Tampere University

KATARIINA TUOMINEN

Making Space for Social Relationships

Understanding ageing in social spaces

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Making Space for Social Relationships

Understanding ageing in social spaces

ACADEMIC DISSERTATION
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What a journey it has been conducting this research. Along with the usual challenges of financial insecurity and changing plans, encountered by many during postgraduate studies, this research has been framed by a pandemic that shook the whole world to the core and significantly affected both work life and leisure. In addition, not long after life had somewhat steadied after the pandemic, the world faced another terrible shock: the outbreak of war in Ukraine. During these times, my research has not felt like the most important thing in life. Rather, these events have emphasised the importance of family, friends and colleagues who help one cope with everyday life during such devastating events. Furthermore, these events have emphasised the importance of caring and compassion the humanity should have more than the prejudice, ill will and divide we too often see. As shown by this study, and many others, we need each other to cope and feel well. Let us embrace that.

There are many people I want to thank for making this journey possible and easier to take. First, I was lucky enough to have three wonderful supervisors to support me in this process. Jari Pirhonen had already supervised my master's thesis, and he had convinced me of my potential to succeed in doctoral studies. I am truly grateful for the encouragement, support, advice and kindness Jari has provided me with from the very beginning until the end of this process. I believe every student should have a role model like Jari in their life to guide them and help them realise their potential. Thank you, Jari, for everything. Jari also introduced me to Ilkka Pietilä, and I am very happy he did. I have often been amazed by Ilkka's ability to connect complicated ideas, concepts and theories in such insightful ways. This research has benefited tremendously from Ilkka's brilliant ideas, way of thinking and tireless demand for me to do some 'gymnastics' with the research manuscripts that always resulted in a better version of the study. Thank you, Ilkka. Kirsi Lumme-Sandt came along a little later, when both Ilkka and Jari had moved to the University of Helsinki and I was in need of a third supervisor. Kirsi was a perfect match, with fresh perspectives and a can-do attitude. Kirsi's wide-ranging knowledge of gerontology and qualitative methodology and the ability to comprehend the bigger picture, which was often difficult for me, was vital in finalising this research. Kirsi has also been the best

Custos one could ask for, helping me with every practical task, answering every question I had about the final steps and kindly supporting me in preparing for the defence. Thank you so much, Kirsi.

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in the Century-Long Lives profiling area. I am very grateful to have the opportunity to continue working as a postdoctoral researcher on such interesting topics.

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Tampere, 8 November 2023
Katariina Tuominen

ABSTRACT

Social relationships play a vital part in enabling a good life in old age. The meanings of social relationships and the opportunities and restrictions associated with them are connected to the contexts within which older persons live. This study explores social relationships and spaces and places of ageing, utilising the concept of social space. In this study, social space is understood as referring to everyday spaces that have meaning for older people and in which social relationships and social activities occur, such as the home or an assisted living facility. These spaces, for their part, are affected by broader societal contexts. Of these contexts, this study considers ageing in place policy and the COVID-19 pandemic. Within these societal, spatial and temporal contexts, this study focuses on the opportunities and challenges that social spaces generate for social relationships and interaction in old age.

The data originated from the *Vitality 90+ Study* and *Ageing and Social Well-being (SoWell)* research projects conducted at Tampere University, Finland. The data utilised in this study consisted of interviews with home-dwelling nonagenarians (n=45), a group discussion (n=7) and individual face-to-face interviews (n=10) with residents of an assisted living facility, and phone interviews (n=31) conducted during the COVID-19 pandemic with older people living in an assisted living facility or at home. The age of the participants ranged between 64 and 101 years. In addition, field notes regarding participant observation (35 hours) conducted in an assisted living facility were utilised. All the data were collected in the Pirkanmaa region in southern Finland. The data were analysed using qualitative content analysis, frame analysis and positioning analysis.

The results indicated that social spaces enable and restrict social relationships and the interaction of older people. The home was a central space of social connectedness for older people, enabling, together with its surroundings, social contact and receiving help and support. However, the home was also a restricted and lonely space. An assisted living facility was also understood to be an older person's home, but at the same time it was a multifaceted social space that included institutional and communal characteristics that enabled various kinds of social relationships and interaction. It was not self-evident that older people could move around in public space. This was because of declining functional abilities but also

because of the regulation of space and the acceptability of older people's presence in public space caused by the COVID-19 pandemic. Virtual spaces provided the means to stay connected to other people, especially for those who found that moving outside the home was difficult. However, virtual spaces were viewed concurrently as excluding older people and insufficient for fulfilling their social needs. Memories also worked as a social space an older person could visit. Similarly to the virtual space, memories could exceed the boundaries of physical space, enabling feelings of social connectedness without leaving one's own home.

Different experiences and interpretations of social spaces and the opportunities they provide for social relationships and interaction indicate that social spaces play a central role in generating well-being in old age. The detected centrality of the home in the social life of older people in this study is a reason to critically consider ageing in place policy in which the meaning of the physical needs of older people and the physical space of the home are prioritised over social needs. The restrictiveness of spaces, which the pandemic emphasised, also reveals vulnerabilities in the spaces of ageing, such as loneliness and exclusion. Ignoring these vulnerabilities leaves older people in a disadvantaged position. The study of social relationships in old age can benefit from widening the spatial and temporal perspective from physical spaces to virtual and imaginary spaces. Nevertheless, it is important to listen to older people's own views of the best ways to meet their social needs. This study contributes to evaluating and developing policies and practices affecting places of ageing as well as social participation and connectedness in old age.

Keywords: social space, place, older people, social relationships, social interaction, home, assisted living

TIIVISTELMÄ

Sosiaaliset suhteet ovat keskeinen osa hyvää vanhuutta. Sosiaalisten suhteiden merkitykset ja niihin liittyvät mahdollisuudet ja rajoitteet kytkeytyvät niihin konteksteihin, joiden puitteissa ikäihminen elää elämäänsä. Tässä tutkimuksessa tarkastellaan sosiaalisia suhteita ja ikääntymisen tiloja ja paikkoja sosiaalisen tilan käsitteen näkökulmasta. Sosiaalinen tila ymmärretään sellaisina ikäihmisille merkityksellisinä arkielämän tiloina, kuten koti ja palvelutalo, joissa toteutuu sosiaalisia suhteita ja aktiviteetteja. Näihin tiloihin puolestaan vaikuttavat laajemmat yhteiskunnalliset kontekstit, joista tässä tutkimuksessa tarkastellaan paikoillaan vanhenemisen politiikkaa ja COVID-19-pandemiaa. Näiden yhteiskunnalliseen tilanteeseen, tilaan ja aikaan sidottujen kontekstien puitteissa kiinnostuksen kohteena ovat sosiaalisten tilojen tuottamat mahdollisuudet ja haasteet ikääntyneiden ihmisten sosiaalisille suhteille ja vuorovaikutukselle.

Tutkimuksen aineisto koostui kotona asuvien vanhoista vanhimpien ihmisten haastatteluista (n=45), palvelutalossa asuvien ikäihmisten kanssa toteutetuista ryhmäkeskustelusta (n=7) ja yksilöhaastatteluista (n=10) sekä koronapandemia-aikana toteutetuista puhelinhaastatteluista kotona ja palvelutalossa asuvien ikäihmisten kanssa (n=31). Lisäksi tutkimuksessa hyödynnettiin osallistuvaa havainnointia palvelutalossa (35 tuntia). Osallistujat olivat iältään 64–101-vuotiaita. Kaikki aineistot on kerätty Pirkanmaalla Suomessa. Aineistot analysoitiin hyödyntäen laadullista sisällönanalyysia, kehysanalyysia ja asemointianalyysia.

Tutkimuksen tulokset osoittivat, että sosiaaliset tilat mahdollistavat ja rajoittavat ikäihmisten sosiaalisia suhteita ja vuorovaikutusta. Keskeinen sosiaalinen tila ikäihmisille oli koti, joka yhdessä sen lähialueen kanssa mahdollisti sosiaalisia kontakteja sekä avun ja tuen saamisen. Koti voi kuitenkin olla myös rajoitettu ja yksinäinen tila. Myös palvelutalo voitiin ymmärtää ikäihmisen kotina, mutta se oli samanaikaisesti myös monitahoinen, laitosmaisia ja yhteisöllisiä piirteitä sisältävä sosiaalinen tila, joka mahdollisti erilaisia sosiaalisia suhteita ja vuorovaikutusta. Kodin ulkopuolella, julkisissa tiloissa, liikkuminen ei ollut itsestäänselvyys ikäihmisille. Syynä tähän oli heikentynyt toimintakyky, mutta myös koronapandemian mukanaan tuoma tilojen sääntely sekä tiloissa liikkumisen hyväksyttävyyden kyseenalaistuminen. Erityisesti niille, joille kodin ulkopuolella liikkuminen oli

hankalaa, virtuaaliset tilat tarjosivat keinon pitää yhteyttä toisiin ihmisiin. Virtuaaliset tilat voitiin kuitenkin samanaikaisesti kokea ulossulkevina ja riittämättöminä tyydyttämään ihmisen sosiaaliset tarpeet. Myös muistot voidaan ymmärtää sosiaalisena tilana, jossa ikäihminen voi vierailla. Samoin kuin virtuaaliset tilat, muistot ylittävät fyysisen tilan rajat mahdollistaen sosiaalisen yhteisyyden tunteita ilman tarvetta poistua kotoa.

Sosiaalisiin tiloihin liittyvät erilaiset kokemukset ja tulkinnat sekä niiden tarjoamat mahdollisuudet sosiaalisille suhteille osoittavat, että sosiaalisilla tiloilla on keskeinen merkitys hyvinvoinnin tuottamisessa ikääntyneille. Kodin merkityksen keskeisyys ikäihmisten sosiaalisen elämän näkökulmasta antaa aihetta tarkastella kriittisesti paikoillaan vanhenemisen politiikkaa, jossa ikäihmisten sosiaalisten tarpeiden näkökulma näyttää jäävän fyysisten tarpeiden sekä kodin fyysisen ympäristön korostamisen jalkoihin. Havaittu tilojen rajoittavuus, jota koronapandemia erityisesti korosti, taas osoittaa ikääntymisen paikkojen haavoittuvuuksia, kuten yksinäisyyttä ja ulossulkemista, joiden huomiotta jättäminen asettaa ikääntyneet heikompaan asemaan. Ikäihmisten sosiaalisten suhteiden tutkimus voi hyötyä laajemmasta ajan ja paikan lähestymistavasta, jossa tarkastelun kohteena eivät ole vain fyysiset tilat ja niihin kytkeytyvät sosiaaliset suhteet, vaan myös virtuaaliset ja ihmisen mielikuvituksessa esiintyvät tilat ja suhteet. Tästä huolimatta tärkeää on kuunnella ikäihmisten omia näkemyksiä parhaista tavoista täyttää heidän sosiaaliset tarpeensa. Tutkimuksen tuloksia voidaan hyödyntää paikkoihin sekä ikääntyneiden ihmisten sosiaalisen osallistumiseen ja yhteenkuuluvuuteen vaikuttavien politiikojen arvioinnissa ja kehittämisessä.

Avainsanat: sosiaalinen tila, paikka, ikäihmiset, ikääntyneet, sosiaaliset suhteet, vuorovaikutus, koti, palvelutalo

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ABBREVIATIONS

COVID-19	Coronavirus disease 2019
ICTs	Information and communications technologies
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2
SoWell	Ageing and Social Well-being research project
WHO	World Health Organization

ORIGINAL PUBLICATIONS

Publication I Tuominen, K. & Pirhonen J. (2019). "Who would take a 90-year-old?" Community-dwelling nonagenarians' perceptions of social relationships. *International Journal of Ageing and Later Life*, *13*(1), 111-137. https://doi.org/10.3384/ijal.1652-8670.18387

Publication II Tuominen, K., Pietilä, I., Jylhä, M. & Pirhonen, J. (2022). A home, an institution and a community? – Frames of social relationships and interaction in assisted living. *International Journal of Ageing and Later Life*, *16*(1), 49–73. https://doi.org/10.3384/ijal.1652-8670.3540

Publication III Tuominen, K., Pirhonen, J., Lumme-Sandt, K., Ahosola, P. & Pietilä, I. (2023). No place to go? Older people reconsidering the meaning of social spaces in the context of the COVID-19 pandemic. *Journal of Aging Studies, 67, Article 101167*. https://doi.org/10.1016/j.jaging.2023.101167

1 INTRODUCTION

Social relationships are a significant part of human life. This notion is almost self-evident for us since we witness it regularly in our day-to-day lives. When people are asked 'what is important in your life?' or 'what influences your well-being?', they rank family and friends at the top of the list (European Commission, 2007, 2011). However, when we talk about older people, we often focus on the absence of social relations, that is, on loneliness and social isolation, rather than on the existence of social relationships. In the media, there are often stories about loneliness in old age rather than of older people having and enjoying a social life. Much of the research on ageing has also focused on loneliness and social isolation. At gerontological conferences, for example, there often are many sessions about the lack of social relationships in old age, that is, loneliness, but only a few focus on social relationships in old age *per se* (Tuominen, 2019).

These observations have guided me towards looking at the other side of social relationships: the side where social life in old age is not reduced to the (potential) lack of social connections, but where there are opportunities alongside challenges. One question guiding my research has been: what is social life in old age like, leaving aside the question of loneliness? I am certainly not the first researcher to ponder this question. Social relationships and their meaning in old age have been of interest for a long time to researchers in various fields of study, including gerontology (Antonucci et al., 2014). What are social relationships in older age like, how are they structured and what kinds of functions do they have in an older person's life? How do older people perceive social relationships and how do social relations affect health and well-being in old age? These are some of the questions that gerontologists and other researchers interested in social relationships have posed, resulting in a vast amount of knowledge about social relations in old age being produced.

The driving force behind the study of social relationships in old age is the understanding that social relationships play a vital part in enabling a good life in old age. Classic social gerontological theories were already being used in the 1950s and '60s to argue that social relationships contribute to ageing well. However, their ideas about how this is done are contradictory. The disengagement theory (Cumming &

Henry, 1961) argues that withdrawal from social relationships and social roles is not only inevitable in old age but also beneficial for the older person's well-being and for society. Activity and continuity theories (Atchley, 1989; Havighurst & Albrecht, 1953), in contrast, emphasise the importance of remaining socially active and holding on to social relationships and roles in old age as the means to ageing well. The more modern theories of successful ageing (e.g. Rowe & Kahn, 1997) also emphasise that social relationships need to be considered one of the aspects of a good life in old age. Empirical research has shown that social relationships are indeed important for the health and well-being of older people. This has been shown in larger population studies (see, for example, Bath & Deeg, 2005) as well as articulated by older people themselves in research aiming at understanding their viewpoints and experiences (e.g. van Leeuwen et al., 2019).

Gerontology scholars, especially those working in the fields of environmental and geographical gerontology, have reminded us of the importance of spaces and places in old age (see, for example, Andrews & Phillips, 2005a; Rowles & Bernard, 2012a). They have emphasised that ageing does not occur independently of the contexts in which individuals grow old. That is, spaces and places affect older people and the experiences of ageing in fundamental ways. Spaces and places are not only physical and material, but also social. Wahl and Lang (2004) emphasise that physical and social environments should not be viewed as separate entities but as intertwined and thus affecting one another. Spaces and places, on the one hand, form the physical boundaries in which human life occurs, but on the other, they are also used by individuals who give them, as well as objects and social relationships within them, meanings (Wahl, 2017). In this study, the interest is in such intertwinement of spaces as both physical and social. The concept of *social space* is used to refer to everyday spaces, such as the home, an assisted living facility and public spaces, which have meanings for older people and act as sites for social relationships and activities.

Ageing and spaces and places of ageing are affected by the societal context. Where should older people live? What kinds of places are the best ones for them? What kinds of places, on the other hand, are completely unsuitable for people of a particular age? The answers to such questions are formed within cultural and political contexts. In this study, ageing in place policy and the COVID-19 pandemic are considered as policy contexts that affect spaces and places of ageing. Ageing in place is a prevalent policy framework in Western countries; it prioritises home and home-like places as the best places to grow old in (Kröger & Bagnato, 2017). The policy aims to enable independent living at home, which is preferred by older people themselves, but this policy has made it difficult for older people to receive the care

and support they need because it simultaneously aims to save money while implementing this goal. Such an emphasis on the home raises questions concerning what exactly a home is and what makes the home the best place to age in. Can a care facility be a home? Is the home the best option in every situation? What kinds of assumptions lie behind the idealisation of the home?

The COVID-19 pandemic was a major disruption to everyday life as we used to know it. Different restrictions were imposed on mobility, working, education, commerce, leisure and social contact to prevent the spread of the virus, and they affected the lives of people of all ages. Because it was soon discovered that the virus is the most dangerous for older people (Singhal et al., 2021), various measures (stay-at-home orders and visiting bans for care facilities) were implemented to protect them especially from contracting the disease (Ministry of Social Affairs and Health, 2020b). As a by-product of this protection, older cohorts were depicted as a homogeneous, vulnerable group, giving rise to ageist views about older people and their lives (e.g. Ayalon, 2020; Fraser et al., 2020). The home became the place where older people were considered to be safe, as long no-one visited. Public spaces, on the other hand, were closed altogether, or visiting them was not recommended for older people. Technology was suggested as a substitute for physical social contact between family members and the older person. Such significant measures to regulate everyday life and social contact between people call for consideration of older people's views of the situation and their own position within it. Continuing from the questions raised by the ageing in place policy, one could ask the following questions: what are suitable and acceptable places for older people? Is the home a good place to age in, even in isolation form others? One might also ask whether the pandemic changed everything in the lives of older people, or only revealed something that was already there.

Within these societal, spatial and temporal contexts, this study aims to explore the opportunities that social spaces generate for social relationships and interaction in old age. The starting point of this study was listening to and observing older people and their everyday lives to try to understand their social lives. In the three individual articles that form the basis of this study, I have explored the perceptions of the oldest old persons of their social relationships, taken a look at how social relationships and interaction are being interpreted and made sense of in an assisted living facility, and studied how older people position themselves amidst the COVID-19 pandemic. A synthesis of these investigations is formed in this integrative work in which the social life in old age is looked at through the lens of social space. By doing this, the study contributes to creating a multifaceted understanding of the

opportunities and challenges that spaces and places provide for social relationships and interaction in old age. Such knowledge is important when evaluating and developing policies and practices that affect places of ageing as well as social participation and opportunities for social connectedness in old age.

This doctoral thesis is composed of three articles and an integrative chapter. I will start this integrative chapter by taking a closer look at social relationships in old age in Chapter 2. I discuss the meaning of social relations in old age, drawing from empirical research as well as theories of ageing and social relations in old age. Chapter 3 places ageing and ageing individuals in the broader conceptual and societal frameworks of the study. How the concepts of space and place are understood in gerontological research, the ageing in place policy and the COVID-19 pandemic as the societal context of the study are discussed. In Chapter 4, I integrate topics discussed in the previous chapters by discussing the interconnections between social relations and spaces and places. I introduce the concept of social space and define some important places of ageing that are relevant in this study. Chapter 5 introduces the aims and research questions of the study and elaborates the path that led to creating the synthesis in this integrative work that is based on the individual articles. The synthesis of the results can be found in Chapter 7. Before turning to the results, however, the data and methods used in the study and ethical considerations are presented in Chapter 6. The last two chapters, Chapter 8 and Chapter 9, discuss and summarise the main contributions and limitations of this study as well as the future research directions.

2 SOCIAL RELATIONS AND AGEING

In the multidisciplinary field of ageing research, social relationships have been approached from a multitude of perspectives. Here, I have structured the vast literature by dividing different perspectives into three distinct, but also overlapping approaches: *social networks*, *health and well-being effects of social relations* and *perceptions, experiences and meanings of social relationships*. These three approaches are depicted and summarised in Figure 1.

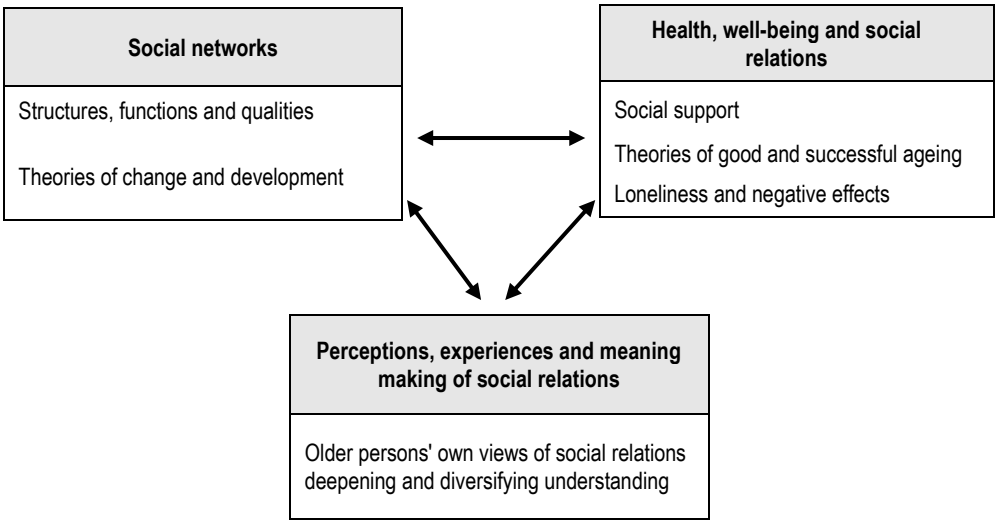

Figure 1. Three interconnected approaches to the study of social relations in old age.

Firstly, social relationships in old age can be approached from the perspective of *social networks*. People have many different kinds of social relationships in their lives. They differ in terms of structures (e.g. size of the social network), functions (e.g. emotional, instrumental support) and qualities (e.g. positive, negative) and their voluntariness, permanence and duration (e.g. obligations related to family ties versus friendships formed voluntarily) (Carr & Moorman, 2011). As Carr and Moorman (2011) note, social networks have both quantitative and qualitative aspects.

Quantitative aspects include such factors as the number of social relationships in the network and the frequency of contact with the network members. Qualitative aspects include, for example, the subjective appraisals of the quality and closeness of the relationships and perceptions of the availability of support in the network.

Processes often encountered in older age, such as retirement, bereavement and health decline, make older persons susceptible to changes in their social networks (Carr & Moorman, 2011; Cornwell & Schafer, 2015). However, there are conflicting theories of how and why social networks in old age change and develop. *Disengagement theory* suggests that disengagement from social relationships and social roles is a natural part of ageing (Cumming & Henry, 1961). Thus, according to this theory, social networks decrease in old age due to life course experiences, such as health decline and loss of loved ones, that affect social connectedness (Cornwell & Schafer, 2015). *Socioemotional selectivity theory*, on the other hand, argues that as people age, they start to prioritise the close and meaningful relationships that already exist in their networks instead of more peripheral and superficial relationships (Carstensen et al., 1999). The assumption here is that as people age, they start to perceive time as limited and thus want to invest in emotionally satisfying social relationships and not superficial ones. Consequently, social networks narrow down in older age due to this prioritisation. *Activity and continuity theories* (Atchley, 1989; Havighurst & Albrecht, 1953), in contrast, suggest that people should maintain social roles, social relationships and activities in old age and should continue engaging with the wider social world (Diggs, 2008; Katz, 2000). Thus, according to these theories, instead of social networks narrowing down, they would remain stable in old age, or even increase.

Life span and life course theories also influence the understanding of social networks in old age. These theories emphasise development as a lifelong process, including gains and losses, and the influence of situations, historical time and geographical locations experienced over the lifetime that shape individuals (Baltes, 1987; Elder et al., 2003). These theories hold that in order to understand the present, one needs to understand the experiences and contexts encountered during the lifetime. The *convoy model* of social relationships draws from life span and life course theories (Fuller et al., 2020) and conceptualises social relationships as a dynamic network that moves with the person through the life course (Antonucci et al., 2014). Social relationships in this network vary in their closeness and quality and in their function and structure, and people move in and out of the convoy throughout the course of their life in response to individual life events and situations. Thus, according to this theory, development of social networks is not stable but a dynamic process in which both

losses and gains are possible depending on multiple life course factors and the needs of the individual.

Empirical research on social networks in old age suggests that older people, in general, have smaller networks and lower rates of social contact (Ajrouch et al., 2005; Bruine De Bruin et al., 2020; Cornwell et al., 2008; Cornwell & Schafer, 2015; English & Carstensen, 2014; Wrzus et al., 2013). A decrease in social networks in old age has been found to occur in the more peripheral social relationships, whereas close social relationships, especially family relations, remain more stable (Bruine De Bruin et al., 2020; English & Carstensen, 2014; Fung et al., 2001; Shaw et al., 2007; Wrzus et al., 2013). However, there is also evidence showing that despite losses, there are also stability and gains in social networks in old age (Bowling et al., 1995; Conway et al., 2013; Cornwell, Goldman, et al., 2021; Cornwell, Schumm, et al., 2021; Cornwell & Laumann, 2015; Donnelly & Hinterlong, 2010; Schwartz & Litwin, 2018; Zettel & Rook, 2004). This evidence suggests that old age is not only a time of loss and isolation, but also of social connectedness and involvement. After retirement, many older people, for example, take part in volunteer work (Ehlers et al., 2011; Morrow-Howell, 2010). As Findlay and McLaughlin (2005) remind us, what the change means for the older person is more important than objectively observable changes in social networks in old age. This leads us to the next approach, where the health and well-being effects of social networks and their changes are considered.

The *social networks* approach, as it is called in this literature review, is characterised by being interested in what kinds of social relationships (in terms of structures, functions and qualities) older people have in their life and what kinds of changes occur in social relationships when people age and why. Researchers interested in social networks in old age, are not, however, only interested in what the networks are like and how they change, but also in how all this is related to health and well-being in old age. Thus, the second approach examines the *health and well-being effects of social relations* in old age.

Research spanning decades has shown that social relationships influence health and well-being in old age. Social relationships have been found to be associated with multiple positive health outcomes (Bath & Deeg, 2005), including, for example, reduced risk of mortality (Lem et al., 2021), depression (Schwarzbach et al., 2014) and cognitive ageing (Kelly et al., 2017; Luo et al., 2021). It is not, however, irrelevant what kinds of relationships a person has, since explanations for the associations between social relations and health are linked to *social support*. Social support refers to '*interpersonal transactions that include one or more of the following key elements: affect, affirmation, and aid*' (Kahn and Antonucci 1980, p. 267). Affect refers to emotional

support such as expressions of liking, respect, care and love, whereas affirmation refers to agreement or to the appropriateness of one's values or point of view. Aid refers to instrumental support: lending money, providing information, helping with chores and so on. Both objective and subjective support are important: that is, help is actually available when needed, but there is also the perception that support is available should one need it (Antonucci et al., 2014). Social support is understood to influence health through behavioural and psychological processes, that is, by influencing individuals' behaviour, such as adherence to a healthy lifestyle, and emotions, such as stress (Uchino, 2006).

The theories introduced earlier as explaining the change in older people's social networks also include assumptions about how social relations are linked to well-being and good life in old age. One of these assumptions is that withdrawal from social relationships in old age, as suggested by the disengagement theory, is not only a natural process of ageing (through which social networks in old age decrease) but is also necessary for *ageing well* (Burbank, 1986). Cumming and Henry (1961) suggest that it is beneficial for both ageing individuals and society that the former abandon their social roles and withdraw from their social networks. According to activity and continuity theories, however, good ageing and well-being in old age are not achieved by disengagement but rather by active engagement with social relationships and by maintaining social roles in old age (Burbank, 1986). Socioemotional selectivity theory, which suggests that there are patterns of losses in more peripheral social relationships and continuity in more emotionally satisfying ones in old age, assumes that the replacement of less satisfying social relations with an increase in emotional closeness to other members of the network is the key to ageing well (Carstensen et al., 1999).

However, the whole concept of ageing well, or ageing successfully, as it is called within the *successful ageing* paradigm, is ambiguous. Rowe and Kahn (1987) have utilised the concept of successful ageing to make a distinction between usual ageing and successful ageing. Successful ageing refers to those who have managed to age without encountering any or only view losses (e.g. physiological) as often related to advancing age, that is, to usual ageing. Rowe and Kahn (1997) developed a model that is now the most well-known theory of successful ageing. In their model they suggest that successful ageing comprises a low probability of disease and disability, high cognitive and physical functional capacity and active engagement with life, including interpersonal interactions. Theories of good and successful ageing raise questions about who gets to define what it means to age well and whether assumptions about inevitable withdrawal, avoidance of loss or middle-aged values of

activity reflect the experience of ageing. Indeed, the concept of successful ageing has been criticised for being unrealistic, ageist and not taking into account older people's actual experiences (Katz & Calasanti, 2015; Liang & Luo, 2012; Martinson & Berridge, 2015; Timonen, 2016). I will return to this later in this chapter.

Although social relations have been discussed here mostly from the point of view of their benefits for older people, it should be noted that there is also a darker side to social relations. This refers to loneliness and social isolation as well as to the negative effects of social relations on the health and well-being of individuals. Although loneliness is often associated with old age, age itself has been found to be a poor factor for explaining the experience of loneliness (Savikko et al., 2005). Factors that better explain the experience of loneliness include social and health-related factors (often encountered in older age) such as widowhood, living alone and limitations on activities of daily living (Dahlberg et al., 2022; Nyqvist et al., 2021). Studies have found that levels of loneliness are higher in old age compared to younger people (Surkalim et al., 2022), but also that higher levels of loneliness are more common among young adults and in very old age (80+ years) (Hawkley et al., 2022; Luhmann & Hawkley, 2016). However, some findings suggest that loneliness does not increase in older age (Chawla et al., 2021).

Although the association between loneliness and age remains somewhat inconclusive, there is much evidence regarding loneliness being detrimental for individuals' health and well-being (Park et al., 2020). Loneliness and social isolation have been found to be associated with negative health outcomes among older people, such as lower cognitive function (Boss et al., 2015) and higher likelihood of mortality (Holt-Lunstad et al., 2015). However, it is not only loneliness that can be harmful to one's health and well-being; social relationships can also be damaging. For example, many older people experience abuse in their social relationships (Fang & Yan, 2018; Gimm et al., 2018; WHO, 2022). Social relations are not only a source of positive experiences and emotions but also of negative emotions, such as anger, sorrow and disappointment, that can have detrimental effects on the well-being of individuals (Dang et al., 2021).

The health and well-being approach to social relationships is characterised by its interest in the benefits and disadvantages of social relationships, and the lack thereof, for health and well-being in old age. Empirical research in the two first approaches introduced often quantify both social relationships and health and well-being. That is, they use, for example, structured questionnaires and interviews to evaluate the structures, functions and qualities of social relationships (Siette et al., 2021) and their associations with health and well-being indicators. The third approach introduced

here relates to research that focuses on how older people themselves perceive, experience and find meaning in social relationships.

Research interested in older people's *perceptions, experiences and meaning making* concerning social relations can provide deeper insights into the social worlds of older people as well as explanations for how and why social relationships change in older age and how and why health and well-being are related to social relations. The understanding of social network changes in older age can diversify and deepen in research on how older people experience changes in their social network after the loss of their spouse (Vos-den Ouden et al., 2023) or after health decline (Vos-den Ouden et al., 2021) or how and why older people reconnect with social relationships they have fallen out of touch with earlier (Ross et al., 2023). Health decline and bereavement are understood as two of the reasons why older people's social networks decrease, and they are recognised as risk factors for loneliness. However, research about how older people experience loneliness and their meaning making in relation to it show the intertwinement of multiple factors, experiences over the life course and cultural understandings of loneliness in how loneliness is experienced (Ågren & Pavlidis, 2023; Jansson et al., 2021; Tiilikainen & Seppänen, 2017).

Research on older persons' perceptions can also provide important information about how ageing and social relations are experienced and made sense of and what it means to 'age well' or 'successfully'. Such research has shown that older people perceive social relationships to be one of the most important aspects enhancing their quality of life and bringing meaning to their life (Bowling, 2007; Hupkens et al., 2018; van Leeuwen et al., 2019). Social relationships are perceived to be important because they provide, for example, help and support, care, love, appreciation, company, belongingness, a means to avoid loneliness, reciprocity and feelings of being needed (Lara et al., 2020; Tuominen & Pirhonen, 2019; van Leeuwen et al., 2019). In addition, research exploring older people's views of successful ageing has shown that these views are more varied than the theoretical understandings of successful ageing. Systematic reviews have shown that although issues related to health and physical functioning are considered components of successful ageing by older people, they emphasise psychosocial components and personal resources (Badache et al., 2021; Cosco et al., 2013). That is, older people perceive good social relationships, contributing to one's community and engagement with interests and hobbies as well as such issues as accepting ageing and adapting to changes, attitudes and positivity, independence, spirituality, good death, environmental factors and finances as important for ageing successfully. Many of these factors are not recognised in the most famous theories of successful ageing.

Indeed, research interested in the perceptions and experiences of older people can introduce viewpoints that would have been hard to detect otherwise. For example, such research has found that it is not only the current social relationships that are meaningful for older people (which are usually those that the research is most interested in), but also those encountered during the earlier stages of one's life course. Some studies, especially those conducted among the oldest old persons, have found that feelings of happiness and good old age are framed and given meaning in relation to events and relationships from the past, such as memories about one's childhood and youth and memories of one's family and a good marriage (Carstensen et al., 2019; Nosraty et al., 2015; Vasara, 2020b; von Faber et al., 2001). For example, a relationship with one's spouse, even after they have passed away, can remain an important social relationship in one's life (Patlamazoglou et al., 2023). These findings point to the importance of the whole life course in understanding the meanings of social relationships in old age.

These few examples of how social relationships have been approached from the perspective of older people themselves shows the importance of this approach in complementing the other two approaches and also raising novel viewpoints. The three approaches presented here do not represent an exhaustive review of all the different approaches in ageing research that focuses on social relationships. However, they provide an overview of some of the main approaches prevalent in the literature and thus affecting our understanding of social relationships and the ways in which we can obtain information about them. All of these approaches are interconnected, though. The interest in the social networks of older people is related to how these networks, the people in them and the changes occurring in them are linked to health and well-being in old age as well as reflected in and constructed by the perceptions and experiences of older people.

3 PLACING AGEING

3.1 Space and place in gerontology

Ageing can be viewed as a journey through time and place. As we age, we move in time further away from our birth and closer to the end of our life (Wahl & Oswald, 2016). The life we live during this time always occurs somewhere – in some *place*. During the passing of time, we move in different places: from our childhood homes, playgrounds and schools to the workplaces, apartments and houses, and leisure-time locations of our adulthood and later life. Especially in older age, we are prone to encounter spatial challenges. Our use of space is bound to become restricted, and independent living is threatened due to our physically ageing body (Iwarsson et al., 2004; Nair, 2005). Thus, the home environment that was suitable for us earlier in life might become too high maintenance, entail barriers for our everyday life and not be located close enough to shopping areas and other services (Wahl & Oswald, 2016). Eventually, we might need to move to a place that better caters for our needs: to an assisted living facility or a nursing home. Although the intertwinement of place and ageing is not related only to the restrictions in the use of space caused by the ageing body (as discussed later), this example illustrates how ageing and place are connected.

For decades, researchers working in the field of ageing have been interested in spaces and places and their connections to the experiences of ageing and the needs of older people (Rowles & Bernard, 2012b; Wiles, 2005). Gerontologists are interested in both understanding how ageing affects spaces and places and how they influence ageing and life in old age. The growing interest in space and place in gerontological research can be located in the wider 'spatial turn' in the social sciences (Andrews & Phillips, 2005b, p. 7). This turn consisted of a change in perspective that acknowledged space and place as central to understanding human life and thus an interest in their impact on human experiences, behaviour and activity (Andrews & Phillips, 2005b; Warf & Arias, 2009). They were no longer seen as subordinate to time, which had dominated how human life had been understood earlier, but as playing a key role in the construction and transformation of social life (Warf & Arias, 2009). Interest in space and place in ageing research has also risen due to social change, such as demographic ageing, changes in kinship, growing health and social

care needs and limited resources to organise them, as well as the development of special housing arrangements for older people (Andrews & Phillips, 2005b; Rowles & Bernard, 2012b).

Similarly to the study of ageing, the study of ageing and place is also highly multidisciplinary (Andrews & Phillips, 2005b). Indeed, just as there is a need to cross disciplinary boundaries in our efforts to understand ageing, doing so is also required to understand the spaces and places of ageing. For example, fields such as social and health geography, environmental psychology, architecture, sociology, social policy, health economics, public health, nursing, occupational therapy and social work have directed research focus to spaces and places. Disciplines such as biogerontology, geropsychology, sociology of ageing, geography of ageing and geriatric medicine also more specifically focus on ageing and places (Wahl & Oswald, 2016). Each of these disciplines has their own view on spaces and places and ageing. Two fields of research in particular within these gerontological disciplines focus extensively on the physical and social worlds of older people: environmental gerontology and geographical gerontology (Andrews et al., 2013).

Environmental gerontology has its theoretical roots in environmental psychology (Rowles & Bernard, 2012b). The development of the field dates back to the 1960s and 1970s and builds on Kurt Lewin's 'field theory' in which it is understood that behaviour is a function of a person's characteristics and those of the environment (Rowles & Bernard, 2012b; Wahl & Oswald, 2016). As a subdiscipline of gerontology, environmental gerontology can be distinguished from other sub-disciplines by its emphasis on the characteristics of both the ageing individual and the environment in understanding human behaviour, or putting more emphasis on the environmental characteristics, whereas other fields, such as geropsychology, tend to focus only on the ageing individual (Andrews et al., 2013). Geographical gerontology began to develop as a distinct and recognisable subdiscipline in the early 1980s and is theoretically based on social geography (Andrews & Phillips, 2005b). Geographical gerontology applies geographical concepts, perspectives and approaches to the study of ageing, old age and older populations. In reality, there is no clear boundary between the work done in these two disciplines; it overlaps (Andrews et al., 2013). However, as Andrews et al. (2013) note, simply put, environmental gerontology is interested in the processes, the 'how' of spatial cognition, whereas geographical gerontology is concerned with the outcomes, the 'what', 'where' and 'when' of spatial life.

