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Ruptures of affiliation: social isolation in assisted living for older people

JARI PIRHONEN*, ELISA TIILIKAINEN† and ILKKA PIETILÄ*

ABSTRACT
Transfer from a private home to an assisted living facility has been pictured as a major change in an older person's life. Older people themselves tend to perceive the change as something eventual that breaks the bonds and familiarities of previous life. The aim of this article is to shed light on residents' chances to reach affiliation (as Nussbaum defines it) in their new living surroundings, and thus adjust to that social environment. Based on ethnographical data gathered in a Finnish sheltered home in 2013–14, we studied residents' affiliations through ruptures, namely residents' perceived social isolation. Social isolation was found to be connected with two separate social worlds: the one inside the facility and the one outside. Social isolation resulted from different factors connected to the quality of social interaction with co-residents and the staff, daily routines of the institution and residents' personal life histories. Also, residents' older friends seemed to avoid visiting care facilities which caused perceived social isolation. This article deepens the insights into the perceived social isolation of assisted living and thus helps care providers to create new strategies to enable due affiliation for their residents.

KEY WORDS – social isolation, affiliation, assisted living, older people, ethnography.

Introduction

Studies show that social isolation has demonstrable negative effects on health, wellbeing and quality of life for older people. Increased risk of mortality (Eng *et al.* 2002; Steptoe *et al.* 2013), heightened propensity for dementia (Fratiglioni, Paillard-Borg and Winblad 2004), an increased number of falls (Faulkner *et al.* 2003) and increased risk for depression (Cornwell and Waite 2009) have been found. These health issues add pressure to statutory health and social care services, and contribute to their costs

* Faculty of Social Sciences and Gerontology Research Center, University of Tampere, Finland.
† Department of Social Sciences and Business Studies, University of Eastern Finland, Kuopio, Finland.

(Devine *et al.* 2014). Much research has focused on social isolation experienced among community-dwellers (*e.g.* Nicholson 2012; Savikko 2008; Victor, Scambler and Bond 2009). However, it is known that social isolation is also present in residential care facilities (*e.g.* Brownie and Horstmanshof 2011; Drageset, Kirkevold and Espehaug 2011). Some studies have found social isolation to be more common among assisted living (AL) residents than among older people living alone (Pinquart and Sorensen 2001; Savikko *et al.* 2005), which has led to growing literature regarding the importance of social relationships in AL.

Transfer into an AL facility has generally been seen as a risk factor for ruptures in social engagement *per se* (Johnson 1996; Prieto-Flores *et al.* 2011; Street *et al.* 2007). Gubrium (1997) describes the transfer from the private home to a care facility as the process of 'breaking up a home', wherein people draw constant comparisons between their past and current lives. They are still attached to people, places, belongings and memorable events from the past, although they do understand that life cannot continue the same way it had earlier. Residents' contacts with friends, relatives and neighbours significantly decrease after transfer into a care facility (Port *et al.* 2001), and relationships become less intimate at the same time (Lindgren and Murphy 2002). Sinclair, Swan and Pearson (2007) have drawn attention to the 'separateness' of care homes, which can produce feelings of being 'cut off or remote' from society (Victor, Scambler and Bond 2009: 206–7).

In addition to lack of contacts outside, relationships with the staff may be task-oriented, with little support given to residents' psychological needs (Marquis 2002). Further, limited time resources and constant turnover of staff have been seen as preventing any real resident–staff bonding (Grenade and Boldy 2008). While some studies have portrayed connections with peers in a facility (Fessman and Lester 2000) or the role of people outside the facility (Burge and Street 2010) as very important to prevent social isolation, others have emphasised the role of the staff, especially when residents have significantly lost their functional abilities (Drageset 2004). Roos and Malan (2012) also found that older people with the capacity to establish meaningful relationships experienced the care facility as unsafe and lacking in care, which limited effective interpersonal relationships.

