expression after the interaction with Greg suggests a shift from a moment of emotional connection to a more challenging and potentially rejecting situation. Despite Greg's insistence, William asserts his agency by refusing dinner. This refusal, coupled with his withdrawal from the social space without saying goodnight, indicates an attempt to exercise autonomy in the face of institutional pressures. The contrast between the joyful visit and the pressured interactions contributes to the affective economies within the care home. Emotional investments are at play, shaping the dynamics between residents and care workers. The act of offering food and the subsequent withdrawal of William highlight the emotional landscape within the care environment. Greg appeared stressed at William’s refusal, and interpersonal tension built between them.

Furthermore, the visit with his daughter and the subsequent interactions with care workers can be seen as both front-stage and backstage moments. The joyful visit is a private, intimate experience (backstage), while the interactions with care workers, particularly Greg's insistence on dinner, become performative aspects in the shared living space (front-stage). William's refusal of dinner and the subsequent withdrawal indicate a preservation of dignity. Despite external pressures, he attempts to maintain control over his choices and interactions. The contrast between the untouched cake and the cheerful cigar box symbolises the tension between individual preferences and institutional expectations.

The interaction involving Jean's desire for sugar in her soup provides a rich context for analysis, particularly through the lens of Kristeva's theory of abjection. Jean's request challenges the cultural norms and expectations held by the staff, leading to a negotiation of preferences and tastes within the communal setting. When Jean expressed a clear preference for sugar in her soup, it was met with scepticism and discomfort by the staff. The emotional reactions, such as surprise and contradiction, underscored the cultural value attached to ordered meal systems. Kristeva's theory of abjection came into play as sugar in soup was considered taboo or unacceptable by societal standards. The staff's attempt to deny Jean's request and normalise it by insisting she wanted salt could be seen as a way to separate Jean's desire from what was considered culturally acceptable (Connell, 1987). The power dynamics in the interaction were evident in Keith's dismissive and condescending tone towards Jean. His attempt to take the sugar away reinforced the staff's authority and their role in enforcing societal norms. Jean's persistence, however, represented individual agency challenging the established cultural expectations[20]. The staff's refusal to give Jean sugar in her soup could be interpreted as an attempt to enforce societal norms and avoid the abject. Conversely, Jean's insistence on her preference highlighted the potential for subversion, challenging established norms and forcing a confrontation with the abject. This is important when thinking about care as a negotiation.

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[20] It is worth noting that Jean was very new to the care home when this instance occurred. It would be interesting to see if she would continue to reject these moments of control, or if she would eventually adopt the “go with it” mentality that we can see in George

Jean’s subversion, though seemingly subtle, was an effort to uphold her sense of dignity in the residential care environment.

The unfortunate manifestation of Kristeva's concept of abjection finds a poignant illustration in George's experiences, where his attempts to assert identity or significance is met with rejection. I argue that this rejection was furthered by his “abject masculinity”, his adherence to the ‘normal’ forms of masculinity that care workers found easier to engage (memories of the Army, drinking pints, engaging in subtle flirty small talk with care workers). Consider, for instance, the Halloween party where George, seeking recognition, donned a paper cat mask but was largely overlooked by the busy care workers. This act of expressing himself through the cat mask unveiled a deep-seated desire for connection and acknowledgement.

George's plea for my return underscored this yearning for emotional connection, yet it became a point of friction with my own time constraints, inducing a sense of guilt regarding his perceived lack of care. This interplay of emotions is a crucial aspect of Ahmed's Affective Economies—where emotions circulate and impact individuals within the social setting—in this case within care home. This emotional dynamic is not isolated but echoes in the broader context, as illustrated by Kate's burnout (mentioned in the dissertation introduction) concerning George's need for emotional connection. Unmet needs, when brought to the forefront, have the potential to affect care workers, triggering feelings of guilt, inadequacy, or burnout. We can see this when William rejects Greg’s prompts to eat as well. Greg becomes shorter with William, offended nearly, when he is unable to smoothly perform a care act. Ahmed’s framework provides valuable insights into comprehending this phenomenon, and its implications will be further explored in later sections of this chapter, contributing to a more nuanced understanding of and potential solutions for the current shortcomings in care.

The Halloween party setting demonstrates affective economies in action, where attention, recognition, and emotional investments are exchanged. George's attempts to engage are met with a lack of response, indicating a deficit in the emotional transactions within this social context. The scarcity of emotional exchange may contribute to a sense of loss and longing, affecting the emotional economy of the caregiving environment. The busy atmosphere of the Halloween party represents a front-stage scenario where the focus is on the external performance and logistics of the event. George's emotional plea, however, provides a glimpse into the backstage, revealing a more vulnerable and neglected aspect of his experience. The juxtaposition of the festive front stage and George's subdued backstage moment highlights the complexity of the caregiving environment. The lack of attention and understanding from care workers suggests a missed opportunity for the emotional investment in acknowledging and affirming the uniqueness of residents. Furthermore, it represented a missed opportunity for care between George and myself: I was not able to miss my train, and had to interrupt the situation. In reflecting, I wish I could have said something to pierce the “front stage” event and to go “backstage” to acknowledge George’s experience of loneliness (Goffman).

Eva's discomfort and subtle rejection of my presence, as discussed in the ethics chapter of this dissertation, provide valuable insights to further explore my role within the care matrix. When I initiated a conversation about the weather, Eva's response indicated a form of social rejection, portraying my presence as an imposition that disrupted the expected interactions within the setting. This interaction reflects the circulation of emotions within the social environment, as my attempt at conversation and Eva's visible reaction created a discernible emotional tension that influenced the overall atmosphere in the room (Ahmed, 2014).

Eva's care worker’s decision to use a thin nightgown in response to the heat introduces a practical consideration for comfort but simultaneously introduced a private element into the communal space. The act of being given a washcloth, typically a private and intimate practice, clashes with the public setting, emphasising the delicate balance between front-stage communal living and backstage personal activities (Goffman, 1959). This situation positioned Eva to potentially feel dehumanised in the moment, prompting my decision to respect her boundaries and withdraw from the interaction, thus reasserting the idea that care is an ongoing negotiation and process. In prioritising Eva's physical well-being to manage the heat, care workers inadvertently placed less emphasis on her need for privacy in that particular moment, while shifting focus to her physical comfort during a heatwave. Recognising Eva’s right to privacy, I made a conscious decision to remove myself from the situation, aiming to honour Eva's sense of dignity while acknowledging the complex interplay between individual needs and the broader context of care provision. In other words, I was trying to make a right decision in the moment.