In gerontology, the concept of space was initially seen only as a neutral surface on which life unfolds: as being something in itself, independent of but facilitating

what happens in it (Andrews et al., 2017). However, when humans and objects are located in space they become important features of human existence, because rates, volumes, times and distances then become visible and calculable. Within this kind of understanding of space, Andrews et al. (2017) recognise two areas of gerontological research. The first concerns research on how older people are concentrated in space and are distributed collectively across it over time (e.g. demographic and migration studies) and the second is interested in tracing the distributive features of older people's services across space. This kind of research does not, however, simply map phenomena, but also attempts to understand the irregularities and consequences of patterns and the individual, social, economic and political processes underlying them. Taking this perspective on space in gerontological research is underpinned by the idea that spatial design of health and social care systems can be improved to address the needs of the ageing population. That is, where one lives and ages should not disadvantage one's health, well-being or length of life.

Place, understood as a location or a study site, broadly features in gerontological research (Andrews et al., 2013). However, as Andrews et al. (2013) note, place has also been recognised to be much more than that: as a complex social and cultural setting that is occupied, acted and felt. Wiles (2005) has identified six (overlapping and interactive) ways in which place has been conceptualised in gerontology. First, place is a process. That is, place is not just a background for events but a part of social relations such as family and caring relations. In a mutually constitutive relationship, a society shapes places and is shaped by them. Second, place is subject to ongoing negotiations. As people age, their relationship to places is constantly renegotiated, for example in relation to their growing needs for support. Also ideas about and associations with place (such as what is the best place for an older person to live in) are changing and constantly negotiated. Third, place is contested. People have different experiences and interpretations of places, for example what kind of place an older person's home is for an older person (e.g. private and full of memories) and for a home care worker (e.g. hygienic and safe). Fourth, space expresses power relations. People have different opportunities to shape places; for example, the policies that influence the locations of care work disproportionally negatively affect women, who are often the carers and recipients of care. Fifth, place is interrelated. Places are connected to other places, for example an older person's home is related to access to resources such as parks and shops, and national-level policies about care services for older people affect the well-being of older people living at home. Sixth, place is material, social and symbolic. For example, institutions

are physical entities, but they are simultaneously imbued with symbolic (e.g. loss of autonomy and independence) and social (e.g. loneliness) meaning.

Sometimes the concepts of space and place are used almost interchangeably. However, space is often understood as abstract and merely a geographical location that does not have any meaning, whereas place is often thought of as meaningful and experienced by people. Thus, it is understood that spaces become places (they become meaningful to us and an expression of our identity) through a complex process involving the use of space (creating patterns of behaviour in space), awareness of space (our learned comfort and familiarity with the space), emotional attachment to space (attaching meaning to space) and vicarious engagement with space (constructing different places that feature in our life as the embodiment of the self) (Rowles & Bernard, 2012b). For example, a house becomes a home only when it is meaningful for an older person and claimed as part of their identity. The outcome of this process can be called a *sense of being in place* (Rowles & Bernard, 2012b) or an *attachment to place* (Wahl & Oswald, 2016). Interest in how spaces and places are perceived by older people relates to the idea that the forming of meaningful ties with places (i.e. attachment to place) is related to better adjustment to ageing and well-being (Wiles et al., 2009).

As I have illustrated, spaces and places are widely recognised as important and multifaceted factors that should be considered in the study of old age and ageing. As described by Wiles (2005), spaces and places are affected by policies that influence the places of ageing and the care of older people. In what follows in this chapter, I discuss two policies influencing places of ageing and the care of older people: the ageing in place policies and COVID-19-related policies.

3.2 Ageing in place

Ageing in place is a policy framework that is prevalent in many European countries, including Finland (Kröger & Bagnato, 2017). Within this framework, home is understood as the primary and best place to grow old in (Vasara, 2015). Thus, older people should be allowed and encouraged to stay in their home, to 'age in place', as long as possible, even when there are care needs (Hennessy, 1995; Vasara, 2015). Institutions, on the other hand, within this framework, are deemed to be the worst dwelling option for older people, indeed as unsafe, inhuman, undesirable and inappropriate (Kaskiharju, 2010). The policy aims to promote well-being, independence, social participation and healthy ageing (Sixsmith & Sixsmith, 2008)

and to enable older people to age in familiar places they prefer (Kaskiharju, 2010; Pulkki & Tynkkynen, 2020). Nevertheless, the incentive for the policy is also economic: to cut down on expensive institutional care and replace it with less expensive care provided at home (Anttonen & Karsio, 2016; Sixsmith & Sixsmith, 2008).

Indeed, the policy has led to an emphasis on care provided in the home environment or home-like environments instead of in institutions, that is, it has led to the deinstitutionalisation of care (Anttonen & Karsio, 2016). In line with ageing in place policy, the Finnish Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons (No. 980/2012) states: '*Local authorities must organise long-term care and attention for older persons principally by means of social and health care services that are provided in the person's private home or other home-like place of residence*.' In 2018, the majority of people aged 75 or over in Finland, 75.4 per cent, lived independently in their own home without regular support or care, and 11 per cent lived in their home but had regular home care (Ministry of Social Affairs and Health, 2020a). For people aged 85 and over, the percentages were 52.7 for independent living at home and 21.6 for regular home care in 2018. Institutional care, on the other hand, has diminished substantially in Finland, as shown in Figure 2. In 2000, 12.6 per cent of people aged 85 and over lived in residential homes and 7 per cent lived in health care centres' long-term inpatient wards in Finland, that is, in institutional long-term care, but in 2021, only 0.9 per cent and 0.3 per cent, respectively, did so (National Institute for Health and Welfare, 2021, 2022). Institutional care has been replaced (although not sufficiently, as discussed later) by regular home care, assisted living with 24-hour assistance, and informal care. Figure 3 shows the clients of home care, assisted living (24-hours and ordinary combined) and informal care support in 2005 and 2020. In 2005, 20.5 per cent of people aged 85 and over received regular home care and 11.9 per cent were clients of assisted living, while in 2020, 33 per cent received home care and 17.7 per cent were clients of assisted living (National Institute for Health and Welfare, 2021). The aim of Finnish eldercare policy at the time of writing is to abolish long-term institutional care by 2027 (Ministry of Social Affairs and Health, 2021).

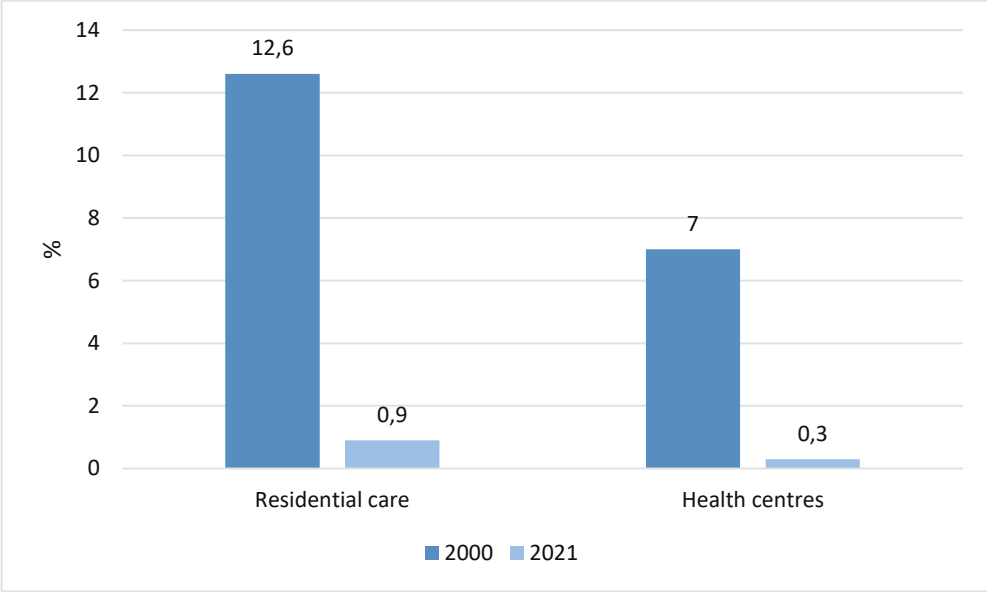

Figure 2. Clients of institutional care (percentage of all aged 85 and over) in Finland in 2000 and 2021 (National Institute for Health and Welfare, 2021, 2022).

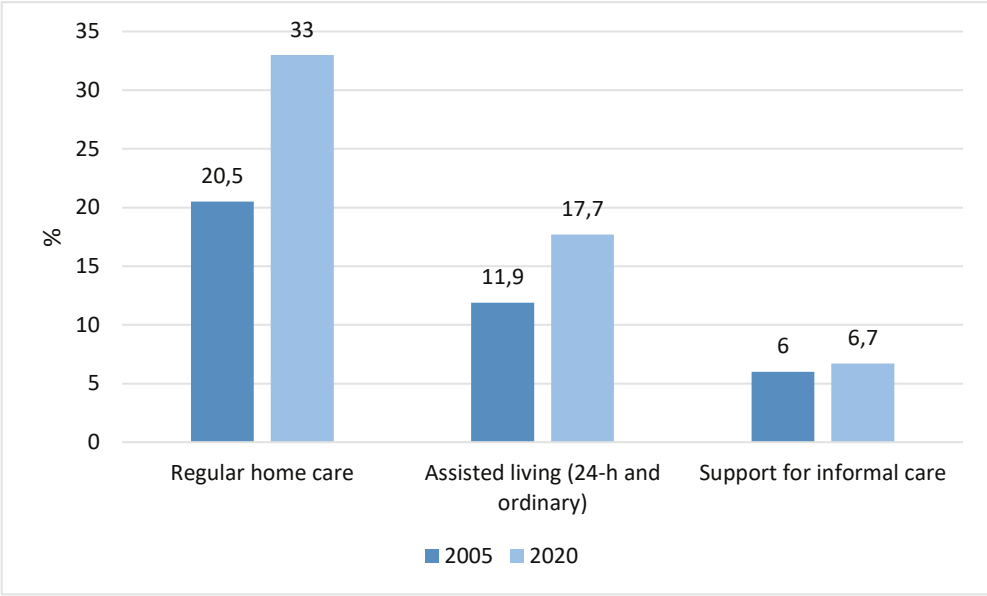

Figure 3. Clients of home care, assisted living (24-h and ordinary) and informal care support (percentage of all aged 85 and over) in Finland in 2005 and 2020 (National Institute for Health and Welfare, 2021).

Home is unarguably important for older people, and they prefer to live in their own home (Karisto & Haapola, 2013; Lehnert et al., 2019). What is meant by the 'home', where older people should, preferably age, however, has been ambiguous within the ageing in place policy and regarding ageing in place as a gerontological concept (Bigonnesse & Chaudhury, 2020; Pulkki & Tynkkynen, 2020). In the gerontological literature, it has been recognised that the concept of 'ageing in place' does not necessarily only refer to ageing in one location or a private home but can be understood as a wider concept of ageing in the community or neighbourhood or in a care facility (Bigonnesse & Chaudhury, 2020, 2022; Leith, 2006; Wiles et al., 2012). Ageing in place, as understood by older people themselves, is also related to much broader topics than that of living in a certain physical location, namely to a sense of attachment and connection, security and familiarity and a sense of identity that is gained through independence and autonomy (Wiles et al., 2012).

Vasara (2020a) notes in her doctoral thesis that in Finland, ageing in place seems to be understood as ageing in one and the same physical home, whereas broader dimensions of ageing in place such as those just mentioned are more visible in international literature. For example, Finnish political discussion about ageing in place lacks recognition of neighbourhoods, communities and social relationships as part of ageing in place (Pulkki & Tynkkynen, 2020). Furthermore, in these discussions only the private home seems to represent the 'real home' of the older person, and other housing options, although they are recognised, do not seem to fit with the authorities' concept of home (Anttonen & Karsio, 2016; Pulkki et al., 2017; Pulkki & Tynkkynen, 2020). Intermediate housing options between home and institution – assisted living – are called 'home-like' rather than homes. The term home-like is used in Finnish legislation, such as in the Act mentioned earlier, but it lacks clear definition (Kaskiharju, 2021). Nevertheless, as Kaskiharju (2021) notes, the term creates positive impressions and implies values of good old age, communality, and ethical conduct. It is a politically correct term that fits the intentions of many actors.

Although older people want to live in their own home, they also want to move to a care facility when care needs increase (Lehnert et al., 2019). However, due to the deinstitutionalisation of care, relocating to an institution has become difficult (Kröger & Bagnato, 2017). Kröger and Bagnato (2017) note that the long-term care needs of older people have not disappeared, so the deinstitutionalisation of care within the ageing in place framework has led to an increasing number of older people with high levels of needs living at home and in assisted living. Although living at home, even with care needs, is promoted by the ageing in place policies, the

resources allocated for home care have not been increased to meet the needs of older people (Anttonen & Karsio, 2016; Kröger & Bagnato, 2017; Kröger & Leinonen, 2012). In fact, the shrinking provision of institutional care has left a gap in long-term care coverage that has not been filled by assisted living or home care (Kröger, 2019). Thus, there is a concern that this situation has led, and is continuing to lead, to *care poverty* of older people who do not receive enough of the care that they need (Kröger, 2022).

As Vasara (2015) argues, the normative perceptions of home, on which ageing in place policies are built, frame the understanding of the acceptable ways to organise housing and care for older people. That is, when promoting home as the acceptable option, other forms of housing are seen as deviating from the expected and as less desirable (Kaskiharju, 2010; Vasara, 2015). Thus, it can be argued that ageing in place policy contributes to defining acceptable and desirable places of ageing, but at the same time, by diminishing the options for housing and care, it contributes to defining the home as the only available space.

3.3 Older people and the COVID-19 pandemic

In December 2019, a coronavirus, later named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and causing Coronavirus disease 2019 (COVID-19), started to spread in China (Malhotra et al., 2021). By the end of January 2020 the virus had spread to 18 countries, and in March 2020, when the virus had spread to 114 countries, causing over 100,000 cases and over 4,000 deaths, the World Health Organization (WHO) declared COVID-19 a pandemic (WHO, 2020). The virus is highly contagious and causes illness that ranges from a common flu-like condition to severe respiratory distress syndrome (Malhotra et al., 2021). The virus causes more severe illness for older people and people with chronic illness. It spreads when there is close contact between people such as when an infected person sneezes, speaks, sings or breaths and small liquid particles spread from their mouth or nose (WHO, 2021). The virus can also spread in poorly ventilated or crowded indoor areas where people spend longer periods of time or when a person touches their eyes, mouth or nose after touching surfaces that have been contaminated with the virus.

Countries all over the world tried to control the spread of the virus by introducing different kinds of measures, such as restrictions on travelling and citizens' movement within the country, called *COVID-19 lockdowns* (Goyal et al., 2021). Such lockdowns included, for example, curfews, quarantines, shelter-in-place and stay-at-home

orders. Because of the way the virus spreads, controlling and restricting human-to-human contact, *social distancing*, has been one of the key measures used to reduce transmission of the disease (European Centre for Disease Prevention and Control, 2020). In Finland, citizens were advised to work from home if possible and to avoid travelling and having close contact with other people (Ministry of Social Affairs and Health, 2020e). Other measures used to control the spread of the virus included, for example, restrictions relating to events, gatherings, cultural venues, leisure centres, customer premises and food and beverage service businesses in various forms between the spring of 2020 and spring of 2022 (Ministry of Economic Affairs and Employment, 2020; Ministry of Social Affairs and Health, 2020c).

Because the virus causes more severe illness and a higher risk of mortality for older people (Singhal et al., 2021), some restrictions were targeted specifically at older people in Finland as well as in other countries. A state of emergency was declared in Finland in March 2020 (Ministry of Social Affairs and Health, 2020d). A few days later the authorities released the following statement: '*As a general guideline, persons over 70 years of age are obliged to refrain from contact with other persons to the extent possible, i.e. in quarantine-like conditions*' (Ministry of Social Affairs and Health, 2020b, para. 2). Family and friends were advised not to visit older persons but to use, for example, the telephone or Skype to stay in touch. Visiting nursing homes and assisted living facilities was prohibited (Ministry of Social Affairs and Health, 2020d). Similar age-based restrictions were introduced in many other countries as well (Ayalon, 2020; Nilsson et al., 2021).

Such restrictions raised concern about the health, well-being and quality of life of older people instructed to live in social isolation during the pandemic. Indeed, the pandemic has been found to have negatively impacted older people's health, mental well-being, social interaction, financial situation and access to health care (Eurofound, 2022). Many studies, however, have shown that older people's experiences of the pandemic and its impact on their lives were manifold. These studies have shown that older people perceived both negative and positive, as well as neutral, effects of the pandemic on their life (Ahosola et al., 2021; Brooks et al., 2022; Kulmala et al., 2021; Whitehead & Torossian, 2021). Ahosola et al. (2021) found that while some older people perceived negative changes to their well-being because of the pandemic, such as feelings of loneliness, some also experienced positive changes, such as more social contact, or thought there was not much change in their well-being compared to the time before the pandemic. Kulmala et al. (2021) studied social networks of older people during the pandemic. Similarly to the study of Ahosola et al. (2021), they found both positive and negative changes as well as no

change in social networks. Some of the participants' social networks reduced significantly because they followed the recommendations not to go outside their home or for other reasons, such as being afraid of the virus or relatives prohibiting them from contacting other people. However, the social network of other participants remained the same as before the pandemic or even expanded because they were encouraged to contact old friends. Brooks et al. (2022) and Rapisarda et al. (2022) found that while older participants in their study were struggling during the pandemic due to the loss of social connections, they also adapted to the situation by remaining active and sustaining social connections and were grateful for what they had at the present moment.

Studies suggest that the loneliness and social isolation of older people increased during the pandemic (Dahlberg, 2021; Ernst et al., 2022; Fuller & Huseth-Zosel, 2022; Su et al., 2022). However, there is also an indication that loneliness decreased over time (Kotwal et al., 2022) and fluctuated considerably due to the ongoing tightening and loosening of the COVID-19 restrictions (Stolz et al., 2023). The risk factors for experiencing loneliness during the pandemic that were identified were similar to those that existed before the pandemic, that is, living alone (Stolz et al., 2023), not having a partner and not having children (Arpino et al., 2022).

Social contact was an important part of meaningful life for older people during the pandemic (Tiilikainen et al., 2021). Whitehead and Torossian (2021) found that older people reported feeling stressed about the confinement caused by the restrictions, about isolation and loneliness and about the well-being of others. However, most of the joy and comfort in their lives in this situation was experienced because of friends and family, digital social contact and engagement with hobbies. As Tiilikainen et al. (2021) found, older people described contact with family, friends and acquaintances as an important part of their day-to-day life during the pandemic. Their participants kept in touch with others by telephone and videocalls, but some also saw their family, friends and neighbours face-to-face, despite the strong recommendation to avoid contact. Neighbours were important social contacts for the participants and also provided social support. Ottoni et al. (2022) also found that neighbours and neighbourhoods played an important part in older people's descriptions of their social connectedness during the pandemic, providing social contact, support and a sense of belonging.

D'cruz and Banerjee (2020) have called the COVID-19 pandemic 'an invisible human rights crisis' due to the marginalisation of older people. They argue that while the direct risks of the pandemic for older people, that is, morbidity and mortality, were (at least partially) addressed by the public health responses to the pandemic,

indirect risks such as ageism, sexism, loneliness and social isolation, elder abuse and allocation of health care resources need more consideration. D'cruz and Banerjee (2020) highlight that although such risks existed before the pandemic, the pandemic situation interacted with the conventional ways of socially excluding older people and thus created new forms of marginalisation. Indeed, many scholars have raised concern about how older people were depicted during the pandemic in an ageistic manner as a homogeneous and vulnerable group and a group that could be 'sacrificed' for the benefit of the economy and the younger generations (Ayalon, 2020; Fraser et al., 2020; Jen et al., 2021; Lichtenstein, 2021; Morgan et al., 2021; Previtali et al., 2020). It can also be argued that these ageist depictions influenced views about ageing and older people and the well-being of older people not only during the pandemic but since then, and the effect is ongoing.

4 PLACING SOCIAL RELATIONS

4.1 Social space

It can be argued that social life does not exist without space. Human social life, as well as the ageing of individuals, always takes place somewhere, in some kind of context (Wahl & Lang, 2004). Gerontologists, as well as scholars in other fields, recognise space and place as central parts of older people's social life, affecting it and being affected by it (Buffel et al., 2012; Wahl & Lang, 2004). It has been argued that the centrality of spaces and places in human social life is especially apparent in older age. As already described in the previous chapters, deteriorating health and functioning, death and illness of loved ones and age peers and other challenges encountered in older age affect older people's opportunities for social connections. Spaces and places play an important part in this by enabling and restricting these opportunities. Declining abilities of older people concerning using and moving in and between spaces leads to restrictions in what can be called their *social space*. However, the strong connections of spaces, places and social relations in older age are not only related to restrictions and challenges encountered but also to such issues as *attachment to place* and *ageing in place*: the fact that older people often live in the same neighbourhoods for a long time and have developed meaningful ties to their familiar surroundings and relationships in them (Buffel et al., 2012; Wiles et al., 2009). On the other hand, older people themselves can also actively construct their social worlds to match their social needs (Carstensen et al., 1999) and thus may choose to diminish their social space.

The interconnection between social relations and space and place in old age have been examined, empirically and theoretically, from multiple perspectives. Wahl and Lang (2004), for example, introduce a variety of different theories in ageing research that address the physical and social environments of older people. They argue that physical and social environments should not be viewed as separate entities but as interwoven and inseparable. That is, the social environment (e.g. social relationships, social support and social networks) cannot be understood as separate from the physical/material environment (e.g. physical-spatial home environment, institutional

setting). They suggest that both physical and social environments constrain and offer resources for older people's lives and that older people themselves regulate these environments, in terms of aspects such as their quality, structure and function, to enhance their social and physical resources. Wahl's and Lang's (2004) model of *social and physical spaces over time (SPOT)* considers the interconnection between physical and social environments by taking into account the needs of ageing individuals and their regulation of and adaptation to both social and physical contexts.

There is much empirical evidence that the social life and social relations of older people are closely linked to spaces and places (Wahl & Lang, 2004). Research shows that places where older people reside are important sites for social relations. Older people's homes have been recognised as important for social life in old age (Barrett et al., 2012; Severinsen et al., 2016; Vos et al., 2020), as have institutional settings, such as assisted living facilities (Street et al., 2007). In addition, neighbourhoods and their social networks have been recognised as playing an important part in the lives of older people (Bromell & Cagney, 2014; Cramm et al., 2013; Holt-Lunstad et al., 2015; Thomese & Tilburg, 2000; Wiles et al., 2009). However, out-of-home mobility and transportation and other services that enable it are also important in regard to social life in older age (Iwarsson et al., 2004; Luoma-Halkola & Häikiö, 2022; Su & Bell, 2009).

In this study I use the concept of *social space* to refer to the interconnection between spaces, places and the social life of older people. There are different ways to define the concept of social space, though. The concept has been used and developed in the disciplines of sociology and geography, for example by Émile Durkheim, Maximilien Sorre, Paul-Henri Chombart de Lauwe and Henri Lefebvre (Buttimer, 1969; Lefebvre, 1991). Henri Lefebvre's concept of social space, in which social space is understood as socially produced in interactions with the physical, the mental and the social space, has also been used in ageing research (Petersen & Minnery, 2013; Petersen & Warburton, 2012; Wallin, 2019). In this study, I draw from gerontological research and the ways in which the concept of social space has been discussed and defined in this context.

In Chapter 3.1 I introduced the concepts of space and place and how they have been defined in gerontology. As described, the concept of space has often been understood merely as a geographical location or a container of people and objects that does not have any meaning. Place, on the other hand, has been conceptualised as having meaning and spaces are seen as becoming places when meaning is attached to them. However, the concept of social space seems to contradict this division between the two concepts. Andrews et al. (2013, pp. 1342–1343) write that because

scholars have recognised space as '*intimately and actively involved in human agency*', they have developed the concept of social space, '*meaning space as used, experienced and navigated by older people themselves*'. Wiles et al. (2009, p. 666) write that social space '*as a concept means the multilayered, connected, and physical, imaginative, emotional and symbolic experiences of people and place*'. Thus, it seems that social space is indeed understood as something older people experience and give meaning to themselves, rather than being just a location, and it consequently evades the definition often given to space in relation to place. Andrews et al. (2013) also note that the concept of social space is associated with the way place has recently been understood in gerontology.

What, then, does 'social' mean in the concept of social space? Some of the empirical gerontological research uses the concept of social space without elaborating further on its definition. Thus, social space is used as a self-explanatory concept in relation to physical space to refer to the construction and meaning of social dimensions (e.g. social interaction and activities) within physical environments (Hartley & Yeowell, 2015; Øye, 2022). Wiles et al. (2009, p. 666) define the social spaces of older people as '*their social relationships, the spaces in which their physical and imaginative activities take place, and the complex emotional and symbolic connections to places and people across time and space*'. My interpretation of this definition is that social space refers to social relationships between and activities involving people in places that older people feel connected to and that (meaning the relationships, activities and spaces) exist in the past, present or future or in the imagination of older people. More simplistically, social spaces can be described as those settings that older people use and move between in their everyday lives as well those that they go to less frequently, such as their or their friends' homes, shops and markets and formal care environments (Andrews et al., 2013).

In this study, I draw from the previous definitions introduced above and understand social space as referring to spaces/places in which older people's everyday lives occur (where they live, spaces they use, move in/between and frequent) and that are linked to social relations and social activities. Such social spaces can exist in the past, present or future or in the imagination of the person, and have complex emotional and symbolic connections to other people and places. Table 1 shows the different definitions of space, place and social space as understood in this study. Because the definitions of the concepts are not fixed, the table does not represent a comprehensive description of the concepts but illustrates the different ways in which these concepts can be understood.

Table 1. Definitions of space, place and social space as understood in this study.

SPACE	PLACE	SOCIAL SPACE
A location in time and space, e.g. a building, a house	Space that has meaning, e.g. the home	Space/place that has meaning and connections to social relations and activities, e.g. the home as a site of social relations

4.2 Spaces and places of ageing and old age

4.2.1 Home

It is not a simple task to determine what a home is. The concept is a complex and multilayered one that is difficult to pin down (Wiles & Andrews, 2020). One could attempt to describe a home by distinguishing it from the concept of a 'house'. Utilising previously presented understandings of spaces and places, a house can be understood as a space, a physical location without meaning, that becomes a place, a home, when meaning is attached to it (Rowles and Bernard 2012b). Understood this way, a home is more than just a physical location with physical attributes. Indeed, in addition to understanding a home as a place where people live, it has been defined as a relationship between people and the environment and as an experience (Gillsjö & Schwartz-Barcott, 2011; Moore, 2000). That is, people 'feel at home' when emotional bonds to places are formed, and the feeling of 'being at home' is constructed by unique experiences of places and when places become part of people's identities.

Home is a central space for older people for many reasons. Most older people live in their own home. In Finland in 2018, 93 per cent of people aged 75 and over lived in their own home (here 'home' also includes home-like places that can be defined as apartments, that is, apartments in assisted living facilities) (Lintunen, 2019). Older people also tend to live in the same home for a long time. 25 per cent of older Europeans have lived in the same home for more than 75 per cent of their adult life (Fernández-Carro & Evandrou, 2014). Most live in the same home they acquired when they were 25–30 years old, but around 6 per cent live in the same home in which they were born. When older people are asked about their residential

preferences, most of them want to live in their own home (Karisto & Haapola, 2013; Lehnert et al., 2019). More specifically, older people want to live in their own home when their care needs are moderate, but say they would prefer to live in a care facility when their care needs increase (Karisto & Haapola, 2013; Lehnert et al., 2019). Home is also a central space for older people due to ageing in place policies, as discussed in Chapter 3.2.

Gerontological research has investigated the meanings of home for older people. The studies show that 'home' does not necessarily refer to one place but can be multiple places, including spaces and places in the past (e.g. childhood home, lost home), the current dwelling of the older person and their future home (e.g. 'heavenly home') (Gillsjö & Schwartz-Barcott, 2011). Home can also be, in addition to the place where one is living, nearby places in the neighbourhood (Felix et al., 2015; Kylén et al., 2019). Home has been found to entail physical, personal and social dimensions. The physical dimension of the home includes, for example, the built environment and design (e.g. suitability for one's needs), the neighbourhood and the location (e.g. closeness of services), thermal and sound insulation, amount of daylight the house receives and the ease of maintenance (Bigonnesse et al., 2014; Felix et al., 2015; Kylén et al., 2019). These different physical aspects of the home are also related to deeper meanings of privacy, safety, freedom and independence, that is, to control and autonomy (Felix et al., 2015). The social dimension of the home connects to the importance of it regarding spending time with meaningful other people, but also to maintaining social roles and a sense of purpose by being useful to other people in one's neighbourhood (Bigonnesse et al., 2014; Felix et al., 2015; Kylén et al., 2019; Molony, 2010). The personal dimension of the home is related, for example, to personal belongings, feelings and memories. Emotionally meaningful objects and furniture create a sense of home and remind people of the past (Felix et al., 2015; Kylén et al., 2019). In addition, the home is described as a warm and relaxing place and as a haven or a refuge (Kylén et al., 2019; Molony, 2010).

Home can be understood as a resource: it provides resources that meet many different needs, such as memories, access to the neighbourhood, family, culture, social connections, freedom, autonomy, personal preferences, routine and security (Barry et al., 2018). In addition, the home of the older person can be understood in terms of being a place of personal power and mastery (e.g. being free to come and go as one pleases, a place where one can make choices about personal space and schedules and about enforcing personal strengths), a place of belonging and inclusion with fewer restrictions than the outside, public world, and a place where one's identity is formed and recognised (Molony, 2010). Place as a process, as

described by Molony (2010), refers to the integration of the self with the physical and social as well as the temporal and spiritual environment of the home. That is, to processes of becoming part of one's environment that lead to feeling at home or a feeling of belonging in the world.

Long-term care facilities, such as assisted living, can also be understood as the older person's home (Eckert, 2009). However, older people themselves do not always regard the facility as their home (Johnson & Bibbo, 2014; Petersen & Minnery, 2013), and as discussed in Chapter 3.2, neither do politicians, public administrators and officials operating within the framework of ageing in place policy (Anttonen & Karsio, 2016; Pulkki & Tynkkynen, 2020). Research has found that physical, personal and social dimensions also play a role in making long-term care facilities feel like a home. Physical aspects of long-term care facilities include, for example, the spaciousness of residents' rooms, the design of the facility, television rooms, patios and access to outdoor areas (Wada et al., 2020). Personal aspects include the ability to personalise one's living space by being able to take one's own furniture and other personal belongings and to have privacy by being able to lock the bedroom door (Johnson & Bibbo, 2014; Petersen & Minnery, 2013; Pirhonen & Pietilä, 2015; Wada et al., 2020). Social aspects include interaction with others in the facility, having common areas for gatherings and building rapport with staff members (Johnson & Bibbo, 2014; Leith, 2006; Pirhonen & Pietilä, 2015; Wada et al., 2020). An important feature of a long-term care facility feeling like a home is related to having autonomy and choice in the facility: having control over one's daily life (e.g. having the freedom to decide on one's own schedules) and person-centred care in the facility enhance the feeling of at homeness (Johnson & Bibbo, 2014; Pirhonen & Pietilä, 2015; Wada et al., 2020). If the older person's move to the facility was an independent and voluntary choice, this contributes to the facility feeling like a home (Johnson & Bibbo, 2014; Leith, 2006).

As Leith (2006) notes, for her participants, home in a long-term care setting meant an ongoing negotiation between their own life situation and their living environments and the resources provided by these environments. Home for them was not a finite product but an evaluation of how well their environment fitted their needs and their view of what home should be (e.g. functional and purposeful). This meant that the concept of home was fluid, changing over time and adapting to new life events. The participants in her study had made a deliberate decision to feel at home in the facility (they thought that they could control whether the facility felt like their home or not) and to become connected to their new community. Thus, home could be wherever they lived. This relates to the concept of 'home enough' used by

Vilkko (2000): home is not just the private home but can be negotiated in relation to one's changing needs and expectations. Thus, instead of seeing places other than private homes, such as long-term care facilities, as less-than-homes or non-homes, they could be regarded as places that are home enough. In the next chapter, I will further define what kind of places assisted living facilities are.

4.2.2 Assisted living facilities

Long-term care in Finland is provided by municipalities, private entrepreneurs and families (Kalliomaa-Puha & Kangas, 2018). Municipalities can, and have, outsourced care services to for-profit and non-profit private organisations (Puthenparambil, 2018). Care provided in the older person's home (home care or informal care provided by family) and supporting care at home (day care, day and service centres) is the priority in Finland (Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons 980/2012; Kalliomaa-Puha & Kangas, 2018). In fact, traditional institutional care (in care homes and nursing homes) has almost vanished and has been replaced by assisted living (also called service housing or sheltered housing) (Kröger, 2019). In Finland at the end of 2021, only 0.9 per cent of older people aged 85 years and over were living in residential homes and 0.3 per cent in health centres' long-term inpatient wards (see also Figure 2 in Chapter 3.2), whereas 15.2 per cent were living in assisted living facilities with 24-hour assistance and 1.8 per cent in ordinary assisted living (National Institute for Health and Welfare, 2022).

In assisted living facilities, residents have their own apartment or own room, for which they pay rent (Kröger, 2019). They also purchase services (e.g. personal care, meals and housecleaning) provided by the facility according to their needs. Assisted living is divided into *ordinary assisted living* and *assisted living with 24-hour assistance* (or *intensive assisted living*) (Kröger, 2019). The two differ in terms of staff availability: in intensive assisted living, staff are present and care is provided round the clock, whereas in ordinary assisted living it is only provided during the daytime. Thus, ordinary assisted living is intended for older people with less severe care needs but who are not able to live in their private home any more. Intensive assisted living is intended for older people with the greatest care needs, such as those with dementia. As Kröger (2019) notes, however, ordinary assisted living has lost much of its purpose, because most people in assisted living actually need the more intensive care that is provided in assisted living with 24-hour assistance.

Assisted living was introduced to provide more individual and person-centred care for older people than traditional institutions (Kröger, 2019; Pirhonen, 2017). It is also promoted as a 'home-like' environment that has a less medical and institutional appearance than institutions (Anttonen & Karsio, 2016; Roth & Eckert, 2011). Often the residents are allowed to take their own furniture and other personal belongings to the facility, which can enhance the home-like feeling (Johnson & Bibbo, 2014; Petersen & Minnery, 2013; Wada et al., 2020). However, as discussed in Chapter 4.2.1, feeling at home in a long-term care setting is not a given. In principle, assisted living facilities are places that provide health care and social services for older people and are workplaces for care and other professionals (Cutchin et al., 2003; Eckert, 2009; Pirhonen & Pietilä, 2015). Hence, they also entail institutional characteristics.

Service centres are facilities that can provide both ordinary assisted living and intensive assisted living for older people. In addition, they provide a variety of services for the residents and for (older) people living outside the facility. Such services can include, for example, a gym and physical exercise classes, events (e.g. music, theatre), hobby-related activities (e.g. handicrafts), meals, and guidance from a care professional, social worker or physiotherapist. Service centres also have common areas that the residents and people living outside the facility can use, for example to socialise in, read newspapers and magazines, play board and card games or use a computer. As well as providing a home or a home-like place for the residents and providing care and social services, the service centres aim to use these additional services to promote social participation by providing a meeting place for older people living in and outside the facility. In that sense, these facilities act as arenas for interaction between community members, thereby exceeding the boundaries of the facility. Research has shown that nursing homes that are connected to the wider community and general society support a sense of belonging and a sense of home (Calkins, 2018; Johansson et al., 2020).

Social relationships and interaction in the assisted living facility are recognised as important aspects for well-being and feeling at home there. Research indicates that all kinds of social relationships are important for the well-being of the residents, including family relations, relationships outside family and the assisted living facility, relationships between the residents in the facility and relationships between the residents and the staff (e.g. Perkins et al., 2013; Pirhonen & Pietilä, 2015; Street et al., 2007; Street & Burge, 2012; Ball et al., 2000).

Assisted living facilities can be perceived as places that help prevent loneliness and social isolation since one does not have to be alone there (Park et al., 2012).

However, forming and keeping up social relations and staying connected to the social world outside the facility is not always easy for the residents, and this can create feelings of loneliness and social isolation (Jansson et al., 2021; Pirhonen et al., 2018). Residents' opportunities for social interaction are limited by their own and co-residents' poor health and functioning (Jansson et al., 2017; Kemp et al., 2012; Park et al., 2012). Residents of assisted living mentioned that fellow residents' cognitive impairment makes it difficult to interact and form relationships in the facility (Park et al., 2012; Pirhonen et al., 2018). Other factors recognised as influencing social relationships and interactions in the facility include the physical space and the policies and practices of the facility (Kemp et al., 2012; Park et al., 2012; Pirhonen et al., 2018). Policies and practices in assisted living facilities can offer opportunities for social interaction for residents but can also hinder interaction. One example is mealtimes: they offer the opportunity to build relationships, but because of unchanging seating arrangements it is difficult to meet new people (Kemp et al., 2012; Park et al., 2012). Physical aspects of the facility, such as an accessible design and common spaces that facilitate social interaction, can promote residents' opportunities for social interaction, or, when they are lacking, can impede it (Kemp et al., 2012; Park et al., 2012).

4.2.3 Public spaces

As with the concepts of home and house introduced earlier, the concept of public space can be understood by distinguishing it from the concept of private space. Peace (2013) suggests that private space refers to spaces that can be described as individualised, familial, concealed, restricted and intimate, such as the family home, and that public space refers to spaces that can be described as communal, civic, free and unrestricted. Public space can be publicly owned, such as a library or a park, but can be owned independently and be consumerised, such as marketplaces and shopping centres. In this study, the concept of public space refers to both publicly and independently owned and consumerised spaces that are located outside the older person's home or other private spaces, such as the homes of the older person's friends or family.