Perceived social isolation and affiliation

Social isolation is often regarded as an objective and quantifiable reflection of the paucity of one's social contacts and reduced size of the social network (*e.g.* Nicholson 2012; Steptoe *et al.* 2013); however, it can also be

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understood and addressed as a subjective experience. Robert Weiss (1973) has referred to social isolation as a lack of a sense of belonging or dissatisfaction towards one's social network. Victor, Scambler and Bond (2009) define social isolation as a lack of communion between individuals, and detachment from the socio-spatial context of daily life, highlighting the spatial elements of social isolation (*see also* Sinclair, Swan and Pearson 2007). On the other hand, Brownie and Horstmanshof (2011) picture loneliness in the context of residential care as an imbalance in one's actual and desired social worlds. When social isolation is seen as a sense of not belonging (Weiss 1973), a lack of communion (Victor, Scambler and Bond 2009), and loneliness in AL as an imbalance in one's actual and desired social worlds (Brownie and Horstmanshof 2011), we suggest that what we should be looking for in AL is *perceived social isolation*. The concept of perceived social isolation acknowledges its objective and subjective natures – it is an experience linked to one's situation and surroundings.

In this article, we explore perceived social isolation as ruptures of affiliation utilising Victor, Scambler and Bond's (2009) conceptualisation of social isolation and Nussbaum's (2007, 2011) concept of affiliation, which can be described as a two-dimensional capability. Firstly, affiliation entails 'being able to live with and toward others, to recognize and show concern for other human beings, to engage in various forms of social interaction, and to be able to imagine the situation of another' (Nussbaum 2011: 34). Since older people reside in AL full time, they should feel like members of a community, living 'with and towards' others. Secondly, affiliation is about 'having the social bases of self-respect and non-humiliation and being able to be treated as a dignified being whose worth is equal to that of others' (Nussbaum 2011: 34). This second precondition of affiliation presupposes that residents may keep the social basis of their self-respect while residing in a facility; namely their prior social connections remain despite the transfer to AL. We argue that affiliation is not something that people simply have or have not, but the sense of affiliation can vary, depending on the level and quality of social embeddedness both inside and outside the AL facility. Perceived social isolation thus reduces affiliation.

Based on ethnographical data, we explore older people's perceived social isolation, which is pictured as ruptures regarding affiliation. We aim to grasp the possibilities for and barriers against affiliation in a context where one is physically close to others, yet at risk of feeling separated from the everyday social environment as well as from the relationships formed before the transfer to AL. We ask how the experiences of social isolation are embedded in the social context and structure of the AL environment, and examine the opportunities of conceptualising and addressing perceived social isolation as ruptures in affiliation. The results offer important knowledge on the

diverse and socially constructed experiences of social isolation, which are needed before effective intervention policies and preventative strategies in AL can be developed.

Materials and methods

The data were collected within an ethnographic research frame by observing daily life and interviewing residents in a sheltered home in southern Finland in 2013–14. Sheltered housing is a form of AL in Finland, ideologically located somewhere between institutional and home care. Residents lived in private rooms for which they paid rent; food, care, medicine and safety service were charged separately. The rooms were furnished with residents' own belongings, and residents wore their own clothing. The goal was to provide as home-like a surrounding as possible. In addition to resident rooms, there were shared living rooms, balconies and a sauna available for the residents.

The research site consisted of two five-storey buildings, including ten group homes. Two of the group homes were run by a private enterprise. We studied the publicly run section where 114 residents lived in eight group homes. The doors of the group homes were always locked and opened with a five-number code to prevent cognitively disordered residents from wandering off on their own. Thus, the residents' social contacts were largely limited to people inside their own group home. The only common space for all the residents was a small room for group activities and physical exercise, yet they could go there only when escorted by the staff.

The majority (about 70 per cent) of the residents were women, yet in each group home there were men and women living together. The residents' ages ranged from 60 to one 100-plus, and their functional abilities varied considerably. Most had cognitive illnesses, such as different forms of dementia or Alzheimer's disease; some lived there for somatic reasons like multiple sclerosis or other chronic conditions. Therefore, their physical abilities varied from independently mobile to being bed-ridden, and their cognitive and therefore communicative capabilities also varied. Only a few of the 114 residents could go outside the home on their own.