Employing a hermeneutical approach, I aim not only to apply theoretical frameworks to my observations but also to engage in a reflective dialogue between theory and practice. This interpretive process allows me to delve deeper into the meanings and implications underlying the phenomena I encounter within the care home setting.

An Ethnographic Perspective on Care

Ethnography allows us to access the complex layerings which make up residential care settings, capturing the nuances of everyday practices and interactions. Through prolonged engagement and participant observation, it is possible to gain a fine-grained understanding of the social, cultural, and organisational dynamics that shape care provision in these settings. Ethnography enables us to listen to the voices of those receiving care, empowering them as active participants in the care process. By exploring power dynamics and uncovering hidden inequalities, we can work towards promoting more equitable and person-centred care practices. Ultimately, ethnographic research has the potential to inform and transform care provision, enhancing the quality of care and the experiences of both care providers and recipients.

Making a decision in the moment is a recurring theme in my findings; my observations and reflections of my experiences in the care home illustrate how difficult it is to make these decisions. While it is the responsibility as an ethnographer to reflect on this process, care workers do not have the same expectations for their work, nor do they have the same tools or resources (namely, the time to do so). In this section I would like to suggest that we recognise and leverage the parallels between ethnographic research and care provision in residential settings. Ethnography, as a qualitative research approach, immerses the researcher in the everyday lives of participants, capturing details and contextual subtleties that contribute to a more profound understanding of care. In the exploration of gender dynamics, ethnographic thinking uncovers layers that theoretical frameworks alone might miss. By immersing in the daily interactions and daily rituals of the care home, findings reveal unspoken norms and subtle power dynamics that shape the experiences of both care workers and residents. Ethnographic thinking extends beyond the immediate caregiving acts, contextualising practices within the broader social and cultural milieu of the care home. The norms and values embedded in care practices emerge as crucial elements in understanding the meaning and impact of caregiving behaviours. Taking an ethnographic inquiry, which is still a rarity in studies on care homes, revealed how cultural backgrounds influence preferences in care practices.

This project values the narratives of participants, recognising them as essential authors and interpreters of the contextual realities of care. The stories shared by care workers and residents provide many different, sometimes contradicting, experiences, offering insights into the multifaceted nature of caregiving. Discussions brought out feelings of pride, overwhelm, and indifference among care workers, illustrating how personal experiences shape caregiving approaches. These narratives elucidate the broader context in which care is provided.

My presence in the field shaped the study, centering ethnographic reflexivity as a critical component of this work. Acknowledging my own biases and subjectivities, I engaged in constant self-reflection to better understand how my perspectives influenced the research process. My reflexivity notes revealed instances where my cultural background influenced interpretations of certain caregiving practices, such as when I identified more with Lucy's instinct to avoid William's sexual advances. I witnessed the flaws in Lucy's attempt to adequately address William's behaviour, but I also recognised that I would react similarly, most likely due to my socialisation as a young woman in a misogynistic society. This self-awareness prompted deeper exploration, fostering a more inclusive and culturally sensitive analysis of care work. Put simply: by reflecting on what I would have done, I understood again and again that care work is hard.

Synthesising ethnographic insights with theoretical frameworks enriches our understanding of care dynamics. The interplay between lived experiences, cultural contexts, and theoretical concepts offers a holistic perspective, avoiding oversimplification and capturing the complexity inherent in caregiving. By intertwining ethnographic findings with the theory I chose to look at findings, I have explored how emotional responses in caregiving situations are deeply entwined with cultural norms, contributing to a gendered pattern of dynamics within the care home. Embracing ethnographic thinking alongside theoretical frameworks elevates the discussion of care dynamics. It allows us to navigate beyond surface observations, providing a textured understanding of gender, power, and identity within the care home. Ethnographic thinking becomes a crucial tool in avoiding oversimplification and uncovering the spectrum of experiences in the realm of caregiving. Importantly, this has allowed me to experience how difficult it is to provide care, to make the best possible decisions in every situation. My experiences of sharing everyday life with the carers helped to expose their hard work and the difficult decisions they must constantly navigate in their quest to provide care. As an outsider to the care relationship, it is easy to point to instances of poor care provision as the sole fault of the care practitioner.

Both care work and research involve building connections with others, listening to their stories, and responding with empathy and compassion. The fact that care, like qualitative research, is relational underscores the potential for these two areas to benefit from one another. The intersections between research and care work provide numerous opportunities for mutual learning and growth. By recognising and building upon the shared relational nature of these fields, researchers and care workers can support each other in their work, leading to better outcomes for all involved.

Active involvement in daily care tasks allows for meaningful interactions with residents, addressing their immediate needs and fostering a sense of connection and trust. However, incorporating analytic reflection into daily practice enables care workers to deepen their understanding of residents' experiences and identify underlying patterns or dynamics that may impact care provision. Reflective practice provides an opportunity to analyse interactions and identify underlying factors influencing residents' behaviours and preferences. This deeper insight allows for more personalised and effective care provision. Additionally, analytic reflection empowers care workers to critically evaluate their actions and decisions, considering the broader context of residents' lives and the impact of intersecting identities. This leads to more informed and thoughtful decision-making in caregiving situations. Furthermore, engaging in reflective practice fosters continuous learning and professional development. Care workers can identify areas for improvement, develop new skills, and refine their approach to caregiving, ultimately enhancing the quality of care provided. While incorporating analytic reflection may require dedicated time and effort, the benefits far outweigh the challenges. By embracing this duality of active involvement and reflective practice, care workers can enrich their caregiving practice, leading to more holistic and compassionate care for residents.