Out-of-home mobility and the ability to use public spaces are important for the maintenance of physical health (Portegijs et al., 2015) and quality of life (Rantakokko et al., 2016) and an important prerequisite for independent living and societal participation in old age (Iwarsson et al., 2012; Mollenkopf et al., 2011). The ability

to move outdoors is necessary for daily activities, such as shopping, running errands, health care visits, visiting friends and family and leisure activities (Iwarsson et al., 2012). As Holland (2015) notes, for older people, who do not go to work and often live alone, public places play an important role in social connectedness. In that sense, public spaces can be important social spaces, especially for older people. However, moving outside the home and the use of public space in older age can decrease due to health and functioning-related challenges (Holland, 2015; Mollenkopf et al., 2011; Portegijs et al., 2016). Research shows that being older contributes to moving less in one's surroundings (Mollenkopf et al., 2011; Rantakokko et al., 2015). The environment can entail barriers to moving outside the home. Such barriers can include, for example, poor weather conditions (e.g. ice and snow), unstable surfaces, stairs, poor lighting, no seating areas, no handrails, hills and heavy doors (Portegijs et al., 2017; Rantakokko et al., 2015). The availability of transportation (Luoma-Halkola & Häikiö, 2022; Tran et al., 2022) and social networks that support or restrict moving outside the home (Luoma-Halkola & Häikiö, 2022; Mollenkopf et al., 2011) are also important factors. In addition, issues such as fears and anxiety, security of public spaces and financial aspects can affect older people's out-of-home mobility (Iwarsson et al., 2012; Luoma-Halkola & Häikiö, 2022; Mollenkopf et al., 2011). Facilitators for moving outside the home can include factors such as appealing scenery and familiar surroundings (Rantakokko et al., 2015).

Older people themselves regard out-of-home mobility as important, for example to avoid loneliness and enable enjoyable activities (Iwarsson et al., 2012). Older people also want to continue engaging with their communities as they did earlier in life (Thang & Kaplan, 2012). But do public spaces enable them to participate? WHO's *age-friendly cities* initiative promotes the idea that older people should be provided with services and spaces that enhance their health and social participation and enable them to age actively (WHO, 2007). That is, when planning and designing services and spaces, the needs and preferences of older people should be considered. There is much interest in implementing and developing age-friendliness, but the challenges related to this are recognised, such as the inability to consider the diversity of older people and communities and the administrative procedures and bureaucratic rules limiting the realisation of age-friendliness (Torku et al., 2021). Furthermore, researchers argue that instead of focusing only on older people's needs and creating age-segregated environments, the priority should be creating intergenerational spaces that enable intergenerational relationships and participation of people of all ages (Nelischer & Loukaitou-Sideris, 2023; Puhakka et al., 2015). It is therefore

important not only to design the spaces to be physically accessible but also to be open and easy to visit for people of all ages.

How services and spaces for older people are planned, designed and implemented is closely connected to the policy context of the country. As Luoma-Halkola and Häikiö (2022) found, the available resources, such as public transport, rehabilitation services and social networks, were important in enabling out-of-home mobility and the daily life of older people. These were connected to the policy context in Finland promoting older people's independence, activity and social networks as well as ageing in place. Policies promoting independent living and activity construct opportunities for older people to move around outside the home, but also obligations to remain mobile and active. The COVID-19 pandemic was a recent disruption in the everyday life of older people (and other people too), discussed in more detail in Chapter 3.3. The pandemic emptied public spaces and made their importance for social interaction more visible (Sepe, 2021). At the same time as public spaces became restricted, private space (e.g. homes) increased in value, causing inequalities in private space ownership, the most affluent enjoying a more comfortable and varied everyday life in their spacious private spaces (Jasiński, 2022). Because it was emphasised that the disease is most dangerous for older people and because older people were strongly advised to remain in their homes in quarantine-like conditions and to avoid moving outside their home (Ministry of Social Affairs and Health, 2020b), the movement of older people in public spaces was especially restricted. Older people in many countries reported, for example, moving less outside their home during the pandemic and not visiting health care services because they were scared they may catch the virus (Eurofound, 2022).

4.2.4 Virtual spaces

The Finnish National Programme on Ageing 2030 states that technology should be used as one of the key measures to prepare for the ageing of the population in the coming years (Finnish Government, 2023) and to promote health, well-being and independent living at home in old age. Things like enhancing health, supporting care, improving safety and improving opportunities to use services are listed as the benefits of using technology. Finland is not alone in this respect, since technology has been identified elsewhere as a potential solution to rising care and pension costs caused by ageing populations (Bloom et al., 2015; Valokivi et al., 2023). However, the focus is often on the financial gains of using technology to prepare for an ageing

population, and the social needs of older people and the implications of technology for social interaction are more rarely discussed in these contexts. For example, in the Finnish National Programme on Ageing 2030 (Finnish Government, 2023), the social use of technology is only a passing remark.

In this study, I use the concept of *virtual space* to refer specifically to the social use of technology. The concept of virtual space can be used in many different contexts and can refer, for example, to a space in virtual worlds (electronic environments) that mimics physical spaces (e.g. Best & Butler, 2015; Saunders et al., 2011), to a space between a doctor and a patient in telemedicine (Yellowlees et al., 2015) or to a space in social networking sites (Harkin et al., 2022). Nevertheless, virtual space often refers to a non-physical space that is produced by means of technology. The concept of technology can also be understood in many different ways. In this study, I refer to information and communications technologies (ICTs) that are used to communicate with and feel connected to other people, such as ordinary voice calls, video calls, email, instant messaging and social networking, and not, for example, to health-related technology. These might be used, for instance, for social participation, leisure, societal engagement or communication with a service provider. Thus, virtual space in this study is understood as a non-physical space that is produced by means of technology to communicate with and feel connected to other people.

ICTs are used widely for social communication by older people (Hülür & Macdonald, 2020). However, it is still less common for the older population to use ICTs than for the rest of the population (Eurostat, 2020). In Finland, in 2020, 92 per cent of the population aged 16–89 years reported having used the internet in the past three months; of those aged 65–74 the proportion was 88 per cent and of those aged 75–89 it was 51 per cent (Official Statistics of Finland, 2020). Although the majority of the older population in Finland reported using the internet at least sometimes in 2020, much smaller proportions have been reported in some other European countries: for example, in Portugal, Croatia, Slovakia, Latvia, Poland, Greece and Romania over 60 per cent of people aged 65–74 years had not used the internet in the past three months in 2019 (Eurostat, 2020).

The internet is used by older people mainly for social purposes. In the countries in the European Union, the most common (44 per cent) internet activity of older people (over the age of 65) in 2019 was sending and receiving emails (Eurostat, 2020). Participating in social networks was not very common; only 18 per cent of older people (aged 65–74 years) in the countries of the European Union used the internet for social networking (e.g. social media) in 2019. However, again, there were great differences between countries: in Finland 81 per cent of people aged 65–74

and 48 per cent of those aged 75–89 years had used email and 46 per cent of the population aged 65–74 had followed social networking services in 2020 (Official Statistics of Finland, 2020). Ordinary voice calls and short message service (SMS) also play an important role in the social use of technology among older people, as shown by data from six countries from 2018 (Rosenberg & Taipale, 2022). It seems, however, that the social distancing instructions during the COVID-19 pandemic motivated, or forced, older people to learn ICT skills, because the number of older people following social networks in Finland increased significantly during the pandemic (Official Statistics of Finland, 2020) and instant messaging on mobile phones and video calls became more common among the oldest age groups (Official Statistics of Finland, 2021).

The increasing use of ICTs in communication can have positive effects for older people. New technologies and electronic communication, such as cell phones, email, instant messaging and social media, have made it much easier to connect with other people than in times of letters, telegraphs and landlines (Antonucci et al., 2017). Older people, just like other age groups, are likely to benefit from increased social interaction, social support, intergenerational and international contact and improved dating possibilities provided by technology (Antonucci et al., 2017; Hülür & Macdonald, 2020). Rosenberg and Taipale (2022) found that using technology for social purposes was positively associated with better life satisfaction among older people. It seems, therefore, that older people use technology to fulfil their social need, which leads to better well-being.

Older people themselves regard enhanced communication and societal engagement as two of the main benefits of technology (Köttl et al., 2021; Lehtinen, 2023; Pirhonen et al., 2020). That is, technology provides the means to stay connected to other people and to stay updated about current issues. Nevertheless, older people sometimes find using technology difficult due to health and functional decline, unsuitable design and the need to constantly learn how to use new technologies (Köttl et al., 2021; Pirhonen et al., 2020). The costliness of technology is also perceived as one of the barriers to using it (Enwald et al., 2016). Older people are also sometimes doubtful of their own, or other older people's skills for dealing with technologies (Kania-Lundholm & Torres, 2015; Köttl et al., 2021; Pirhonen et al., 2020) and sometimes express a complete lack of interest in technology (Köttl et al., 2021).

Furthermore, increasing inequalities are viewed as a drawback of the increasing use of technologies in society by older people (Pirhonen et al., 2020). In Finland, an ability to use ICTs is required to do many everyday errands, because, for example,

banking services, medical records and drug prescriptions are almost solely available online (Eriksson-Backa et al., 2021; Pirhonen et al., 2020). The use of remote care, that is, video calls, in the home care of older people is also increasing in Finland (Heinonen et al., 2022; Johnson, 2019). However, some older people, and scholars too, are worried that people who cannot or do not want to use technologies will be worse off in a digitalising society (Komp-Leukkunen, 2022; Köttl et al., 2021; Pirhonen et al., 2020).

5 AIMS AND RESEARCH QUESTIONS OF THE STUDY

The aim of the study is to explore the meaning of social spaces for the social relationships and social interaction of older people. The main research question of this study is *how do different social spaces enable or restrict the social relationships and social interaction of older people?* I explore this by posing the following four questions:

1. How does the home appear as a social space for older people?
2. What is the assisted living facility like as a social space?
3. How do older people negotiate challenges and opportunities related to public and virtual spaces?
4. What role do memories play in the social life of older people?

The process of formulating the empirical research questions addressed in the individual articles, creating the synthesis in this study based on the articles, and finally formulating the main aim and individual research questions in this study is presented in Figure 4.

	Article I	Article II	Article III
Theoretical problem derived from previous literature	Social relations are important for health and well-being in old age. What is the meaning of social relationships for the home-dwelling oldest old persons?	Assisted living is a multifaceted environment that is promoted as a home but is necessarily not. What is the role of social relations and interaction?	The COVID-19 pandemic has affected social relations and spaces of everyday life. Pandemic restrictions have affected older people especially. How have older people themselves experienced the situation?
Empirical research questions	How do nonagenarians perceive social relationships? How do well-known models and theories about the quality of life in old age relate to the perceptions of social relationships of nonagenarians?	How do home, institution and community frames define social roles and shape social relationships and interaction in assisted living facilities?	How do older people position themselves in relation to social spaces during the COVID-19 pandemic?

Formulating the synthesis	
Shared theoretical problem in the articles	Experiencing, perceiving and making sense of social relations in old age. What is the meaning of the socio-physical settings of older people's everyday lives for social relationships and interaction?
Conceptualising the shared theoretical standpoints	The concept of social space linking social relations and the context of ageing and providing a lens through which the experiences and sense making of social relations in old age can be viewed.

Aim and main research question of the study
To explore the meaning of social spaces for the social relationships and social interaction of older people: how do different social spaces enable or restrict the social relationships and social interaction for older people?

Research questions of the study
How does the home appear as a social space for older people? What is the assisted living facility like as a social space? How do older people negotiate challenges and opportunities related to public and virtual spaces? What role do memories play in the social life of older people?

Figure 4. Theoretical problems and empirical research questions in individual articles and formulating the synthesis in this study.

6 DATA AND METHODS

The data in this study consist of individual interviews, a group discussion and observations collected in two different research projects, the *Vitality 90+ Study* and the *Ageing and Social Well-being (SoWell)* research project, conducted at Tampere University. First, I will briefly introduce the two research projects, and, in more detail, the data used in this study. Second, I will introduce the different methods, qualitative content analysis, frame analysis and positioning analysis, utilised in the study. Finally, I will discuss the ethical considerations related to this study. A summary of the data used in this study can be found in Table 2.

Table 2. Summary of the data used in this study.

Project	Data used in this study	Description of data	Article
Vitality 90+ Study	Life story interviews with nonagenarians	➢ Year of collection: 2012 ➢ 45 persons (25 women, 20 men) ➢ Age: 90–91 years ➢ Length of recordings: 34 min–3 h 20 min	I
SoWell	Group discussion with assisted living facility residents	➢ Year of collection: 2018 ➢ 7 participants (5 women, 2 men) ➢ Age: 68–101 years (mean 86.6 years) ➢ Length of recording: 1 h 26 min	II
	Individual interviews with assisted living facility residents	➢ Year of collection: 2018–2019 ➢ 10 persons (5 women, 5 men) ➢ Age: 68–94 years (mean 82 years) ➢ Length of recordings: 37 min–1 h 56 min	II
	Participant observation in an assisted living facility	➢ Year of collection: 2018 ➢ 35 hours of observations in shared areas of the facility ➢ Field notes: 62 pages	II
	Phone interviews	➢ Year of collection: 2020 ➢ 31 persons (19 women, 12 men) ➢ Age: 64–96 years (mean 79 years) ➢ Length of recording: 5 min–51 min	III

6.1 Vitality 90+ Study: life story interviews with nonagenarians

The Vitality 90+ Study, initiated in 1995 at Tampere University, Finland, focuses on longevity and the oldest old population. The multidisciplinary research project aims to '*make visible the diverse lives and needs of the oldest old, to improve the position of older people in society, and to develop services for older people so that they can continue to enjoy a good life until the end*' (Tampere University, n.d.-b, para. 3). Since 1995, data for the project has repeatedly been collected via mailed surveys sent to home-dwelling individuals aged 90 or older and later sent to all individuals in that age group living in the city of Tampere, Finland. Data from the national register on mortality and health and social care use have been linked with the survey data. Physical performance tests and blood samples for biological measurements have also been conducted in several years.

Face-to-face life story interviews were conducted in 1995 and 2012. In these interviews, which utilised a semi-structured topic guide (Attachment 1), the participants were asked to tell their life story from childhood to the present day. If needed, elaborative questions were asked about different life stages, such as childhood living conditions, school years, work life or family life. In addition, the participants were asked to talk about their perceptions and experiences of topics related to, for example, ageing, longevity and good old age, hobbies, everyday life and social relationships, illness and health, and changes in the world and in Finnish society during their lifetime.

In this study, the face-to-face life story interviews from 2012 were utilised. In 2012, one out of five home-dwelling men and women living in the city of Tampere aged 90 or 91 years (born in 1921 or 1922) were sent a request to participate in an interview. Of the 99 women and 41 men the request was sent to, 25 and 20, respectively, agreed to participate. The response rate was 25% for women and 48% for men. The participants were sent a short questionnaire along with the interview request asking about marital status, living arrangements, their need for help, and a self-rated health rating. According to the answers to this questionnaire, the majority of the participants were widowed, lived alone, had no need for help and rated their health as average. The characteristics of the participants can be found in Table 3.

The participants were interviewed by three experienced researchers and two medical students who had been trained to conduct interviews. I did not take part in the collection of the interviews in any way. All the interviews were conducted in the participant's home, tape recorded and later transcribed. Each interviewer also wrote short notes about the interview situation and/or the interviewee after the interview. The interview time varied between 34 minutes and three hours and 20 minutes.

Table 3. Characteristics of the participants in the life story interviews.

	Men (n)	Women (n)	Total (n)
Number of participants	20	25	45
Marital status			
married	9	3	12
widowed	11	17	28
unmarried	1	4	5
Living arrangement			
alone	11	23	34
with spouse	9	2	11
Need for help			
no	12	12	24
sometimes	6	8	14
daily	3	4	7
Health			
good/fairly good	8	6	14
average	12	16	28
poor	1	2	3

6.2 Ageing and Social Well-being (SoWell): group discussion, interviews and observations

The SoWell research project is working on the assumption that when attempting to improve well-being in old age, older peoples' own perceptions of what is important for their well-being is essential (Tampere University, n.d.-a). Thus, the project is interested in the expectations, needs and actions of older people regarding well-being and a good life in old age. The project was initiated in 2018 at Tampere University, Finland. Data in the project were collected via group discussions, individual face-to-face interviews, phone interviews and a mailed survey. In addition, I collected data through participant observation. These group discussions, face-to-face interviews, phone interviews and the participant observation and how they are used in this study are elaborated on next.

Group discussions. In 2018, seven group discussions with older people with different backgrounds were conducted. The participants were recruited through service centres located in the Pirkanmaa region of Finland that provide assisted living and low-threshold and free-of-charge services, activities and events for (older)

people living in nearby communities. Participants were also recruited from a group of politically active older persons. The participants lived in urban, suburban and semi-rural areas. Altogether, 40 people aged 55 to 101 years (mean age 78.5 years) took part in the discussions about well-being and different topics that are related to it; a researcher provided topics for the discussions and moderated them. The discussions followed a semi-structured interview topic guide (Attachment 2) in which the participants were first asked what they think well-being is. After a discussion on this topic, the participants were asked how ageing, the living environment, services, the municipality and organisations, technology and the society affect well-being. The aim was to allow the participants to discuss these topics together, and another researcher only acted as a facilitator of the discussions. I took part in the discussions as an observer, making sure the topics in the interview topic guide were covered and that everyone could participate. Each of the group discussions was tape recorded and transcribed later.

One of these group discussions was utilised in this study. It involved seven persons, five women and two men, living in an assisted living facility in the Pirkanmaa region of Finland and aged 68–101 years (mean age 86.6 years); the discussion took place in the assisted living facility. This facility is described as a service centre that provides ordinary assisted living, assisted living with 24-hour assistance and a variety of services and activities for the residents of the facility, but also for older people living in the community (for more information, see Chapter 4.2.2). The participants were all residents of the ordinary assisted living. The facility is located in a suburban area and comprises approximately 150 apartments, half of which are in assisted living with 24-hour assistance and half are in the ordinary assisted living. The facility includes a restaurant/café, recreation and TV rooms, a gym, common saunas and many common areas with sofas, armchairs, and tables and chairs that the residents and visitors can use for socialising, reading, watching television, playing cards and other activities. Recreation rooms are used for socialising but also for events and hobbies (e.g. handicrafts). The participants were recruited with the help of staff members, who evaluated the potential recruited participants' ability to give their informed consent to participate in research, and thus their eligibility for the study. The group discussion took one hour and 26 minutes and was tape recorded and later transcribed verbatim.

Individual face-to-face interviews. Individual face-to-face interviews were conducted during the SoWell project to obtain more detailed and in-depth knowledge about people's perceptions and experiences of well-being in old age. Altogether, 36 people, 15 men and 21 women aged 63–94 years (mean 78 years) were interviewed between

autumn 2018 and spring 2019. Participants were recruited from the group discussions that had been conducted earlier. In addition, in order to increase diversity, new participants were recruited with the help of outreach social work done with the older people and through associations working with older people. The majority of the participants were home-dwelling and ten interviewees lived in an assisted living facility. The interviews followed a similar semi-structured topic guide (Attachment 3) to that used in the group discussions, so the focus was on well-being. The participants were asked first what the word 'well-being' brought to their mind. After that, different themes were covered relating to how ageing, other people, the living environment, society and digitalisation affect well-being. The interviewers allowed the participants to talk about the different topics freely, introducing different aspects of the topic into the discussion and asking elaborative questions when needed. The interviews were conducted by me and another, experienced, researcher.

The ten face-to-face interviews with people living in an assisted living facility were utilised in this study. I interviewed five women and five men aged 68–94 years (mean age 82 years) living in their own apartment in an assisted living facility. The participants were residing in the ordinary assisted living and staff members helped to recruit people who were able to give informed consent to participate in the study. This ensured that no cognitively impaired persons took part in the interviews. All the participants were also relatively independent in functioning: no-one was bedridden, and only a few used a wheelchair or a walker. They used different services provided by the facility (e.g. personal and nursing care, cleaning, meals, social programme) depending on their needs and preferences. Each participant had a rented one-room or two-room flat in the facility that they had furnished themselves. Eight of the interviews were conducted in participants' apartments and two in a recreation room in the facility. The length of the interviews varied between 37 minutes and one hour and 56 minutes. All the interviews were tape recorded and transcribed verbatim.

Participant observation. Participant observation is a method used in ethnography (Hammersley & Atkinson, 2019). As described by Hammersley and Atkinson (2019), ethnography, through participant observation, aims to study people's accounts and actions in an everyday context, that is, in 'natural' settings. The aim of this approach is to understand what people do in their everyday settings, what are the contexts of their actions, what follows from these actions and how they see and talk about their own and others' actions. Through participant observation, one can '*learn the culture*' (Hammersley & Atkinson, 2019, p. 10) of the people being studied and thus better understand their actions and meaning making. I conducted observations in the

assisted living facility where the ten interviewees lived in the spring and summer of 2018, that is, before conducting the individual interviews. I observed only in the ordinary assisted living, where the interview participants lived, and only in the common areas of the facility, not in the participants' apartments. The sites for observing were the corridors of the facility, the recreation rooms, the restaurant/café and the courtyard. Observations took place during weekdays and the time varied from morning (around 9 a.m.) until evening (around 7 p.m.). I observed the everyday life in the facility (what goes on there), had discussions with residents, staff members and visitors, and took part in some of the events and activities organised there. I paid attention especially to social relationships and interaction between people. I chose the sites for observation each time based on where I saw people spending time or moving around. Sometimes I just waited in the lobby to see what is going to happen. Some residents, visitors and staff members approached me to have a chat when they saw me in the facility and I also approached them. Staff members and the residents sometimes invited me to take part in events and activities and sometimes I took part in them out of my own interest. Detailed field notes were written immediately after each visit to the facility. The visits usually took around two hours. I conducted approximately 35 hours of observations and wrote 62 pages of field notes.

Phone interviews. In the summer (June–August) of 2020, we contacted all the participants who had taken part in individual interviews earlier in the SoWell project during 2018 and 2019 and asked them to take part in a follow-up interview. Thirty-one participants (19 women and 12 men) out of the 36 interviewed earlier were reached and agreed to participate. The participants' age ranged from 64 to 96 years (mean age 79 years). In March 2020, before the interviews, the COVID-19 epidemic had begun in Finland and a state of emergency had been declared (Ministry of Social Affairs and Health, 2020d). Although the situation improved during the summer of 2020, by August the situation showed signs that it was worsening again (Ministry of Social Affairs and Health, 2020f). The interviews were conducted by phone to avoid physical contact with the interviewees. In the interviews, everyday life during the pandemic was discussed. The semi-structured interview topic guide (Attachment 4) consisted of three main topics. First, matters relating to everyday life, such as running errands, social contact, loneliness and well-being were discussed. Then the participants were asked about their perceptions and experiences of the aged-based restrictions in Finland. Lastly, the use of digital technologies was discussed. The interviews lasted between 5 and 51 minutes and were recorded and transcribed verbatim. Similarly to in earlier interviews, the participants were allowed to talk as freely as they wanted to about their perceptions and experiences.

6.3 Qualitative content analysis (Articles I and II)

Qualitative content analysis is a method used frequently to analyse text data in qualitative research (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). It is used to systematically code and identify patterns in the content of text data (Hsieh & Shannon, 2005). Hsieh and Shannon (2005) suggest that there are three different approaches to conducting qualitative content analysis: conventional, directed and summative approaches. Conventional qualitative analysis refers to a similar way of utilising qualitative content analysis to what Elo and Kyngäs (2008) call the inductive approach. The conventional, or inductive, approach is used when prior knowledge about the studied topic is scarce and preconceived categories derived from earlier theory or literature are not used as the basis of analysis. That is, the researcher generates categories from the data rather than looking for certain themes in the data that are based on earlier research or an earlier theory. In contrast, in the directed approach, or the deductive approach, as it is called by Elo and Kyngäs (2008), existing theory or prior research is used as the basis of analysis: in this approach the aim is often to validate or extend theory or a theoretical framework. Here, therefore, the preconceived categories guide the analysis. A combination of these, the abductive approach (Graneheim et al., 2017), moves back and forth between inductive and deductive approaches. For example, the analysis can begin without employing any theoretical framework but utilises prior literature later when creating categories.

Hsieh and Shannon refer to summative content analysis (2005) as an approach used in qualitative content analysis that starts by quantifying certain words or content in text to identify how often and in what kinds of contexts certain words or content appear in the data. The analysis is then continued by interpreting the underlying meanings of the words or content in the studied context. This relates to what Graneheim and Lundman (2004) call one of the basic issues when performing qualitative content analysis: deciding whether the analysis will focus on the manifest or the latent content. Manifest content refers to what is said in the text, the obvious content of the text, which would be the focus in the first phase of the summative approach of content analysis. Latent content refers to what the data is talking about, that is, interpreting the underlying meaning of the content, which would be the second phase of summative content analysis. Both manifest and latent content, however, require interpretation (Graneheim et al., 2017).

What exactly is being studied, and how, with qualitative content analysis naturally relates to the researchers ontological and epistemological assumptions. Graneheim et al. (2017) point out that researchers with a positivistic view (used in quantitative

content analysis) strive to capture some objective 'truth' in the data, whereas those with a hermeneutic view (used in qualitative content analysis) aim to reveal meaning in the data using different levels of interpretation. Graneheim et al. (2017) go on to suggest that qualitative content analysis moves between phenomenological and hermeneutic approaches: during the analysis the researcher often begins with a more phenomenological approach, grouping the coded manifest content into categories, and then moves on to interpreting the meanings, the latent content, of the data.

Qualitative content analysis was used in Article I and Article II. In Article I, qualitative content analysis was used to study how the oldest old persons perceive social relationships. As the perceptions of the oldest old persons of social relationships have rarely been studied, and as the interest was in exploring different perceptions related to the topic, the conventional, or inductive, approach to qualitative content analysis was used (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). This meant that no preconceived categories or theoretical framework was used when analysing the data and instead the researchers generated the categories from the data. In practice, I began the analysis process by thoroughly familiarising myself with the data by reading and re-reading it. After that the data was coded, that is, the sections of data relating to social relationships were identified and initial codes relating to what is being said in the text sections were allocated to them. For example, sections in which a participant described help were coded as 'help from relatives', 'help from neighbours', 'helping friends', 'being independent' etc. based on what was described. This can be identified as the phase of the data analysis where the focus was more on the manifest content of the data (Graneheim et al., 2017), although interpretation of the underlying meanings inevitably occurred at the same time. The analysis proceeded by going through all the coded data and concentrating on finding similarities and differences between the coded segments. Next, categories were created (e.g. 'receiving help', 'giving help', 'independence') by grouping codes with similar content. This was continued to create higher-order categories (e.g. 'help'), which described the content at a more general and abstract level. In these latter phases of the analysis the focus was more on the latent content (Graneheim et al., 2017). Interpretations were made to discover the meanings of the content. For example, how descriptions of receiving help, giving help and being independent relate to the meaning of social relationships for the oldest old persons.

In Article II, qualitative content analysis was used to study the assisted living facility as a social environment. The aim was to find out how home, institution and community frames define social roles and shape social relationships and interaction in an assisted living facility. The analysis was guided by Erving Goffman's

(1974/1986) theory of frames (see next chapter for more information). Thus, the analysis can be called a directed approach of qualitative content analysis. The initial phase of this approach was similar to that of the inductive approach: the analysis began with reading the data carefully multiple times to familiarise myself with it. In the next stage, I coded the data by identifying sections of data that related to social relationships and interaction. That is, sections in which the participants talked about, or where I had observed, their relationships and interaction with staff members or other residents were coded, for example, as 'staff as helpers', 'staff as friends', 'other residents as friends' or 'indifference towards other residents'. After these phases had been completed, the theory of frames was applied and three frames, home, institution and community, guided the analysis. The last phases of the analysis conducted in Article II are described in the next chapter after the introduction of the theory of frames on which the analysis was based.

6.4 Frame analysis (Article II)

Frame analysis is a book by Erving Goffman (1974/1986) and the name of a method of qualitative analysis used in many different disciplines to study different kinds of topics (e.g. Cornelissen & Werner, 2014; Harnett & Jönson, 2017; Tynkkynen et al., 2012). Goffman's frame analytical theory and thinking has been thoroughly introduced elsewhere (Peräkylä, 1990; Persson, 2019; Puroila, 2002). Here, the aim is to briefly describe how the concepts of frame and framing can be understood and how they have been utilised in this study.

In the book *Frame analysis: An essay of the organization of experience*, Goffman (1974/1986, p. 10) studies '*the basic frameworks of understanding available in our society for making sense out of events*' and the ways in which these frameworks are subject to transformations and disruptions. That is, Goffman is interested in understanding 'frameworks' that appear in society and that affect our understanding of events that happen around us and involve us. He is also interested in understanding the vulnerabilities of such frameworks. What are these 'frameworks', then, that Goffman is referring to? He says (pp. 10–11): '*I assume that definitions of a situation are built in accordance with principles of organization which govern events – at least social ones – and our subjective involvement in them; frame is the word I use to refer to such of these basic elements as I am able to identify.*' That is, the way in which each social situation is defined depends on 'principles of organization' that not only guide events that happen around us but also the way in which we are involved in these events. These principles of

organisation, which Goffman calls *frames*, affect our understanding of social situations.

In Article II we argued that in the everyday life of an assisted living facility at least three frames could be identified: a home frame, an institution frame and a community frame. This observation was based on earlier literature showing that assisted living facilities are complex environments that, on one hand, should be an older person's home, but on the other hand are also sites of care work and institutional practices (Eckert, 2009; Pirhonen, 2017; Roth & Eckert, 2011) as well as spaces that aim to facilitate social participation and act as a meeting place for older people (Johansson et al., 2020). A similar idea of different frames in the older people's nursing homes was presented already by Gubrium (1975/1997, p. xix) who suggested that the nursing home consists of different 'worlds', that of the staff members and the residents, that affect the ways of knowing and experiencing in the facility. These different worlds organise life and relations in the facility and affect the way different experiences in the facility become understandable. Building on this, understanding the different characteristics of an assisted living facility as frames meant understanding that each of them affects, in their own way, how everyday life social relationships and interaction in the facility are organised, interpreted and made sense of. These three frames can be thought of as lenses through which social life in an assisted living facility is viewed, as illustrated in Figure 5.

Goffman (1974/1986, p. 8) suggests that when we enter an event, we ask ourselves '*What is it that's going on here?*'. The answer to this question defines the event and the expectation concerning the actions of individuals at such an event. When we are trying to find the answer to this question, we draw from our culturally constructed understanding of the norms and rules that guide such events. That is, we draw from frames in order to understand events and how we should be involved in them. In an assisted living facility, this would mean that people involved in the facility's everyday life are constantly *framing* the events (e.g. encountering staff members and other residents or taking part in organised activities) in the facility. How each of the events is being framed affects how an individual acts, or interacts, in the facility. Thus, different ways of framing the facility, as a home, on one hand, or as an institution or community on the other, define social relationships and interaction in the facility by enabling different kinds of interpretations of the setting and related 'rules' for action.

The beginning of the analysis process in Article II was described in the previous chapter. In the first phase of the analysis, the sections in the data that related to social relationships and interaction were identified and coded. In the second phase, the

theory of frames by Goffman guided the analysis: the aim was to identify how the three frames – home, institution and community – define social relationships and interaction within the identified data sections. Three questions were developed to identify the frames: 1) what kind of relationships and interaction are enabled or ruled out in the situations concerned? 2) who or what defines the 'rules' of interaction? and 3) to what extent can residents control their own social interaction? These questions were used when reading the data and trying to identify the different ways of framing social relationships and interaction in each of the data sections. For example, when the code created in the first phase of the analysis, 'indifference towards other residents', was examined using the three questions, we found that the institutional practices in the facility affected the interaction between the residents and that the contact with other residents was not necessarily voluntary. Thus, we coded these under the institution frame. On the other hand, when we examined data sections previously coded as 'staff as residents' friends', we saw that the institutional practices or formal 'rules' of the facility were not present and that more informal social relationships were enabled. These were coded under the home frame. After reading each of the previously coded data sections carefully multiple times and posing the above questions regarding each of them, the sections were grouped under the applicable frame. Hence, an understanding of the social relationships and interaction in each of the frames was created.

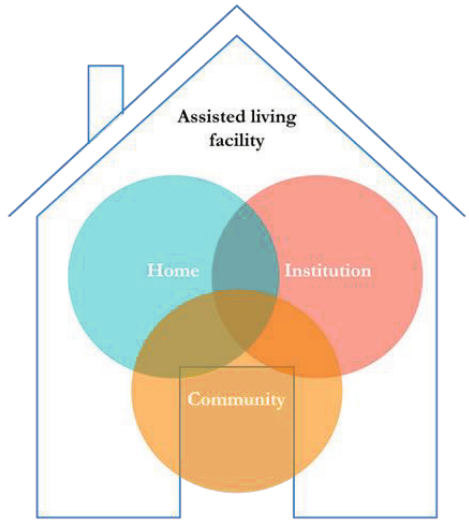

Figure 5. Three frames in assisted living facilities.

6.5 Positioning analysis (Article III)

Discourse analysis refers to a multitude of ways to approach language use (Cheek, 2004; Potter & Wetherell, 1987). Drawing from social constructionism (Burr, 2015), discourse analytical approaches take the view that language not only describes things but also does things (Potter & Wetherell, 1987): people use language to construct versions of the social world, to construct reality. Positioning theory and the methodological application of it, *positioning analysis*, are grounded in these notions; they suggest that how people use language and respond to others' use of language constructs social reality (Harré & van Langenhove, 1999). The way in which everyday language, discourse, is used, makes *positions* available that constitute people's understanding of themselves and of others (Davies & Harré, 1990). These positions, which are constructed through discourse, determine the perspective from which an individual sees the world and assigns related rights, obligations and duties that can, however, also be resisted and rejected (Davies & Harré, 1990; van Langenhove & Harré, 1999).

The concept of position relates to the concept of role in that it provides a more flexible alternative to it and draws attention to the dynamic aspects of encounters between people (Davies & Harré, 1990; R. Harré & van Langenhove, 1999). Hence, people, through various discursive practices, can flexibly position themselves and also be positioned by others (van Langenhove & Harré, 1999). Positions, in turn, are elaborated by larger normative stories, storylines, that provide the context in which positions are taken (Allen & Wiles, 2013b; Davies & Harré, 1990). That is, people not only position themselves in relation to other people but also in relation to storylines that are drawn from cultural repertoires, or can be invented, and that act as a tool to make sense of why certain positions are unfolding. For example, the position of someone who does not have children can be made sense of in relation to the normative storyline of 'married with children' being the only acceptable way of life (Allen & Wiles, 2013a). The discourses used and the positions and storylines unfolding are interconnected and determine each other (Allen & Wiles, 2013b; van Langenhove & Harré, 1999). That is, people use discourses to position themselves within familiar and personal narratives, but these narratives also affect the way people position themselves and use discourses.

Positioning analysis was used in Article III to study how older people positioned themselves in relation to social spaces during the COVID-19 pandemic. That is, the article was interested in what kinds of positions unfolded in the interviews with older persons and how these positions are related to different social spaces in the context

of the pandemic, which was when the interviews were conducted. Because the pandemic, through the enforcement of restrictions targeted especially at older people (Ministry of Social Affairs and Health, 2020b), can be viewed as positioning older people as a vulnerable group (e.g. Fraser et al., 2020; Morgan et al., 2021), Article III aimed at identifying the ways in which older people positioned themselves in this context. Furthermore, as the restrictions during the pandemic concerned the social life of older people and the spaces and places in which that social life occurred, the concept of social space was used to direct the focus to positions taken in relation to spaces and places of social life. To this end, we also utilised *environmental positioning*, which draws from the framework of positioning theory, to focus on how people negotiate multiple meanings of self and places (de Medeiros et al., 2013). Environmental positioning, according to de Medeiros et al. (2013), suggests that the human and non-human dimensions of space play an important part in taking up positions. That is, the relational, fluid, contradictory and contested relationship between a person and the environment affects the way people position themselves. Thus, in Article III we posited that the way older people position themselves during the pandemic was influenced by the meanings given to and the relationship with the spaces and places in which their lives unfolded.

The analysis can be divided into two phases. In the first phase the aim was to identify talk about social life in the interviews and identify the spaces that the social life talked about related to. First, the data was read and re-read carefully. Next, the data was coded by identifying the sections of the data in which the participants talked about their social life (e.g. family, hobbies, receiving help, loneliness). After thoroughly familiarising myself with these sections, they were coded based on the space they referred to (e.g. social life in the home). Finally, groups were formed representing different social spaces and related talk.

In the second phase of the analysis the aim was to identify the ways in which the participants positioned themselves in relation to the social spaces identified in the first phase of the analysis. This was done by looking for recurring patterns of talk, discourses, in the data by identifying different ways the participants talked about social life in the context of different spaces. The identified discourses were examined to see what kinds of positions they construct. That is, we tried to find out what kind of perspectives the participants saw the world from and how these perspectives relate to human, non-human and time-contingent aspects of spaces, such as physical distance, accessibility and past experiences of spaces. The larger normative stories, storylines, were identified next in order to understand the unfolding positions. That is, the positions were examined in the context in which they were taken up. For

example, as the participants positioned themselves as restricted within their social spaces, these positions could be understood within the storyline of 'following the rules' as the only option during the pandemic or within a personal storyline of illness that prevents one from moving outside the home. By examining each identified pattern of talk this way, an understanding of the different ways the participants positioned themselves in relation to social spaces was created.

6.6 Ethical considerations

The collection of data in the Vitality 90+ Study was approved by the Regional Ethics Committee of Tampere University Hospital. In the SoWell project the research protocol was approved by the Ethics Committee of the Tampere Region. The collection of participant observation data was also approved by the Ethics Committee of the Tampere Region. I was involved in writing the detailed requests for the ethical review statements in the SoWell project and in the collection of the participant observation data in 2018. I was not involved in the process of acquiring the ethical approval for the Vitality 90+ Study. I have familiarised myself with the ethical guidelines issued by the Finnish National Board on Research Integrity TENK (2019), especially in preparation for writing the requests for the ethical review statements and have followed these guidelines throughout the study.

One of the central ethical principles in research involving human participants is the informed consent of the participants (Finnish National Board on Research Integrity TENK, 2019). The participants interviewed in this study (both in individual interviews and the group discussion) were informed about the research prior to participating and gave their consent (verbally and in writing) to participate in the research. Informing the participants meant providing them with an information letter containing information about the study (such as the topic and aims), the procedures that the study would follow (how data would be collected and where, when and how the results would be reported), the participants' rights (voluntariness and right to discontinue participation at any time), confidentiality of the information collected, the use and storage of data and the researchers' contact information. The participants were also provided with a written privacy notice concerning the data collected during the SoWell project from autumn 2018 onwards (the group discussions and individual interviews) in accordance with the General Data Protection Regulation (EU 2016/679) that has applied to European Union countries from the spring of 2018. The privacy notice includes information about data privacy

and security. The contents of the information letter and the privacy notice were also discussed with the participants before the interview or group discussion to ensure they understood them and had the opportunity to ask questions about the research and participation in it.