The eight group homes were divided into three administrational units (two or three group homes per unit) run by a head nurse, and the staff circulated throughout the group homes of one unit. The staff were available at all times. Usually there were two practical nurses (per 15 residents) working both morning and evening shifts. In Finland, practical nurses locate professionally between registered nurses and nursing assistants. They complete a

three-year nursing programme and may, for example, hand out medicine and take care of wounds. In addition, there were several registered nurses, two physiotherapists and two leisure activity instructors working in the building. The latter organised group activities, such as pottering, and trips outside, such as visiting a marketplace nearby. Some nursing assistants helped with the kitchen work during meal times.

There were also some volunteer workers recruited by the local parish to keep residents company, take them outside and escort them outside the facility (*e.g.* when they went to a doctor located elsewhere). These volunteers usually came once a week or when they were called to escort someone. Residents' relatives and friends visited sporadically, and many residents had their own phones to keep in touch with them.

Participant observation was chosen as a research method to gain a deeper understanding of the research site (Geertz 1973; *see also* Diamond 1992; Gubrium 1997). It lasted two months and produced a total of 165 hours of observation by a single researcher (the first author). The observations were concentrated in one of the group homes, in which four men and 11 women lived. The researcher participated in daily living by talking to the residents and taking part in the recreational activities; he also participated in tasks available to volunteer workers, such as feeding people or moving them along with the staff. Short notes were written into a notebook during observations, and the lengthier descriptions were transcribed on a computer right after the observation sessions, employing a method called jotting (Emerson, Fretz and Shaw 1995).

Along with observation, ten thematic interviews were undertaken with the residents. The interviews lasted from 25 to 65 minutes and were transcribed verbatim. Thematic interviews (Fylan 2005) were conducted in order to give the interviewees a chance to describe their own experiences openly. The themes of the interviews were broad-based to allow for a study of the multiple phenomena related to life in AL. The themes were formed around residents' pasts, their perceptions of the sheltered home as a living environment, the care they received and the course of their everyday lives. Residents were allowed to include other topics as they wished, yet were guided by the chosen themes. Referring to Hughes (1992: 444), 'I [we] did not simply ask the questions; the questions were asked when they were appropriate and when there was something to ask about'. Although certain themes were discussed, all the interviews were unique since questions were asked based on the situation. Perceived social isolation was thus not a particularly accentuated topic in the interviews, but we found the issue to be present in all the interviews when analysing the data.

Since most of the residents in the more closely observed group home suffered from cognitive illnesses, the staff were asked to nominate ten possible

interviewees out of a total of 114 residents. The risk of this procedure was that the staff could have nominated people who have the most positive views of the facility in which they live. However, the personnel were perceived as the most qualified to decide who were cognitively capable of giving informed consent and participating in an interview. Alongside this process, the study was prepared and conducted using thorough ethical consideration, as good scientific practice demands (Hammersley and Atkinson 2007; Wilkinson 2002). Both the ethical committee of the local hospital district and the manager of our research site approved the research plan.

The staff were informed of the research in several staff meetings, and the researcher told every person about it when meeting them for the first time on-site. In addition, information notices written in plain language were placed on notice boards. Despite these arrangements, not all the residents understood that there was a research study going on due to their severe cognitive illnesses. However, there is precise understanding that cognitively incapable people have the right to participate in research intended to improve their situation when that research does not cause them any harm (Finlex 1999).

The data were analysed using directed content analysis (Hsieh and Shannon 2005), seeking excerpts that referred to experiences of social isolation as described in previous research (*e.g.* Victor, Scambler and Bond 2009). In the first phase of the analysis, the first author who conducted the field study searched the data for references to social isolation, which was perceived in AL in multiple forms. People rarely talked about it as such, but residents missed people, places and activities from their past. They also described the difficulties they had regarding bonding with other people in the facility. Observational notes lent positive support to residents' accounts and also revealed new nuances of social isolation caused, for example, by staff timetables or physical features of the facility. In the first phase of the analysis, excerpts referring to social isolation were gathered from the main data.