The lifeworld-led care perspective accounts for this complexity of care, arguing that truly comprehensive care acts must include a careful integration of “a philosophy of the person, a view of well-being and not just illness, and a philosophy of care that is consistent with this” (Dahlberg et al., 2008). In this study, care workers have shown that they do reflect on their attitudes, biases, and values and how this influences their work. Perhaps naming this and giving some structure and conceptual framings to this process would help them understand how the ways they interpret events and how they can better serve the needs of the residents in their care, reflecting on their attitudes, sense of what is normal and not, and the values and perspectives they bring to their interactions. This helps understand how they interpret different events, impacting how they interact with others. Care homes have their own culture, and care workers must understand this culture to help residents feel a part of it and notice when certain things fall outside of the normal culture established as a group. The goal is to better gain a deeper insight into the care worker's role in the care relationship.

When looking at care through the Gender & Power framework as provided by Connell, issues of power, labour, and cathexis are not cleanly separate categories: rather, they are interlocking, and they contradict, shape, and exacerbate one another. Care as a negotiation between actors is influenced by gender relations. There is tension between the power dynamic of carers, residents, and men and women. The findings from this study can provide valuable insights into the humanisation of care framework and its future application. The study highlights the importance of recognising the emotional and physical labour required in care work and the need to value and support the work of care workers.

The humanisation of care framework focuses on promoting the dignity and autonomy of care recipients and creating a more person-centred approach to care. The findings from this study help inform the development and implementation of the framework by highlighting the challenges and opportunities in care homes. For example, the study suggests that greater attention needs to be paid to the emotional needs of care workers, who may experience burnout and stress due to work demands. Furthermore, the study highlights the importance of creating a supportive environment for care workers, including training and development opportunities, support from colleagues and management, and adequate resources and equipment. By considering these factors, care homes can create a more positive work environment for care workers, which can improve the quality of care provided to residents. Overall, the findings from this study help inform the development and implementation of the humanisation of care framework by providing insights into the challenges and opportunities in care homes and highlighting the importance of recognising and valuing the work of care workers.

Effective caregiving transcends merely acknowledging needs, as care workers often strive to do; rather, it necessitates a willingness to perceive the needs of others as potentially distinct yet resonant with one's own. This requires the ability to transcend one's own worldview and empathetically engage with the experiences of others, akin to the approach of ethnography.

Drawing upon Kleinman and Benson's concept of "anthropology in the clinic," care workers can derive benefit from interpreting these interactions through an ethnographic lens, thereby grasping the cultural contexts and relational complexities inherent in caregiving dynamics (Kleinman & Benson, 2006). Treating care interactions as mini-ethnographies diverges from the tendency to categorise each care recipient based on preconceived notions or stereotypes (e.g., as "old" or "female"). Instead, it involves careful observation and exploration to discern what constitutes good care for each individual. Central to this inquiry is an examination of the resident's lived experience within the care home, encompassing considerations such as the nature of their transition into the care home and the significance of their unique circumstances.

When considering the dynamics of abjection and affinity between care workers and residents, it becomes pertinent to inquire who possesses the aptitude and rapport to effectively address the needs of each resident. I observed numerous instances where a particular care worker struggled to connect with a resident, necessitating assistance from another individual who possessed a better understanding of, or was more favourably received by, said resident. In many respects, numerous care workers already exhibit tendencies akin to those of ethnographers in their professional endeavours. Emphasising the parallels between quality care provision and ethnographic research serves to underscore the critical role such approaches play in delivering quality care. Through the lens of gender, as explored within this thesis, we gain insight into the fundamental significance of identity and our relational dynamics in caregiving—an inherently interpersonal endeavour. The analysis presented in the empirical chapters prompts us to confront the transformative potential inherent in our understanding of gender norms within caregiving contexts. By acknowledging the influence of gender norms, we are presented with an opportunity to reconceptualise and redefine the landscape of care. Nurturing affective economies that prioritise human connection goes beyond transactional interactions, fostering deep and meaningful relationships within care settings. Recognising the value of emotional labour and its impact on the lives of both residents and staff is crucial.

Context matters greatly in understanding the provision and reception of care. Historical socio-economic disparities, coupled with regional cultural norms, exert significant influence in this regard. Gender roles, deeply ingrained within societal structures, shape expectations and behaviours within caregiving relationships. Moreover, the intersection of gender with other factors such as class, ethnicity, or religion further complicates the dynamics of the care relationship. For example, consider George's situation—a white cis-male married to a white cis-woman, both actively involved in the Church of England community. Initially, they may seem fully integrated and understood within the care home setting. However, upon closer observation, I discovered that seemingly minor distinctions in George's preferences and background held considerable sway over his treatment. Subtle nuances such as a distinct accent (which, unbeknownst to my American ears, carried weight among locals), differing priorities, and even the preference for wine over the expected pint subtly marginalised George. Yet, within the context of the care home environment, where daily interactions shape one's entire world, these seemingly insignificant factors posed significant challenges for George and his care workers.

The intersection of age with gender and class introduces additional complexities. Older individuals may face unique challenges and vulnerabilities within the care system, particularly when compounded by factors such as gender identity and socio-economic status. Acknowledging and interrogating these intersecting dynamics is crucial for a comprehensive understanding of care work for older adults. By examining how gender, class, and age intersect and manifest within the caregiving context, we can better appreciate the experiences and challenges faced by individuals within this region. This contextual lens enriches our analysis and underscores the importance of addressing systemic inequalities in care provision. However, it is essential to avoid reducing residents to mere categories that define their status. Each individual possesses a unique identity and set of experiences that cannot be fully encapsulated by societal labels. Recognising the complexity and individuality of each resident is paramount in delivering dignified and person-centred care.

Strengths and Limitations

Employing an ethnographic approach, this study led me deep into the lived experiences and perspectives of both care workers and recipients within this care home. This immersive exploration yielded a nuanced and comprehensive narrative, unveiling many, often contradicting, challenges in care work. Each interaction, observation, and conversation added layers to the rich and granular data, contributing valuable insights to the current discourse on caregiving dynamics. I employed feminist methodology and process consent to address biases, create a safe research environment, and value diverse perspectives. These approaches were crucial for conducting ethical and inclusive research with older people in a care home setting, establishing rapport, gaining trust, and producing meaningful findings.

It is important to acknowledge that ethnographic studies, by their very nature, are inherently focused on specific settings, groups, or phenomena. While the insights gained from this study offer profound revelations for the particular care home setting under investigation, they may not directly translate to diverse care homes in different regions or countries, or to various types of care services such as home care or hospital care. Navigating the limitations of ethnography requires a delicate balance. On one hand, acknowledging the contextual specificity of the findings is crucial for maintaining integrity and relevance. On the other hand, I recognise the unparalleled ability of ethnography to answer complex research questions and unveil the hidden dimensions of caregiving relationships.