In ethnographic fieldwork, the question of informed consent is somewhat more complicated. It is often not possible or practical to acquire informed consent from all of the people present in the setting (Murphy & Dingwall, 2007). I conducted my fieldwork in the common areas of an assisted living facility, such as the corridors, the courtyard and the restaurant, so lots of people were present in the setting and passed through it. Because the settings in which I conducted the observations can be described as semi-public spaces, it is reasonable to think that informed consent was not required from each person encountered there (Murphy & Dingwall, 2007). However, because the setting was semi-public and the facility was the workplace of the staff members, the home of the residents and was visited by the latter's relatives, I put a lot of effort into thoroughly informing the people in the facility of my presence there, my position and the research I was conducting there.

I obtained permission from the organisation to conduct the fieldwork and the staff members were informed about the research by the organisation. I attended a staff meeting and a gathering organised for the residents and their relatives to introduce myself and my plans for the collection of data in the facility. A staff member showed me the different parts of the facility and at the same time introduced me to staff members, residents and visitors to the facility when we encountered them. Information letters about my research (including a short description and the aims of the study, information about the data collection and my contact information) were distributed in the facility. When I was observing in the facility, I wore a name tag that also indicated my position (researcher). I also introduced myself to people I approached (or who approached me) and told them about the research I was conducting there. I wanted to do this to make sure people were aware that I was not a staff member or a volunteer but a researcher collecting data for research purposes. This gave them the opportunity to decide whether they wanted to discuss anything with me and what they wanted to share with me, knowing that what they said may be used in research.

While observing in the facility, I paid a lot of attention to ensuring that my behaviour towards other people in the facility was respectful and courteous. As Murphy and Dingwall (2007) note, ethnographical research requires ethical sensitivity and situational judgement that often cannot be enforced by ethical regulatory regimes. This means the researcher needs to be sensitive to participants'

signals when deciding, for example, whether to approach them at a particular moment or to give them privacy or whether a discussion topic might be uncomfortable for the participant. The same kind of sensitivity is required when interacting with the participants while conducting interviews and group discussions. For me, being respectful and sensitive in encounters with the participants of this study was a core principle.

Qualitative research should be based on reflexivity. This means the researcher should actively acknowledge the impact of her own positionality (e.g. gender, age, race, immigration status, sexual orientation) and biases, beliefs and personal experiences arising from that on the research process and outcome (Berger, 2015). Since the researcher is intimately involved in the process and product of research, reflexivity is necessary to evaluate the plausibility and trustworthiness, as well as the ethical conduct, of research (Berger, 2015; Horsburgh, 2003). I am aware that I am not free of assumptions and prejudices that could have guided my thinking, from planning the research to analysing the data and making conclusions about it. As a relatively young person (under 30 at the time of the data collection) without any professional experience of older people or the services they may use, I did not have a prior understanding of older people's lives, experiences or services. This does not mean, however, that my thinking would not have been influenced by the socio-cultural understandings of old age prevalent in Finnish society (e.g. ageistic views of what older people are like). When studying 'others', that is, a group of people we do not belong to ourselves, reflexivity is vital (Fawcett & Hearn, 2004). As Lumme-Sandt (2005) argues, younger people who are unfamiliar with old age and the experiences of older people might have particularly prejudiced and stereotypical views of older people that should be acknowledged when conducting research. During the process of this study, I have aimed to acknowledge my own positionality and bias by critically reflecting on my initial thoughts arising from the data collection and the analysis and interpretation of the findings. The co-authors of the individual articles and the supervisors of this study, as well as other colleagues and peers, have helped me to question my own assumptions by providing their views and interpretations throughout the process of this study.

The Finnish National Board on Research Integrity TENK (2019) states that a limited capacity of a person due to, for example, illness or age does not in itself limit the autonomy of a person to decide whether or not to participate in research. When a person's capacity to give consent to participating in research is limited, written consent from the person's relative or legal representative is needed. The people participating in this study did not have such limited capacity, e.g. dementia-related

illnesses, that would have affected their ability to give their consent to participate in the research. In the assisted living facility, the participants' ability to give their consent to participate in the study was evaluated by staff members, who helped to recruit the participants for the group discussion and interviews. The intention of the ethnographical observations in the facility was not to study persons with advanced cognitive impairment. For example, I only made observations in the ordinary assisted living setting; I did not conduct any in the setting of assisted living with 24-hour assistance, which is where older people with dementia-related illnesses mostly live. However, it was impossible not to encounter persons with more advanced cognitive impairments in the common areas of the facility, since they sometimes took part in activities and gatherings in the facility or spent time with their relatives in the common areas. The same issue of the practical impossibility of excluding people with cognitive impairment from ethnographic research in assisted living or nursing home settings has been found in earlier research too (Balkin et al., 2023; Pirhonen, 2017). Similarly to Balking et al. (2023) and Pirhonen (2017), I aimed to inform people about my research in a way that meant people with different capacities could understand it, and I used situational judgement and ethical sensitivity at all times in the facility, e.g. backing off from or not approaching situations I evaluated as not ethically sound.

Respecting the participants, one of the core principles in this study, goes beyond the data collection phase and extends to reporting the results and storing the data. When reporting the results, I have aimed to protect the privacy of the participants by using pseudonyms and not including personal information relating to the participants (e.g. names of places and people) in the data excerpts. I have aimed to depict the participants in a respectful way when reporting the results, avoiding any prejudiced or demeaning depictions. The data has been stored securely in Tampere University's backed-up and password-protected cloud storage so that no outsider can gain access to it and no data can be lost by mistake. The Vitality 90+ data is discretionally available for research purposes upon request from the project leader. The plan for the SoWell project is that after the project has ended, the data will be deposited in the Finnish Social Science Data Archive after it has been ensured that the data are fully anonymised. The participants have been informed about how the data will be stored and used.

7 RESULTS

In this section I will present the main results from Articles I, II and III. In the articles I have addressed questions related to the perceptions of social relationships of home-dwelling oldest old persons, the social relationships and interaction in an assisted living facility and older people's views of social relationships and spaces during the COVID-19 pandemic. The results are organised under four subheadings and provide a synthesis of the main results in the three original articles. In this synthesis, I examine the ways in which different social spaces – home, assisted living, public spaces, virtual spaces and memories – are important for older people and their social lives. The results are illustrated by using excerpts from the data. All the names used in the text and in the excerpts from the data are pseudonyms.

7.1 Depicting home as a social space

As discussed earlier, in Chapter 4.2.1, home is a complex construct. In relation to discussions about old age, home is strongly linked to ageing in place policies (Chapter 3.2) and the idea that the best place for an older person to live is in their home. Home-dwelling oldest old persons can be regarded as successful because they are living their life according to the ideals of the ageing in place policy. The COVID-19 pandemic (Chapter 3.3) also placed home, especially the homes of older people, at the centre of everyday life. Thus, what the home means for older persons living their everyday lives within these contexts is a matter of great interest regarding the opportunities and challenges the home environment provides for them. In the first research question of this study, I am interested in what kind of a picture of home as a social space is being drawn in the interviews with home-dwelling nonagenarians (Article I) and older people during the COVID-19 pandemic (Article III): how home as a social space appears in these interviews.

The life story interviews with the oldest old persons were a fascinating read. Although I did not conduct the interviews myself, the format of the interviews allowed me to get absorbed in the life events and experiences of people who had led long and diverse lives. Their lives, I noticed, were surrounded by other people. These

other people in the nonagenarians' lives were of great importance to them. The nonagenarians felt especially close to their children and grandchildren and often talked about their relationships with them as significant and meaningful in their lives. Nevertheless, the participants also highlighted that having social relationships in general – having social relations in the first place, being surrounded by other people and being social – were valuable in life. The reason for this valuation of social relationships, close relationships and having relationships in general, was related to the help received but also to being needed by others, to feeling valued and safe, to having company and to feelings of joy and grief.

The way the nonagenarians maintained their social relationships suggests that home was the central social space for them. The participants said that they met with their children and grandchildren and also, sometimes (although quite rarely mentioned), with other relatives. What was characteristic of these descriptions of meeting other people was that these other people visited the nonagenarian's home; it was rarely the other way round. Thus, the home of the nonagenarian, but not the homes of these people who were close to them, played an important role as a site for social life. The main reason for the centrality of the home space was the nonagenarian's deteriorating health and functioning. Poor eyesight, hearing and functional ability and increasing health problems were reasons why the nonagenarians did not leave their home very often. The participants' friends of a similar age, as explained by Martta next, were in a poor condition themselves as well, or had died already, so visiting them or them visiting the participant was not possible.

> Then, all my childhood friends and close acquaintances and workmates too, they have all died. I no longer have those kinds of close acquaintances, that's what's true. And when there's someone, who'd still be there, they're so sick, and so forth.

The centrality of the home space for nonagenarians' social life, what we called *place-bound sociality* in Article I, was also evident in the descriptions of the important means of staying in touch with other people and in the descriptions of neighbours. The difficulties the nonagenarians experienced in maintaining social relationships were facilitated by using the phone. Since it was not self-evident that moving outside of home was possible for the participants, the social relationships that would have been hard to have anyway, with friends in poor health and relatives living further away, for example, were brought closer by phone calls. The phone played a key role in the social life of the participants, allowing them to bring those further away close, 'inside' the nonagenarian's home. Thus, the emotional closeness of the social relationships was a significant factor in social relationships, but so was the physical

proximity of other people. This was evident in the descriptions of neighbours, who were described as having an important social relationship with the participants. Neighbours were a vital source of help, especially with different kinds of outdoor chores, such as snow clearance, and also a source of company, because they lived close to the nonagenarian: their proximity allowed the participants to be social within their home environment.

Home space for nonagenarians was not just characterised by the existence of social relationships within the home, but also by the lack of them. The death of loved ones was commonly brought up in the interviews with nonagenarians. Erik was one of the interviewees who had lost their spouse (in fact, most of the participants were widowed). The loss of his wife made his home a lonely space:

> Researcher: What is most unfortunate at this old age?
>
> Erik: It would be nice to sometimes talk in here, sometimes when you wake up. When you're not completely conscious, you can almost feel that your wife is lying next to you. That you ought to talk, but then you realise that you're all alone here. Indeed, there's no one else here.

Erik could still almost feel the presence of his wife in their home, but then eventually noticed that there was no-one else there but him. The presence of his late wife that he felt in the space reminded him of and accentuated his own aloneness. It was not only the spouses of the nonagenarians who had died, though, but also many of their friends and relatives. This was sometimes talked about as a very natural thing and that the death of their loved ones had made them less interested in the outside world and more interested in their life in the home. Thus, having a busy social life and being able to be connected to the outside world was not very important any more for all of the nonagenarians; the most important thing was having a good home. Like Amanda said, '*I can be happy, when I have a good house and I feel good.*'

Not every difficulty with maintaining social relationships in the oldest old age was related to illness and death, however. Sometimes the relatives and friends of the nonagenarian lived further away or the nonagenarian herself/himself had needed to move further away from familiar social relationships. This sometimes made the participants feel lonely. The nonagenarians also sometimes felt that their relatives did not have time to visit them: they felt that younger people had such busy lives that they did not have time for them. However, this was also seen as a natural part of life: that younger people should be busy and thus not have much time for the older generation, as Helena said:

> But that's how it is, my relatives, they have so much of their own activities. […] Those younger people, they don't have time. I get it that they have their own hassles.

The nonagenarians talked about getting help from their children and grandchildren with various everyday tasks, such as cleaning, banking and shopping. However, they also talked about maintaining independence, and although they needed help, they wanted to make sure they were not patronised by their helpers. Nevertheless, for some, being independent was not a matter of choice, but a necessity: not having anyone to help meant having to be independent whether they liked it or not. Wanting to be independent was related to the constraints of living at home in the oldest old age and inevitably needing help from others: if help was available, independence needed to be sustained by making sure no-one was patronising, but when help was not available, being independent was the only way to continue living in one's own home as an oldest old person. Thus, for some of the participants being independent was a choice, whereas for others it was a necessity, a *forced independence*. This depicts a picture of the nonagenarian's home as a site where life is managed with the help of others, but also as a space that has to be coped with on one's own.

The centrality of the home was also evident in the descriptions of social relationships by older people during the COVID-19 pandemic (Article III). As older people were 'obliged' to stay in their home and to avoid moving outside their home, some of the participants had the impression that they were not 'allowed' leave their home. The participants therefore regarded home as a space where they should remain. In this situation they saw it as natural that they received help from their relatives (mostly children) with running errands, such as shopping, while they stayed at home. Similarly to the nonagenarians' situation, life at home was managed with the help of other people. They understood not being allowed to move outside their home as restricting their option to have social contact, as Reijo reflected when he was asked how the pandemic had affected his life:

> Well, I've lost friend- not lost but people have become more distant. I haven't been allowed to maintain social contact. That's the first thing that comes to mind. I mean I would have wanted to maintain more social contact. Because I wasn't all that afraid of the virus, but I wasn't sort of defiant either. I kept my distance, but there were a few of us here who talked with one another, even daily in the yard, remote discussions.

Although he was not allowed to maintain social contact the way he would have wanted to, Reijo discovered that his neighbours could provide the company he needed, because they could meet in the outdoor areas of their apartment block and

keep some distance from each other. Neighbours, who are easily reached within one's home environment, became an important source of company in the same way as for the oldest old persons. The participants, in addition to using people close by, the neighbours, and the more spacious outdoor areas as, respectively, a source of and site for social contact during the pandemic, relied on phone calls, again similarly to the nonagenarians. This was an easy way to maintain social contact and social relationships 'safely' from one's home, since face-to-face contact was not recommended due to the risk of contracting the virus. In this case, also the maintenance of social relationship was possible with the help of the phone from the safety of one's home.

Staying at home and having limited social connections, although described as unfortunate by some of the participants, was also experienced as a natural circumstance. Being alone at home was regarded as a natural part of life in old age and was not seen as a problem. However, some of those who talked about how natural being alone at home was for them, also mentioned that they are sociable people and miss social contact. Thus, seeing home as a space where being alone is natural did not mean one would not want to have social relations and to be sociable. It was also suggested that one can adapt to life alone at home without much social contact. Engaging in solitary activities at home, such as knitting and weeding, was considered a way to adapt to the situation of obligatory near-isolation that arose because of the pandemic.

Although some of the participants talked about needing to stay at home or even preferring to do so, their lives were also tied to their home space for reasons that were not related to the pandemic, nor to their willingness to be alone at home. Some participants said that they did not have close relatives who could visit them or whom they could visit. Some had an illness that prevented them from moving outside of their home. The pandemic did not really have much effect on their lives since life for them was already characterised by being alone at home. As Markku, who had limited mobility, put it, '*I'm still here, existing and sort of isolated in a way*': his home was a place where he 'existed' in isolation from others during the pandemic, but also earlier and in the future, if he was not able to relocate to an assisted living facility, as he wished. These personal situations not related to the pandemic resulted in having to be alone at home whether or not one wanted this.

In summary, in this study, home as a social space appeared to be a hub of social life. This was due to declining health and functional abilities (of oneself and one's social network), the death of loved ones and not being allowed to move outside the home. At the same time, the home appeared to be a lonely space where one's

aloneness was accentuated by the lack of meaningful social relationships and the inability to move outside the home. Nevertheless, home could also be a space where one did not mind being alone and a space that gained importance when interest in having a busy social life in the outside world was decreasing. Home was also a space that existed not only inside four walls but extended to the neighbourhood and outdoor spaces nearby where other people were encountered and from where help was received. The meaning of those four walls of the home was also diminished by technology, that is, phone calls, which enabled social contact in situations in which keeping in touch with others would have been difficult or impossible otherwise. Finally, the home appeared to be a space in which living was enabled and supported by social relationships or was defined by the need to remain active and independent on one's own.

7.2 Framing the social space of assisted living

The previous chapter considered the meaning of the home for social relationships in two different but somewhat similar contexts: in the oldest old age and during the pandemic. In this chapter I turn my attention to a place that, on one hand, can also be understood as a home, but that, on the other hand, also entails different characteristics that make it different from a private home: an assisted living facility. As previously argued (Chapter 4.2.2), although assisted living facilities are promoted as the older person's home, or at least a home-like place, they inevitably entail characteristics that make them different from the private home. They are also a workplace for care professionals in which certain routines and procedures are in place. The presence of staff and the schedules and rules of the care work and communal living bring some institutional characteristics into the assisted living facility environment. Assisted living facilities are designed to bring together the older people who reside there, for example to spend time in the shared areas, and they can also act as meeting places for older people living outside the facility. Thus, they can also be understood as communities.

Bearing these points in mind, the second research question in this study asks what kind of social space an assisted living facility is. I approach this question by studying the different characteristics of an assisted living facility and how they are related to social relationships and interaction (Article II) and by studying older people's thoughts about and experiences of assisted living facilities during the COVID-19 pandemic (Article III).

On one occasion, as I was observing everyday life in the assisted living facility, I sat with the residents in the dining room, listening to their discussions and taking part in them myself too. What caught my attention in one discussion was how the word used to refer to another older person sitting further away from our group was negotiated. The word 'patient' was suggested first, and then 'customer'. These were quickly rejected, however, as not suitable for describing the person. Finally, the word 'resident' was found to be suitable by the participants in the discussion. Why were words such as patient, customer and resident relevant words to describe another older person living, or at least spending time (the person could have come from outside the facility to use some of the services there), in an assisted living facility? The participants had been trying to find the right word to describe a person who was similar to themselves: who was in the same place where they lived and spent their time. In that sense, finding the correct word was not just about how to talk about other older persons in an assisted living facility, but about how to describe oneself in such a setting. In other words, the discussion entailed framing the assisted living facility in a way that allowed them to describe themselves in a certain way. Is the assisted living facility a place where we are patients (such as a hospital or another kind of an institution), is it a place that provides services for customers (a service centre) or is it our home, where we are residents, just like in any private dwelling?

During my further observations and by analysing a group discussion and individual interviews with the residents of the facility, it became clear that the assisted living facility could be understood differently in different situations. At another time, I was observing, again in the dining room. The residents were sitting around the tables, but they did not make much contact with others or talk to each other much. I wondered *what might be going on here* (Chapter 6.5, Goffman 1974/1986): why are people sitting here together but not doing anything together, not even talking to each other? After a while, members of staff came into the dining room and started serving meals to the residents, and the reason for the residents sitting together in this way became clear to me. They had come to wait for their dinner. What happened in the dining room made sense within the institutional framing of the facility: the rules and schedules of the facility determined when, why and how the residents came together, and these rules and schedules affected the expectations of how they would act in such situations. Socialising in such a situation seemed not to be a priority, but the meal itself was.

The rules of the assisted living facility were also visible during the COVID-19 pandemic. The interview participants, who lived in an assisted living facility, said that since visits inside the facility were prohibited due to the pandemic, visitors could

only be met in the outdoor areas of the facility. This was common in assisted living facilities in Finland. However, even these meetings in the outdoor areas were supervised and regulated: staff members made sure the rules of the facility, for example, wearing a face mask, were followed. Jussi, an assisted living resident, described how, when his daughter visited him in the outdoor area of the facility, '*a nurse turned up and said they'd been informed there was an outsider here, that you should be wearing a mask*'. Jussi did not have much privacy in this situation or much control over how he wanted to meet his relative. The rules of the facility determined how and where the residents were allowed to be in contact with other people.

As we have seen, an institutional frame exists in the assisted living facility through which events, social relationships and interaction are viewed. Alongside this way of framing the facility lies framing it as a home. Actually, there was sometimes a fine line between these two frames, as one of the participants, Anna, noted in an interview:

> Yes, and really this home-like peace, sometimes when I first came here you might have had nurses, all of a sudden a nurse just came in with her/his own key, but there were lots of complaints back then, that we want to live here like all by ourselves, but there's also the policy that if someone doesn't answer the knock on the door or, you know, then you have to see if something has happened or something. So, it's a fine line again what the nurse can do.

She, like other residents of the facility, was not happy that sometimes members of staff had come into her apartment using their own keys and without permission. She thought of the apartment as her home and that no-one should be allowed in without permission. In these situations, however, it seemed that the members of staff framed the facility (and the apartments in the facility) as an institution and their workplace where they had the right to check in on their patients when they needed to. This need was also recognised by the participants, who thought that it was important that the staff members checked the residents to make sure everything was all right.

While I was interviewing another resident in the facility, in their apartment, two members of staff suddenly came in, using their own keys, interrupting the interview. The interviewee did not mind that at all, and told me that it added to his sense of security to have the staff members check on him. The residents of the facility recognised their own vulnerability and the need for institutional procedures in the facility, but nevertheless also wanted to live in the facility as if it was a private home where they had their own privacy and the power to determine who was allowed to enter their home and when.

Some participants were keen to describe the assisted living facility as their home. I interviewed Anna, whose words we read in the previous excerpt, twice (Articles II and III), and she was eager to explain during both interviews that the facility was her home, since she could live there just as she could in any other 'normal' home. In the interview that took place during the COVID-19 pandemic, I wanted to know whether the staff members at the facility had adopted any new procedures or were acting differently in the facility because of the pandemic. Anna was keen to tell me that she had not noticed anything because she lived in the facility just as she would in a normal home and did not have much contact with the staff. Not being aware of the institutional procedures implemented in the facility due to the pandemic allowed her to justify that she was not living in an institution, but in a home: '*And because I live in a rented apartment I can live a normal life, normal home-like life*.'

Although these procedures and rules of the facility were sometimes ignored by a participant so they could describe themself as just a normal home-dwelling person, they were also valued sometimes. When the participants talked about life in the assisted living facility during the pandemic, they highlighted that the rules in place, such as not allowing visitors inside the facility, were important for protecting the residents. By providing their own view of the need for the visiting and other restrictions in the facility, the participants were able to portray themselves as people who did not just mindlessly follow the rules but evaluated the rules themselves and wanted to act according to the rules because it was good for others in the facility. Rather than seeing the rules as being imposed on them, they saw it as their responsibility, as people who understood the risks of the situation, to follow them. Keijo explained that he believed the restrictions in the facility were important because they protected his wife and other more vulnerable people in the facility (by referring to those 'who live alone and are cared for on a different level' he meant people living in the assisted living facility with 24-hour assistance, like his wife).

> Keijo: No I mean yes, it's been very good in the sense that outsiders can't get in. Even family members or other relatives so that's how they have kept the disease out. […] this is a big facility, there is this one group unit where we have those who live alone, that's where my wife is, there are five group homes. So these people who live alone are cared for on a different level and with lots of people so I mean it's quite right what they are doing.
>
> Researcher: Yes, yes. So even though it has affected your chances to get to see your wife, you still think it's a good rule that outsiders can't get in.
>
> Keijo: That's right, that's right, I mean it meant my wife got into a safe place in that regard.

One fact that was relevant to the argument that the assisted living facility is a home and not an institution was that some of the older people in the facility were more dependent on help and lived in what was called by some the 'dementia ward' of the facility. They used this name to refer to the assisted living with 24-hour assistance, where those people needing round-the-clock care due to, for example, dementia, lived. The home of the interviewed residents, the ordinary assisted living, was not an institution at all when compared to this other place. Similarly, the older people visiting the assisted living facility wanted to make clear that they did not actually live in the facility, but were only visiting: for them, being a resident meant being old and frail and they did not want to be associated with that. These examples illustrate that the facility was framed not just as a home or as an institution but also as a community where distinctions were made regarding who belonged to the same community. In general, the residents thought that it was very important to have a sense of community in the facility and that the facility was a place where one needs to pay extra attention to taking other people into consideration. Being able to live together with other people harmoniously in the facility meant acknowledging the fact that one needs to get along with these other people, despite differences in opinions, habits and tastes. Other people were not ignored, but the presence of others defined the way one should act and behave in such a place.

Older people who did not live in an assisted living facility had quite different views of the facility to those of residents. The former seemed to believe that such facilities are quite lonely places and that people living there would be in a worse position during the pandemic than other older people. However, those who were living in an assisted living facility thought, before and during the pandemic, that it was a safe and good place to live in the sense that they did not have to be alone, as they would be in a private home, but were constantly surrounded by others and could meet others whenever they wanted to in the shared areas of the facility. Outsiders who visited the facility also had a different way of framing the facility. For them, the facility was obviously not a home, but it seemed not to be an institution or a community either. When I was observing in the facility during a show that was taking place there, I noticed that outsiders who had come to watch the show acted somewhat oddly:

> I was rather annoyed by the other adults and their children on the same floor with me. The children could not concentrate but were wrestling and fooling around with each other. In addition, they shredded all the streamers along the corridors. After the show ended, they just left and left all the shredded streamers on the floor. Their parents did not comment on the wrestling or the shredding and did not tell them to clean up the mess they'd made.

The children fought throughout the show, shredded the streamers that were handed to them as part of the event and spread this litter in the corridors, in front of the residents' apartment doors. The adults that were with the children did not comment any of it, and finally, after the show, just left with the children, leaving the litter on the corridor. Once again, I found myself wondering what was going on in this situation. How did these people see the facility? Their behaviour did not seem to fit into the expectations one has within the home or the institution frames, nor did it fit with the idea of 'taking other people into consideration' that had manifested in the residents' thoughts about the community in the facility. Rather, they seemed to see the facility as some kind of public space where they could behave as customers and were not obliged to acknowledge other people in the same way as residents did within the community frame.

To sum up, the assisted living facility can be understood, based on this study, as a social space that includes home-like, institutional and communal characteristics that affect social relationships and interaction. In this sense, the facility was an institution where certain schedules and procedures determined social contact and the ways of interacting in the facility. On the other hand, it was a home where one could live just as one would in a normal rental apartment. However, feeling at home was not entirely in the hands of the residents but was defined in their encounters with other people in the facility. If nurses enter residents' home in a facility, can the place feel like a private home? The facility in this study was also a community in which the presence, needs and preferences of other older people needed to be considered more comprehensively than in a normal apartment block and where the presence of others also provided feelings of safety and comfort. However, at the same time it was a community where the exclusion of some others (people in the 'dementia wards' and other residents or outsiders during the pandemic) was warranted to gain agency or to feel part of a community of 'normal older people' rather than of frail older people. In addition, the assisted living facility seemed to be a social space in which outsiders did not seem to follow the same 'rules' of the home, institution and community frames as the residents.

7.3 Negotiating public and virtual spaces

The two previous chapters have considered spaces that older people live in. This chapter takes another perspective by exploring public and virtual spaces from the

point of view of older people. Public spaces (Chapter 4.2.3) are an important part of everyday life: they are where our lives outside our private home space occur. Nowadays, the importance of virtual social spaces (Chapter 4.2.4) cannot be ignored. Virtual social space can sometimes be seen as a substitute for not being able to move around in public space: it is a place where we can be connected to other people without physically leaving our own home. I explore these two spaces by asking how older people negotiate challenges and opportunities related to public and virtual spaces.

During the COVID-19 pandemic, different public spaces became inaccessible in general. Older people, however, were specifically advised not to leave their home and to isolate themselves in their home and have relatives run their errands, such as shopping, for them. This advice from the Finnish government was first formulated as an obligation: that older people were obliged to stay in their home in quarantine-like conditions. This made some of the older persons in this study (Article III) think they were not allowed to go out and run errands on their own. They therefore relied on their relatives to run errands for them outside the home while they stayed inside their home. Consequently, for them it was natural, in such circumstances, to rely on the help of others.

For nonagenarians (Article I), leaving their home was not about being allowed to do so but about being able to do so. Although home was a central social space for the oldest old persons, their social activity also sometimes took place in spaces outside their home. Taking part in events and hobbies outside the home was described as a way to meet people and to make friends. Examples of activities that they described were taking part in veteran associations and spiritual clubs, for example. Association activities were a source of lifelong friendships for the nonagenarians, but also a way to meet new people. Taking part in such activities and the relationships this created could even work as a safety net. However, as described in Chapter 7.1, the opportunities for nonagenarians to take part in activities outside their home were reduced by factors related to their health and functioning: due to deteriorating health and functional abilities, it was not self-evident that they could move outside their home.

Both nonagenarians and older people during the pandemic had to give up moving in spaces outside their home. Giving up activities done outside the home due to the pandemic was difficult for some of the participants (Article III), because these activities, hobbies and events occurring outside one's home had been an important part of their lives. Examples of such activities were concerts, exercise groups, voluntary work and going to the gym. Because many of them had led an active life

outside their home before the pandemic, giving up the option to take part in such activities felt negative, and the participants said they also missed these activities because this was where their social activity had occurred. However, the participants did not have much influence over the issue: many places were closed, hobby-related activities were suspended, and events were cancelled due to the pandemic. Thus, it was accepted as self-evident that they could not take part in spaces outside the home.

Although some of the participants understood that moving outside the home was not 'allowed' during the pandemic, some also had a different understanding of the situation. For some, moving outside the home to run errands, for example, was a matter of using common sense. They thought that they could move around in public spaces if they acted in a certain way: if they were responsible and sensible. In this situation, being sensible and responsible meant, for example, not going to the grocery store during the busiest hours to avoid mixing with too many people, washing their hands and using disinfectant when moving around in public spaces, and keeping a distance from others. In this situation, it was not self-evident that they could move around in public spaces, so it was something they had to justify by applying common sense and acting responsibly. Olavi, one of the participants, said that he used his own reasoning when evaluating the recommendations to stay at home and continued to move outside his home with his wife. He did not obey the recommendations to stay at home, '*like some others did*':

> But well, but but, neither one of us has stopped moving outside or visiting stores or the library when libraries have been open and so on. So that, so so, I never took that government's instruction in the spring, that has now been interpreted as a binding instruction, I never took it as a binding instruction but viewed it as a mild recommendation back then already. And, did not, not not, in any ways literally started taking action and staying at home like some others did.

During the pandemic, to reduce face-to-face contact and thus the spread of the disease, technology, as a means to communicate and stay in touch with other people, gained importance. Relatives of older people were advised by the Finnish government not to see their older relatives face-to-face but to use the phone or video calls instead. Despite different technological solutions being available, phone calls were the most important way to stay in touch with other people during the pandemic (Article III). Technology, understood especially as 'normal' phone calls (compared to videocalls), are not only important means of communication for older people during abnormal situations such as the pandemic, but also for people with mobility difficulties, such as the nonagenarians (Article I), who were able to keep in touch with others by phone, as we saw in an earlier chapter, although leaving their home

was difficult. Other technology that the participants used during the pandemic (Article III) to communicate and stay in touch with other people were computers, laptops and smartphones. These were used to make videocalls, to receive and send photos and emails, to use social media and for videoconferencing.

Despite the fact that some of the participants used digital technology to communicate and stay in touch with other people during the pandemic, they also felt that they were outsiders in the virtual social space. They thought that such space was not for them but for younger people, who are familiar with technology and know how to use digital devices. Although the term 'younger' was relative and was, for example, referred to by 86-year-old participant Elina as '*those under 80*', the participants considered, as Elina put it, that for them, and people their age, digital technology was '*beyond reach*'. Reasons for not using digital technology were thinking that it would be too hard to learn to use it, being told they could not learn to use it and not being interested in it. Some had physical impediments, such as a hand tremor, which prevented them from using digital devices. The participants depicted themselves as too old and incapable to be part of the virtual social space.

In addition to describing how they were not able to be part of the virtual social space, the participants did not want to be part of it, at least not much. Most of those who used digital technology said that it made staying in touch with other people and running daily errands easier. They thought that such technology can be useful. However, they were also sceptical regarding technology and thought it should not be considered as a substitute for face-to-face social contact. The virtual social space was therefore not enough to fulfil their social needs.

This chapter showed that it is not self-evident that older people could move around in public space but a matter of being allowed to do so (in the context of the pandemic) and being able to do so (in the context of declining health and functioning). Older people engage in important social contact and activities in public spaces, however, and the inability to move around in public spaces was regarded as a regrettable loss. Public space also appeared to be a space where one's presence needed to be justified: a space where one's ability to use common sense and consider others in that space were negotiated. Virtual space was identified, on the one hand, as an important space that facilitates life. On the other hand, it appeared to be an exclusionary space: a space that is not for older people but for younger, healthy and capable people. It was simultaneously recognised as an insufficient social space that does not fulfil one's social needs.

7.4 Visiting the social space of memories

In the earlier chapters I have paid particular attention to the current social relationships of older people, that is, to social relationships that existed in the lives of older people when the research was conducted. In addition, I have examined the relatively concrete social spaces where the social lives of older people occur. However, as we noticed in Article I, it is not only concrete spaces and current social relationships that are important regarding one's social life, but also those that exist in one's memories. In this chapter I explore the meaning of memories by asking what role they play in the social life of older people.

As previously noted, social relationships were of great importance to the oldest old persons in many regards. Other people were an important source of help and provided company, and having them, in general, in the nonagenarians' lives was highly valued. However, in the interviews it became evident that not only those social relationships that existed in the nonagenarians' lives at the moment and who could provide concrete help for them were important, but so were relationships in their past that existed in their memories. The participants reminisced about the relationships they had had during their life course, about different events and situations that had occurred and the importance of those relationships in their life. For example, funny things that had happened involving their children and grandchildren were reminisced about and, as Aili said in the interview after reminiscing at length about some events that had taken place with her own children and grandchildren when they were little: *'Those things stick in your mind, you then always reminisce about them.'*

Relationships from their past and memories of social relationships could make the oldest old persons happy, or sad, in the present moment. Indeed, memories of past relationships were not always happy. Some had had, for example, a troubled childhood, and the memories of relationships that existed during their childhood and the way they were treated by others earlier in life caused them sadness. Past relationships still affected the participants' lives in the oldest old age. Some nonagenarians said they had 'inherited' their parents' healthy way of life, such as being sporty or not drinking any alcohol. Sometimes their lifelong abstinence from alcohol was not due to a positive example from their past relationships but to bad experiences in their childhood family. Even in the oldest old age, one's own grandmother could provide emotional support. Some of the participants talked about what an important social relationship they had had with their grandmother, because she had taught them early in life about religiosity and what attitude to have

towards death. Now, as an oldest old person, they found their own approaching death easier to deal with, thanks to the memories of their grandmother.

The way the nonagenarians had lived their life, and still continued to live it, and their attitude towards life in the oldest old age was affected by the meaningful relationships in their past, which now existed in their memories. Memories of past relationships were a source of much happiness for the nonagenarians but also a source of negative feelings. As described in Article I, memories of past relationships could work as an *emotional depository* for the nonagenarians: a place they could visit to relive the events of the past and experience the feelings they evoked. This emotional depository of memories could be visited easily wherever they were physically, even when the possibility of taking part in social interaction evoking such emotions would otherwise be limited.

8 DISCUSSION

The aim of this study was to explore the meaning of social spaces for the social relationships and interaction of older people and to study how different social spaces enable or restrict social relationships and interaction for older people. To this end, I have, by considering older people's perceptions, experiences and everyday life, studied the home, an assisted living facility, public space, virtual space and memories by utilising the lens of social space. In this chapter I draw from the wider theoretical framework of this study to discuss the key findings presented in Chapter 7. A summary of the key findings of the study is presented in Table 4.

Table 4. Summary of the key findings of this study.

Key findings of this study	
On the one hand	**On the other hand**
❖ Home and its surroundings are a hub of social life, especially in very old age.	❖ Home can be a lonely and isolated space.
❖ An assisted living facility is a multifaceted social space. ❖ Social relationships and interaction in the facility contribute to how the facility is understood as a home, and institution or a community.	❖ An assisted living facility is depicted as a lonely place but experienced as a sociable and safe place.
❖ It is not self-evident that older people could move around outside the home.	❖ Public spaces are important for enabling social contact.
❖ Virtual spaces provide older people opportunities for social contact beyond the physical space.	❖ Virtual space is understood as an exclusive social space that is not sufficient or suitable for older people.
❖ Memories can be a social resource for older people that, similarly to virtual spaces, extend the boundaries of physical space.	

8.1 From ageing in place to ageing in social space

Home is a central site for social relationships and social interaction for older people. This was evident in this study and has also been recognised in earlier research (Bigonnesse et al., 2014; Kylén et al., 2019). Home is positioned as a central place of

ageing in Finland and internationally in ageing policies that promote home as the best place in which to age (Kröger & Bagnato, 2017). These *ageing in place* policies frame the way we understand how and where ageing should occur. That is, what is available and acceptable in terms of housing for older people (Vasara, 2015). The emphasis on home and home-like places depicts home as the priority and independent life at home as desirable. I argue, however, that the policy lacks understanding of the places of ageing as social spaces that are framed by social connections (or lack thereof) and that are able to support life at home in old age and improve the quality of life.

Researchers have shown that Finnish policymakers and public administrators and officials have a very restricted view of what a home of an older person is (Anttonen & Karsio, 2016; Pulkki et al., 2017; Pulkki & Tynkkynen, 2020). Home was depicted by policymakers as lacking enjoyment, a good life and social contact: a place where older people 'manage', 'survive' and are treated and live without social contact (Pulkki & Tynkkynen, 2020). The social needs of older people within the home were not discussed; only the needs related to health and functional ability were considered (Pulkki et al., 2017). These discussions and depictions frame what is considered to be good and suitable housing for older people and affect the development of the service system.

The results of this study depict a very different picture of the home of the older person to that conveyed by the discussions of the policymakers in the study of Pulkki and Tynkkynen (2020) and Pulkki et al. (2017). Based on interviews with older people, home in this study was depicted as a *hub of social life*. Social relationships, which were described as bringing joy to one's life, providing help and support and being highly valued overall, were centred in the older person's home environment. However, the results of this study do not suggest that the home of the older person should be understood as always and automatically a space that is able to fulfil the social needs of the older person. Home can be the centre of social life in old age only when social relations exist in the first place and are available in the older person's life. In fact, the centredness of social life was related to challenges concerning health and functioning and the death of friends and family that are both recognised as occurring frequently, especially in the oldest old age (Enroth et al., 2023; Jylhä, 2020), and as obstacles for remaining socially connected (Enroth & Pulkki, 2021; Mikkola et al., 2015). On the other hand, the centredness of social life was affected by the restrictions imposed during the COVID-19 pandemic, which severely limited social contact and portrayed home as the safest space for older people. These factors and circumstances, at the same time as they make home a central space for older people

and their social life, also make older people susceptible to aloneness and loneliness (Dahlberg, 2021; Dahlberg et al., 2022).