In the second phase of the analysis, the data excerpts were categorised on the basis of reasons for feeling socially isolated. The first and second authors coded the data and the third author participated in interpreting the findings. Triangulation (Thurmond 2001) was achieved by combining two forms of qualitative data by three researchers. Eventually, two distinct categories were apparent: social isolation appeared as difficulties in connecting with people inside the facility and as separateness from the social world outside AL. We realised that reading the data in the light of prior conceptualisations (*e.g.* Victor, Scambler and Bond 2009) had brought us to Nussbaum's (2007, 2011) definition of affiliation. In our Results section, we thus examine our findings in relation to two distinct social worlds: the

one inside the facility and the one outside. All the names in excerpts highlighting the results are pseudonyms. 'R' stands for the researcher in interview excerpts.

Results

Detachment inside the AL facility

According to Nussbaum's (2007, 2011) definition of affiliation, residents should be able to connect with other people on-site. In Finland, older people primarily enter the AL environment through the municipal authorities, who refer people to care facilities based on their needs and the spaces available. One can express a wish regarding the facility of choice, but in practice, people have to take the first vacancy to which they are appointed. This means that the person transferring to AL does not have an opportunity to choose his or her social surroundings, which eventually becomes his or her primary social world. The fact that residents cannot influence the composition of their primary social world sometimes results in feeling socially isolated.

One of the residents, Andy, felt out of place in his group home, where the majority of residents were female and much older than him. Just over a year before the interview, Andy had played up to five gigs per week in a dance band as a drummer. Then a somatic disease broke his health down quickly and considerably, and after a rather long stay in the hospital, he moved into the AL facility. Now Andy needed help in all his daily functions except for eating. During the interview, Andy referred to himself as a drummer, emphasising its importance in his social identity. Although Andy was 73, he described the other residents as *oldsters*, drawing a clear distinction between other residents and himself as a professional musician.

R: Well, so do you spend time anywhere else than in your room? Do you go to the common room to watch television?
Andy: Well I really can't; you know I'm a musician, so normal people's stuff just don't work, you know…
R: Okay.
Andy: It just doesn't work. They can't deal with my stuff.
R: Okay. So do you miss the company of other people in here?
Andy: Well I do miss someone to talk to, but there's no one on my wavelength here except for me – there's no one like that.
R: Okay. I get it.
Andy: So it's like talking to a wall. It's really different for musicians than for normal people. (Male, 73, moving only with assistance)

There were recreational activities available, but Andy was not interested in being in the company of co-residents, since the company did not meet his

requirements. Elsewhere in the interview, he stated that 'doing activities with damn bitches like that, bitches who are a hundred years old – there's nothing to talk about you know, and we have nothing in common, so I feel like a hairy troll, fuck it'. Thus, he had chosen to spend time alone in his room. Perhaps the other residents did not even know about his background and his passion for music.

Another resident, Henry, implied being very different from the other residents. Most of the people living in Henry's group home were cognitively disordered. Henry had asked the staff to keep his door locked to prevent co-residents from entering his room, in order to gain privacy. Furthermore, Henry indicated that he did not blame the other residents, since it was their illnesses that made them act inappropriately. Henry said that he sometimes helped the others, guiding them to their rooms and helping them get up from armchairs. However, he had only a few persons with whom he could really interact and engage.

R: Have you made friends with anyone? Nurses or other residents or…
Henry: Yeah, there are a couple of guys who still have their marbles left.
R: Yeah.
Henry: Some of them just stare out in space. Can't really connect with them.
R: You mean some guys have some kind of memory disorders?
Henry: Memory disorders.
R: Yeah, then it's kind of difficult to make contact.
Henry: No, it won't work. Even when we were in the sauna with a couple of these guys, you can't really have a decent conversation with them. (Male, 82, moving independently with a walker)