Central to this endeavour was the introspection into my own positionality and reflexivity. As the researcher, I recognised the profound impact of my biases, assumptions, and perspectives on the interpretation and analysis of data. Transparently acknowledging these influences became imperative for ensuring the validity and reliability of the findings. Engaging in reflective practices allowed me to navigate the complexities of subjectivity, constantly interrogating my own role in shaping the research process.

Moreover, the practical challenges inherent in ethnographic research demanded resilience and adaptability. Balancing the demands of establishing rapport with participants, collecting and analysing data, and maintaining ethical conduct required careful planning and resource management. Yet, despite the logistical hurdles, the immersive nature of ethnography offered unparalleled access to the intricacies of care work and relationships.

In the end, embracing these challenges and being mindful of the distinctive contributions of ethnography allowed me to generate insights that transcend mere data points. It enabled me to capture the essence of caring care, not just as a theoretical concept, but as a lived reality intertwined with the complexities of human interaction and empathy. As researchers continue to explore the nuances of care work, embracing the immersive and reflective nature of ethnography will remain essential for unravelling the intricate threads of caregiving dynamics in specific contexts.

Using multiple theories in this study presents both strengths and challenges, and is a decision worth defending. By integrating insights from Connell's power and gender theories, Kristeva's abjection, Ahmed’s affective economies, and Goffman's front stage and backstage concepts, we explore the complexities of relationships, emotions, and gender norms in care homes. This theoretical meshwork does not just aim for complexity for complexity's sake. Rather, it offers practical insights for improving care practices. Each theory brings a unique perspective, contributing to a comprehensive exploration of the caregiving environment. Importantly, not every case neatly fits all theories equally, and that's where the flexibility of this "meshwork" proves invaluable. It allows us to adapt our analytical lens to the unique aspects of each case, without sacrificing depth or breadth.

While the theoretical meshwork offers practical insights for enhancing care practices, it's essential not to overstate its reach. Rather, each theory brings a distinctive perspective, contributing to a comprehensive exploration of the caregiving environment. For instance, Connell's theory illuminates structural influences, while Kristeva's work delves into the emotional dimensions of care. This flexibility in approach ensures that our analysis remains grounded in the complexities of real-world care contexts, avoiding oversimplification while confidently advancing our understanding and potential for improvement.

The use of various frameworks reveals tensions and contradictions within the data. It brings to light the complexities of individual experiences, such as the simultaneous adherence to and subversion of traditional gender roles in different contexts within the care home. From a practical standpoint, the insights gained from this approach can inform targeted policy recommendations. Understanding power dynamics, emotional labour, and gendered expectations enables the development of interventions that address specific challenges within care home environments, promoting the well-being of both residents and staff. Ultimately, this method encourages reflexivity within the research process. It prompts the continuous questioning of assumptions, recognising the diverse and fluid nature of social phenomena. Such self-awareness contributes to a more transparent and robust study, acknowledging the subjectivity inherent in ethnographic research and enhancing the validity of the findings. This method isn't about narrowing our focus; it's about broadening our lens to encompass the multifaceted nature of care. By weaving together insights from various theoretical frameworks, we can illuminate the diverse facets of care provision and resident experiences. This approach not only aligns with established qualitative research methodology but also embodies a commitment to robust and comprehensive analysis. By incorporating insights from multiple theories, we not only enhance the depth of our exploration but also ensure that our findings are firmly grounded in the complex realities of care home environments.

Finally, it is important to revisit the limitations of conducting in-person research in a care home, with adults who do not possess the capacity to self-consent on forms, and during a pandemic which disproportionately impacts old adults. I would have loved to interview more participants, but they were unable to provide written consent for this. I grappled with feelings of guilt for being able to spend time with people who had not been able to spend time with relatives or friends for months. During the study, pandemic-related restrictions were gradually easing, allowing a glimpse into the reopening of the care home environment. However, this newfound openness was fragile, constantly under the looming threat of re-closure upon the discovery of a COVID-19 case on the premises. The study's progression mirrored a continuous effort to secure permission and access to a population that, even as pandemic restrictions lifted, remained somewhat secluded from broader society. It is important to clarify that describing the structure of the care home itself as a limitation may not be entirely accurate, as this is the inherent reality for care home residents. Nevertheless, the boundaries and barriers associated with this population significantly shaped the design and facilitation of the study, profoundly influencing how I came to understand and engage with both residents and care staff.

Implications for Research, Practice, and Policy

Building upon the examination of findings, I have here aimed to explore the broader implications of the emotional intricacies within the care home, analysing the impact of gender dynamics on care practices and relationships to gain insights into the complexities that shape the caregiving environment. Findings underscore the importance of acknowledging and respecting individual identities, emotional investments, and the intersectionality of factors such as gender and old age in caregiving interactions. By examining how gender norms influence caregiving responses, we uncover subtle shifts in power dynamics. care workers, consciously or unconsciously, navigate societal expectations, influencing the nature of care provided and shaping the overall caregiving landscape.

The acknowledgement of individual identities and emotional investments contributes to the development of more individualised care approaches. This recognition fosters a deeper understanding of residents' needs and preferences, moving beyond generic caregiving practices to a more personalised and humanised approach. The case studies emphasise the role of emotional bonds in caregiving. By navigating gender norms with sensitivity, care workers have the opportunity to build trust and connection with residents. This, in turn, enhances the quality of care and promotes a supportive and empathetic care environment. The challenges faced by care workers, such as those seen in Theresa's case, highlight the difficulties in adhering to societal norms while providing genuine and individualised care. These challenges offer opportunities for reflection on how normative expectations can impact the caregiving experience.

Exploring the affective economies at play opens avenues for enhancing cultural sensitivity in care practices. Recognising the diverse responses to societal norms within the care home allows for the development of inclusive and culturally aware caregiving approaches. The collective insights from the case studies call for a paradigm shift toward "caring care." This approach transcends traditional norms and institutional roles, placing a greater emphasis on individualised, emotionally aware caregiving that recognises and respects the diverse identities of both care workers and residents. In essence, the emotional intricacies within gender dynamics not only influence care practices and relationships but also have profound implications for humanising the care environment. This human-centric approach recognises the multifaceted nature of caregiving, emphasising the importance of emotional connections and individualised care.