Research shows that neighbourhoods play an important role in older people's lives (e.g. Bowling, 2007; Felix et al., 2015; Kylén et al., 2019; Ottoni et al., 2022). This is because older people often have lived in the same neighbourhood for a long time and have developed meaningful ties to this area and have social relations with people living nearby (Wiles et al., 2009, 2012). Neighbours also provide help, social contact and security (Brooke & Clark, 2020; Felix et al., 2015; Kylén et al., 2019). The oldest old persons in this study, as well as older people during the pandemic, mentioned their neighbours were an important social contact and a source of help with specific tasks such as clearing snow and grocery shopping. They were also a central social contact since they lived nearby and were easily available for a chat and for general support. However, the importance of familiar and meaningful neighbourhoods for older people is not recognised in political discussion (Pulkki et al., 2017), although international ageing in place literature has recognised their importance (Bigonnesse & Chaudhury, 2020, 2022). A simplistic view that an older person's home could be anywhere (as long as it is not in an institution) and that moving to another place would be simple in old age (Pulkki & Tynkkynen, 2020) does not take into account the familiar and meaningful ties that older people have in their neighbourhoods. Nor does it seem to take into account that such ties can act as a significant resource that supports independent living and well-being in the home environment (Bigonnesse et al., 2014; Wiles et al., 2012).

Within ageing in place policy, assisted living is understood as an 'intermediate option' between the home and an institution for older people with care needs (Pulkki et al., 2017) and thus as a better place to age in than an institution but still inferior to the home (Anttonen & Karsio, 2016; Pulkki et al., 2017; Pulkki & Tynkkynen, 2020). Public administrators and officials are keen to call assisted living a 'home' for the older person, although they still differentiate it from their 'real home' (Anttonen & Karsio, 2016, p. 162). As Anttonen and Karsio (2016) note, labelling care facilities as 'home' blurs the distinction between home care and residential care: all older people, even those with extensive care needs, by definition live at home. It can be argued that the distinction in relation to the so-called ordinary assisted living examined in this study is especially blurred, since older people live fairly independently in their own apartments inside the facility, only receiving services according to their needs and wishes, similarly to in home care. However, since an assisted living facility is not a 'real home', it is described as 'home-like'. The meaning of this concept is left ambiguous (Kaskiharju, 2021).

Although assisted living facilities are promoted as homes or home-like environments for older people, their institutional and communal characteristics cannot be dismissed. In this study, the assisted living facility has been viewed as a multifaceted social space that has characteristics of a home, an institution and a community. No matter how much policymakers and public administrators and officials would like to call an assisted living facility a 'home' or 'home-like', it still entails institutional traits (Anttonen & Karsio, 2016). The aim of service centres, the kind of facility examined in this study (for more information see Chapters 4.2.2 and 6.2), is to enable older people to participate socially and to provide them with social contact, to bring older people living in the facility and those living outside the facility together. Thus, such facilities can also be understood as communities.

This study shows that an assisted living facility can be understood as a home. However, this is not self-evident but is negotiated within social contacts one has inside and outside the facility and within one's own community. That is, social relationships and interaction in the assisted living facility contribute to understanding the place as one's home, an institution, or a community. The findings of this study indicate that the interpretations individuals make of the facility (whether it is a home or something else) relate to the opportunities for and qualities of the social relations and interaction they have there, for example to how formal, informal or voluntary the relationships in the facility are. And vice versa: how the social relationships and interaction in the facility are made sense of contributes to the understanding of what kind of place an assisted living facility is. This study shows that there is a need to approach assisted living facilities as multifaceted social spaces. Forcing the idea that assisted living facilities are simply a home for an older person or only an institution and a non-home should be avoided. Instead, to acknowledge the ambiguousness of these facilities, recognising them as social spaces can work as a fruitful way to increase our understanding of their different characteristics, the different meanings of the places and ways of making sense of them.

Other people contribute to giving older people the option to continue living independently, to 'age in place' and to feel at home. This was evident in the situation of the oldest old persons and older people living in the assisted living facility and older people living in their own home during the pandemic. In fact, the pandemic situation highlighted the importance of other people supporting living at home. However, the importance of other people supporting ageing in place refers not only to help provided for doing everyday chores, such as grocery shopping and banking, but also to the meaningfulness of life that social connections contribute to, that is, avoiding loneliness, feeling joy and being connected to other people. This notion,

however, seems to be completely lacking in ageing in place policy, where the role of social contact is not recognised and only the older person's needs related to health and functional ability are considered (Pulkki et al., 2017; Pulkki & Tynkkynen, 2020). Social needs should be one of the focus points in the policy as well. *Ageing in social space* would mean taking into account the social nature of places of ageing both in terms of the available and meaningful social contact within the home space and the neighbourhood and in terms of the lack of social contact within these spaces and the implications of both of these scenarios for an older person's ability to lead a safe and satisfying life in their living environment.

8.2 Restricted and contested social space

The previous chapter highlighted the home as the hub of social life in old age. This study has shown, however, that out-of-home mobility was important for older people's social life as well. The ability to move outside the home contributes to better functioning and well-being and to opportunities to participate in society (Iwarsson et al., 2012; Mollenkopf et al., 2011; Portegijs et al., 2015; Rantakokko et al., 2016). However, as shown in this study, and by other studies as well (Mollenkopf et al., 2011; Portegijs et al., 2016; Rantakokko et al., 2015), it is not self-evident that older people could move around outside their home. In this study, not moving around outside the home was due to challenges concerning health and functioning and pandemic policies strongly recommending not moving outside the home.

Most of the participants interviewed during the pandemic said that before the pandemic they had been actively moving around outside their homes and taking part in different activities and events outside their home too. It was in those out-of-home places where their social activity also occurred. During the pandemic, however, this was no longer possible for them, because many public and leisure spaces and event venues were closed or, as the participants said, they were not 'allowed' to go outside their home to visit these spaces. The spaces that the participants deemed to be important for their social life were subject to external regulation, restricting their opportunities for social contact and interaction. In this situation, the participants 'extended' their home space to include the nearby outdoor areas, as also found in other studies (Kulmala et al., 2021; Tiilikainen et al., 2021); meeting other people there was deemed safer because they could keep a safe distance when they had 'remote discussions' with them. Thus, this restriction of the social spaces of older people created new ways for them to use space to interact with other people.

It was not just the pandemic-related restrictions that prevented the participants from moving outside their home, but also their personal situations, such as an illness affecting their functional ability in a way that meant leaving their home without help was not possible or having no social relationships so no-one they could visit. Although home was found to be a hub of social life in old age, it could also be an isolated space, something that could even be called a prison, as found in earlier research (Jarvis & Mountain, 2021; Morgan et al., 2023). As also detected by Morgan et al. (2023), home being like a prison was, for some, an ongoing daily situation rather than a novel imprisonment brought about by the pandemic. However, although some people framed staying inside the home and avoiding moving outside as a must, for others it was a choice they had made and a situation they preferred. For some of the participants, staying at home and not having a busy social life in the outside world, similarly to some of the participants in the study of Vasara (2020b) and congruent with the disengagement theory (Cumming & Henry, 1961), felt natural for their life stage as older or oldest old persons.

Although the recommendations during the pandemic were enforced to protect older people and to save lives, they have also contributed to depicting older people as a homogeneous group that is passive, vulnerable and easily 'sacrificed' in the interest of the younger generations, thus reinforcing ageistic views of old age and older people (Ayalon, 2020; Fraser et al., 2020; Jen et al., 2021; Lichtenstein, 2021; Morgan et al., 2021; Previtali et al., 2020). Simultaneously, it can be argued, the encouragement to abide by the age-related pandemic-related restrictions has depicted the home of the older person as the only safe and desirable space for them, accentuating the idea of ageing in place policy that home is the best place for older persons. Both these views, given from the outside, were contested in this study. Instead of accepting that, as older persons, they had to stay inside their homes, some of the participants in this study continued to move outside their home during the pandemic. They justified this by describing themselves as responsible and sensible persons who were capable of making their own decisions, and they rejected the view of themselves as belonging to a group that should be patronised and given special instructions. It was not self-evident, though, that they could be viewed as this kind of persons as older individuals. Thus, although many of our participants were physically capable of moving outside their home during the pandemic, they needed to negotiate having permission to do so by highlighting their ability to be responsible and careful persons.

Being a responsible and sensible person not only related to being able to move outside the home but also to remaining inside the home. Indeed, being 'responsible'

during the pandemic also meant not being too independent but accepting help from others. This finding contrasts with earlier research showing that presenting oneself as independent and not needing help from others was described in positive terms by older people, whereas needing support from others was seen as negative (Allen & Wiles, 2014). That is, in the earlier study of Allen and Wiles (2014), older people did not want to be seen as dependent on other people because they thought it would present them in a negative light. However, this study showed that needing help during the pandemic was not described in negative terms but as a more natural and an obvious need. In contrast, not needing help during the pandemic because one moved around outside the home to run errand on one's own was viewed as needing justification: being 'too independent' during the pandemic was regarded as negative, since moving around outside the home positioned older persons as irresponsible and selfish (Brooke & Clark, 2020). It seems that the pandemic shifted the way independence in old age was understood, moving away from the assumption that remaining independent in old age is a virtue to the possibility that a person could be 'too independent', and therefore accepting help and support with all daily errands was seen as an act of responsible citizenship.

The image of the institutional care of older people is poor. Older people associate institutional care with such undesired issues as a loss of freedom, autonomy and privacy and feelings of isolation, loneliness and insecurity (Lehnert et al., 2019). In addition, they do not want to be associated with institutional care, since it entails representation of being for old and needy people – a group they do not want to belong to (Lindenberg & Westendorp, 2015). This poor image of institutional care can be argued to have been reinforced by the pandemic, during which visiting care homes was prohibited and they were depicted in a negative light by the media (Miller et al., 2021). People who did not live in an assisted living facility thought that those who did live in such facilities were the most unfortunate citizens of all during the pandemic. Those living outside them thought they were doing fine compared with residents of care facilities. A similar division was visible before the pandemic between those living in ordinary assisted living and those living in assisted living with 24-hour assistance. The participants in this study who were living in an ordinary assisted living made it clear that they saw themselves as different from those who were living in assisted living with 24-hour assistance: they lived in a different kind of surroundings (home-like) and were more independent than the latter group of people. A similar observation was made already by Gubrium (1975/1997) who saw that it was important for the nursing home residents in his study to make clear distinctions between the people and their lifestyles in different floors. The people

living in the upper floors were regarded as not belonging to the first floor which was a place for residents who, opposite to the upper floor residents, are 'sane' and 'can take care of themselves' (Gubrium, 1975/1997, p. 25). In this study, older people visiting the assisted living facility for recreational purposes but not living in it also wanted to make a distinction between themselves and those who lived in the facility: they did not want to be associated with the assisted living facility and thus as being old and needy.

When we look at the viewpoints of the older people who were living in the assisted living facility, we can see that they are very different from the 'outsiders" views. Instead of experiencing the facility as a lonely space and their life as miserable, the residents emphasised that an assisted living facility is a safe place to live in and that it is a better place to live in than a private home because in the former one does not have to be alone but is surrounded by other people. The safety aspect and being surrounded by other people in assisted living came up as advantages in the interviews conducted both before and during the pandemic. In addition, the residents did not describe themselves as the unfortunate ones in terms of living in a care facility during the pandemic or as being at the mercy of the staff members and the facility's rules and restrictions, but rather as persons who wanted to follow the rules and act responsibly in order to protect others. In a way, this can be understood as 'imagined liberty' (Repo, 2019, p. 238), since everyone had to follow the rules of the facility in any case, but it can also be viewed as a way of rejecting the stereotypical presentation of the self as an assisted living resident. Thus, what we can also see is that the participants in this study seemed to want to avoid seeing themselves as someone in the so-called 'real old age' (Pirhonen et al., 2015, p. 1640) and positioning themselves 'straightforwardly as older people' (Jones, 2006, p. 83). That is, they compared themselves to other older people living in different environments and came to the conclusion that it was other people in other places who were doing worse than they were: people who were not living in home-like surroundings, who were more dependent and who were old.

Despite the fact that the residents in the assisted living facility presented themselves as capable of evaluating the facility's rules and restrictions during the pandemic themselves, the life of the residents in the assisted living facility was indeed controlled by the staff. It can be argued that the home-likeness of the assisted living facility became especially contested during the pandemic because the residents had very little say about what social contact they had there. As Bennett et al. (2017) have argued, if an assisted living facility is supposed to be a home, the residents should be able to decide who enters their home. However, this was not even always the case

before the pandemic, because staff members sometimes entered residents' apartments without permission, and during the pandemic the residents were not allowed to decide for themselves whether to meet their relatives and if so how they would do so.

Restricting social space can lead to new ways of understanding and making use of the space and thus it can be part of reorganising social life. Restricting social space as well as being restricted in space can lead to restrictions in opportunities for social contact, and therefore the vulnerabilities of such spaces as sites for social life can be revealed. However, it can also lead to renegotiations of one's position in the space, which indicates that there is flexibility concerning how social space is made sense of. The study also showed that social space is contested in that it can be interpreted in several different ways and can have several different meanings that can manifest themselves in stereotypical depictions of old age and the best spaces of older people.

8.3 Technology blurring the boundaries of space

One solution for many issues caused by ageing populations, such as increasing needs for care and support, is technology (Bloom et al., 2015; Finnish Government, 2023; Valokivi et al., 2023). It is also believed to be a possible means of decreasing loneliness among older people (Site et al., 2022), and recently, during the COVID-19 pandemic, suggested as a substitute for meeting other people physically (Ministry of Social Affairs and Health, 2020b). In this study, utilising technology to communicate with other people was regarded as interacting in a virtual space. The use of such space seemed to blur the boundaries of physical space: people living far away or those one were not able to visit due to health and functioning-related challenges or the COVID-19 pandemic were brought 'inside' one's home by means of technology. By connecting people located in different physical spaces, technology, and the virtual space it created, is diminishing the meaning and restrictive nature of physical space.

Although older people in this study benefited from virtual space, which allowed them to stay connected to other people in situations in which it would have otherwise been difficult, or even impossible, they did not feel part of this virtual space. Some of the participants could not use technology due to health-related obstacles, such as a hand tremor, but in general the participants thought, or had been told by other people, that they could not use or learn how to use technologies. Such perceptions are not rare among older people, and other studies have also found that

older people were unsure about their own ability or that of other older people to use technologies and said that they were not interested in technology (Kania-Lundholm & Torres, 2015; Köttl et al., 2021; Pirhonen et al., 2020). The reasons that the participants in this study gave for not using technology were age-related, and some of them expressly stated that people their age cannot or do not want to use technology. Such internalised ageism, that is, self-stereotyping based on age, was also detected by Köttl et al. (2021), who had very similar results. As Köttl et al. (2021) note, internalised ageism can therefore constitute an invisible barrier to ICT use in old age.

However, data from Finland (Official Statistics of Finland, 2020) and Europe (Eurostat, 2020) as well as earlier research (Kania-Lundholm & Torres, 2015; Pirhonen et al., 2015) shows that older people make use of ICTs in a versatile manner and benefit from them. There is also an indication that the COVID-19 pandemic has motivated, or forced, older people to learn new ICT skills (Official Statistics of Finland, 2020, 2021). Indeed, the participants in this study also acknowledged the benefits of technology, stating that it made everyday life easier by facilitating social contact and running errands. The most frequent way of using technology was making normal voice calls, which have also previously been found to be the most frequently used type of social technology by older people (Rosenberg & Taipale, 2022). In addition, the participants said that they used video calls, sent and received emails, sent and received photos, and used social media and videoconferencing to communicate with other people. These have also been recognised previously as frequently used by older people (Eurostat, 2020; Official Statistics of Finland, 2020; Rosenberg & Taipale, 2022). Despite some of the participants in this study using ICTs and recognising their benefits, technology was viewed a poor substitute for face-to-face contact: the participants wanted to interact with others in physical spaces rather than in virtual spaces.

Based on this study, virtual social space is depicted as a space for younger, healthy and capable people and a place from which older people are excluded. Older people were seen as part of the virtual space, but not in the same way as younger people. Although technology can be seen as blurring the boundaries of physical space and, thus, a significant means of interaction for older people with mobility or access difficulties, much work still needs to be done to fight age-based stereotypes regarding using technology that limit older people's opportunities to fully benefit from what virtual space can offer. Furthermore, despite the benefits of virtual space for older people, the needs and preferences of older people themselves must be heard. Technology can be a good addition to an older person's repertoire of means of social

contact, but it should not be the only option for social interaction, since face-to-face social contact is highly appreciated. However, the care of older people in Finland is constantly moving in the direction of care being increasingly provided in virtual space, through video calls (Heinonen et al., 2022; Johnson, 2019). One of the aims of this shift is to support ageing in place in a society with an increasing number of older people needing care and with a diminishing number of care workers (Heinonen et al., 2022). More discussion, however, is needed about how the social needs of older people, especially from their own point of view, are being and should be addressed in view of the increasing use of technology in care services.

8.4 Memories as a social depository

Memories can be powerful. They can create a sense of purpose in life (Sharma & Bluck, 2022) and can give rise to personal growth (Mroz et al., 2020). In this study, memories of past social relationships were seen to be influential in the current lives of the oldest old persons. That is, both the good and the bad memories of social relationships, such as those existing in the participants' childhood family, of their children or grandchildren when they were young or of their marriage influenced the way the participants led their lives as older persons and influenced their feelings in the current moment.

The meaning of reminiscing and memories in an individual's life can be summarised using the words of Birren and Birren (1996, p. 299): '*You don't know where you are going unless you know where you have been*.' Memories are part of creating who we are because they become part of our life stories. That is, memories are used to construct the story of the self and to make sense out of life (Mcadams & McLean, 2013). Looking at human life from a life course perspective, reminiscing and memories can be seen as not only creating who we are but also as an important resource from which to draw (Bluck & Mroz, 2018). Both of these aspects were found in this study, since memories were used by the oldest old persons to explain their current way of life and as a resource to enable them to experience emotions evoked by social relationships. In the Article I, we used the term *emotional depository* to refer to memories as a space older people could visit to relive emotions evoked by past events and relationships. In this study, I have refined this idea and call memories a *social depository*. This term emphasises that memories can be a social resource from which to draw: a space to visit and utilise both in understanding who

one is and has become and in experiencing feelings and events related to social relationships.

Earlier research has found that reminiscing and memories are an important aspect of a 'good old age'. Carstensen et al. (2019) and Nosraty et al. (2015) found that when the oldest old persons were considering ageing and a good old age, they reminisced about various aspects of their past such as those relating to their childhood, their family and working life and their marriage. Their present views of what a good life was in the oldest old age were framed by events and people in their past. It has also been found that memories of loss and other negative life events are powerful in shaping people's lives (Bluck & Mroz, 2018). Such memories can have negative effects on well-being, but they can also be integrated into one's life story in a positive manner (Mroz et al., 2020). Memories of loss can prompt positive memories of and feelings towards the person who was lost, and the social relationship with that person can remain an important one (Patlamazoglou et al., 2023). The oldest old persons reminisced positively about their past relationships, such as those with their late spouse and their parents and grandmothers, as important relationships in their life, but also negatively, such as in relation to being mistreated by their parents in their childhood. Negative memories, such as about a parent's drinking problem, had been used as motivation for building a healthier life for themselves. Both positive and negative memories evoked feelings such as happiness and sadness respectively in the current moment of the participant's life.

I have also discussed in this study how the social worlds of older people shrink due to issues related to a reduction in general functioning, worsening health and the death of a spouse, other family members and friends. However, as Rowles (1978) argues in relation to assumptions about the life space shrinking in old age, this way of thinking is limited by young and middle-aged people's values relating to what human social life should be like. Instead of viewing social worlds in older age as getting smaller, they can be seen as expanding to 'beyond spaces' (Rowles, 1978, p. 170) by means of 'geographical fantasy' (p. 179). That is, older people make use of spaces that exist in their imagination, beyond the immediate physical space, and draw from the past, present and future to expand their social worlds. Furthermore, reminiscing in old age can be understood, from the perspective of disengagement, as withdrawing from society, social roles and social relationships – as escaping from the present to the world of memories (Bluck & Mroz, 2018). However, as Bluck and Mroz (2018) suggest, reflecting on one's life can also be understood as an adaptive psychosocial process that integrates the past and the present.

Wiles et al. (2009) found that their participants talked about the places, events and social relations of their past but also about events that they were not able to be physically present at but felt as if they were. The very concrete and current social relationships and places were not the only important ones for them. This study, similarly to the study of Wiles et al. (2009), draws attention to the way in which social life in older age could be understood not only as tangible but also as imagined. In this study, the memories of past relationships evoked feelings, both positive and negative, in the oldest old persons, built the continuous story of their lives as persons they had become and still were in the oldest old age and provided resources that could be used to think about and prepare for their life at the end of human life span and the inevitable death at the very end of it.

8.5 Limitations of the study and further research directions

Although the participants in this study are a very heterogeneous group in terms of, for example, their age (ranging from 64 to 101 years), functional abilities and living conditions, there are no participants with very poor health and functioning, such as people who are bedridden or have dementia. This research concerns assisted living and has concentrated on so-called ordinary assisted living, which is a lighter version of assisted living for older people who are not able to live in a private home due to, for example, reduced physical and cognitive capabilities and/or illness. Thus, none of the participants in this study were living in assisted living with 24-hour assistance and, consequently, none with more demanding care needs or, for example, with dementia. It is possible that the experiences of older people with poorer physical and cognitive abilities living in a more institution-like setting would differ from those of the participants in this study. However, by concentrating on the ordinary assisted living, this study has been able to show that even such 'lighter' facilities entail complex characteristics that contribute to organising everyday social life.

Furthermore, this study concentrates on only one assisted living facility in Finland and thus cannot recognise, for example, regional diversity or differences between facilities. However, being able to examine one facility in detail enabled deep immersion into the everyday life and experiences in the facility. The facility staff helped to recruit participants for the study. This was necessary to make sure the participants were able to give their informed consent to participate, and staff members were able to evaluate this. However, this could have resulted in staff members choosing the most active and positive residents (for example, those having

most positive attitudes towards the staff and the facility) as potential participants. There were also very critical views of the facility and the staff among the participants, though, showing that this would not be entirely true.

Overall, I recognise that older people who are in more vulnerable positions (e.g. social exclusion, mental health issues) or have difficult life situations (e.g. poverty, care poverty) might not have the resources or the capacity to participate in research. Thus, the participants in this study probably represent more active and well-off older people. For example, regarding the interviews with nonagenarians, it is likely that those who were interested in meeting new people and talking about their lives and experiences agreed to take part in the interviews. Those who were struggling to get by in their everyday lives, on the other hand, might not have been able or willing to participate. In the SoWell research project we managed to recruit a few older persons who were in less favourable positions with the help of outreach social work with older people. The participants in the SoWell project were also recruited through associations and service centres, which could indicate that those agreeing to participate were active older people. However, service centres provide low-threshold and free-of-charge services for older people that those in more vulnerable positions could also use. Hence, this enables variability in relation to the type of participants involved in this study.

Considering the time of the COVID-19 pandemic, this research only considers the experiences of older people at the beginning of the pandemic and the epidemic in Finland in 2020. It is possible that the experiences changed over time as knowledge of the disease increased and people got more used to the situation and experienced fluctuations of better and worse periods. Moreover, this study only considers the situation in Finland, but responses to the pandemic varied in different countries, likely resulting in varying experiences among older people. However, many countries introduced similar restrictions to those implemented in Finland, and thus the results of this study may reflect the experiences of many older people. Moreover, it can be argued that especially at the beginning of the pandemic, it was not only the restrictions introduced by different countries that affected people's attitudes towards the pandemic, but also the significant amount of news coverage that created menacing visions of the dangers of the disease.

This study touches upon different kinds of spaces that are relevant for the everyday social lives of older people and uses only a few perspectives to study these spaces. Hence, this study cannot capture all aspects of older people's social relationships and interaction in these spaces or consider all possible social spaces in older people's lives. The study is also limited by how and for what purposes the data

utilised were collected. As described in Chapter 6, the data in the Vitality 90+ Study and the SoWell project were collected to get information about oldest old persons' lives and about older people's views of well-being and everyday life during the COVID-19 pandemic. Thus, the aim of the data collection was not to gather information on social relationships, interaction and spaces and places as such. Data that had concentrated especially on those issues could have provided a more diverse and detailed view in this study. However, using these data enabled a variety of views to be considered of people of different ages and in different life situations. Furthermore, this enabled me to view these data from a novel perspective, which showed that spaces and places manifest themselves in the lives of older people even when they are not the explicit focus of discussion.

Regarding the generalisability of the results, this study, just like most qualitative research, does not aim to generalise the results, in the sense of quantitative research, but instead provides context-based knowledge that can be generalised theoretically (Carminati, 2018). This means that as the aim of this research has been to deepen our understanding of spaces as affecting social life in old age, the identified experiences and ways of making sense in these contexts can be generalised theoretically to apply to other older people who inhabit, frequent and use such spaces. Theoretical generalisability relates to the transparency, reflexivity and accuracy of the research (Carminati, 2018) that I have aimed to highlight throughout the research process, and I reflect on this in more in detail in Chapter 6.6.

Future research should include diverse older people, in terms of their health and functional and cognitive abilities, life situations and backgrounds (e.g. immigrant) to enable different views to be heard. Different kinds of living and other environments should also be considered. While some of the spaces considered in this study, like the home and assisted living, or care, facilities, have received research attention earlier, such spaces as public spaces, virtual spaces and memories as a space, especially from the viewpoint of social relationships and interaction in old age and of older people themselves, need further research. For example, understanding social space as not necessarily physical space could provide interesting new viewpoints from which to study social life in old age. In addition, crisis situations, such as the COVID-19 pandemic, can dramatically alter the context of ageing. Research on the effects of such crisis situations on the social life of older people is also needed to be able to respond to the various needs of older people in these situations, not just the health-related ones. Overall, research is needed, regardless of the spaces being studied, that listens to older people's views, experiences and worries related to and ways of making sense of social spaces and their own position within them. This kind

of research can discover new ways to understand spaces and places and the lives of older people within them and can direct attention to the social needs of older people.

9 CONCLUSIONS

The aim of this study was to explore the meaning of social spaces for the social relationships and interaction of older people. The starting points were, first, that social relationships play an important role in the everyday lives of older people and, second, that those relationships are contextualised by spaces in which human lives occur and by societies that frame that human life. In this study, I have explored the social life of older people in varying life situations and different contexts. The participants were of many older ages, had different life situations and lived in different places. The initial task was to listen to the views and observe the lives of the older people themselves and to try to make sense of the multifaceted worlds of their social lives. I have brought together the views and experiences of the participants in this study by exploring their social worlds within the socio-physical settings in which their everyday lives take place. To this end, I have utilised social space as a synthesising concept.

In this chapter, I will summarise the discussion in the previous chapter by highlighting four main contributions of this study. First, this study contributes to the timely discussions about older people's homes, especially to the discussions about the priority and superiority of the home evident in the ageing in place policy implemented in Finland and globally. I have suggested that the discussions about older people's homes within ageing in place policy, especially in the Finnish context, are limited by the emphasis on the physical needs of older people and the physical space of the home. As for the social needs of older people within the home space, they seem to be completely unaddressed. As my research showed, however, 1) the home and its surroundings are central places for social contact and help and support for older people, indicating that social relationships can be an important resource enabling independent life at home and 2) social relationships can be a factor that brings 'quality' to 'ageing in place', that is, a factor that makes life at home a life worth living. Instead of looking at homes as containers of older people with possible care needs, the ageing in place policy could be enriched by viewing older people living at home as ageing in a social space that fundamentally affects the nature of the home space as well as older people's opportunities to live independently and enjoy their lives.

Second, and relating to the first conclusion, this study contributes to our understanding of spaces as enabling, on one hand, and restricting, on the other, social relationships and interaction. If we are to enrich ageing in place policy with the viewpoint of homes being fundamentally social spaces, we must also recognise the vulnerabilities of the home space. Home is not necessarily a place an older person chooses to stay in and to have social contact in, but it might be the only available space. This is the case when the health and functional abilities of the older person decline so that moving outside their home is difficult or even impossible. However, this was the case in this study during the COVID-19 pandemic for those with no physical challenges, because they were 'ordered' to stay inside their homes. Forcing the home to be the only available option for older people fails to recognise the diverse life situations of older people and the social needs within those situations, as well as the preferences of older people themselves regarding how they want to live their life. This study showed, however, that social spaces are given meanings by older people and that those meanings that come from the outside are not necessarily accepted. When moving around outside the home became forbidden, in a sense, for older people, they started negotiating their right to move around in public space and some continued moving outside the home. Also the meaning of home as the safe place was negotiated by highlighting, not the vulnerable position of oneself as on older person or assisted living resident, but the position of a responsible person who wants to protect others. These meanings and ways of making sense should be utilised to better understand the reasons for certain behaviours in different situations and the way in which spaces and places are used by older people.

Third, this study showed that assisted living facilities can be understood as an older person's home. Nevertheless, recognising the multifaceted nature of the assisted living facility as a space with the characteristics of a home, an institution and a community is important when attempting to understand everyday life in such facilities. As this research showed, social relationships and interaction play an important part in defining what kind of place an assisted living facility can be: the ways in which social relationships and interaction in the facility are interpreted and made sense of also affect how the facility is understood. That is, social relationships are part of what makes a place feel like a home, or not like a home. Thus, good communication and a shared understanding between the residents, staff members and visitors to the facility regarding what kind of place the facility is can reduce conflicts and improve well-being. Furthermore, people's assumptions about assisted living facilities can be very different from the experiences of those living in such facilities. In this study, it was detected that people who did not live in an assisted

living facility thought life in one of them would be lonely and miserable, whereas those who lived in one thought that it was a safe and a sociable place. That is, the poor public image of care facilities seems to contribute to a distorted view of what kind of place a care facility can be and how it can provide social support, security and comfort for older people.

Fourth, this study contributes to the discussions about the nature of social relationships and spaces. We tend to think of social relationships as those relationships we have in the current moment. The study of social relationships in old age concentrates mostly on such tangible social relations. However, gerontological research could benefit from including a wider view of social relationships in terms of both spatiality and temporality, that is, considering social relations as occurring throughout the human life course and beyond physical space. As shown here, virtual spaces can act as important means of social contact for older people who find it difficult to move around outside their home. Thus, technology can be understood as blurring the boundaries of physical space, thereby enabling social contact and participation within the otherwise restricting home space. In other words, virtual space can be thought of as a space that exists inside the physical home space that brings other people and social activities close to the older person. Memories can also work in this way. People encountered during the life course can be meaningful and important even though they do not physically exist anymore. Visiting the social space of the memories of loved ones can evoke emotions and work as a social resource.

Overall, this study highlights the importance of listening to older people's views. Older people are not a homogeneous group for whom one-size-fits-all solutions and approaches will be sufficient. Instead, the meanings, interpretations and preferences of different social spaces vary considerably. Thus, understanding the diversity of older people should form the basis of developing and evaluating policies and practices that affect the spaces and places in which older people live and move as well as social participation and connectedness in old age.

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11 ATTACHMENTS

ATTACHMENT 1. TOPIC GUIDE FOR THE VITALITY 90+ STUDY INTERVIEWS

Translated from Finnish into English by the author.

Can you tell me your life story starting right from the beginning?

- Childhood, parents, grandparents, siblings, other family
- Childhood home, conditions, atmosphere in the home, golden rules in life given by parents, upbringing
- School attendance, studying
- Work life, jobs during the lifetime, nature of work
- Marriage, spouse
- Starting a family, children and their life
- Wartime
- Deaths of loved ones

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- What has been most important to you in your life? What is most important now?
- How have you coped with difficult matters/times in your life?

- Hobbies
- Retirement
- Current family and important people, friends
- Course of the day, everyday life, managing one's finances
- Current housing

- What is good old age in your opinion? What is needed for it? What kinds of things does it include?
- What do you think is the secret of your long life?

- What is your state of health currently? (Health, functional capacity, memory, mood, compared to age peers)

- Illnesses and medications (on a general level)
- How do you take care of your health?
- Experiences of doctors and hospitals
- Do you have experiences of being an informal carer for a loved one? Have you cared for a sick loved one for longer periods?

- How has the world, in your opinion, changed during your lifetime?
- What are, in your opinion, the biggest/most important changes?
- What is better than before in Finland, what is worse?
- Position of and respect for older people?
- What would you want to say to the future generations? Do you have a life wisdom of some kind?

Is there anything else you would like to tell, or do you have questions?

ATTACHMENT 2. TOPIC GUIDE FOR THE AGEING AND SOCIAL WELL-BEING (SOWELL) GROUP DISCUSSIONS

Translated from Finnish into English by the author.

What is well-being?

- What is well-being, in your opinion, for an ageing person? What is an ageing person's good life like? How about from your own perspective?
- What kinds of things affect well-being? What is needed for a good life? (health, social relationships, respect?)
- How can one affect one's own well-being and good life? What can be done to improve them?
- What kinds of things, in your opinion, affect an ageing person's well-being negatively? What impedes or threatens it?

Ageing

- How do you think an older person's well-being differs from a younger person's well-being?
- Are different things more important now than at a younger age? Is something different needed for well-being compared to a younger age?
- How do you think someone could prepare for advancing age, for real old age? What kinds of things are important for well-being then? Could one do something for it in advance? (The assumption here is that most of the participants would be under 80 years of age.)

Living environment

- What do you think is the meaning of the living environment for well-being? What kinds of things support or undermine well-being in one's living environment, like in this place X [the place where the participants live]? What can one do here, in what kinds of things can one participate here?

What would you like to change here in this city or in X [the place where the participants live]?

Services

- What is the meaning of different services, like health services and other such services, for well-being? How have these been arranged here? How should they be improved?

Activities provided by the city and organisations

- Do the city and organisations organise other activities in this area that are important to you?
- What kinds of activities would you like to have?
- What kinds of things affect people's participation in these activities?
- What is the situation of those who cannot attend organised activities?

Technology

- Nowadays there is lots of discussion about technology and many activities are moving online. What do you think about this?
- Is it a good thing to handle doctor's appointments and banking, for example, on the internet? Could older people use Skype, for example, to keep in contact with other people? Does digitalisation excite you or worry you?

Society

- What do you think, in general, is the position of ageing persons and older persons like in society?
- How are old age and ageing persons, in your opinion, talked about in public? Does that affect your mood or your life?
- If you think this is not appropriate, what should be done and by whom?

What is the best thing in your life?

Any pieces of advice on how Finland could remain a good place to live for older people?

Anything else you would like to say?

ATTACHMENT 3. TOPIC GUIDE FOR THE AGEING AND SOCIAL WELL-BEING (SOWELL) INDIVIDUAL INTERVIEWS

Translated from Finnish into English by the author.

Background information

- Age, place of birth, marital status, type of housing (and alone or with someone), education, primary occupation

What kinds of things does the word well-being bring to your mind?

- What does well-being mean to you? When do you feel well?
- What is your own evaluation of your health and functional capacity? (Ask to evaluate based on a scale: very good, fairly good, average, fairly poor and poor. Separately for health and functional capacity.)
- What kinds of things do you do to feel well?
- What kinds of periods have there perhaps been in your life when you have been feeling worse?
- What was the cause of the more difficult periods?
- How have you pulled through the difficult periods?

What kinds of changes happen to well-being when one ages?

- How did you feel about retirement?
- How have you prepared for the future, perhaps?
- In what ways have you adjusted your activities, like hobbies, along with ageing?
- Do you use assistive devices? What? From whom do you receive help when needed?
- What kinds of things have you had to give up due to ageing, perhaps? How have you felt about that?

- What good has age brought along?
- How has ageing changed you as a woman/man?
- What do you think would be a good age for a human being to live to?
- In what ways have you prepared for death, perhaps? (Concrete and psychological)
- What does spirituality mean to you?

How do other people affect well-being?

- Who do you have in your immediate circle and how often do you meet them? Former colleagues?
- Number of children, number of (great) grandchildren (if this has not come up earlier)
- Are there other people you would meet regularly, although maybe not that often? Where do you meet them?
- Many people chat with other people in grocery stores or marketplaces even though they do not know each other. What do you think about these kinds of encounters?
- What is the meaning of other people for well-being? Has the meaning of other people changed in some way along with ageing? (If this has not come up earlier.)
- Is intimacy important for ageing persons?
- What does intimacy mean to you? (possibly sexuality)
- How are you able to fulfil your human need for intimacy?
- What kinds of communities do you think you belong to at the moment? What do you get from these communities?
- Do you feel you have something to give to other people? What? How?

Next discussion topic relates to how society and the living environment can affect well-being

- How does your neighbourhood acknowledge older people? (Is it easy to move around, pedestrian and traffic routes, lighting, snow clearance, leisure facilities?)
- What kinds of services do you use and what, perhaps is missing? (Are there activities for older people? Who organises them?)
- What kinds of things create a sense of security in your neighbourhood? What about a sense of insecurity?
- What is the state of respect for older people these days, in your opinion?

- Do you feel that other people's respect towards you has changed along with age?
- What is older people's position like in present-day Finland, in your opinion? (Are older people acknowledged in decision making, can they participate in society and in decision making the same way as younger people?)

Does digitalisation (explain the term) affect the well-being of older people?

- Do you use the internet? If so, with what kinds of devices and for what purposes?
- Who helps you with technology if needed?
- Do older people you know use the internet/computer/smart phone and for what purposes?
- What things do you consider to be benefits of the digitalisation of society? What are the downsides?

Questions for the end, time permitting:

What is the best thing in your life at the moment?
What would you like to say to Finnish policymakers?
Do you have a piece of advice on how Finland will remain a good place to live for older people?

ATTACHMENT 4. TOPIC GUIDE FOR THE AGEING AND SOCIAL WELL-BEING (SOWELL) PHONE INTERVIEWS

Translated from Finnish into English by the author.

How has this time of the coronavirus disease affected your life?

- Meeting relatives and friends, feeling lonely (if do not come up)
- Problems, such as challenges with grocery shopping and running errands? Has the situation caused you any practical difficulties?
- Maintaining well-being
- What if restrictions are continued, what will autumn look like?

People aged 70 and older were advised at the beginning of the epidemic to stay at home and avoid meeting other people. How have you felt about that? What were the implications of this in your life?

What do you think about the fact that people aged 70 and older have been treated differently than younger people and they have been given special instructions?

Visits to institutions and round-the-clock care facilities have been prohibited altogether now during the coronavirus epidemic. How has this concerned you? What do you think about these rules?

Now, during the coronavirus epidemic, there has been lots of discussion about how one can run errands and be in touch with other people through computers, by means of digital devices. What do you think about this? Have you been able to make use of these yourself?

Now we have gone through all the preplanned questions. Do you still have something on your mind that you would like to say?