Other studies have provided evidence that Henry is not alone in his dilemma; the mix of high- and low-dependency residents within the same facility creates problems for both residents and staff (Roos and Malan 2012). However, when Henry was asked if people with dementia should not reside with cognitively capable people, he stated, 'Well, they have to live somewhere, and it is probably cheaper that they live with us'. By referring to costs, Henry meant that in homes aimed solely for people with dementia, the staffing ratio would have to be higher. Like we saw, he often helped the confused ones himself. Sarah also said that she encouraged other residents to socialise, and Tim mentioned that he often pushed wheelchairs for other residents when they were exercising outdoors as a group. Paula stated that she could plan leisure activities for others if the staff encouraged her. It seems that mixing high- and low-dependency residents produces unused potential to both ease the workload of the staff and to provide low-dependency residents with meaningful activities.

Andy, Henry and Ida pictured social interaction with other co-residents as problematic, but the heterogeneity of the fellow residents was also

appreciated. The fact that there were both men and women living in this same group home suited Sally since she preferred the company of men. Sarah told us how she had decided to have conversations and would keep talking to other residents during meals until they began to answer. Eva and Judith became friends after they moved into the home. In one group home, there was even a short romance between residents. Making significant, emotional bonds with their peers seemed difficult but not impossible for these AL residents.

In addition to co-residents, the staff also played an important role in the social world of the older people residing in AL, especially when relations outside were rare, and cognitively capable co-residents were few and far between. However, a close relationship with the staff was not self-evident, as Paula implied:

Paula: Certain people – nurses and others – are close, but then there are those who barely remember my name.
R: I get it. So all nurses don't know your name nor what your individual needs are?
Paula: No, and they don't want to know. Some of them are like that. (Female, 85, moving independently with a walker)

Sometimes the residents' personal characteristics kept the staff distant. Andy, who indicated that he preferred to avoid the company of 'damn bitches', spoke about his relationship with the staff. He said that the nurses did not really know who he was and rarely came to talk with him, and if they did, it was something 'work-related'. Andy was quite a straightforward person, which may be the reason why the staff avoided, or at least appeared to avoid, contact with him. Andy described that he sometimes had to wait until 4 or 5 pm for the staff to help him go for a smoke on the balcony. During the interview, it was just past lunch time, and he was still waiting for a nurse to help him with his morning routines. Toby highlighted the importance of interacting with the staff. He related positive events in the home to attention given by the nurses: 'It's nice to sit with the nurses and talk and laugh about things with them when they are not busy working'.

The staffing ratio at the research site met the national recommendations on paper, but in reality, both residents and staff found it too low. Almost all of the interviewees implied that there were too few hands and help available. One commented that there was enough aid for her, but not for those with severe disabilities. Only one interviewee said that she was able to get all the help that she needed. However, residents felt sympathy for the staff. Sarah stated that 'they [staff] rush all the time and get exhausted. They don't show it, but I learned to see it on their faces that they become tired'. Paula said

that she did not ask for an escort to get outside since she felt sorry for the overworked staff, who mentioned themselves that their resources covered only basic care.

Many of the residents were not able to get out of bed independently, so the minimal staffing ratio resulted in being helped out of bed only once a day, usually for lunch. This meant that these residents stayed alone in their room for most of the day. Furthermore, as the staff members had stated, their time was directed towards basic care. Many said that they were sorry about this policy because they would have preferred to spend more personal time with residents. The maxim of keeping the staffing ratio to a minimum came from the economics of staffing, but it had negative influences on the wellbeing of both the residents and the staff. At our research site, residents had fewer social contacts and the staff felt moral distress when they felt they could not perform their work as well as they wanted (*cf.* Corley 2002). Some other procedures, such as serving supper in residential rooms instead of eating together in the dining room, lessened social contacts as well.

According to previous research (Roos and Malan 2002), AL residents are not exposed enough to activities that could facilitate the establishment of interpersonal relationships. In our research site, there were common activities for residents available only when there were outsiders (like an activity instructor or physiotherapist) in the home. In addition, Paula told us she missed the daily chores in her private home, stating that 'one does not cook or fry in here'. Laura also once wondered why there was not work available for her in the home. It seemed that providing residents with opportunities to take part in daily chores would have been an efficient way to involve residents in social interaction. In addition to participation in daily chores, prior research has emphasised the importance of giving the residents a voice regarding how residential settings should be organised and managed (Abbott, Fisk and Forward 2000).