It is crucial to reflect on the overarching themes that have surfaced throughout the study. This section engages in a thoughtful reflection on the findings and proposes recommendations for future research and practical applications within the care home setting. The case studies and analyses underscore the complexity of gender dynamics within the care home. Beyond a binary perspective, we observe a spectrum of responses that residents and care workers navigate, shaping emotional landscapes and power structures within the caregiving environment. Connell's concept of cathexis becomes particularly relevant in understanding the emotional labour inherent in caregiving. The intersectionality of factors such as gender and old age reveals how emotional investments contribute to the construction and maintenance of social order within the care home.

Research

This study lays a sturdy foundation for subsequent research endeavours to delve into other dimensions of care work, offering a springboard for exploration into diverse aspects that warrant further investigation. leveraging the insights gleaned from this study, future research could probe into various facets, including the influence of cultural diversity on care provision and the intricate relationship between care work and mental health. Cultural diversity presents a rich terrain for exploration within the realm of care work. While this study focused on gender, future studies could investigate how cultural backgrounds shape caregiving practices, perceptions of ageing, and expectations surrounding care provision. By examining the intersections of culture, ethnicity, and caregiving within the care home environment, researchers can deepen our understanding of how cultural diversity influences the dynamics of care and the experiences of both care workers and residents.

Additionally, the relationship between care work and mental health represents another promising avenue for inquiry. Research could explore the psychological impact of caregiving on individuals, examining factors such as burnout, compassion fatigue, and resilience among care workers. By shedding light on the emotional dimensions of care work, future studies can inform strategies for supporting the mental well-being of care workers and enhancing the quality of care provided to older adults. The ethnographic lens, with its immersive and holistic approach, emerges as a powerful tool for unravelling the intricacies of care work. Future research projects can build upon this foundation by employing ethnographic methods to explore new dimensions of caregiving experiences. By immersing themselves in the daily lives of care workers and residents, researchers can capture the complexities and lived realities of care work in ways that quantitative approaches alone cannot achieve.

This study also contributes to ongoing debates and discussions about care research and the ethics of consent. In the ethics chapter, an exploration of the barriers and issues related to access to the field of care work unveiled significant challenges that I faced in gaining entry to this care home. Paternalistic attitudes towards older adults, as well as towards care recipients, can act as formidable barriers, impeding researchers' ability to conduct thorough investigations and limiting our understanding of these critical environments. It is crucial to examine the contours and origin of these preconceptions.

Paternalistic attitudes, rooted in ageism and societal perceptions of dependency, can manifest within care settings, where older adults may be marginalised or dismissed, their voices and perspectives overlooked or undervalued. This paternalistic lens not only undermines the dignity and rights of older adults but also distorts our understanding of their lived experiences within care environments. Similarly, paternalistic attitudes towards care recipients, particularly those with complex care needs or cognitive impairments, can perpetuate a power imbalance that compromises the ethical conduct of research. Care recipients may be perceived as passive subjects, rather than active participants in the research process, leading to their exclusion or marginalisation. This condescending stance not only violates the principles of respect for persons and autonomy but also hinders researchers' ability to capture the full spectrum of experiences and perspectives within care settings.

Addressing these barriers requires a concerted effort to challenge and dismantle paternalistic attitudes towards older adults and care recipients. Researchers must advocate for the rights and agency of older adults, recognising them as active participants in the research process with valuable insights to contribute. Moreover, fostering a culture of respect, dignity, and inclusivity within care environments is essential for creating ethical research conditions that prioritise the well-being and autonomy of all individuals involved. By confronting paternalistic attitudes and advocating for ethical research practices, researchers can pave the way for a more nuanced and comprehensive understanding of care environments. This ethical imperative not only enhances the validity and integrity of research findings but also promotes social justice and equity for older adults and care recipients within society.

Practical Applications for Care Practices

The lifeworld-led care perspective emphasises the importance of integrating theoretical concepts into the development of competence at work. As I reflect on the findings of this study, it becomes clear that care workers are not just providers of care; they are experts in their field, navigating the complexities of caregiving with empathy and sensitivity. Through my interactions with care workers, I have witnessed their willingness to reflect on their attitudes, biases, and values, recognising the profound influence these factors have on their practice.

Formalising this reflective process and providing structured conceptual frameworks can further empower care workers to navigate their interpretations of events and better meet the needs of residents in their care. For instance, training sessions or workshops introducing theoretical concepts relevant to 'thinking like an ethnographer', such as 'culture' and 'norms', can guide care workers in critically reflecting on their attitudes and perceptions. Fostering an organisational culture that values ongoing learning and reflection is essential in supporting care workers to integrate theoretical knowledge into their daily practice.

The relational nature of care and qualitative research suggests a symbiotic relationship that holds the potential for mutual enrichment. Both care work and research entail the cultivation of connections with individuals, active listening to their narratives, and responding with empathy and compassion. By acknowledging and embracing the relational aspects intrinsic to both fields, practitioners can refine their skills and contribute to improved outcomes for those under their care.

Understanding care through an ethnographic lens provides care workers with a valuable opportunity for self-reflection on their attitudes, biases, and values. This introspective exercise is pivotal in recognising how diverse interpretations of events can influence their interactions with residents. Adopting an ethnographer's mindset prompts care workers to critically examine their perceptions of what is considered normal and how their values shape their interactions. Given the unique culture within care homes, this reflective process becomes essential for care workers to comprehend and integrate into the established cultural norms. Such awareness is fundamental in identifying deviations from the norm, ensuring a cohesive and inclusive environment for residents.