12 PUBLICATIONS

PUBLICATION I

"Who would take a 90-year-old?" Community-dwelling nonagenarians' perceptions of social relationships

Tuominen, K. & Pirhonen, J.

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"Who would take a 90-year-old?" Community-dwelling nonagenarians' perceptions of social relationships

By Katariina Tuominen & Jari Pirhonen**

Abstract

This article aims to deepen understanding of the informal social relationships of the oldest old by applying qualitative methods. It considers ideas of the fourth age, socioemotional selectivity theory, and gerotranscendence theory from the viewpoint of Finnish community-dwelling nonagenarians. Qualitative life-story interviews were analyzed using qualitative content analysis. Nonagenarians described the significance of social relationships but also social restrictions and loneliness. In addition, the interviewees described the company and help their social relationships provided, and the pleasant and unpleasant emotions they experienced in their existing and past relationships. Our findings indicate that social relationships can contribute to the ability of nonagenarians to live a good life in old age, and that nonagenarians' successful aging is not necessarily related to voluntary disengagement from social relationships, as suggested by some theories. Rather, our findings indicate a pursuit of engagement with other people to be important for the good aging of the oldest old.

Keywords: the oldest old, nonagenarian, community-dwelling, social relationships, qualitative research.

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Introduction

Despite the fact that the populations of Finland and most developed countries are aging rapidly (Eurostat 2018; National Institute of Health and Welfare 2018), our knowledge about the social relationships of the oldest old is limited. There is strong evidence that social relationships are important for older individuals' health and well-being (Berg-Warman & Brodsky 2006; Borgloh & Westerheide 2012; Yang & Stark 2010), yet our understanding of the social relationships of the oldest old from their own viewpoint is almost nonexistent. Consequently, our existing knowledge about social relationships in very old age is strongly based on quantitative research.

Previous studies have shown, for instance, that social engagement remains an important determinant of physical health in old age (Cherry et al. 2011); that social relationships can have a protective effect against mortality (Giles et al. 2005); and that social relationships are associated with cognitive performance (Gow et al. 2013), life satisfaction (Berg et al. 2006; Okabayashia & Hougham 2014), attachment to life (Jopp et al. 2008), and self-perceptions of disability (Kelley-Moore et al. 2006). Furthermore, social relationships have been found to be one of the most important aspects for the well-being and successful aging of the oldest old (Nosraty et al. 2012, 2015; von Faber et al. 2001). Numerous quantitative studies have shown that social relationships play an essential role in the lives of older and the oldest old people.

The qualitative approach is also needed to reveal new aspects of the factors perceived to be important for the well-being of older people. This is essential in order to promote the health and well-being of the older population, as quantitative measures are not always able to capture the essence of the studied subject, as the study by von Faber et al. (2001) demonstrates. They studied successful aging using both quantitative and qualitative methods, and found a considerable difference in their findings: the quantitative findings showed a very low proportion of successfully aged people, whereas the proportion of those perceiving themselves as successfully aged in the qualitative findings was significantly higher. Interestingly, when the older people were able to offer their own perceptions of successful aging, it turned out that it was not a matter of objectively measured physical functions but of successful adaptation to physical limitations. Thus, when the opportunity was given to older

people to give their own views on the matter in their own words, a whole new perspective to the studied subject was found, one that could not have been detected using only quantitative methods. Similarly, as with the case of von Faber et al. (2001), the quantitative studies mentioned above emphasizing the advantages of an active social life cannot say much about the personal meanings that older people give to social relationships.

The primary focus of this study is on acquiring information about the informal social relationships of community-dwelling nonagenarians, also referred to as the "oldest old." The secondary aim is to consider some well-known ideas about the quality of life in old age – namely, the fourth age, socioemotional selectivity theory (SST), and gerotranscendence theory (GT) – from the viewpoint of these nonagenarians. This will be done by using life-story interview data, which are analyzed using qualitative content analysis. This study provides diverse information about the social relationships of the oldest old, including knowledge about the perceived limitations for – and the significance of – social relationships in the lives of the oldest old, and the valued aspects of social relationships in very old age. Thus, this study provides new knowledge about the social world of the oldest old, which is needed to promote their health and well-being.

Theoretical Background

The theoretical background of this study arises from the conception of affiliation, as outlined by the philosopher Nussbaum (2011: 34, 39–40). Nussbaum considers affiliation to be one of the most important human capabilities. 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). Therefore, community-dwelling nonagenarians should indeed be able to feel like members of a community, living "with and toward" 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 community-dwelling nonagenarians should not be in a disadvantageous position compared to others due to their advanced age and limited capabilities.

However, due to the various functional, social, and psychological challenges that very old individuals experience – such as reduced physical health and the loss of well-liked activities and family and friends (Jopp et al. 2016) – their social relationships, which are important for Nussbaum's (2011: 34) first precondition of affiliation, tend to decrease. Therefore, it is important to study qualitatively the nature of the social networks of people aged 90+ who are still living in well-established homes. In addition, reaching very old age may result in different forms of social and cultural stigma (Gilleard & Higgs 2010; Nussbaum & Levmore 2017), hampering nonagenarians' chances for Nussbaum's (2011: 34) second precondition – namely, to be treated as dignified beings whose worth is equal to that of others. In the next section, we will enter into these sociocultural challenges.

The Fourth Age and Successful Aging

Now that people are living longer, our perceptions of old age have become more multidisciplinary and diverse. Furthermore, it can be argued that old age cannot be studied without considering the life experiences and social context of individuals' lives. The fact that people are living longer has also resulted in the division of old age into ever smaller and more distinguishable life stages (Degnen 2007; Heikkinen 2004).

A well-acknowledged division is the one between the third and the fourth age (Laslett 1989). The distinction between and the definitions of the third and fourth age are not straightforward. Based on one definition, the fourth age can begin at very different ages, ranging from 60 to 90 years (Baltes & Smith 2003), which would make our interviewees (aged 90+) fourth agers. The third age is often referred to as the good news of old age, whereas fourth age is the bad news. Hence, the third age refers to the ability of older people to be effective and productive members of society, while the fourth age refers to a high prevalence of dysfunction, a reduced potential to recover functionality, and to loss of identity, autonomy and a sense of control which are threatening the features of the human mind and the chance to live and die with dignity (Baltes & Smith 2003). However, the shift from the third to the fourth age is not necessarily tied to the chronological age or life stage of the person; it can be a state of "unbecoming" (Higgs & Gilleard 2014) characterized by a lack of agency. A person becomes a subject of the fourth age when

others determine him or her to be no longer able to manage everyday life (Gilleard & Higgs 2010). This study will provide new knowledge on whether people aged 90+ who still live in their well-established homes closer match the definition of third or fourth agers.

Considering the issues raised above, one could ask whether successful aging is at all possible for the oldest old who are often classified as fourth agers. What is considered successful aging depends on the definition used. Successful aging has been approached from three different perspectives: biomedical theories, psychological approaches, and lay views (Bowling & Dieppe 2005). Therefore, one could emphasize successful aging as the absence of disease and disability (Rowe & Kahn 1997); as consisting of life satisfaction, social participation, and functioning (e.g. Carstensen et al. 1999; Freund & Baltes 1998); or as consisting of manifold lay definitions that are only partly captured by theoretical models (Bowling & Dieppe 2005).

The concept of successful aging is problematic, and it has been criticized for creating unrealistic expectations. It implies that older people must stay active and be productive members of society, and that one can choose to age successfully (Dillaway & Byrnes 2009). Furthermore, the shortcomings of the theoretical conceptualizations of successful aging are related to their very limited opportunities to represent a wide range of older people's experiences of aging, rather than only a select group (Bowling & Dieppe 2005; Dillaway & Byrnes 2009). Thus, Dillaway and Byrnes (2009) argue that the definitions of successful aging provided by older people themselves can be more appropriate than external definitions. In addition, as Bowling and Dieppe (2005) argue, lay views are important for testing the validity of existing models and measures.

Indeed, studies conducted among the oldest old people suggest that the viewpoint of successful aging being merely the absence of disease and disability is problematic, as it would exclude most older people (e.g. Nosraty et al. 2012; von Faber et al. 2001). Although differing results can be found (Cherry et al. 2013), many studies instead point to the importance of social relationships in the successful aging of the oldest old people, even when studying older people's own perceptions (Jopp et al. 2008; Nosraty et al. 2012, 2015; von Faber et al. 2001).

The meaning of social relationships for successful aging has been theorized by SST and GT. SST suggests that as people get older, they become more present-oriented instead of future-oriented, focusing on

experiences occurring in the moment. Therefore, they are likely to pursue goals related to emotional meaning and emotional satisfaction. This would also lead to the preference for familiar social partners in order to ensure the predictability and positivity of emotions and the emotional quality of social interaction. SST argues that reduced social contact in old age is not due to age-related losses or emotional withdrawal from social life but due to older people themselves being active agents, constructing their social worlds to match their social goals (Carstensen et al. 1999).

GT, on the other hand, suggests that the very process of living into old age is characterized by a general potential toward gerotranscendence, which means that as people age, they encounter changes in the way they perceive themselves, others, and the world. As a natural consequence, the social relationships of older people change from wider and more superficial to narrower and more profound (Tornstam 2011). However, there is a troubling inconsistency between these approaches and previous studies emphasizing the importance of social relationships in old age.

In this study, we aim to shed light on the social relationships of community-dwelling nonagenarians while bearing in mind Nussbaum's (2011: 34) view of affiliation in addition to the theory of the fourth age, SST, and GT (Carstensen et al. 1999; Tornstam 2011). We aim to determine whether our informants achieve affiliation as Nussbaum (2011) defines it, and whether SST and GT still hold up for nonagenarians. In addition, we aim to clarify whether cultural definitions of the third and fourth ages match the reality of our informants, and whether our informants can be seen as successful agers.

Data and Methods

The data used in this study originate from the Vitality 90+ study carried out in the city of Tampere in southern Finland. It is a multidisciplinary study focusing on longevity and the oldest old. This study utilizes life-story interview data from 2012. Every fifth community-dwelling woman and man living in Tampere (born between the years 1921 and 1922, thus aged 90–91 at the time) was sent a request to participate in the interview. The request was sent to 99 women and 41 men, of whom 25 and 20, respectively, gave a positive answer. The response rate was 25% for women and 48% for men. The collection of the data was approved by the ethics committee of the local hospital district.

Along with the interview request, a short questionnaire was sent to the participants asking about marital status, living arrangements, need for help, and self-rated health. Information about the participants' characteristics can be found in Table 1. As can be seen, the majority of the participants were widowed, lived alone, had no need for help, and rated their health as average.

The interviews were conducted by three researchers who were experts in the field of aging studies and two medical students trained to conduct interviews. The participants were interviewed in their homes. The shortest interview took 34 min and the longest 3 h and 20 min. There were nine interviews which took less than an hour, 24 interviews that took 1–2 h, ten interviews which took over 2 h, and two interviews lasting over 3 h. All 45 interviews were tape-recorded and transcribed into 1073 text pages. The interviewers had also documented short details of the interview situation and their personal observations about the

Table 1. Characteristics of participants in the interviews (n = 45)

Number of participants	Men (n) 20	Women (n) 25	Total (n) 45
Marital status			
Married	9	3	12
Widowed	11	17	28
Unmarried	1	4	5
Living arrangements			
Alone	11	23	34
With spouse	9	2	11
Need for help			
None	12	12	24
Sometimes	6	8	14
Daily	3	4	7
Health			
Good/fairly good	8	6	14
Average	12	16	28
Poor	1	2	3

interviewees, which helped the authors to delve deeply into the interview material, despite not having conducted the interviews themselves.

The same interview framework was used in all of the interviews; the participants were first asked to tell their life story from childhood to the present day. If necessary, additional questions were asked about school and studies, working life, marriage and children, wartime, and the death of loved ones. After that, questions about various topics, such as health, hobbies, everyday life, social relationships, a good old age, and longevity were asked.

The data were analyzed using the inductive approach of qualitative content analysis (Elo & Kyngäs 2008). Qualitative content analysis can be defined as a "research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon 2005: 1278). This method of analysis was chosen because it allowed us to concentrate on a special viewpoint in the vast amount of text data, and thus it allowed a detailed identification of descriptions related to social relationships.

As the authors were not familiar with the interviews beforehand, the first phase of the analysis included a thorough familiarization with the data, ensuring an understanding of the data as a whole. In the next phase, by looking for descriptions of informal social relationships, the transcribed interviews were coded and short notes about the codes written. After that, the coded sections were read multiple times in order to recognize differences and similarities between the codes. In that way, an understanding of different descriptions of social relationships was created. Based on the observations made in this phase, codes identified as similar were grouped and preliminary categories were thus created. By observing the content of the preliminary categories created, similar categories were combined to create subcategories. Then, subcategories were observed in a similar way and combined in order to create general categories and, finally, the main categories.

The coding and the grouping of the codes into preliminary categories and the combining of the preliminary categories into subcategories were done by the first author. After that, the second author examined the codes in each category and presented his own observations. Together, the categories were revised and the generic categories and main categories formulated. The grouping of the categories is presented in Table 2. In the next section, these categories are presented and their content described.

Table 2. Categories created in the analysis process

The main category	General-level descriptions		Particular-level descriptions		
Generic category	The significance of social relationships		The nature of social relationships		
Sub-category	Restrictions and loneliness	Appreciation of social relationships	Company	Help	Emotional activity
Preliminary category	Death of friends and relatives	Being social	Visits	Receiving help	Feelings of joy
	Poor health	Having people around	Neighbors	Helping others	Unpleasant feelings
	Busy lives of relatives	Having family and friends	Telephone	Independence	Impact of childhood family
	Relatives living far away	Harmony of social relationships	Association activities		

Results

Based on the analysis, community-dwelling nonagenarians talked about their social relationships on both the general and particular level. The general level consisted of articulations about the significance of relationships and associated ideas of social restriction and loneliness. On the particular level, the participants described the nature of their existing social relations. We identified these levels as "the significance of social relationships" and "the nature of social relationships." The findings are illustrated below by extracts from the interview data. The extracts were translated from Finnish into English by the authors. The names of people and places appearing in the extracts are pseudonyms, and the letter R in front of a quotation refers to the researcher.

The Significance of Social Relationships

People reaching very old age are likely to encounter changes in their social surroundings. The participants talked about factors in their life that limited their opportunities to gain, maintain, and enjoy social relationships. Poor eyesight, deteriorating functional abilities, and increasing health problems resulted in fewer trips outside the home. The ever poorer condition of friends of the same age was mentioned as a social restriction as well. Anna explains how poor hearing became a reason for her to avoid conversations:

> Anna: This hearing of mine harms me so much, because I can't hear. A lady was talking to me in an Ostrobothnian dialect, it's strange to me, and I couldn't hear. Sometimes I can't understand a word and it's so awkward. I can't take part in conversations… I can't hear questions, I can't hear answers, only when they burst out laughing. And I don't get to be part of it. (Female, living alone)

Anna felt awkward in social situations due to her impaired hearing. The phrase "I don't get to be part of it" reveals that she feels like an outsider. She feels worse off compared to others, which may have negative effects on her affiliation. In addition, one's own age as such was experienced as an obstacle to social relationships. Maria noted that in old age one cannot find a new partner.

R: How has life been on your own?
Maria: It's been okay. I've thought many times, that it would be nice to have a gentleman friend, but when you're old you can't find one anymore.
R: Why not?
Maria: No, who would take a 90-year-old? I'm in good shape though, I could manage just fine. But still. (Female, living alone)

Maria suspects that no one would take a 90-year-old lady friend. She believes that nonagenarians lose desirability in the eyes of others. Bearing in mind Nussbaum's (2011) definition of affiliation, Maria's dignity and equal worth to others seem threatened.

When relatives and friends lived far away, communication was naturally restricted. Moving to another area, away from old friends and acquaintances, had also caused feelings of loneliness in one participant. Some also felt that relatives did not have time to visit them because they are busy with work and hobbies.

Helena: But that's how it is, my relatives, they have so many of their own activities… They don't have time, these youngsters. I understand that they have their own hurries. (Female, living alone)

Helena felt that "these youngsters" had no time for her anymore, indicating she felt like an outsider in relation to her family. However, Helena, like many other interviewees, considered her relatives' busy lives natural, and expressed this in an understanding tone.

When interviewing 90-year-old people, death was a common theme. The interviewees talked about the deaths of several friends and relatives. Sometimes they had outlived all their friends. Amanda was asked whether she had any close friends.

Amanda: Not anymore. I've had a huge circle of friends, since I've had so many hobbies and been involved in everything. But everybody dies. When I look at those pictures… I counted the other day, when I was there tidying up and looking at those pictures. That one is dead, that one is dead. Everybody is dead, but the only one alive was me. Then I had those bosom friends, there might

be 6–7 of them even. We always visited one another, drank coffee and so on, but all of them are already dead. There's none of them left. (Female, living alone)

Amanda shed light on an interesting angle of social relationships in very old age. Due to living to a very old age, she had lost her primary social circle to death, which is a distinctive phenomenon for this age group. The death of loved ones was also related to loneliness. For example, the death of a spouse meant that one no longer had anyone to talk to at home.

R: What is most unfortunate in this old age?
Erik: It would be nice to sometimes talk in here, sometimes when you wake up. When you're not completely conscious, you can almost feel that your wife is lying next to you. That you ought to talk, but then you realize that you're all alone here. Indeed, there's no one else here. (Male, living alone)

Erik pictured loneliness that seemed almost existential, yet the death of loved ones was not always experienced necessarily as a purely bad thing, but rather as a natural situation. Then again, losing loved ones could result in the loss of interest in social life altogether. This would not, however, mean that one could not be content with life and all the other things that make life good in the moment.

Amanda: When all your friends and all loved ones are gone, you don't even have much interest in those things, or in life outside. I can be happy, when I have a good house and I feel good. (Female, living alone)

As the excerpt above shows, being alone was not necessarily experienced as a bad thing as such, and it was not synonymous with being lonely. The ability to control being alone, by going where one wants or by calling someone, was a reason why some participants mentioned that although they were alone, they did not feel lonely.

Elsa: I have gotten to know people in this building, but this is the kind of place where you don't really have any collective events. I don't know, we are all just in our own boxes here.

R: Do you feel lonely then?

Elsa: No, I have never really felt like that. If I do, then I grab my phone and call my friend or my sister. (Female, living alone in an assisted living residence)

Indeed, as Elsa puts it, it was not being alone but loneliness that was considered unfortunate. Sometimes loneliness entirely preoccupied a person, as Emil explains:

Emil: I must say that although I still have much left in me, this loneliness, it imprisons you in a certain way. And when it imprisons you, it cuts down your way of thinking in some way very powerfully. It doesn't mean that one wouldn't understand, but the flight of thoughts… You can't get that kind of inspiration. (Male, living alone)

For Emil, loneliness seemed to be an overwhelming experience of emptiness that made him feel excluded, even imprisoned. Loneliness not only isolated him from other people but also from his own "flight of thoughts."

All these restrictions on social relationships and feelings of loneliness made social relations valuable to the participants. In particular, the importance of children, grandchildren, and the spouse was highlighted, as were social relationships in general. In addition, being social – talking to other people, being surrounded by people, and getting along with others – was highly appreciated. Mikael was asked what would make old age good:

Mikael: I can't think of anything else than having loved ones. To have someone who takes care of you or is interested in you. But they are quite rare in this busy crowd. (Male, living alone in an assisted living residence)

Mikael aptly sums up the significance of social relationships to our interviewees; in very old age, you need people to take care of you and take an interest in you. As we have seen, the absence of these other people may even result in existential loneliness and feelings of imprisonment.

Nature of Social Relationships

Despite all the restrictions regarding social relationships described above, the participants enjoyed the various kinds of relationships with their children and grandchildren, other relatives, friends, and neighbors. Based on the analysis, we arrived at three categories, which we named "company," "help," and "emotional activity." The content of these categories is outlined below.

Company

In the interviews, it was common that children and grandchildren visited the nonagenarians' homes; it was rarely the other way around. Meeting other relatives or friends was not very common, and again, it was more common that the other person would be the person doing the visiting. Nevertheless, some also described going outside to meet friends or occasionally going out to eat with children and grandchildren.

Neighbors seemed to be an important social contact for community-dwelling nonagenarians, as the participants described meeting and spending time with them. Neighbors were met and chatted to in the garden of the housing cooperative, and they could also be company for activities, such as taking walks, drinking coffee, or playing cards. Neighbors were a good source of company, because they were close by and usually present, as Eeva explains:

Eeva: If you want to be alone, you can be alone. But when you go out there, you are always surrounded by friends. (Female, living alone in an assisted living residence)

The telephone was important for the maintenance of social relationships, as friends and relatives were often reached specifically by phone. The telephone was a means to bring friends and relatives living further away closer. Calling was a way of maintaining the relationship when it otherwise would be too hard or even impossible, as Hilda describes:

Hilda: I have a friendship of 80 years with this friend of mine, but she lives in a different city. We have been friends since we were 10 years old – and we still are. She has lost quite a lot of her memory, but I call her quite often. That's a long friendship. (Female, living alone)

Taking part in association activities, such as veteran associations and spiritual clubs, was described as a way to meet people and make friends. Some described having made lifelong friendships in association activities earlier in their lives, but taking part in associations was also a way to meet new people and enjoy interesting events, such as presentations and trips. Sometimes associations could even act as a social safety net. Liisa gave an apt example when she was asked what kind of features belong to a good old age.

> Liisa: One has to have friends. Or some kind of a safety net, like that of my sister's mission circle… Good friends are left behind when you leave a place. Then you have to learn all that again and make friends. My sister's friends have now become my friends, so I'm sort of an associate member in their mission circle. (Female, living alone)

As the previous excerpt demonstrates, being part of an association provides one with company, which also offers security. In addition, all kinds of company may have positive effects on nonagenarians' affiliation.

Help

Giving and receiving help was a frequent theme in the interviews. Help seemed to play an important role in nonagenarians' lives, as help given in everyday chores by relatives, neighbors, and friends was a common theme raised by the interviewees.

Relatives, usually children and grandchildren, helped nonagenarians with all kinds of everyday chores, such as cooking, cleaning, shopping, and paying invoices. Some also mentioned that their children and grandchildren helped them with everything that they needed. Besides describing getting concrete help, nonagenarians also noted that children and grandchildren took care of them, for example, by calling or visiting often just to make sure everything was all right. Friends also helped them in everyday life by taking them shopping, for example. Neighbors mostly helped with outdoor chores such as plowing the snow in winter and tidying up the garden, but some also said that their neighbors took care of them more comprehensively, as Erik relates:

Erik: I haven't had any worries about those outdoor chores. And with all those other things as well, like I said, that neighbor of mine really gets it done. And helps me with everything I need. I've never had a situation where I would have been left helpless, thinking on my own, "what am I going to do?" (Male, living alone)

The nonagenarians were not only receivers of help, they also helped others. Amanda describes helping others as an important value in her life:

Amanda: To me, the most important thing in this life has been adjusting to everything and helping in general. I've always been like that, I want to help those worse off. (Female, living alone)

Few of the nonagenarians described helping the children from whom they themselves received a lot of help. Rather, they mentioned helping other elderly people who were in poorer state of health than they themselves were. Helping was also related to the experience of being needed, and it boosted the nonagenarians' self-esteem, as Ida explains:

Ida: Think about it, even at this age I'm able to do something. It's darned good for my self-esteem that I'm necessary to someone. And I can still do things, I'm not totally empty-headed. (Female, living alone)

Some interviewees were – or had been at some point – a carer for their spouse. They often stated that taking care of a spouse at home was natural. Being able to take care of the spouse at home – thus avoiding transfer to a nursing home – sometimes seemed to be a matter of principle. Taking care of a sick spouse at home was not necessarily easy, but it could be even more important than one's own well-being.

Alma: Many people say that I should put him [sick husband] in some institution. But the way I see it, I won't put him out, for this is our shared home. I couldn't tolerate it if he would end up in some place. I don't bother about myself so much. For sure, it would be much easier for me, because this is not an easy life for me. It's been easier sometimes, but I will bear it as long as I bear this life. (Female, living with a spouse)

The three previous excerpts are important regarding Nussbaum's (2011) affiliation, encompassing "being able to recognize and show concern for other human beings." As Ida puts it, being necessary to someone boosted the nonagenarians' self-esteem.

Being able to make one's own decisions and rule one's own life was described as an important way to stay independent and not be patronized. On the other hand, a few nonagenarians also mentioned how the lack of social relationships forced them to be independent. Therefore, independence was not always a choice.

Emma: I've known how to ask and demand all kinds of care for myself so that I would be able to manage on my own, because I don't have a single relative in this city. And all my acquaintances, my age group, are already gone or in the same condition as I am, so there's not much help. (Female, living alone)

Although the ethos of managing on one's own is strong in older generations (Jolanki 2009; Pirhonen et al. 2016), nonagenarians highly appreciated help received from other people. Emma's account of her situation reveals that her independence was reluctant. Thus, for some independence is a choice, whereas for others it is a necessity, a forced independence.

Emotional activity

The participants described how their social relationships brought joy and enrichment to their lives.

Leo: Well, certainly our retirement has been enriched by our grandchildren; we have 11 of them. And there was some care when our daughters quite readily brought them to us to be looked after. But somehow, it was a richness… When my grandson was little, he once said to me, "Grandpa, now I am leaving, you must feel so bored as you'll have nothing to do." Yes, that was about right. (Male, living with a spouse)

Nevertheless, unfortunate issues related to social relationships were also described. The illness and death of a child and the disappointment caused

by one's own child were among the issues causing grief. In addition, a few nonagenarians felt sad that their relatives did not really remember or keep in contact with them, feeling that no one really cared about them anymore. Other peoples' wrongdoings were also described by some, for example, experiences of injustice and mistreatment in childhood.

Erik: And well, then began that gloomy time. My father was a very quarrelsome man. Practically never did I hear a friendly word coming out of his mouth, he was always so bossy… That idea grew in my mind, when I always heard my father, he was the one who put it in there. When they [mother and father] were fighting, I could clearly hear those words: "You are crazy." And at school age I started to wonder if I really am crazy. Is there something wrong with me when they always say that again and again? (male, living alone)

However, some nonagenarians also described their family's positive impact on their lives. Some described having learned or "inherited" their parents' sportiness or healthy lifestyle. For example, some described how their parents' abstinence from alcohol resulted in them being teetotalers their whole life too. Memories of happy childhoods and loving parents still made participants feel happy in very old age. A couple of nonagenarians also raised the importance of their grandmothers in their lives because of what they taught them about religiosity and attitudes toward death. Social relationships, both past and present, seemed to work as a kind of emotional depository one could access spiritually when physical activity was restricted.

Discussion

Community-dwelling nonagenarians talked about social life on both the general and the particular level. On the general level, nonagenarians talked about the significance of social relationships. This was not only related to the great appreciation of social relationships in the first place but also to the social restrictions and loneliness the nonagenarians encountered in their lives. We found that the interviewees' deteriorating health, advanced age, distance from friends and relatives, limited

opportunities to see loved ones due to time pressures, and the death of friends and relatives were experienced as restrictions to social relationships. Due to these restrictions, some nonagenarians also felt lonely. However, the restrictions and loss of social life were also experienced as natural phenomena in old age, and being alone and being lonely were not synonymous. For example, if one could control being alone by popping out or calling someone, it prevented one from being lonely, even while being mainly alone.

On the particular level, nonagenarians described the nature of their existing social relationships with their children, grandchildren, other relatives, friends, and neighbors. Social relationships were described as a source of company, as having them meant having someone who visits, someone to spend time with, and someone to talk to on the telephone. In addition, taking part in association activities was described as a way to meet friends, and even as a social safety net. Nonagenarians also described receiving help from their relatives, neighbors, and friends with all kinds of everyday chores. However, being able to help others was important to nonagenarians as well, and they mostly helped other older persons or acted as carers to their spouses. Despite receiving help from others, nonagenarians also wanted to be independent. However, independence was a choice for some; for others, it was a necessity due to a lack of social relations. Thus, while some struggle with not being dependent on loved ones despite their very old age, others struggle with the necessity of being independent because of their very old age, as they have no other choice. The latter we call "forced independence."

Considering the features of the social lives of the nonagenarians, certain special characteristics can be found based on our results. One distinctive feature of the social life of the oldest old seems to be what we call "place-bound sociality." By this, we mean that the social life of the oldest old seems to be bound to the place of their residence. As the nonagenarians described, they were usually visited by others; they tended not to go on visits themselves. In addition, neighbors – that is, those who lived near them – were described as an important source of company and help. The telephone was an important means of communication and brought friends and family living further away closer to the nonagenarians. Therefore, it seems that the place of residence plays a particularly important part in the social life of the oldest old people.

An interesting feature in the descriptions of the nonagenarians was the significance not only of their existing social relationships but also of the social relationships in their past. Both existing and past relationships were a source of pleasant and unpleasant feelings. The participants explained that their way of life, life choices, and attitude toward life had been influenced by the social relationships of their past, reaching as far back as their childhood. Furthermore, the nonagenarians noted that happy memories of past relationships made them feel happy in the present. This would suggest that a life-course perspective (Dannefer & Settersten 2010) – that is, taking into account the whole life experiences of an individual – should be adopted when attempting to understand the lives of the oldest old. Our participants used memories of other people during their life course as an emotional depository they could access to avoid feelings of loneliness.

Based on their age and life stage, the nonagenarians in this study can be said to be living the fourth age. However, the idea of the fourth age as a phase of frailty and dependency (Baltes & Smith 2003) or complete lack of agency (Higgs & Gilleard 2014) is not supported by the findings of our study. Although the social life of nonagenarians was limited by a variety of factors and they were in need of help to some extent, they also described having and enjoying various social relationships. As Tanner (2016) suggests, the fourth age should be seen not only through the various limitations encountered in very old age but also through the opportunities the oldest old people still have. As was found by Lloyd et al. (2014) and Tanner (2016), the meaning and support social relationships bring to life may enable the oldest old to live meaningfully and maintain their identity, dignity, and autonomy in the fourth age.

Therefore, despite the limitations the nonagenarians in this study experienced, it seems their meaningful social relationships have contributed to their ability to continue living a good life even in very old age, and they thus do not meet the criteria for being fourth agers. In accordance with the findings of Pirhonen et al. (2016), this study indicates that the socially determined category of the fourth age does not apply to the level of individual experience. We argue that belonging to the fourth age cannot be determined by considering solely the individual's characteristics, the characteristics of the individual's social surroundings must be considered as well. Indeed, these social surroundings can enable a good life despite the challenges encountered in very old age.

Our findings indicate that social relationships play an important role in the lives of the oldest old people and that social relationships are important and valued by them. In particular, family – one's own children and grandchildren – played an important part in the nonagenarians' lives. According to SST (Carstensen et al. 1999), by emphasizing close and satisfactory relationships, our interviewees had successfully adapted their social worlds to match their social goals. Therefore, they could be considered successfully aged. It is noteworthy, however, that there is no indication in the findings of this study about the willingness of the oldest old people to disengage from their social relationships, although both SST (Carstensen et al. 1999) and GT (Tornstam 2011) suggest it to be important for older people. Indeed, although in some studies, some of the oldest old people have emphasized solitariness over social relationships (Cherry et al. 2013; Ness et al. 2014), our interviewees found being alone undesirable, and their valuation of peace and the absence of negative emotions was reflected in their desire for a certain kind of social relationships, not in the desire to live a solitary life.

Furthermore, we found that the experienced limitations in social relationships and the narrowing down of the social network did not occur due to the active or voluntary efforts of our interviewees themselves, but rather due to circumstances they could not influence themselves. Thus, the oldest old were not able to choose to reduce their social relationships; this reduction instead happened due to factors beyond their control. Consequently, voluntary and active disengagement from social relationships as a means of pursuing successful aging was not relevant to them at all.

Indeed, based on these findings, we argue that it is not necessarily the voluntary disengagement that is significant for the successful aging or good old age of the nonagenarians, but rather the pursuit of engagement despite the many kinds of limitations encountered in very old age. Thus, in accordance with the findings of von Faber et al. (2001), a different perspective was found by giving the oldest old opportunities to offer their own views on what is important for their good aging. Our findings indicate that being able to maintain meaningful social relationships in very old age seems to be something that could enable successful aging for the nonagenarians. Conversely, disengaging from and not having social relationships could lead to undesirable feelings of loneliness.

Nussbaum's (2011) bipartite definition of affiliation,[1] together with our findings, add to our knowledge of how to improve the life satisfaction of the oldest old people. The ability of community-dwelling nonagenarians to live with and toward others was found to be problematic. Deteriorating functional abilities and the loss of friends and relatives caused loneliness – in other words, loneliness arose from restricted opportunities to live with and toward others. Therefore, these people would benefit from services that make it easy for them to go out on the one hand, and services that make socializing possible in their own home on the other hand. Both social and technological innovations are needed. For example, well-organized volunteer work and transport services could bring nonagenarians together, while different kinds of telepresence technologies to provide company are already being developed for older people (Frennert et al. 2013; Mitzner et al. 2014). In addition, in line with Nussbaum's (2011) definition, showing concern for other human beings was also highlighted, as our interviewees' self-esteem was partly based on helping others even in very old age. Thus, there is a need for social innovations that would provide nonagenarians with a sense of reciprocity.

The latter part of Nussbaum's (2011: 24) definition – being able to be treated as a dignified being whose worth is equal to that of others – was also found to be problematic for community-dwelling nonagenarians. In many cases, nonagenarians stated that their children did not have time for them, although they said so in an understanding tone. Some also felt that their relatives had forgotten about them. One interviewee, Maria, suspected that nobody would want her as a lady friend anymore because of her age, which is perfectly in line with the previous theories of the fourth age as a life stage that is socially defined (Gilleard & Higgs 2010; Higgs & Gilleard 2014). Therefore, nonagenarians' generational equality could be strengthened by affecting public representations of old age and the oldest old people. Nussbaum's (2011) bipartite definition of affiliation reminds us that older people need both concrete social relationships and societal and cultural respect. Qualitative studies highlighting the individuality

[1] Being able to live with and toward others, showing concern for other human beings, and being able to be treated as a dignified being whose worth is equal to that of others.

and diversity of nonagenarians would help to break stereotypes and make them visible and accepted as the people they are.

Conclusions

By conducting a qualitative study using extensive life-story interviews, we were able to take into account the in-depth and varied descriptions provided by nonagenarians with different backgrounds and life situations. Thus, we were able to consider multiple perspectives in this study, which led to the recognition of different aspects of social life in very old age. We argue that in order to better understand very old age in its complexity, various – and also divergent – perspectives need to be acknowledged. This can best be accomplished by qualitative studies, which allow the oldest old to reveal their perceptions in their own words. Consequently, more studies using a qualitative approach are needed to capture the multiple aspects of social life in the oldest old people.

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PUBLICATION II

A home, an institution and a community? – Frames of social relationships and interaction in assisted living

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A home, an institution and a community – frames of social relationships and interaction in assisted living

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Abstract

Assisted living facilities are presented as the older person's home but, at the same time, defined by institutional and communal characteristics. Using Goffman's (1974/1986) concept of frame, we aim to find out how home, institution and community frames define social roles and shape social relationships and interaction in assisted living facilities. Directed content analysis was used to analyse the data consisting of observations, one group discussion and ten individual interviews with residents in an assisted living facility. We found that the home frame was characterised by meaningfulness, spontaneousness and informality of social relationships and interaction, whereas the institution frame by indifference and formality of them. Acknowledging and tolerating other people was not only central in the community frame but also dissociating oneself from some people. Frames can shed light on how different interpretations of the

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multifaceted social environment of assisted living affect homeliness of the facility and well-being of the residents.

Keywords: assisted living, frame analysis, home, social interaction, social relationships.

Introduction

Population ageing and the high costs of institutional long-term care have resulted in a growing commitment in many Western countries to ageing in place policies that allow older people to stay at home as long as possible (Genet et al. 2011; OECD 2005). The care of older people has therefore increasingly shifted from institutional settings to private homes or other home-like environments. This shift has also been evident in Finland where home care, informal care and housing services have increased at the expense of institutional care (Anttonen & Karsio 2016). In 2000, 12.6% of the Finnish population aged 85+ lived in nursing homes, and by 2019, this share had dropped to 1.5%. At the same time, the number of clients in sheltered housing with 24-hour assistance rose from 3.6% to 15.9% (National Institute for Health and Welfare 2021).

Assisted living – also called sheltered housing or service housing – consists of many different ways to organise housing and care services for older people. In Finland, *assisted living with 24-hour assistance* provides housing and care services for older people with the greatest care needs, such as those with dementia. Skilled care staff is available 24 hours a day, and residents' needs are similar to those in institutional care. *Ordinary assisted living* is intended for those older people who have less care needs but who, due to deteriorating health and/or functioning, are unable to live in their private homes. However, the care needs of older people also in this type of housing have become more and more intensive, calling for 24-hour assistance. Residents in both these types of services have their own rented apartment or room in the facility and pay separately for services they require. (Kröger 2019.) *Service centres*, then, can provide ordinary assisted living and assisted living with 24-hour assistance and also offer some of their services to (older) people living outside the facility. Such services include, for example, meals, guidance from a care professional, and events and social activities in the facility. The facility in focus in this

study falls under the service centre category, but for clarity, we use the more general term assisted living facility (ALF).

The main distinguishing feature of ALFs compared to such institutions as nursing homes is their home-likeness: ALFs have a less medical and institutional appearance than nursing homes (Roth & Eckert 2011). ALF residents can, for example, bring their own furniture and other belongings to their apartment or room. ALFs are also supposed to uphold the self-determination of residents and to provide more person-centred care than institutional settings (Pirhonen 2017). As ALFs, at least in policy papers, are considered to provide home-like environments, it is also necessary to approach social relationships differently than in traditional institutional environments. More attention must be given to how social relationships are structured by the socio-physical environments of ALFs. Research shows that social relationships are critical to the way that residents perceive ALFs (Cutchin et al. 2003; Lewinson et al. 2012; Roth & Eckert 2011). Roth and Eckert (2011) point out that although ALFs are formally designed as home-like environments, it is the residents and the staff who shape the facility into what it actually is. For example, private spaces in the facility become contested and redefined when staff freely enter residents' private apartments. A similar observation can be made about visitors to ALFs: if an ALF were an older person's home, the resident should have control over who has access to them and who can come into their home. However, this is not always the case (Bennett et al. 2017). Although social relationships very much affect what kind of places ALFs are and become, it is equally true that the physical and organisational setting of ALFs affects how social relationships in these environments can develop. The relationship between the environment and social relationships in the ALF is a two-way street.