Separateness from the social world outside AL

Nussbaum's (2011: 34) second precondition for affiliation was about 'having the social bases of self-respect and non-humiliation and being able to be treated as a dignified being whose worth is equal to that of others'. As we pointed out in the introduction, transfer to a care facility is often perceived as a rupture in social engagement *per se* (Gubrium 1997; Johnson 1996; Prieto-Flores *et al.* 2011; Street *et al.* 2007). According to previous research (Gubrium 1997) and observations made in this study, relatives and friends visiting the facility have a significant impact on the social embeddedness of older people living in AL. Visitors improved the residents'

status in the eyes of other people living there, which became evident during interviews like Ira's. After the researcher had shut off the recorder, Ira said, 'You did not ask the most important question – do your relatives visit you often?' The researcher turned the recorder on again and asked her that question; Ira proudly stated that her daughter had visited just last week and was coming again in the current week; her son visited with his family and even her son's parents-in-law visited sometimes. It was important for her to feel that she was still part of the family while residing in AL.

Our results lend support to the prior understanding (Zimmerman *et al.* 2005) that older people avoid becoming a burden to other people, especially their close family members. Ida had a cell phone to call her son. She had lived in the home for eight months, but had never called, although she obviously missed her son, stating that 'I only have one son and he's got his own family and they've got their own lives, so I'm really lonely'. She understood her son's situation with his own family and did not seek his attention for herself. It appears that Ida chose the experience of social isolation over the risk of becoming a burden to her son.

Toby indicated that he was happy with the relationships inside the group home, but missed the company of his own sons:

Toby: I would like my sons to visit me more often. Both of them could come here more often.
R: I get it. You miss your sons.
Toby: Yes (moved).
R: Have you told them this?
Toby: I have told them. In an e-mail. But they are both so bitter about their childhood years, when I was drinking a lot. I never raised a hand against my children nor my wife, but I had a foul mouth. That's why they are hurt, still, even if it was such a long time ago, they are still hurt, so… (Male, 60, moving independently with walker)

Toby and his wife were divorced, and the relationship with his two sons became problematic. The older son visited him rarely, and the younger had broken ties with him altogether because of Toby's prior drinking problem. Toby was a 'young man' (60) who was already living in a sheltered home, as his rough life had taken its toll, hampering his abilities to function insomuch that he needed round-the-clock attention. However, Toby did not feel isolated all the time. He was connected to the world outside via his laptop and internet connection, and he talked on the phone with some of his friends. He also explained how he talked and joked with the staff when they had time, and he also said that there was one resident he spent time with. Toby perceived social isolation in relation to his children.

One plausible means of reducing residents' feelings of social isolation today is communication technologies (Choi, Kung and Jung 2012). Most

of our interviewees had cellular phones. However, having a phone is not a solution *per se*, but one needs the ability to use the phone, people to call and a working telephone network. Residents had problems regarding phone calls that were related to the building itself. Like many buildings in Finland today, the house was insulated so well that wireless networks did not necessarily function well. The building itself also had another flaw, which made it sometimes difficult to enter from outside, as the next excerpt shows.

> When I arrived, the front door was locked and there was an angry woman, some resident's relative, standing at the door. It was raining and she could not get inside. She had already pressed all the buzzers outside, but nobody had answered her. She said that it had always been the same kind of hell with this building. (A note from observation diary)

This note was written on Christmas Eve, when there are more visitors in AL facilities than usual, since many people have their holidays, and visiting people in institutions at Christmas time is a tradition. The front door had an electrical lock, which meant that it automatically opened in the mornings and locked in the evenings. For some reason, it was locked all day during midweek holidays, and visitors had to press a buzzer connected to a group home to get the door opened. The buzzer sounded in the staff's office, which was usually empty since the staff were working around the group home. Many times people had to press all the buzzers to get contact with people inside. It often took time, and people got frustrated. The situation is still the same today, although many visitors have made complaints about the door to the management.