Aligning with the lifeworld-led care perspective urges care workers to navigate the complexities inherent in caregiving. This approach emphasises the integration of a philosophy of the person, a holistic perspective on well-being beyond mere illness, and a congruent philosophy of care. The goal is to foster a comprehensive understanding of the care worker's role within the care relationship, emphasising the importance of holistic care that goes beyond addressing immediate physical needs. By intertwining the principles of ethnography and the lifeworld-led care perspective, care workers can navigate the intricate landscape of caregiving, promoting not only physical well-being but also a profound understanding of the individual's lifeworld. This comprehensive approach, rooted in self-awareness and cultural sensitivity, enables care workers to provide person-centred care, ultimately enriching the lives of those entrusted to their care. The findings from this study highlight the strengths and limitations of current care practices and aims to inform the development of more effective and equitable care services responsive to the diverse needs and experiences of care workers and care recipients. It emphasises the importance of gender-sensitive care services and highlights the need for training care workers to recognise and respond to care recipients' diverse needs and preferences, particularly those related to gender, relationships, and culture.

Policy

While the primary focus of this project is not on policy impacts, the findings from this study offer valuable insights that contribute to broader discussions on policy reform in the care sector, both within the UK context and beyond. Specifically, they underscore the pressing need for comprehensive reforms that prioritise the well-being and recognition of care workers and centre the experiences of older persons in discussions on the future of care provision for this demographic.

Through rich and descriptive data, such as the introductory vignette detailing Kate, a care worker experiencing burnout, this study sheds light on the challenges faced by care workers in their everyday roles. Witnessing care workers taking on extra shifts and over-extending themselves to support their colleagues emphasises the urgency for substantial improvements in remuneration and overall support for care workers. Adequate compensation not only addresses economic justice but also acknowledges the essential nature of their work, which is integral to the functioning of society.

Moreover, investing in training and efforts to support care workers define and develop an ethos of care is crucial. Care work demands a dynamic skill set that evolves with the ever-changing needs of care recipients. Comprehensive training programs empower care workers with the knowledge and skills necessary to navigate the complexities of the care sector, ultimately enhancing the quality of care provided. Additionally, there is an urgent need to shift societal perceptions regarding the value of care work. Policymakers must champion initiatives that not only address immediate challenges within the care sector but also contribute to reshaping societal attitudes toward the profound importance of care work. By advocating for better remuneration, continuous training, enhanced support systems, and a societal ethos that values care work, policymakers can lay the groundwork for a transformed and dignified caregiving landscape.

In addressing the policy needs for older adults in care, it is imperative to centre policies around the lived experiences of this demographic, recognising and respecting the unique life experiences, preferences, and needs of each individual. This study advocates for new paradigms to make sense of care priorities, such as attention to the ‘smaller’ aspects of cultural normals as a vital element of life in residential care. This study supports that highlighting the voices and experiences of older adults themselves is an essential, and often left out, component of improving the outlook of care services.

Final Thoughts

During my last visit to the care home, I sat in the sun with Julia and her godson. On that particular day, a funeral procession unfolded in the back parking lot, with a hearse parking for a while as friends and housemates bid their goodbyes. When Julia's godson asked if she would like to participate, she dismissively remarked, "I don't know her." It struck me that Julia might have been disturbed by the presence of a funeral procession on another day and in a different mood. A nearby care worker explained that these processions visit the deceased’s "last neighbourhood"—which, for residents, is the care home grounds. I could not help but reflect critically on the idea that the care home is the final community setting for many of its residents. One might have lived in a traditional neighbourhood for decades, possibly woven into a generations-long history. However, this care home is a place where most residents have typically been for only a few years, many having moved from other towns. “But this is not home, is it”, Joan remarked in an interview a few months earlier.

Even within the relatively short span of this ethnography, the care home had undergone significant changes since my first day of fieldwork. Despite participants passing away or being moved to higher levels of care, and members of staff leaving, the rhythm of the care home persisted. On this particular day, a funeral took place, yet more people seemed to comment on the rarity of sunny weather, an event less frequent in this rainy region than the inevitable cycle of illness and death. Embracing the inevitability of illness and death is an integral aspect of the reality within the realm of old-age care.

However, it is crucial to recognise that both residents and staff do not necessarily confront this reality openly in their daily lives. A notable illustration of this is observed in the intentional choice made by a care worker not to showcase a portrait of George in Julia's living space following his passing. Rather than consistently revisiting the explanation of George's death, the decision was made to spare Julia unnecessary stress, allowing her to remain rooted in the present and often omitting reference to her late husband.

Contrary to being merely a site for medical or clinical interventions, the care home serves as the backdrop where individuals experience and live out their lives. Residential care, in essence, promises to provide much more than just medical attention; it pledges to be a holistic environment where life unfolds. However, despite possessing awards and high ratings for the level of care, the care home did not always manage to provide comprehensive care to all residents. George's experience at the care home was an unfortunately salient example. Termed a "bottomless pit" by a stressed care worker, George's attempts to secure care for himself and his wife seemed more like survival tactics. His frequent utterances of "Just go with it" reflected his resignation to the lack of control within this environment. Due to a feminised connotation, read: undervalued set of skills, much of the emotionally nurturing aspects of care work go unrecognised, and, "amplify the ambivalence of emotional nurturance in practice" (Hanlon, 2023; 1).

The overarching aim of qualitative care research is to discern how services can be improved, ensuring that individuals like George are less likely to experience shortcomings in existing care services. As we navigate complexities within care homes, the Humanisation of Care Framework serves as a compass pointing toward a more compassionate and holistic approach to care provision, supporting the cultivation of environments that honour individuals' uniqueness, fostering not only physical well-being but also a deeper sense of connection (Todres et al., 2009). The exploration of societal norms within caregiving is a strategic endeavour to identify areas for improvement and innovation in care provision.

Examining gender norms, power dynamics, and instances of abjection help us navigate toward transformative care. By questioning established norms, we discover opportunities to redefine caregiving parameters, opening avenues for humanisation where care workers authentically engage with the unique needs and experiences of care recipients. Moments of abjection, as Kristeva articulates, are not only disruptive but also hold potential for transformation. Instances where societal norms clash with individual identities present opportunities to challenge and reshape the existing framework, fostering more personalised care practices. Moreover, an awareness of gendered power dynamics underscores the need to shift toward more equitable caregiving practices. Recognising power imbalances becomes an opportunity to cultivate a supportive work environment that values and empowers care workers, establishing a reciprocal and respectful relationship between care workers and care recipients. The call for "caring care" underscores the need to move beyond traditional norms and institutional roles, advocating for a more individualised, emotionally aware, and compassionate approach to care provision.