As social environments, ALFs are hybrids of a home and an institution. On the one hand, ALFs are portrayed as private homes, and their purpose is to offer home-like living for older people. On the other hand, ALFs offer health care and social services for residents, and at the same time, they are workplaces for care and other professionals and, therefore, have institutional characteristics (Cutchin et al. 2003; Eckert 2009). Importantly, however, ALFs (particularly service centres) also organise various services, events and activities not only for residents but also for other (older)

people living in the neighbourhood. These ALFs aim to bring older people together, to act as a meeting place for a wider community and, thus, promote the social participation of older people living both in and outside the facility. From the perspective of social relationships, these ALFs also involve characteristics of a wider community and represent an arena of interaction between community members that exceeds the boundaries of the facility (Johansson et al. 2022). In other words, social relationships in ALFs are simultaneously framed by the characteristics related to those homes as private homes, institutions and local communities. Such a multifaceted environment sets certain rules for social relationships and interaction that individuals need to understand and interpret when attending different social situations. Erving Goffman's (1974/1986) theory of frames explains how individuals come to understand these rules in varying social situations.

In his book *Frame Analysis*, Goffman (1974/1986: 10) studies "basic frameworks of understanding that are available in our society for making sense of events" and the vulnerabilities of these frameworks, such as *keyings*, *fabrications* and *frame breaks* – ways in which these frameworks are subject to transformations and disruptions. He argues that when attending any current situation, often involving other individuals and not necessarily restricted to face-to-face gatherings, individuals face the question "What is it that's going on here?" (p. 8). The answer to this question defines the situation and, thus, determines the expectations for action. To define a situation, then, key factors are the "principles of organization" (p. 10) that govern social events and individuals' involvement in them. Goffman calls these principles of organisation as *frames*. In other words, to answer the question "what is it that's going on here?" we need to contextualise the events and understand the norms and rules that control the interaction (Persson 2019). We can do that by employing the culturally constructed "schemata of interpretation" (Goffman 1974/1986: 21) – frames – that are shared by the members of the community.

The idea of frames relates well to ALFs as the members of these communities can be seen to share similar ways of understanding and interpreting social situations in the facility. Especially, central for these interpretations is, we argue, the different distinguishable characteristics of ALFs: the characteristics of a home, an institution and a community. Drawing from Goffman's theory of frames, features of a home, an institution and

a community can be understood as interpretative schemata that are employed in making sense of social events and defining social situations in ALFs. The aim of this study is to find out how these three frames define social roles and shape social relationships and interaction in ALFs.

Studies by Harnett and Jönson (2017) and Gjernes and Måseide (2019) represent examples of the ways in which frames can be used to empirically study everyday situations of care facilities, and they can deepen our understanding of the functioning of everyday life in such facilities. Harnett and Jönson (2017) studied the framings of meal situations in a nursing home and found that an *institutional frame*, *private frame* and *restaurant frame* were employed in these situations. These different frames had implications for the actions of residents and staff members. For example, in the institutional frame, the staff members were in control of the situation, and the resident's role was that of a care recipient, whereas in private frame, staff members and residents acted as friends. In the restaurant frame, the staff members acted as waiters, considering the personal requests of the residents. Gjernes and Måseide (2019) found that in a day care centre for persons with dementia, the staff members guided and controlled the eating of the individuals during breakfast unnoticeably. By doing this, they framed the meals as "ordinary breakfast meals" instead of as meals arranged particularly for persons with dementia. This was done to display and maintain the older persons' dignity and normality. Both studies suggest that using the concept of frame in empirical research can reveal important details about the everyday social situations of care facilities that have implications for the well-being of the older persons.

Widening the view of frames in care facilities, our study aims to deepen gerontological knowledge of the use of the home, institution and community frames in the everyday social life of ALFs and the implications thereof for social relationships and interaction. This study contributes to our understanding of how the multifaceted social environment of ALFs affects well-being of the residents and staff members.

Materials and Methods

The data for this study was collected as part of a research project *Ageing and Social Well-being (SoWell)* conducted at Tampere University. The project explores older people's expectations, needs and activities regarding

their well-being and enjoyment of a good life in old age. The study protocol was approved by the Ethics Committee of the Tampere Region.

The data were drawn from one ALF (service centre) for older people in southern Finland. The facility is an outsourced service provider that provides both assisted living with 24-hour assistance (called group homes) and ordinary assisted living. In addition, the facility offers various services for (older) people living outside the facility. The facility consists of two joint apartment blocks located in a suburban area close to nature. The blocks comprise approximately 150 apartments, of which approximately half are in the group homes and half in the ordinary assisted living. There is a restaurant/café and are many common areas with sofas, armchairs, chairs and tables that the residents and visitors can use for socialising, reading, watching television and other activities. Recreation rooms are used not only for socialising but also for events and hobbies (e.g. handicrafts). There is also a gym and common saunas in the facility.

The data consist of observations, one group discussion and ten individual interviews with older people living in the facility. The observations were made, and the group discussion and interviews conducted in the facility's unit providing ordinary assisted living. The observations took place in the facility's shared areas, such as the restaurant, recreation rooms and the yard. The researcher observed everyday life in the facility, concentrating on social relationships and interaction, and interacted with residents and staff. Detailed field notes were written immediately after each observation session. The observation data consist of 35 hours of observations that were made during the spring and summer of 2018 by the first author.

All participants in the group discussion and the individual interviews were recruited with the help of staff. Residents with a cognitive disorder not allowing for informed consent were excluded; this was evaluated by staff members. The group discussion involved seven persons. The group met once to discuss well-being based on a semi-structured interview framework with themes and questions related to well-being. One researcher served as moderator of the discussion and another one observed the discussion, making notes and ensuring all topics in the interview framework were covered. The age of the group discussion participants ranged from 68 to 101 years, mean age being 86.6 years. Five of the participants were women and two were men. The group discussion took place

in the ALF in autumn of 2018 and lasted 1 hour 27 minutes. The audio recorded discussion was transcribed verbatim.

Five of the seven participants in the group discussion were later interviewed individually by the first author. An additional five participants were recruited with the help of staff. The individual interviews followed a similar semi-structured interview schedule as the group discussion. The participants' age ranged from 68 to 94 years, mean age being 82 years. Five of the interviewees were men and five were women. The length of residency in the facility ranged from approximately 5 months to 5 years. The interviews were conducted during late autumn of 2018 and early spring of 2019. The shortest interview took 38 minutes and the longest 1 hour and 56 minutes. Eight of the interviews took place in the participant's own apartment in the ALF and two in a recreation room. The audio recorded interviews were transcribed verbatim.

All participants in the group discussion and interviews were relatively independent in functioning. Some were able to move without any aids, others required a wheelchair or a walker. All participants lived alone in their own rented apartments in the ALF and used different services provided by the facility depending on their needs and preferences (e.g. health care, cleaning, laundry, restaurant and social activities).

Using the concept of frame (Goffman 1974/1986) as an analytical lens, we utilised a theory-driven approach, directed content analysis (Hsieh & Shannon 2005), to analyse the data. We divide our analysis into two phases. In the first phase, we read the whole data carefully and separated all sections of data including descriptions of social relationships and social interaction. By doing this, we created an initial understanding of the different topics related to social relationships and interaction in our data.

In the second phase of the analysis, we examined how our data extracts, identified in the first phase, are defined by the different frames (home frame, institution frame and community frame). We developed three questions to help us identify the different frames in the data: (1) what kind of relationships and interaction are enabled or ruled out in the situations concerned, (2) who or what defines the "rules" of interaction and (3) to what extent can residents control their own social interaction. We used these questions to identify different ways of framing social relationships and interaction in our data extracts. For example, we observed that in some extracts, the rules and practices of the ALF, such as mealtimes,

played a central role in interaction, pointing to the institutional frame. On the contrary, in some extracts, such rules played no or only a small role, pointing to home or community frames. To identify the frames, we read the data extracts carefully multiple times, reflecting on the three questions, and finally grouped each of the extracts under the applicable frame. The frames are elaborated in the sections below and illustrated with excerpts from the data. All names are changed for anonymity.

Results

The following observation excerpt illustrates residents' awareness of the existence of different frames in the facility's everyday life. The researcher is sitting with the residents in the restaurant:

> Another person sitting at the table asked: "Is that person over there a patient?," referring to a person sitting alone at another table. A person sitting in front of me said: "That's no patient, that's a customer." To that, a person sitting at a table behind us remarked: "No, that's a resident." The person sitting next to me and the person sitting in front of me said: "Exactly, a resident." The person under discussion did not react at all.

A resident is using the term "patient" to refer to another person. However, this resident is immediately corrected: the term "patient" is not correct in another resident's opinion, who calls the person a "customer." But another resident objects again: this person should be called a "resident." This term finally gains the approval of others. The residents are thus aware that their role in the facility might be understood in different ways: an ALF is a place where one might be seen as a patient (institution), a customer (community) or a resident (home). For the people involved in such a situation in such a place, finding the right term requires an understanding of the different frames that are applicable to the place and the situation. Using Goffman's (1974/1986) terms, what occurred in the situation was *clearing the frame*: the frame became clear for all participants after erroneous interpretations of the frame were corrected by other participants. The exchange over the most appropriate term demonstrates the residents' awareness that the ALF is a multifaceted place where the home, institution, and community frames influence everyday life. This example also illustrates the dynamic nature of frames: all these different frames

exist in the ALF at the same time and are invoked in different situations by different actors in different ways.

Next, we elaborate on how these three frames affect and define social relationships and interaction in ALF.

Home Frame

In the home frame, social relationships and interaction occurred on the residents' own initiative, and they were not determined by the rules or obligations of the institution or community frames. Thus, the relationships appeared casual or home-like, since they were determined by the residents' own preferences to be in contact with people they considered meaningful in their life. The participants had meaningful social relationships both within and outside the facility. Those most often mentioned as closest relationships were one's own children, grandchildren, their families and other relatives. Children and grandchildren were also often mentioned as one's most frequent visitors and the persons one visited, who took them out to see other people, and who helped with various everyday chores such as shopping and banking. Most participants also said they had meaningful social relationships inside the facility, and within the home frame, they described other residents as friends. Some participants said they had made good friends in the facility, and others indicated that they only had "acquaintances." Some said they spent time almost daily with friends from the facility, for instance playing cards in the common areas, eating together in the restaurant or sometimes visiting one another. Almost all participants mentioned having friends outside the facility, such as former colleagues, old friends from where they used to live or friends from hobbies. They usually talked to them on the phone but sometimes visited them or had them come to visit.

Social relationships and interaction appeared informal within the home frame. Some participants also counted staff amongst their friends and said they were close to them. Matti reflected in the interview on the kind of place that ALFs are and how his relations with staff affect his approach:

> Matti: Well here, in a place like this, in a way, as this is, kind of… even though this is our home, everybody's home, it's also a bit, maybe slightly like an institution, more or less. Because we're in contact with staff every day, more or less, but anyway, the thing with our relations is, we're told, we're on first-name terms, which is good, I think. Staff are

> on first-name terms with customers, I'm not sure if that's with everybody, but anyway, in some way it eases the personal relationship between staff and customer.

Matti describes an ALF as an institution, although it is also a home at the same time: he perceives his living environment as a combination of both these frames. The reason why he sees the ALF less as an institution and more as a home lies in the casual and not too hierarchical relationship with staff. Here, the home frame is invoked by the casual way the staff and residents talk to each other. Matti is aware that in the context of the institution frame, the relationship with staff members would be a more hierarchical one. Matti also uses the term "customer" when referring to himself and others living in the facility, and by doing so, he is highlighting the relationship being more relaxed than that between a patient and a care professional. Thus, the different frames overlap and residents themselves also consider how the use of certain frames affects different situations and life in the facility. The next observation excerpt describes an interaction situation between a nurse and a resident.

> A nurse came to a group of people sitting around a table to dispense medicines to one of them.
> Nurse: "I brought you some water because I thought you must be very thirsty" (hands a glass of water).
> Man (laughing): "Yes I am, but this water won't help with that."
> Nurse gives the pills and says: "Well, would these be of any help?"
> The person takes the pills and the nurse simultaneously puts a plaster on his upper back.
> Man (laughing): "Ugh, these pills taste terrible."
> Nurse (laughing): "I'm sorry but I haven't been able to influence their taste."
> Nurse leaves. The situation around the table continues normally: the people are reading magazines and occasionally someone comments on something they have read.

In this situation, a nurse approaches a resident sitting with other residents at a table to give him his medicines and to change a plaster on his back. This situation could be very formal: for example, the nurse could take the patient to a treatment room. However, in this case, the situation is framed differently. The dispensation of medicine and the treatment, which would normally belong to an institution frame, had the appearance of a casual encounter of friends rather than a hierarchical or formal care situation. The nurse and the resident are making friendly jokes and laughing, as if

they were just two friends chatting together. This way of interacting invokes the use of more relaxed home frame in the situation instead of the formal institution frame. The interaction is shaped by the overlapping of these two frames. Using Goffman's terms, this could be called *keying*: planting a frame inside another frame (Goffman 1974/1986).

Social relationships and interaction in the ALF were not always casual or meaningful. For example, nurses did not always act according to the rules of the home frame, but sometimes took a stronger role in determining the nature of interaction. Next, we show how social relationships and interaction appeared in the institution frame.

Institution Frame

Whereas in the home frame, social relationships and interaction were initiated and the rules of interaction were determined by residents, in the institution frame, those rules were determined by the institution, and residents had no control over their interactions. Furthermore, interaction was mostly limited to exchanges between residents and staff. In the next excerpt from the group discussion, Liisa is talking about the rules of the facility.

> Liisa: I would have wanted to do a book that's useful when you come to an old people's house like this. Whenever an old person is admitted, they'd be handed that book, so there's a person at the front door who will tell you where to go, where your room is and all those sorts of things. So the book has everything, your rights and your responsibilities. But right now, when I ask where to put my rubbish, they'll just say "I don't know, ask this or that person" and it'll be a week before I get an answer. – So I mean you have to have that kind of responsibility, and it's not the responsibility of whoever comes to the facility but who teaches that person the ropes.

Liisa is talking about the rights and responsibilities of the facility's residents and about "learning the ropes" when a new resident is admitted to the facility. She acknowledges that there are certain rules at the ALF, and that staff members, as representatives of the facility, should inform residents about these rules. Institutions have schedules that need to be followed. The most visible and obvious rules that became apparent during the observations at the ALF were the meals schedules. The next observation excerpt is from the restaurant:

> Next, I went to see whether there were more people downstairs in the restaurant. There were about fifteen persons around the tables. They weren't talking with each other, just sitting quietly and I was a bit curious as to what was going on. Occasionally someone at some table would say a few words, but otherwise it was very quiet. After a while staff started to enter the room and hand out dinners, and I realized what was happening: people were sitting there because they were waiting for their meals. Before this realization I thought it very strange that all these people had been sitting there side by side but not talking to each other. They hadn't come there so socialize, but to eat.

This situation – people sitting around tables without speaking – began to make sense when staff entered the room and started serving food: it was dinner time at the facility, and residents had turned up, or those in wheelchairs had been brought there, to wait for their dinner to be served. In other words, the facility's schedules affected when, why and how residents came together. When they were waiting for and having their dinner, residents did not seem to be interested in one another and their relationships appeared distant and indifferent. Mealtimes were not always as quiet as this, but it was clear that some of the diners were friends, laughing and talking with each other, whilst others hardly made any contact with others. Some residents, then, came to the restaurant to eat with their friends (home frame), whereas others just came to eat in the facility's restaurant because this was the scheduled mealtime (institution frame) (cf. Harnett & Jönson 2017). Following the schedules works as a cue for the institution frame and, thus, for certain kind of actions, but laughing and chatting with friends as a cue to abandon the institution frame and adopt the home frame in the meal situation instead.

In the institution frame, the residents' relationships and interaction with staff appeared to be more formal than in the home frame. Staff appeared as helpers and professionals. When talking about the help they received from the facility, some residents pointed out that they had to pay for this help – making it clear that the help they get from staff is different from the help they get from relatives. Family members help them because they care (home frame), and staff members help because it is their job (institution frame).

Many participants said they were content with the staff and with the help they received at the facility. Some, however, also told of bad experiences with staff members, saying they had not been helpful and took a long time to get things done. Some participants said they were concerned

about friends who did not have the help of relatives and had in fact intervened to offer help because they thought that staff were not doing enough. Some even felt that staff members had downplayed residents' concerns. In these descriptions, staff were seen as representatives of their occupation, and this was reflected in residents' expectations about the relationship. That is, for residents, staff appeared within the institution frame as care professionals who were expected to show helpfulness, compassion and efficiency. In these expressions of dissatisfaction with staff, residents' expectations of appropriate staff behaviour within the institution frame were not met.

Although staff were seen, within the institution frame, as care professionals who were expected to show professionalism, the multifaceted ALF environment meant that the position of staff was not always clear. In the next interview excerpt, Anna is talking about nurses entering her apartment in the facility.

> Anna: Yes, and really this homelike peace, sometimes when I first came here you might have had nurses, all of a sudden a nurse just came in with her/his own key, but there were lots of complaints back then, that we want to live here like all by ourselves, but there's also the policy that if someone doesn't answer the knock on the door or, you know, then you have to see if something has happened or something. So, it's a fine line again what the nurse can do.

Anna is reflecting on the most appropriate frame when interacting with staff. She feels that the home-like atmosphere of her home in the ALF has been violated by nurses who have entered her apartment without permission, using their own keys. In these situations, nurses have treated the resident's apartment not as a private home but as their workplace: entering the apartment without permission thus invokes the institution frame in the situation. As Anna admits, nurses must have their own keys and enter if the resident does not answer the knock on the door. After all, one expects nurses to come and check on their patients. However, as Matti pointed out, "*after all this is our home and you can't just barge in*". Nurses should treat the apartment as a private home: "*ring the doorbell, knock and wait for a while.*" Residents think that nurses should act according to the home frame, not the institution frame. Residents want to be able to decide when and how they interact with staff. Within the institution frame, residents are denied the right to make this decision, which

means this is not an appropriate frame for them. This situation involves a *frame break* (Goffman 1974/1986): the acts of staff differ radically from residents' expectations in the situation. The overlapping frames are at variance with each other because there is no clear, shared understanding of the appropriate frame. Thus, residents have a *negative experience* (Goffman 1974/1986) as they find that the frame they thought would be applicable in the situation, is not and they are uncertain of what rules apply in the interaction.

When the first author was conducting an individual interview in a resident's apartment, two nurses entered with their own keys to remind the resident about lunch. The nurses interrupted the interview but did not acknowledge the presence of the guest or apologise for the interruption. It was clear that the nurses did not think they were entering someone's private home, but rather their workplace. However, later in the interview, the resident said that having nurses check on him adds to his sense of security. Although residents are keen to live in a private home, they are also aware of their own vulnerability and, thus, are aware of their need for the institution frame. Like Anna reflected, there is a "fine line," how the staff should act in an ALF and also the residents' perceptions of the staffs' suitable behaviour vary. Nurses are thus expected to balance between the home and institution frames.

Community Frame

The community frame falls somewhere in between the home and institution frames: within this frame, residents could not decide who they wanted to interact with, but, nonetheless, had more influence over their interaction than in the institution frame. Another difference was that whilst in the home and institution frames, there was no ambiguity about the source of the rules of interaction, in the community frame, these rules were not determined by a single actor, but rather by the more abstract social codes of the ALF. Within the community frame, relationships and interaction included those with other residents, staff, ALF visitors and flexibly with the whole ALF community.

ALF residents cannot always choose their company in the same way as they could in a private home, but on the other hand, social life and activities in the facility are not entirely controlled by staff, as they would

be in an institution. Therefore, it is necessary for residents to make an effort to acknowledge and get along with other people. In the next group discussion excerpt, residents are talking about their sense of community in the facility.

> Liisa: But anyway, there are many people here with many infirmities, and yet they get along and exactly this, that there would be some kind of community spirit. That's so important.
> Researcher: Do you have that here?
> Liisa: Not really.
> Saara: There's no way that could happen here.
> Liisa: Yes, but you can't expect everybody to be the same, you can't expect that.
> Anna: I think the same that it's quite impossible to try to get that kind of community spirit because we're all different persons so we have different tastes in music, hobbies, and everything, so we'd need to be tolerant and not assume that everybody should think the same way as I do. It's a richness that we're all different and allow others to be different.
> Hanna: That's right.

Whereas in the institution frame, relationships and interaction with other residents appeared distant and indifferent and were determined by the rules of the facility, in the community frame, other people in the facility appeared as individuals who deserved to be treated with understanding and tolerance. Other residents were not necessarily friends with whom the participants had formed relationships by choice (home frame), neither were they just random people who follow the same rules of the facility and happen to be at the same place at the same time (institution frame). Other residents were those people who form the community around one's home and institutional practices; these were the people one needed to get along with when outside the familiar home and institution frames. The rules of interaction in the community frame are, thus, defined by the community's shared ideas of what is considered appropriate behaviour in such a context. On the other hand, the eagerness of residents to emphasise tolerance of diversity can also be seen as a reaction to tensions between the home and the institution frames, and the acknowledgement of diversity helps to protect the home frame from the harmonising effects of the institution frame. In other words, by emphasising the importance of tolerating diversity, the residents are protecting their own privacy and individuality as residents of the facility.

Other people are also more readily acknowledged and taken into account in an ALF than in, say, a normal apartment block. This is demonstrated by the following observation excerpt. A group of residents is sitting in the day room talking with the researcher about living in the facility:

> "We have quite accepted this as our home," said a person sitting in front of me. However, after a while, a person sitting next to me said: "Well, an institution is nevertheless always an institution," explaining that you can't just follow your whims there because you obviously have to take others into account as well.

One of the residents points out that the facility is not a home because you have to take into account of the other people living there. The fact that the place is an "institution" where people need to live together harmoniously prevents the place from being an actual home. The presence of others cannot just be ignored, but it affects the whole experience of living in an ALF. Thus, in the community frame, residents had some control over who they wanted to interact with, but, on the other hand, the participants are aware of the presence of others and its implications for their expected behaviour (e.g. expectations of social activity). At the same time, this constant awareness of other people in the facility was also considered to provide a source of security. The participants pointed out that the presence of other people, other residents and staff in the facility enhanced their sense of security and reduced their sense of loneliness.

ALF visitors became more visible during events organised at the facility that are open not only to residents but also outsiders. People visiting the facility to attend events and activities were not mentioned very often either in the group discussion or in the interviews. When they talked about acknowledging others and accepting diversity in the facility, the participants were mostly referring to other residents. It seems then that visitors attending events and activities or using services are not necessarily seen as part of the ALF community. Nonetheless, they are a visible part of the facility, as demonstrated by the following observation excerpt. People from the outside the ALF have come with their children to attend an event:

> I was rather annoyed by the other adults and their children on the same floor with me. The children could not concentrate but were wrestling and fooling around with each other. In addition, they shredded all the streamers along the corridors. After the show

> ended, they just left and left all the shredded streamers on the floor. Their parents did not comment on the wrestling or the shredding and did not tell them to clean up the mess they'd made.

In the situation described above, the visitors were standing in the corridors, close to the doors to the residents' apartments, but did not behave as if they were visiting someone's home or a care facility. The visitors' actions were determined by their understanding of the most appropriate frame for such a situation. The visitors did not frame the ALF as a home or an institution, but as a public space in which they may behave as they pleased and let their children fool around or assume that someone else will clean up after them. This frame was invoked by the event organised in the facility that made the facility seem for the visitors not as someone's home or as a care facility. They did not consider that the mess they left behind might be inconvenient for residents or the staff. In contrast to residents, then, they did not acknowledge the other people in the facility, but followed different rules that may not be explicit.

Another group of people missing from the participants' descriptions were those who lived in group homes. When talking about the ALF community, the participants sometimes referred to their circle of friends or people living on the same floor, but did not mention group homes or their residents; sometimes, it seemed they were actively excluded from the residents' community. When asked what kind of communities she thinks she belongs to, Anna described herself as an ALF resident but her community does not comprise the community as a whole:

> Anna: Because we're here in home-like circumstances and not in an institution. Sure there are these two floors, or are there three, where there are these closed wards, dementia wards, but I don't know much about them. Because there are so many different types, but in that sense I think it's good you can get it [more care] from here, if your health greatly deteriorates you can stay here in the same building. And you just move a bit to another place then.

Anna makes a point of her home-like living environment by saying that she knows very little about the *"dementia wards"* in the same building. She is making a point that these places are different form where she lives and distancing herself from the people who live there: they are different from her and her home-like way of life as an ALF resident. When the

institutional "dementia wards" are excluded, she can be seen as living in a home-like environment. Nevertheless, those places might become part of her life sometime in the future if her "*health greatly deteriorates*." In the next interview excerpt, Ida is making distinctions between herself as an ALF resident and others in poorer health.

> Ida: And I've been satisfied. If someone's being critical, they're being critical without a reason. We can live here as we would in any other rented accommodation. But here we have the security so that if anything happens, then… Although we're private residents and we don't belong to those service centre things at all. We can't get a doctor here or, there's a nurse only once a week.

Ida says that she and other residents like her are living in the facility as private residents. She seems to take the view that those who really "*belong to those service centre things*" need a lot care and other services from the facility. These people are different from her and other "*private residents*" in the facility. So, although we saw social relationships and interaction in the ALF appearing as constant acknowledgement and acceptance of others within the community frame, they also appeared as making distinctions between oneself and others in the facility.

Not only did ALF residents set themselves apart from others, but so did also outsiders visiting the ALF. One staff member said she had been told by some of these visitors that they do not like to be associated with the ALF because otherwise they too might be seen as old and frail. During observations of a group of people coming from the outside to attend activities, one of the participants said she has not dared to ask others if they lived in the facility. Apparently, she did not want to cause offence by assuming they might be living in the facility. It, thus, seems ALF visitors do not want to be seen as part of the ALF community.

Whilst the community frame is recognised and referred to by ALF residents, it is less distinct and structured than the home and institution frames. In the community frame, other residents are recognised as individuals who need to be acknowledged, but they are not regarded as personal friends or simply as fellow patients in the institution. The participants recognise that the ALF is a wider community that includes "*dementia wards*," for example, demonstrating that this frame entails not only those in the individual's immediate proximity but also those who form the wider community. At the same time, however, the boundaries of this

frame become visible when distinctions are made between oneself and others in the facility. It seems that the determination of the circle of people who are involved in this frame is not fixed but negotiable. Furthermore, when considering the wider community of the ALF, the characteristics and the rules that govern interaction within this frame become unclear. In this sense, the community can even be described as a no-man's land where social relationships and the boundaries of action and interaction are not defined by the familiar rules of a home or an institution.

Discussion

We found that the way in which social relationships and social situations are structured in the ALF is influenced by the way the facility is framed and understood. Previous research shows that social relationships affect residents' perceptions of the ALF (Cutchin et al. 2003; Lewinson et al. 2012). Our study adds a new layer to this by suggesting that perceptions of the ALF also impact on social relationships. On this basis, we suggest that it is important to take into account of the multifaceted nature of the facility and its effects on social life when attempting to understand ALFs as social environments. Harnett and Jönson (2017) found institutional framings of meals in nursing homes so dominant that other framings, like home frame, were hard to find. This study adds to our knowledge of what kind of role institutional, home and community frames play in an ALF.

Different frames enable different kinds of social relationships and interaction in the ALF. In other words, what kind of social relationships and interaction are feasible is influenced by the way in which social situations in the ALF are framed. For example, the relationship and interaction between residents and staff is influenced by the frame adopted by the participants in the situation. Sometimes frames are not shared (*frame break*) by the participants, which may give rise to conflict and *negative experience* (staff enter residents' apartments without permission), but they can also be piled upon or planted within each other (*keying)* to purposefully create a shared understanding of the situation that differs from the expected one (making a treatment situation seem as two friends joking instead of an interaction between a care professional and patient) (Goffman 1974/1986). Thus, the relationship between the frames is dynamic, and they exist in the facility at the same time, being invoked by different

actors in different ways and eventually being accepted or rejected by the participants. Frames also define the nature of social relationships: other people in the ALF can be seen as friends, fellow patients, fellow residents, professionals or "others" who are intentionally left out. Frames play an important role in defining social relationships and interaction in ALFs and impact upon the smooth running of everyday life.

The provision of home-like housing and care services for older people is a central policy objective in Finland and elsewhere (Anttonen & Karsio 2016; Genet et al. 2011), and therefore, it is important to understand how social relationships and interaction affect residents' perceptions of the facilities and their home-likeness. Based on our findings, the presence of institutional features in social interaction in an ALF does not adversely affect the perceived home-like nature of the facility, so long as staff know how to use the home frame in situations that are meaningful to residents. As we saw, lack of control over social interaction, for example in situations where staff enter apartments with their own keys, diminishes residents' sense that they are living in a home-like environment. At the same time, however, residents appreciate that in some situations, staff need to enter apartments with their own keys. This implies that the interpretations staff make about different social situations and about their expected and appropriate behaviour in the ALF are important to residents' experience of living in a home-like environment. In their interaction with residents, staff need to balance between the home and the institution frames. Our finding supports earlier results on the key role of staff in enabling a home-like ALF experience and residents' well-being (Pirhonen & Pietilä 2015; Street et al. 2007; Williams & Warren 2009). Like in the study of Gjernes and Måseide (2019), the actions of staff members in framing meals as ordinary breakfast meals in a day care centre for persons with dementia maintained the older persons' dignity and normality, the actions of staff in framing social situations as home-like can maintain the feeling of home-likeness for the residents.

Although the sense of private space is important in the ALF, this importance has to do not only with physical aspects such as having beloved items and furniture in one's own room or apartment but also with social aspects that affect the way in which the space is defined (see Roth & Eckert 2011). Our findings suggest that having a home in an ALF is not only

about a private space and personal belongings but also about the power to determine one's social relationships. Anyone who has the power to determine their social relationships will also have the power to define their private space. In the institution frame, residents did not have this kind of power, in the home frame they did. In the community frame, the situation was less straightforward: residents did have some say over their social relationships and interaction, but at the same time, they were constrained by the facility's rules. Frames are, thus, important regarding residents' autonomy in the facility.

Our study also draws focus to the nature of ALFs as communities. We found that social relationships and interaction in the ALF were affected not only by the home and institution frames but also by the community frame, which falls somewhere in the middle ground between the former two. As our findings indicate, the presence of other people, mainly other residents, cannot be ignored in ALFs; indeed, it is an important feature of everyday life there. The home and institution frames do not in themselves fully cover all kinds of social situations in such places. ALFs are neither just a home nor just an institution but also places where residents live their private lives in a public space (Roth & Eckert 2011) that has its own rules for social relationships and interaction. This is supported by the existence of *restaurant frame* alongside institutional and private frames in nursing home meal situations (Harnett & Jönson 2017). The restaurant frame challenges the institutional arrangements of meals, but is also not private or home-like, but something in between.

The community frame in our study indicates that in addition to the clearer rules for social relationships and interaction posed by the home and institution frames, there are also more abstract social codes that define social life in ALFs. These codes or rules guide residents towards acknowledging and tolerating other people around them in the facility, but, at the same time, towards dissociating themselves from those people who might threaten the impression of their home-like living in the facility. It seems that the community frame serves as a placatory frame in between the home and the institution frames, in which it maintains residents' privacy and individuality, but, at the same time, recognises the communal characteristics of the place. The community frame indicates that an ALF is a home that is supposed to be communal, but not to the extent that it is too homogenising, as in an institution.

Visitors to the ALF, that is, people who do not live in the ALF but who attend its events and recreational groups, were not mentioned very often in the interviews or in the group discussion. This might indicate that their presence is not very meaningful to residents. However, the behaviour of these visitors demonstrated that outsiders might have their own way of framing the place. For these people, the home, institution or community frame did not seem appropriate, but they appeared to view the facility as a public space where they can behave as customers and are not obliged to acknowledge other people in the same way as residents felt they were within the community frame. More research is still needed to better understand the meaning of outsiders visiting the ALF and the ways in which they make sense of the facility and their role in different situations. Our findings suggest that non-residents did not want to be associated with the ALF because they feared they might be regarded as old and frail. However, ALF residents were equally reluctant to be associated with cognitively impaired or frail persons. In the words of Pirhonen et al. (2016), both visitors and residents viewed more frail older people as *ability others* and used this reasoning to maintain the impression of themselves as capable individuals and residents instead of patients of an ALF.

Our findings contribute to ongoing discussions about how the housing and care of older people should be organised in such a way that their autonomy and well-being are enhanced. If it is understood that all the individuals involved in ALFs interpret and make sense of social relationships and interaction through different frames, then it will also be easier to see how different expectations of interaction and action in different situations can lead to misunderstandings and conflicts. Successful social life in ALFs can be created and maintained when everyone involved in the ALF is able to recognise the ways in which they themselves and people around them make sense of everyday social situations in the facility. The idea of frames in the ALF could be used to educate both staff and residents about the multifaceted nature of ALFs and its implications for social interaction. Making frames visible in ALFs can lead to better communication and an enhanced sense of autonomy for residents as they are given the opportunity to decide for themselves about their social relationships and interaction. If ALFs cannot be totally private homes, the idea of frames could help to transform them into communities that allow all their members to have a say over what kind of place they are.

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No place to go? Older people reconsidering the meaning of social spaces in the context of the COVID-19 pandemic

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No place to go? Older people reconsidering the meaning of social spaces in the context of the COVID-19 pandemic

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ABSTRACT

Under COVID-19 restrictions, older people were advised to avoid social contact and to self-isolate at home. The situation forced them to reconsider their everyday social spaces such as home and leisure time places. This study approached the meaning of social spaces for older people by examining how older people positioned themselves in relation to social spaces during the pandemic. The data were drawn from the Ageing and social well-being (SoWell) research project at Tampere University, Finland, and they consisted of phone interviews collected during the summer of 2020 with 31 older persons aged 64–96 years. The data were analysed using the frameworks of positioning analysis and environmental positioning. Results showed the positions of older people being manifold, flexible and even contradictory. Within home, the participants portrayed themselves as restricted due to limited social contact, but also as able to adapt to and content being alone. Virtual spaces were depicted as spaces for younger and healthy persons, and the participants themselves as sceptical technology users not satisfied with technology-mediated interaction. Within an assisted living facility, the participants described themselves as sensible and responsible persons who wanted to follow the facility's pandemic-related rules but also as independent persons having nothing to do with these rules. In the spaces outside the home, the participants portrayed themselves as persons who followed pandemic instructions but also as persons who were not required to follow the instructions because they could use their own judgement. These self-positions shed light on the social needs of older people in the spaces of their everyday lives. Our results provide useful insights for policy makers and professionals working with older people and will help to promote spaces of living, care and everyday life that can enhance and maintain social interaction and well-being both in times of change and in more stable times.

Introduction

The COVID-19 pandemic re-emphasised the vital importance of social relationships and social interaction in everyday life. As the virus began to spread, governments around the world introduced social distancing measures to protect citizens from transmission. In Finland, measures to limit the spread of the disease included, for example, limiting the number of attendees in public events; closing schools, universities and other educational institutions; closing museums, cultural venues, libraries, hobby and leisure centres and other such facilities; closing cafés, bars and restaurants or restricting their opening hours (Ministry of Economic Affairs and Employment, 2020; Ministry of Social Affairs and Health, 2020c). Finnish citizens were advised, if possible, to work from home and to avoid travelling and close contacts with other people (Ministry of Social Affairs and Health, 2020b). Older people, both in Finland and elsewhere, were advised to avoid social contact because they were at the highest risk of severe illness (Singhal, Kumar, Singh, Saha, & Dey, 2021). People aged 70 or older were given targeted instructions on how to protect themselves and how others should protect them from the virus. Older people were 'obliged to refrain from contact with other persons' and advised to stay at home in quarantine-like conditions (Ministry of Social Affairs and Health, 2020a, para. 2). Family and friends were advised to avoid any non-essential visits to anyone over 70. In addition, as visits to care and housing facilities for

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older people, such as assisted living facilities, were forbidden (Ministry of Social Affairs and Health, 2020c), older people were particularly affected by the restrictions put in place during the pandemic.

These restrictions raised discussion about the well-being and quality of life of older people living in isolation. Older people reported feeling stressed about the sense of loneliness and isolation and concerned about the well-being of other people (Morgan et al., 2023; Whitehead & Torossian, 2021). Studies also indicated an increase in loneliness among older people during the pandemic, although others showed that loneliness remained stable (Dahlberg, 2021). Social contacts, on the other hand, were thought to give a sense of meaning in everyday life and to bring joy to older people (Tiilikainen et al., 2021; Whitehead & Torossian, 2021). Older people were differently affected: some saw very little change, and others reported a significant decline in social relationships to the point of almost complete isolation (Kulmala et al., 2021).

There has been less research into how the pandemic restrictions impacted the different social spaces in which people interact, despite their obvious significance in view of the limitations placed on mobility (Burns, Follis, Follis, & Morley, 2021). The pandemic not only affected older people's social relationships but also made more visible the different spaces in which their social life takes place. Even before the pandemic, older people's homes were described as restricted spaces with limited social connections (Pulkki & Tynkkynen, 2020), and the COVID-19 self-isolation rules arguably enhanced these depictions. Older people were advised to avoid spaces outside the home, and places for hobbies, events and gatherings were closed. Virtual social spaces, meanwhile, assumed increasing importance as relatives of older people were told to use the phone or Skype, for example, to keep in touch (Ministry of Social Affairs and Health, 2020a). Care facilities did not allow visitors and thus became spaces only for staff and residents (Ministry of Social Affairs and Health, 2020b). Overall, it can be argued that social spaces and the possibilities they enable for older people's social life changed during the pandemic.

The places and spaces inhabited by older people are of much interest to gerontologists, as well as researchers in other fields, who are interested to understand how they are interconnected with ageing (Wiles, 2005) and care (Milligan, 2009). The concepts of space and place are sometimes used interchangeably, but Wiles (2005) points out that in geography, place is conceptualised as a portion of space that holds meaning, is experienced and shapes relations between people and societal processes. Thus, space is understood as not holding meaning but rather referring to universal and abstract ideas, like geometrical distance (Wiles, 2005). However, space can also be conceptualised as more dimensional: as a social space that is used, experienced and navigated by older people (Andrews, Evans, & Wiles, 2013) that holds complex emotional and symbolic connections between social relations, activities and places (Wiles et al., 2009). Social space can be understood as those settings in which older people's everyday lives take place: their homes, friends' and family members' homes, retail locations and formal care environments, for example (Andrews et al., 2013; Wiles et al., 2009). Relational thinking, in addition, takes into consideration the temporality of such spaces: instead of being isolated and fixed, space can be understood as ever-developing, changing over time and related to other spaces (Andrews et al., 2013). Indeed, space can provide a fruitful concept for studying older people's social life during the pandemic.