Most of the residents were visited by family, such as children, but for many, contact with friends had decreased or even ended when moving to the facility. 'I used to have friends when I was home, but none of them have been over to visit me, even though my daughter asked them to come', Ira described. Sarah also indicated that her husband had encouraged their common friends to visit her, yet nobody had come. One staff member had a clear idea about why residents' friends and relatives do not necessarily come to the facility, stating that older people who are still living in private homes find care facilities frightening and avoid visiting them.

Discussion

In this article, we studied AL residents' chances for affiliation through experiences of perceived social isolation. According to our findings, social isolation (Victor, Scambler and Bond 2009; Weiss 1973) was mainly perceived in connection to two different social worlds. Our results suggest

that, on the one hand, perceived social isolation in AL seemed to arise from difficulties in reaching other people on-site. Prior research has emphasised the importance of co-residents regarding the older people's overall well-being in AL (Street and Burge 2012; Street *et al.* 2007). Yet, our interviewees had only a few close relationships with other residents due to feelings of otherness in relation to co-residents. Our findings lend support to indications (Roos and Malan 2012) that the mix of high- and low-dependency residents within the same facility is an issue for the latter. The less-dependent residents had a dilemma regarding their actual and desired social surroundings. Andy and Ida solved this by staying alone in their room, while Henry took a helping role in the facility.

Prior research has emphasised the importance of sufficient mental stimulation in old age to postpone mental impairment (*e.g.* James *et al.* 2011). Our cognitively fit interviewees seemed to avoid common leisure activities. Andy, Henry, Toby, Sarah and Ida explicitly stated they did not wish to participate. Toby said that common activities were aimed for 'the older people', and Paula said she would be happy to organise something herself. Paradoxically, the available activities seemed to isolate the cognitively fit residents. Based on our results, cognitively fit residents should be provided with activities of their own, and their willingness to help others could be better utilised to affirm their affiliation in AL.

There has been a vivid public discussion in Finland about the neglect of older people residing in care facilities ever since a survey was published which indicated that 93 per cent of nursing staff admitted to having witnessed resident neglect in their workplaces (Valvira 2016). Some parties, such as trade unions for nursing staff, claim that the phenomenon strictly rests on resources. Some others, such as many of the residents' relatives, consider that there are problems regarding the nursing staff's attitudes towards their work and towards older people. Based on our results, both parties have a point. Both residents and staff considered the staffing ratio too low in terms of residents' needs. However, our interviewees stated that there were also problems with the attitudes of some members of staff. The dispute between resources and attitudes is not a matter of black and white. Based on prior research, we know that good management and opportunities for staff to design their own work may compensate for low resources in care facilities regarding residents' quality of life (Räsänen 2011; Shepherd *et al.* 1996). On the other hand, all the resources in the world make no difference if a resident feels that people surrounding him or her pay no interest.

In addition to relationships inside the facility, social isolation was felt in relation to the social world outside. Interviewees missed the company of old friends, as well as contact with family members. Pirhonen *et al.* (2016)

found that Finnish community-dwelling nonagenarians feared their own transfer into a nursing institution, sometimes even more than dying. Thus, negative representations may isolate residents from their previous friends and same-age peers who are still community-dwellers. Gilleard and Higgs (2010) even argue that public failure in self-management and transfer to a care facility alienate older people from the rest of society. Also, AL residents do not live up to expectations set by the paradigm of successful ageing (Baltes and Carstensen 1996; Rowe and Kahn 1997), which may isolate them socially and culturally. However, social ties outside the home are of high importance. As we reported in another study (Pirhonen and Pietilä 2016*a*), residents even based their feelings of autonomy partly on outside people, who took them out of the home and brought them items and goods they needed. They also supported their own agency by transferring it voluntarily to their friends and relatives (Pirhonen and Pietilä 2016*b*), and people outside the home also affirmed residents' continuity of self (Pirhonen and Pietilä 2015). All this emphasises the importance of making AL facilities as accessible as possible regarding outside society.