This study has offered a context-specific analysis of a particular care home, augmented by detailed case studies and the application of carefully selected theoretical frameworks. Together, these elements yield a transformative understanding of gender dynamics in caregiving within the care home setting, shedding light on all-too-often overlooked complexities. Moreover, this study highlights the potential of ethnographic research in care research, emphasising the symbiotic relationship between "caring care" and ethnographic methodology. Through its innovative approach, this study not only contributes valuable insights to academia but also offers practical implications for enhancing the quality of care provided to older adults in care homes. leveraging these insights allows us to actively shape caregiving practices that are more attuned to the diverse needs of individuals, ultimately paving the way for a more humanised and empathetic approach to the well-being of care recipients such as George.

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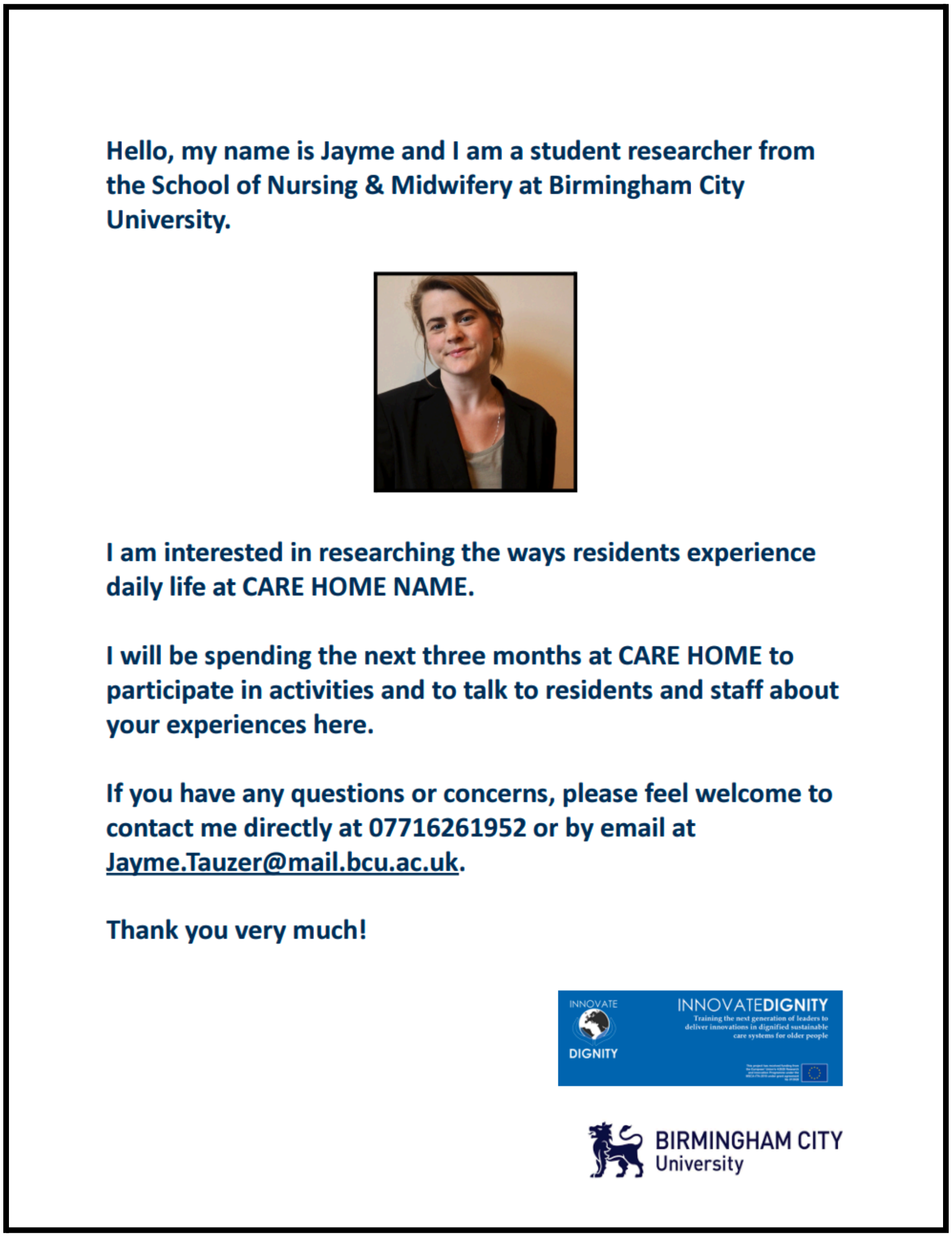
Appendices

Appendix 1- Recruitment Materials



Hello, my name is Jayme and I am a student researcher from the School of Nursing & Midwifery at Birmingham City University.

I am interested in researching the ways residents experience daily life at CARE HOME NAME.

I will be spending the next three months at CARE HOME to participate in activities and to talk to residents and staff about your experiences here.

If you have any questions or concerns, please feel welcome to contact me directly at 07716261952 or by email at Jayme.Tauzer@mail.bcu.ac.uk.

Thank you very much!

Participant Information Sheet

EXPERIENCES OF CARE IN A RESIDENTIAL SETTING

I am inviting you to join in a research study on experiences of care at CARE HOME NAME. Before deciding whether or not to participate, please have a read through the following information. Please contact researcher Jayme with any questions by phone at STUDY PHONE #, or by email Jayme.Tauzer@mail.bcu.ac.uk.

WHO I AM AND WHAT THIS STUDY IS ABOUT

I am a PhD researcher at the School of Nursing and Midwifery at Birmingham City University. I am interested in looking into the ways men and women experience dignity and well-being in this community. I will be spending a period of time at CARE HOME NAME to participate in activities and to talk to residents about their experiences here.

WHAT WILL TAKING PART INVOLVE?

I will live at CARE HOME NAME for 3 months, during which I will participate in some social events and interview participants. If you want to participate in this study, you will have some conversations and interviews with me during my stay at Belong. Interviews will not last longer than 30 minutes and I will ask for permission to record our discussion.

WHY HAVE YOU BEEN INVITED TO TAKE PART?

You are being asked to participate in this study because I want to understand your experiences living at CARE HOME NAME. Participation in this study is completely voluntary and will not impact your access to services or care.