In order to capture the different ways social spaces are experienced by older people, we drew from positioning theory (Davies & Harré, 1990; van Langenhove & Harré, 1999) and environmental positioning (de Medeiros, Rubinstein, & Doyle, 2013), which allowed us to investigate how older people located themselves in the social world and, more specifically, in relation to spaces. In brief, the aim of this study was to explore how older people positioned themselves in relation to social spaces during the pandemic.

Positioning theory and environmental positioning

Positioning theory is an approach grounded in social constructionism and the concept of discourse (van Langenhove & Harré, 1999). The theory states that what people say and how they respond to what others say matters in constructing social reality. In other words, everyday language use and discourse constitute people's understanding of themselves and others by making available positions that determine the perspective from which they see the world. The notion of positioning is used as a more flexible alternative to the more static concept of role, drawing attention to the dynamic aspects of encounters. Individuals are thus constituted and reconstituted through various discursive practices, and they can position themselves and be positioned by others (Davies & Harré, 1990). Positions are elaborated through storylines that serve as a sensemaking tool: storylines provide the context in which positions are taken (Allen & Wiles, 2013b). People position themselves not only in relation to others but also in relation to storylines that give credibility to what has been said. What has been said needs to be looked at in relation to the larger normative system in which people live (Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009). What people say, their positions and the unfolding storylines are interconnected and mutually determining (Allen & Wiles, 2013b; van Langenhove & Harré, 1999). In other words, when individuals position themselves by what they say, they locate themselves within different familiar and personal narratives which, in turn, affect the position taken up in the situation.

Positioning theory has proved to be a relevant framework in ageing research (Allen & Wiles, 2013b). Allen and Wiles (2013a) used it to study childlessness among older people. They found that a childless identity was positioned as positive, as an active choice and as a matter of discernment. Older people made sense of their childlessness by locating these positions in different cultural and personal storylines, such as 'married with children' being the only acceptable way of life or 'breaking the cycle of family violence'. Another study investigated how older people position themselves as older active information and communications technology (ICT) users and as different from younger users and non-users. Against different storylines, such a position emerged as favourable, as a privilege and as exceptional. For example, against the storyline of socio-economic inequalities that contribute to the reproduction of the digital divide, the position of an active older user emerged as a privilege (Kania-Lundholm & Torres, 2015).

Österholm and Samuelsson (2015) found that while older people are positioned by others, they can also re-position themselves. In meetings to assess older people's support needs, persons with dementia were ignored, talked about as if they were not present and talked to using 'elderspeak'. Both social workers and relatives positioned persons with dementia as less competent. However, this was sometimes rejected by affected older persons who instead re-positioned themselves as competent and capable individuals, allowing them back into the conversation from which they first were excluded. Other studies using positioning theory have examined, among other things, how older people position themselves as if they are not older people (Jones, 2006), how receiving support is positioned (Allen & Wiles, 2014) and how people with Alzheimer's disease position themselves in a support group (Hedman, Hellström, Ternestedt, Hansebo, & Norberg, 2014).

These studies show how positioning theory can offer valuable insights into the way older people understand themselves and how they are understood as part of the social world. This study directs attention to positioning in social spaces and thus draws also from environmental positioning (de Medeiros et al., 2013). This approach draws form the larger framework of positioning theory and focuses on how people negotiate multiple meanings of self and places. Environmental positioning holds that the environment itself contributes to the positioning of the actors and observers: that the human and non-human dimensions of space matter in taking up positions. The meaning and the relationship between a person and an environment are not unchanging but rather relational, fluid, contradictory and contested. Thus, space is not only

seen as physical but containing also relational aspects between past, present and anticipated future (de Medeiros et al., 2013). For example, living in a senior housing complex was given meaning by comparing it to one's previous, current and future living environments (Jolanki, 2021). In the context of the pandemic, the views of older people of different social spaces were seen in contrast to life in those spaces before, and after, the pandemic.

Social spaces and individuals' roles or positions in these spaces are inherently complex even in normal times, but doubly so during the infectious COVID-19 pandemic. The approach of environmental positioning is especially useful in trying to understand the multiple meanings different spaces hold and how they were negotiated by older people living amidst a pandemic that forced them to consider these spaces from a novel point of view. For example, distance to others in spaces suddenly became an important part of life, as did limited access to different spaces. The cultural store of space rules, rules associated with uses of space, were interrupted and thus affected the discursive process through which self can be made known (de Medeiros et al., 2013).

Perhaps not surprisingly, the pandemic laid bare the enduring global problem of ageism, with older people described as a vulnerable group who need to be segregated (Jen, Jeong, Kang, & Riquino, 2021; Lichtenstein, 2021). In a sense, older people were positioned by others as not having the same opportunities as younger people for social life during the pandemic. Positioning theory and environmental positioning offer a useful tool to study how older people themselves experienced the pandemic and their relation to different social spaces during that time.

Data and methods

Our data came from the Ageing and social well-being (SoWell) research project at Tampere University, Finland. In June–August 2020, we interviewed by phone 31 (19 women and 12 men) persons aged 64–96 years about their experiences and thoughts of everyday life during the COVID-19 pandemic. The interviews lasted between 5 and 51 min (most usually around 20 min) and were recorded and transcribed verbatim. Although a couple of interviews were relatively short, the interview framework was built in a way that it allowed the participants to explain their thoughts in their own words, even in the shorter interviews. The interview framework consisted of three main topics: 1) everyday life during the pandemic, 2) restrictions targeted to persons aged 70 or older and restrictions in care facilities, and 3) digital technologies. The interviewers asked some elaborative questions (e.g., experiencing loneliness, running errands), but the aim was to allow the participant to tell freely about their experiences and thoughts.

Participants were recruited in an earlier stage of the SoWell project when they took part in qualitative one-on-one interviews related to well-being in late 2018 or early 2019. Some had also participated in group discussions in autumn 2018. The one-on-one interviews and group discussions were conducted to learn about older people's perceptions of well-being and various topics related to it (e.g., social relations, living environment, digitalisation). The participants were recruited by contacting organisations and associations providing activities, support and counselling for older people and by contacting older peoples' service centres, providing assisted living and activities for older people. Inclusion criteria were being of pensionable age (approximately 63 or older) and being able to give an informed consent to participate in the study. All participants had given their written consent to participate in the study and to be contacted for follow-up interviews. Altogether 36 persons were interviewed in the earlier stage of the research project, and 31 of them were reached and agreed to participate in the follow-up interview. The study protocol was approved by the Ethics Committee of the Tampere Region.

The participants lived in the Pirkanmaa region in southern Finland, most in urban and a few in rural areas. Functional level and care needs of the participants varied. Most of the participants lived independently in their own home and needed no care. Some of the participants received care regularly, needed help with some daily chores and used moving aids, such as a walker or a wheelchair. None of the participants were bed-ridden. Nine interviewees lived in an assisted living facility; the others were community dwelling. Most of the participants (22) lived alone, while nine lived with a spouse or a partner.

Analysis

Drawing on positioning theory (van Langenhove & Harré, 1999) and environmental positioning (de Medeiros et al., 2013), our analysis was interested in the way older people talk about social life and social spaces and how this talk constructs self-positions for them. The analysis is based on discourse analysis (Potter & Wetherell, 1987), one form of which is the methodological application of positioning theory – positioning analysis. In the first stage the interviews were read and re-read to gain a holistic grasp of the material. Next, we turned to coding the data, that is, identifying the sections in the data in which the participants talked about social life (e.g., family, hobbies, getting help, loneliness). These sections were again carefully examined and coded based on the space they referred to (e.g., social life in the home environment). Once these sections had been examined multiple times, we formed four groups representing the different spaces referred to in the sections: home, virtual space, assisted living facility and outside of home.

In the second stage, we looked at how the participants positioned themselves in relation to social spaces. We aimed to identify the different ways the participants talked about social life in the context of various spaces, that is, recurring patterns of talk or discourses. These discourses were then examined to see what kinds of positions they construct: from what kind of perspective(s) does the participant see the world in different sections and how these perspectives are related to the human, non-human and time-contingent aspects of spaces. For example, to physical distance, accessibility, surveillance in and past experiences of spaces. As the unfolding positions can be understood by identifying the storylines (Allen & Wiles, 2013b), we then proceeded to identify these larger normative stories related to the positions that unfolded. For example, the position of being restricted, of not being 'allowed' or able to meet people, can be understood within the storyline of 'following the rules' under the COVID-19 pandemic, but also within the personal storyline of having an illness that prevents social contacts. Thus, the position of being restricted becomes understandable within the storyline that locates it in its wider context. Table 1 describes the positions identified in the analysis. These positions are presented within the social space in which they unfolded. In addition, the Table presents the storylines and examples from the data.

Results

In this section we describe how our participants positioned themselves in relation to the four social spaces identified: home, virtual spaces, assisted living facility and spaces outside of home. All the names used are pseudonyms to protect the privacy of the participants. Interviews were conducted in Finnish and the data excerpts used were translated into English by the authors and checked for accuracy by a professional language reviser and translator.

Home

Leaving the home was avoided by most of the participants. Instead of going out themselves, they received help with everyday tasks from friends and family. For example, most participants had had groceries delivered to the door. For some, staying at home was a change compared to life before, but for some not so much.

For example, Sirkku had led an active life outside the home before the pandemic. In the interview excerpt below, she portrays herself as an active person who usually attends handicrafts groups, does volunteer work and goes to the gym. However, she adapted to the new, changed,

Table 1
Examples of positions from the data and storylines.

Positioning oneself in relation to home as	Examples	Storylines
Adaptive	'*You just have to find all sorts of things [to do] here for yourself.*'	Resilience
Content being alone	*'I'm used to being alone.'*	Old age/widowhood is a time of solitude
Restricted	*'I'm still here and sort of isolated in a way'* *'I haven't been allowed to maintain social contact.'*	Personal storyline of illness Following the rules
Active	Taking part daily in '*remote discussions in the yard.*'	Using initiative
Positioning oneself in relation to virtual social space as	**Examples**	**Storylines**
Sceptical user of technology	'*I want to meet people in person, in services and as friends, like closely, or as they say, face to face.*'	Technology cannot substitute for real-life social contacts
Old and incapable	'*We don't really want that anymore, that even learning is hard for us.*'	Technology is not for older people
Positioning oneself in relation to assisted living facility as	**Examples**	**Storylines**
Sensible	Being doubtful about masks: *'But now that research has shown it has no effect.'*	Being up to date
Responsible	*'It's been very good in the sense that outsiders can't get in. Even family members or other relatives so that's how they have kept the disease out.'*	Older people are rational adults
Independent	'*And because I live in a rented apartment I can live a normal life, normal homelike life.*'	Assisted living facility is a normal home
Privileged	*'But you shouldn't complain, when you think about all those older people, when you think about them who are even more lonely than I am.'*	Old age as a time of vulnerability
Positioning oneself in relation to spaces outside the home as	**Examples**	**Storylines**
Restricted	Giving up activities '*feels bad.*'	Victim of circumstances
Compliant	Not being '*allowed*' to go to the shops so relatives deliver groceries.	The parent/child or family storyline
Sensible	'*I viewed it [instructions on social isolation] as a mild recommendation. I didn't literally start taking actions and staying at home like some others did.*'	Older persons are rational adults
Responsible	*'I've kept my distance and been, I'm cautious, and made sure to wash my hands.'*	Responsible citizenship

situation by keeping herself busy with solitary activities at home. By locating herself in the storyline of 'resilience' she positioned herself as adaptive in this new situation. Sirkku was asked whether she had been affected by the rule that prohibited visitors to care facilities:

> I have, it was the same thing at the assisted living facility where I used to go to do handicrafts and other things and was a volunteer, you couldn't get in. Yes, and nor in the gym. Yes, so that's that now. But you just have to find things to do here for yourself, we've been knitting and weeding and, yes. Yes, so no, it hasn't affected us mentally at all.

The position of being 'adaptive' contradicted with the one that was ascribed to the participants during the pandemic situation. The rules that suspended the active life outside the home, positioned the participants as victims of circumstances. This was however rejected by describing oneself as still active and being able to adapt, rather than just accepting the situation and feeling sorry for oneself. It is worth noticing, however, that Sirkku also talked about 'us'. She lived with her husband so perhaps for her, having to give up social contacts outside the home was not all that difficult; after all she had her husband's company.

The pandemic did not bring major changes to the social life of all our participants. Some, such as widows Anna and Ritva, said they were 'used to being alone' and the recommendations to stay at home and avoid social contacts were not a big deal for them. Locating themselves in the storyline of 'old age/widowhood is a time of solitude', they described themselves as persons who were content being alone: for whom being alone at home is natural part of life. This did not, however, prevent participants from taking up a more socially active position during the interview. Alli, for example, described herself as a 'loner': 'Well I don't know if that means I'm a loner or a special case but, for me, I don't find it hard being with myself.' However, she also acknowledged that she had struggled with the lack of social contacts because she was a 'social person.' This was not uncommon: participants said both that it was fine being alone and that they missed social contacts. They were able to position themselves flexibly both as a person who needed social contacts and as loners who could manage on their own.

For some, life had been restricted even before the pandemic because of illness or lack of close relationships. Markku had had very limited mobility within his home even before and could not go out on his own. The interviewer asked him how he saw the worsening epidemic situation in Finland affecting his life in the future: 'Well it's not really having any effect at all. I'm still here, existing and sort of isolated in a way. – My illness is so advanced that it's taken my ability to move in any case.' He portrayed himself as restricted in his home and located his assessment of his situation during the pandemic in his personal storyline of illness rather than in the storyline of 'older people as victims of the COVID-19 pandemic' offered in the interview, as the interviewer was assuming the pandemic had an effect on his life. Thus, the position he took up relates to his assessment of the home space as having been restricted in the past, continuing to be so, and also in the future, regardless of the pandemic.

During the pandemic the social space of home seemed to expand to the garden, yard or other outdoor spaces, which served as places for meeting other people. However, a few participants also said they had met other people in their homes or their friends' or relatives' homes, while taking precautions such as keeping their distance and not touching one another. Reijo had met other people outside in the yard. In the next excerpt, he explains how the pandemic had affected his life:

> Well I've lost friend-, not lost but people have become more distant, I haven't been allowed to maintain social contact. That's the first thing that comes to mind. I mean I would have wanted to maintain more social contact. Because I wasn't all that afraid of the virus but I wasn't sort of defiant either. I kept my distance, but there were a few of us here who talked with one another, even daily in the yard, remote discussions.

Meeting others in the home's outdoor areas was located in the storyline of 'following the rules' but also in the storyline of 'using one's initiative', that is, taking control of one's life within the given restrictions. Above, by saying he was not 'allowed' to meet others, Reijo referred to the instructions for older people to socially isolate themselves and thus he took up a position of being restricted by these instructions. However, he continued to describe a new way of having social contacts with his neighbours in the yard when close contact was not possible, portraying himself thus as an active and resourceful person. Distance to other people became an important aspect in the social spaces of the participants and it was best provided by outdoor areas. Thus, the possibility for keeping a distance in a space allowed for positioning oneself

as active despite the restrictions that came along with the pandemic.

As physical social contact with other people was restricted, some participants used technology to stay in touch with others. Technology allowed the participants to stay at home but still be connected with friends and family. Next, we turn to examine how the participants positioned themselves in relation to virtual social space.

Virtual space

Digital contact with other people gained increasing importance during the pandemic. All interviewees were asked about their thoughts on using technology to run errands and stay in touch.

Phone calls were the most important method of communication and served as the principal substitute for physical social contact during the pandemic (see also Ahosola, Tuominen, Tiainen, Jylhä, & Jolanki, 2021). Computers, laptops and smart phones were used to communicate and stay in contact with others, to make videocalls, receive and send photos, receive and send emails, to use social media and for video conferencing. A slight majority of the participants used some of these digital devices. Most of those who used digital technologies said they made it possible to stay in contact with others and to run daily errands but added that these technologies do not and should not be considered a substitute for face-to-face social contact. Some also pointed out that these technologies can involve risks (e.g., social media scams) and be addictive. Within the storyline of 'technology cannot substitute for real-life social contact', the participants described themselves as sceptical users of technology. Virtual social space was not enough for them in this situation, nor had it been so before.

> Reijo: But I do use this to pay the bills, with my daughter's assistance.
> Researcher: Your phone.
> Reijo: Yes. Although I am firmly opposed to electronic contact, I mean I want to meet people in person, in services and as friends, like closely, or as they say, face-to-face.

Some of those who had digital devices did not know how to use them or want to. Others had no devices at all. Most of those who did not use digital technology portrayed themselves as old or incapable. They did not know how to use digital technology because they thought – or had been told – that it would be too difficult to learn. Some said they were not interested in digital technology but acknowledged that it could sometimes be useful. However, they thought technology was not for older people, but for the younger generation who are familiar with it and know how to use it. The term 'younger' is relative: Elina said that she and people her age (86 years) don't know how to use digital technology, but 'it's different for younger people, those under 80 will probably have different possibilities.' For people her age, she felt digital technology was 'beyond reach.' Some had physical impediments that prevented them from using technology, such as hearing problems or hand tremors. Riitta had talked about using technology with other people living in the assisted living facility: 'But we've discussed this several times earlier, that we don't really want this anymore, that even learning is hard for us. So we wouldn't like normally, we wouldn't learn anymore.' Riitta thought she and other older people do not want to use technology and that it would not be easy for them to do so because learning is difficult for them. The positions of an old or incapable person were taken up within the 'technology is not for older people' storyline in which older people are seen (by themselves or others) as not knowing how to use or not interested in digital technology.

Assisted living facility

During the COVID-19 pandemic, life in an assisted living facility differed from living in a private home because no visitors had been allowed into care facilities and strict rules were applied regarding social contacts. Nine of our participants lived in an assisted living facility and all were asked what they thought about the restrictions in care facilities. In the following excerpt, Jussi, who lived in an assisted living facility, describes his daughter's visit:

> Researcher: So have you been able to see close relatives at all?
> Jussi: Well in the yard there's a bike shelter and it's been possible to see friends and relatives there. It's just that they have to have a mask. But now that research has shown it has no effect, I don't know if they still have to wear masks. My daughter was there the other day and then a nurse turned up and said they'd been informed there was an outsider here, that you should be wearing a mask. So she had a mask of course and took it out of her pocket and put it on. But we residents don't have to wear them.

The new rules in the assisted living environment became visible to residents by the monitoring of their everyday interactions in the facility. This affected how the residents were positioned within this environment. Jussi's relative's visit was supervised by the staff members, and he was not allowed to assess himself what kind of risks he was prepared to take when he saw his daughter. For example, he was not allowed to make his own decision about meeting someone without a mask. The staff member in this situation positioned Jussi within the 'nurse/patient' storyline as a resident of an institution who must follow the rules, whereas Jussi portrayed himself as a sensible person capable of weighing the need for restrictions such as masks himself. The two positions contradict each other: the social space of the assisted living facility is on one hand supposed to be a place where institutional rules are followed, but on the other hand it is a place of residence for older adults capable of evaluating the situation themselves.

As most other residents, Jussi nevertheless accepted these rules, and thought that they were there for a reason. Keijo's wife lived in the same assisted living facility, but in a group setting for people with more demanding care needs. He had had some problems meeting his wife because of the restrictions in place. The interviewer asked what Keijo thought about these restrictions:

> Keijo: No. I mean yes, it's been very good in the sense that outsiders can't get in. Even family members or other relatives so that's how they have kept the disease out. – this is a big facility, there is this one group unit where we have those who live alone, that's where my wife is, there are five group homes. So these people who live alone are cared for on a different level and with lots of people so I mean it's quite right what they are doing.
> Researcher: Yes, yes. So even though it has affected your chances to get to see your wife, you still think it's a good rule that outsiders can't get in.
> Keijo: That's right, that's right, I mean it meant my wife got into a safe place in that regard.

Keijo thought that the decision not to allow any outside visitors is a good way to protect the most vulnerable residents, such as his wife. Although the residents sometimes accepted the pandemic rules without questioning them, they did also talk about how and why they did this. By locating themselves within the 'older people are rational adults' storyline, they rejected the position of a powerless patient within the 'patient/care professional' storyline available in the context of the assisted living facility and positioned themselves as sensible and responsible persons who actively considered the situation and the need for the restrictions. In reality, residents had no choice whether to follow the COVID-19 rules, as was seen in the case of Jussi's daughter. However, the positioning as a sensible and responsible person allowed them to consider the restrictions from the point of view of a rational adult rather than a vulnerable patient.

Although assisted living facilities were sometimes perceived as places where residents had little control over their social life, as in the case of the visit by Jussi's daughter, the position of a powerless or vulnerable assisted living resident was not always accepted. The next excerpt is from an interview with Anna:

> Researcher: I was just wondering that in your assisted living facility, have you seen any indications that the staff would have, like during the epidemic, acted somehow differently or adopted new practices?
> Anna: Well I have very little contact because I don't need a lot of services, I've used the hairdresser's and the pedicurist's services and of course I've noticed that they have these face coverings or masks. But otherwise it's all been perfectly normal. And I know that they've changed the meal arrangements. But in these last few years I've cooked for myself so for me there have been no changes. And because I live in a rented apartment I can live a normal life, normal homelike life. So I mean, of course when you see staff members you'll notice that they are wearing face coverings and like, times have changed. But no I haven't, I haven't noticed any major changes.

Anna refused to see her living arrangement in the assisted living facility as having changed because of the pandemic. For her, the facility still was the same 'normal rental apartment' as before. Thus, she was not accepting the interviewer's framing of being a patient in an institution by assuming she would know about the nursing practices in the facility, but portrayed herself rather as an independent person continuing to live 'a normal, homelike life' in the facility. Within this positioning, the storyline of 'assisted living facility is a normal home' is invoked and the expectations related to living in such a place during the pandemic challenged. Indeed, the positions and storylines in the assisted living facility were related to the facility being a place for older people with different levels of care needs. The facility was just a normal home *in relation to* the place not being a normal home for those with more demanding care needs.

The framing of older people as victims of the pandemic was prevalent (Jen et al., 2021). This view was shared by most of our study participants. However, the victims were always somebody else, never oneself. The participants talked about how other, often older people (people they knew, had heard about, or just other people in general) were worse off than they were and, therefore, they were actually quite fortunate. It was assumed that other people were more alone and suffering more because of the various restrictions on social life. Tiina was asked about how she was doing during the pandemic:

> Well I mean it's been a little weird, like, I mean it hasn't been very nice has it. But I can't say it's been all that hard either because I know people whose mother for instance has been in a care home and then no one was allowed to get in to see them or have a chat. And so for the mother it was really hard.

The participants portrayed other older people as the victims of the pandemic and themselves rather privileged in this situation. Care facilities often appeared as places where people have the hardest time compared to oneself. However, even people who lived in a care facility (assisted living) thought that others were having a harder time of it than they were. Many of them thought they were in a safe place and were pleased that there were other people around. The interviewer asked Siiri, who lived in an assisted living facility, about the effects of the pandemic on her life:

> Well I suppose we have, there have been, you know, sometimes, sometimes I do miss people. But my son calls me and the children and, but you shouldn't complain, when you think about all those older people, when you think about them who are even more lonely than I am. - - so I have to say that for my part, things could be worse.

The participants saw their situation within their place of residence in relation to their knowledge and expectations of different spaces inhabited by older people. This was reflected in being able to position oneself as privileged compared to others no matter where one lived: there always was some imagined person having it worse. Thus, the storyline of old age as a time of vulnerability manifested itself in the talk of our participants, but this vulnerability concerned other older people, not oneself.

Outside of home

Not all our participants had stayed at home and avoided social contacts. A small minority said they had continued to lead a normal life despite the pandemic: they had continued to run their own errands and saw their family and friends (almost) normally.

Most activities and events outside the home, such as handicrafts and exercise groups, concerts and voluntary work, had been suspended. This was a source of much sadness and frustration since there was a big contrast to what life for many had been before. Hobbies and activities were important; some participants said they normally took part in them very frequently. But now, it was felt that they had very limited influence over what went on outside their home. They described themselves as being restricted within the 'victim of circumstances' storyline.

> Researcher: What if the restrictions are continued, what will the autumn look like?
> Kirsti: I miss my hobbies because they are, it's like the social activity that I miss. But I mean, it's annoying not knowing how long this will go on. But erm, I've decided not to think about it. All hobbies basically, except for physical exercise, independent activities, they're all on hold, so that's not nice. None of these group activities, they're all off.

Those who continued to move in different spaces outside their home explained why they had chosen to do so. Olavi had to some extent restricted his social life but viewed the official rules about staying at home and socially distancing as 'mild recommendations.' He had therefore decided not to follow the recommendations 'literally' and not to 'stay at home like some others did.' Instead, Olavi relied on his own judgement and continued to run errands and visit places outside his home. Drawing from the 'older people are rational adults' storyline, he portrayed himself as a sensible person. He also compared himself to 'some others' who he felt passively stayed at home because they were told to do so. He located these 'others' in the 'old age is patronised' storyline that he himself was resisting.

Moving outside the home was often explained and justified by our participants, in contrast to staying at home and receiving support. Getting help was not seen as anything out of the ordinary: 'Because I mean I wasn't allowed to go to the shops or anything, so my cousin's daughter came round once a week and brought several carrier bags full.' Tiina thought she was not 'allowed' to run errands on her own, so it was natural for a relative to come round and bring her groceries. Within the parent/child or family ('children help their aged parents') storyline the participants portrayed themselves as compliant persons who stay at home and receive help from others, as expected.

In contrast, not receiving help with everyday tasks seemed a much more complicated issue and clearly needed to be explained. Reijo said he ran his own errands during the pandemic and needed no help: 'There was hardly anyone' in the shops and therefore 'plenty of room to do your shopping.' He said that disinfectants were made available to customers, and explained to the interviewer all the other precautions he had taken. Olavi, too, described how he constantly moved outside the home to run errands during the pandemic, although 'of course' he had made sure not to go to the shops during 'the busiest hours' and to keep his distance and wash his hands. Overall, he has been very 'cautious.' The amount of people in and roominess of the space as well as certain objects, like disinfectants, became important aspects of space one needed to take into consideration when moving outside the home. Taking these into consideration was considered an act of responsibility and of using common sense: Reijo and Olavi, on the one hand, portrayed themselves as sensible persons who can run errands on their own because they know how to be careful. On the other hand, they also positioned themselves as responsible persons being careful, even though they were not following the recommendations. They located their actions within the 'responsible citizenship' storyline, which involves weighing one's own decisions and their effects on others. At the same time, they rejected the position of a

bad citizen offered within the storyline of 'insurgence' for failing to adhere to the rules and thus to contribute to the collective effort to fight the disease.

Discussion

When talking about life in different social spaces, participants contrasted their then current situation with the one before the pandemic. Because of the pandemic, respondents had to reconsider their position in these different social spaces. The participants, on one hand, perceived that the pandemic situation had changed their life within the different social spaces and, on the other hand, sometimes thought it remained unchanged. In some cases, the participants thought that there was a change due to the pandemic, but it did not concern them. We found there were several contradictions between the positions that were offered to the participants in the context of the pandemic or by the interviewer in the interview situation, and the ones they took up themselves. In what follows, we discuss in more detail these positions and how the different self-positions of older people construct different meanings of social spaces.

The participants viewed the social space of the home in relation to the experiences of home and other spaces in the past and in the anticipated future. Normal life outside of home had become, to a certain degree, prohibited, and a few of the participants felt they were able to adapt to that by engaging only in solitary activities in their homes. This has been found in other studies to be an important coping mechanism and a way of maintaining a sense of a meaningful life (Portacolone et al., 2021; Tiilikainen et al., 2021). Some viewed being alone at home as natural for their stage of life as an older person now and in the future: the position they took, being content alone, reflected their expectations of living at home as an older person. The meaning and relationship between a person and a space is fluid and contradictory rather than fixed and unchanging (de Medeiros et al., 2013). Thus, positioning oneself as content being alone at home did not mean these people denied the importance of social relationships. In fact, a couple of participants positioned themselves as loners but also as social persons who needed social contact in one and the same interview. This shows that positions are flexible: they allow understanding oneself and others in a multitude of different, even contrary ways.

Older people often met others in outdoor spaces where it was possible to socially distance (see also Kremers et al., 2022; Kulmala et al., 2021; Tiilikainen et al., 2021). Indeed, spatial distance from others became an important aspect of social life: spacious outdoor spaces provided an opportunity to remain socially active and in control of one's social life despite the restrictions. Although some positioned themselves as being restricted in their home because of the pandemic rules, social isolation was an enduring reality for other older people, as was found also by Morgan et al. (2023). Positioning oneself in relation to home space was relative to past, present and anticipated future experiences: not all our participants positioned themselves as restricted in their home within the available storyline of 'older people are victims of the COVID-19 pandemic', but in their personal storyline of illness or lack of close relationships. COVID-19 raised much concern about the loneliness and isolation of older people self-isolating in their homes (Armitage & Nellums, 2020). However, we should not forget that loneliness and isolation existed long before the pandemic and will continue to do so.

In the positions taken up by older people in relation to the social space of the home, the home was constructed, on the one hand, as a lonely social space isolated from other people. This is in line with earlier accounts of older people's homes (Pulkki & Tynkkynen, 2020). However, these positions also constructed the home as an adequate social space where the lack of social connections is a natural part of life and something one can adapt to, rather than an unpleasant situation. Home was also constructed as a social space that can be adapted to one's social needs and allows for inventing new ways to stay in touch with others, such as meeting others in the yard or from a distance.

Given the pandemic restrictions on physical social contact, virtual social spaces gained increasing importance as places where people kept in touch and communicated. The majority of our participants used digital technologies to communicate and stay in touch (see also Kremers et al., 2022; Kulmala et al., 2021; Tiilikainen et al., 2021). Nevertheless, we found that even those persons who used information and communications technology (ICT) to compensate for physical social contact were not satisfied with having access to virtual contact only. In the virtual social space, participants positioned themselves as sceptical users who acknowledged the benefits of ICT as a way of staying in contact, but they were also wary of using technology as a substitute for physical social contact. This finding is not unique to older persons, but there is indication of virtual social contact not substituting for in-person contact also among younger people (Rouxel & Chandola, 2023; Williams, Armitage, Tampe, & Dienes, 2020). Additionally, a few of the participants positioned themselves as old and incapable and thought their age and health prevented them from using or learning how to use technology. These participants' age-based stereotypes of themselves as too old to use technology (internalised ageism) affected their willingness and possibilities to use ICT, similarly to the study of Köttl, Gallistl, Rohner, and Ayalon (2021). These positions constructed virtual spaces as social spaces for younger, healthy and capable persons and, thus, inaccessible to older people and those with declining physical abilities. Virtual spaces were also constructed as insufficient social spaces that could to some extent replace physical social contact, yet not satisfy the need for real-life social contacts. In relation to other social spaces, virtual spaces appeared as inferior sites for social interaction.

Nine of our participants lived in an assisted living facility, and all interviewees were asked about their thoughts regarding the restrictions in these facilities. Nursing homes received extensive media attention during the pandemic (Miller, Simpson, Nadash, & Gusmano, 2021), with the spotlight turned on the health and well-being of residents. Our study showed that older people residing in assisted living facilities might not see themselves as victims of the pandemic, yet that seems to be the prevailing thinking in our social imaginary. The social lives of our participants were affected by the pandemic rules and restrictions in that they were not allowed to have visitors indoors, and even visits in outdoor spaces were regulated. However, our participants positioned themselves as sensible and responsible persons who followed the rules because they recognised their importance, not because they had no choice. They did not see themselves as victims of the restrictions but instead as being in control. The facility was also constructed as a normal home, rejecting the expectations of what it means to live in a care facility during the pandemic. However, all our participants residing in an assisted living facility were relatively independent, had no memory disorders, and none of them resided in facilities with 24-h assistance. It is quite possible that older care facility residents with more demanding care needs or cognitive impairments would have reported very different experiences.

Our participants assumed that other people were more affected by the pandemic restrictions than they were. Some who lived in the community assumed that people living in care facilities were worse off. However, even some assisted living residents thought that there were other (older) people who were having a harder time of it. In other words, our participants positioned themselves as privileged compared to others. This finding is in line with a persistent and widely reported dynamic in ageing studies: that people do not want to describe themselves as old. For example, Brooke and Clark (2020) found that their participants did not believe they were stereotypical older persons and did not want to identify themselves as old and in need of support: those stereotypical older persons were somebody else. Pirhonen, Ojala, Lumme-Sandt, and Pietilä (2016), reported that even the oldest old persons thought that true old age was represented by someone else, not by them. In our study, we saw that the 'vulnerable old age' storyline was not perceived to apply to oneself but others. Thus, our participants did not position themselves straightforwardly as older people (Jones, 2006).

Participants constructed assisted living facilities and other care facilities, on the one hand, as lonely and miserable social spaces where one is at the mercy of institutional restrictions and where one lacks any opportunity for social interaction. On the other hand, assisted living facilities were positioned as safe spaces where one did not have to be alone because other people were around. Those who did not live in an assisted living facility had negative perceptions of nursing homes as social spaces during the pandemic, whereas residents seemed to take a more positive view. For example, Keijo was unable to see his wife who was in another unit in the same facility where he lived, but he still considered these restrictions important and thought they helped to keep his wife safe. In other words, aspects that were described as downsides of living in a care facility during the pandemic, such as not being able to meet loved ones due to visiting restrictions, might in fact be seen as benefits of living in such a facility.

The vast majority of our participants used to be active in different social spaces outside their homes. Most of them stopped taking part in activities during the pandemic. In fact, as these activities were suspended, they had had no choice. Therefore, they positioned themselves as restricted and located themselves in the 'victim of circumstances' storyline. This position constructed the social spaces outside of home where one usually would spend time as inaccessible and out of reach. Nevertheless, not all our participants avoided social contacts and stopped moving outside the home. The instructions about avoiding social contacts and staying at home could be dismissed, accordingly, if one was sensible enough and knew how to be careful. The positions of a sensible and responsible person were taken up within the 'older people are sensible adults' and 'responsible citizenship' storylines. These storylines were opposed to the narrative, evoked by the age-based guidelines and recommendations, that older people needed guardianship and, if they failed to adhere to the restrictions, would be irresponsible. According to Brooke and Clark (2020), their participants thought that those who did not follow the social distancing recommendations were selfish and irresponsible and that their behaviour was prolonging the pandemic. This position of a bad citizen was rejected by our participants through careful explanations and justifications for one's actions and talking about the precautions one took when moving outside the home.

The way that older people positioned themselves in relation to spaces outside their home constructed these spaces as negotiable: one's presence in these places needed to be explained and the different positions taken up justified. Staying at home and receiving help from others, on the other hand, was taken for granted and did not require any explanation. This contrasts with the findings of Allen and Wiles (2014), who reported that older people positioned needing support as negative, while being independent was described in positive terms. Their participants framed the position of support recipient as acceptable by carefully justifying their need for support. However, our participants did not think that receiving help positioned them in negative terms as incapable or dependent. Clearly, receiving help during the pandemic was not something our participants felt needed explaining because it was thought to have nothing to do with the person's capabilities or dependence. So, while being independent was positioned as positive in the study of Allen and Wiles (2014), in our study being independent and moving outside the home needed to be justified to avoid the position of a bad citizen invoked by dismissing the instructions on how an older person should act during the pandemic. This shows how receiving support as an older person has different meanings and can be understood differently at various times. Additionally, it shows how space is intertwined in our understanding of the morality and acceptability of our behaviour and actions in relation to other people and how rights and duties, such as the right to be active, or even present, in different spaces and the duty to acknowledge others in different spaces, are conferred by positions (see Allen & Wiles, 2013b; Harré et al., 2009).

Since the study was conducted in the early phase of the COVID-19 pandemic, the findings represent the experiences and thoughts of older people at that time. It is likely that older people experienced the situation differently in later phases. Research suggests that well-being remained relatively stable among some older adults during later phases of the pandemic (Fields, Kensinger, Garcia, Ford, & Cunningham, 2022; Matovic et al., 2023), but well-being also decreased among some as the pandemic situation prolonged (Hansen et al., 2022; Matovic et al., 2023). Possible changes in well-being due to the prolonged pandemic situation and restrictions could have affected the answers of our participants had we conducted the interviews in a later phase of the pandemic. Countries were differently affected by the pandemic and took on different levels of control measures. Research suggests that feelings of loneliness among older people fluctuated according to the strictness of the control measures over time in one country (Stolz, Mayerl, & Freidl, 2023). Thus, it is possible that in countries with less strict or stricter control measures compared to Finland, the experiences of older people would have been different and resulted in different findings in relation to positions and social spaces. However, it is also likely that, especially at the beginning of the pandemic, not only the epidemic situation or strictness of control measures in the country affected people's thoughts about the disease and the need for restrictions, but also the large news coverage of the pandemic situation all over the world that created menacing visions of the dangers of the disease.

Conclusions

The rise of ageism during the COVID-19 pandemic, as observed by many scholars (Fraser et al., 2020; Jen et al., 2021; Lichtenstein, 2021; Previtali, Allen, & Varlamova, 2020), is bound to have impacted the way that older people are positioned by others. This study showed how older people positioned themselves in diverse and flexible ways. These positions painted a very different picture to the one of older people being vulnerable, dependent and a problem. In fact, they represented older people as rational, cautious and resilient, as individuals who carefully analyse and evaluate the situation in order to cope. However, our participants also held negative assumptions about 'older people' with which they did not want to associate themselves, and they did feel restricted by the pandemic. Older people had diverse experiences of the pandemic that cannot be captured by the single, pejorative narrative of being a victim of the situation.

Our study highlights the meaning and importance of different spaces for older people that extend far beyond the time of the pandemic. One's own position in social spaces was negotiated in relation to various individual experiences that resisted the ones offered by the pandemic situation. The meaning of social spaces was related to the wider individual experiences of ageing in these spaces and not only to the time of the pandemic. Thus, this study deepens our understanding of the possibilities and challenges related to being an older person in these spaces. By understanding how social spaces are experienced and how they construct social life, policymakers and professionals working with older people can better promote spaces of living, care and social activities that can enhance and maintain social interaction and well-being in times of change and in more stable times.

Statement of ethical approval

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Data availability

The data that has been used is confidential.

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