In our research site, residents had problems keeping in touch with people outside the home due to problems with audibility of cellular phones. The electrical front door also posed challenges for friends and family trying to visit the residents, since it was closed during the holidays and the doorbell did not always reach the staff. Communication and other technologies have been pictured as one possible solution to reduce social isolation and loneliness of the elderly in the future (*e.g.* Sharkey and Sharkey 2012). Video calls and other telepresence systems are being developed in Finland (Kelo and Haho 2016). In addition to ethical dilemmas regarding technology in care (*e.g.* Zwijsen, Niemeijer and Hertogh 2011), there seem to be problems with the basic technology, which should be overcome first.

There are conflicting results in the previous research regarding the importance of residents' social relationships. Sometimes, relationships that are formed before one transfers into a facility have been pictured as being more important to the residents' wellbeing (Burge and Street 2010), and other times, relations inside the facility have been more emphasised (Fessman and Lester 2000). Our study obviously highlights the importance of both kinds of relationships for positive affiliation with AL surroundings. For example, Toby seemed quite happy with his relationships inside the facility, but missing his sons made him feel isolated. Henry's friends and his daughter visited him a lot, but being less dependent than other residents in the facility increased his social isolation. Andy was one of the worst in terms of isolation; he felt socially isolated from the other residents and he had no connections to his prior musical circles outside AL, which he seemed to miss a lot. Affiliation in AL seems to be a twofold

capability as Nussbaum (2007, 2011) stipulated; one has to feel connected to both people inside and to life outside the facility to reach due affiliation.

Since we studied life in a single AL facility, we cannot suggest that our results are generalised as such. AL includes a wide range of facilities that are operating according to different policies and principles. However, an ethnographic study is not basically designed to provide facts, but to deepen understanding about the daily life of its research subjects (Gubrium 1995), thus revealing a variety of people's interpretations and perceptions regarding the phenomenon being studied. The reasons behind social isolation, which we found in our research site, may be tracked as well in other facilities that are providing round-the-clock care for older people. Thus, our results can be generalised theoretically. Care providers may utilise our results to detect and then to ease social isolation in their own facilities.

The biggest drawback regarding this study is the absence of people with dementia, although dementia is a significant cause of institutionalisation in Finland as well as in other countries (Aaltonen *et al.* 2012; Agüero-Torres *et al.* 2002). We involved ten residents capable of giving informed consent and an interview, which ruled out experiences of people with dementia. Our observational data contained some information on affiliation of these particular people. Sometimes a lack of cognitive competence seemed to cause conflicts between residents, sometimes it seemed to cause unsociability and sometimes people with dementia made friends inside the home. According to Linda Clare (2002), people with dementia in AL may be studied when there are observations and interviews of both residents and staff. Tom Kitwood (1997) holds that even people with severe dementia can express themselves meaningfully in words. However, the study on their affiliation remains to be done in the future.

Our focus on constraints of affiliation in terms of residents experiencing social isolation may make life in AL seem all doom and gloom. This is not our intention. Drawing from ethno-methodological tradition (Heritage 1984), it is plausible to study social order by observing disturbances regarding it. Residents' chances for affiliation may thus be studied by concentrating on issues rupturing it. Another justification for the approach comes from philosopher Avishai Margalit (1998: 4), who considers that there is a weighty asymmetry between eradicating evil and promoting good. It is much more urgent to remove painful evils than to create enjoyable benefits. This justifies concentrating on perceived social isolation to find ways to diminish the 'evil'. Margalit's idea could perhaps function as a maxim regarding the development of AL: it is more urgent to remove suffering than to promote enjoyment, especially since removing flaws (like structures furthering social isolation) promotes good (like affiliation) as such.

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Address for correspondence:
Jari Pirhonen,
Faculty of Social Sciences and Gerontology Research Center,
33014 University of Tampere,
Finland

E-mail: jari.pirhonen@staff.uta.fi