WHAT ARE THE POSSIBLE RISKS AND BENEFITS OF TAKING PART?

There are no known risks to participation, and benefits include the chance to discuss your views and share your experiences which may help to improve care services for people in the future.

WILL TAKING PART BE CONFIDENTIAL?

Taking part will be confidential. I will not use any names in field notes, data analysis, or writing up of findings. I will not disclose the name or location of CARE HOME NAME. Furthermore, if you choose to withdraw from the study, your data will not be included from the study and any notes from interviews will be destroyed.

HOW WILL INFORMATION YOU PROVIDE BE RECORDED, STORED AND PROTECTED?

I will observe life at CARE HOME NAME and will interview some residents who wish to participate. I will also record data from conversations. Because the objective of this study is to center the perspectives of older adults and recipients of care, interviews may be recorded with your permission. In addition, and with your permission, quotes from interviews may be used in publications that result from this research project. Your data will be protected and any identifying information will be anonymised. If you chose to withdraw your data will not be included from the study and any notes from interviews will be destroyed. Encrypted, anonymized data will be held in a secure location for up to 3 years after research is completed. I will adhere to University and policy to hold and discard data. Electronic data will be removed from all files in line with guidance from the University IT department. Any physical data will be held in a locked and secure location on University premises for 3 years until the completion of analysis. Physical data will be destroyed and discarded using my University's confidential waste facilities.

WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?

I will publish results from this study in a dissertation through Birmingham City University. I may use direct quotes from our conversations and interviews, but these will be anonymous. I will not identify Belong as the location of this study. Electronic data from this study will be used in a pilot program to contribute encrypted, anonymised data to an open access data archive. I will adhere to EU requirements for the dissemination of data for the Marie Curie Skłodowska Action data initiative. Any data used for this pilot program will be anonymised.

WHO SHOULD YOU CONTACT FOR FURTHER INFORMATION?

Should you have any further concerns about this study, please feel free to contact study supervisor, Fiona Cowdell, at Fiona.Cowdell@bcu.ac.uk. You may also contact the Ethics board at Birmingham City University should you have any concerns about the ethics of this study: HEL_Ethics@mail.bcu.ac.uk.

Thank you,

Jayme Tauzer
PhD Researcher, School of Nursing & Midwifery
Birmingham City University
Seacole Building, City South Campus
Westbourne Rd, Birmingham B15 3TN

2 Articles

Tauzer J. Accessing a "bounded space": An ethnographic map of a residential care home for old persons during COVID-19. ageing Health Res. 2023 Jun;3(2):100141. doi: 10.1016/j.ahr.2023.100141. Epub 2023 Apr 5. PMID: 37038548; PMCID: PMC10076071. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10076071/

Tauzer J, Cowdell F, Nässén K. From ethical approval to an ethics of care: Considerations for the inclusion of older adults in ethnographic research from the perspective of a 'humanisation of care framework'. J ageing Stud. 2023 Sep;66:101162. doi: 10.1016/j.jageing.2023.101162. Epub 2023 Jul 30. PMID: 37704280.

https://pubmed.ncbi.nlm.nih.gov/37704280/

APPENDIX 3 Exhibition photos and invitation

INVITATION

Exhibition & opening reception

Når vi bliver gamle
When we get old

Opening reception: **Thursday 2nd of February 2023, 3pm**

Keynote speakers:

- Kathleen Galvin, Project Leader for INNOVATEDIGNITY, professor of Nursing Practice, University of Brighton, England
- Jørn Høgh Nielsen, Chairman Dane Age Kolding
- Representative of INNOVATEDIGNITYs PhD students

Participation is free, registration is required for catering reasons:
https://events.au.dk/whenwegetold/registration

The exhibition will take place from the 2nd of February to the 31st of March 2023

Danish museum of nursing history

Fjordvej 152, 6000 Kolding, Denmark

INNOVATEDIGNITY
Training the next generation of leaders to deliver innovations in dignified sustainable care systems for older people

Invitation to the exhibition When We Get Old in Kolding, Denmark 2023

Discussing my contribution to the exhibition “When We Get Old”. Kolding, DK 2023

Appendix 4 Participant Information Table

Participating Residents

Home # 1

Pseudonym, gender, age	**Capacity/Participation**
George, man, 89	Yes -Interview and Participant Observation (PO)
Julia, woman, 92	No - PO
Max, man, 67	Yes - Interview and PO
Lisa, woman, 83	No - PO
Susan, woman, 85	No - PO
Kelsey, woman, 88	No - PO
William, man, 87	No - PO
Sarah, woman, 81	No - PO
Lucas, man 76	NO-PO

Home # 2

Pseudonym	**Capacity/Participation**
Theresa, woman, late 60’s	No - PO
Silvia, woman, 102-years-old	No - PO
Matthew, man, 87	No - PO
Margaret, woman 78	No - PO
Diana, woman, 79	No -PO
Eileen, woman 82	No - PO

Ruby, woman, 92	No - PO
Carol, woman, 93	No - PO

Home # 3

Pseudonym	**Capacity/consent**
Orla, woman, 81	Y - interviews & PO
Emma, woman 98	N - PO
Krys, woman, 65	N - PO
Lynne, woman, 84	N - PO
Harry, man, 96	Y - PO & Interview
Suzie, woman, 82	No - PO
Mary, woman, 89	No - PO

Home # 4

Pseudonym	**Capacity/Consent**
Luna, woman, 85	N - PO
Joan, woman, 93	Y - Interview & PO
Monica, woman, 98	Did not consent to interviews, but yes to PO
Henry, man, 93	N - PO
Brian, man, 88	Y
Lucinda, woman 91	N

Participating Staff

Pseudonym

Karen, woman, late 40’s
Lucy, woman, early 20s
Linda, woman, mid-50’s
Larry, man, mid 20s
Kate, woman, early 40’s
Irene, woman, mid 50’s
Emma, woman, late 30’s
Judy, woman, mid 50’s

Hannah, woman, mid 20’s
Emma, woman, late 30’s
Kenny, man, mid 30’s

Marcus, man, mid 40’s
Katrin, woman, late 20’s
Frances, woman, early 30’s
Vivian, woman, early 50’s
Mary, woman, early 40’s
Becca, woman, early 40’s
Rachel, woman, early 40’s