Enjoying the third age! Discourse, identity and liminality in extra-care communities

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ABSTRACT

Extra-care housing has been an important and growing element of housing and care for older people in the United Kingdom since the 1990s. Previous studies have examined specific features and programmes within extra-care locations, but few have studied how residents negotiate social life and identity. Those that have, have noted that while extra care brings many health-related and social benefits, extra-care communities can also be difficult affective terrain. Given that many residents are now 'ageing in place' in extra care, it is timely to revisit these questions of identity and affect. Here we draw on the qualitative element of a three-year, mixed-method study of 14 extra-care villages and schemes run by the ExtraCare Charitable Trust. We follow Alemàn in regarding residents' ambivalent accounts of life in ExtraCare as important windows on the way in which liminal residents negotiate the dialectics of dependence and independence. However, we suggest that the dialectic of interest here is that of the third and fourth age, as described by Gilleard and Higgs. We set that dialectic within a post-structuralist/Lacanian framework in order to examine the different modes of *enjoyment* that liminal residents procure in ExtraCare's third age public spaces and ideals, and suggest that their complaints can be read in three ways: as statements about altered material conditions; as inter-subjective bolstering of group identity; and as fantasmatic support for liminal identities. Finally, we examine the implications that this latter psycho-social reading of residents' complaints has for enhancing and supporting residents' wellbeing.

Background to the research

This paper draws on the qualitative element of a three-year, multi-method study, whose overarching aim was to investigate the health and wellbeing

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benefits delivered by the ExtraCare Charitable Trust[1] (henceforth, ExtraCare). ExtraCare, as an organisation, came into being in the late 1980s as a response to the paucity of housing and care choices for older people. It is one of the largest providers in the United Kingdom (UK) of what is more generically referred to as extra-care housing, a particular type of retirement community, which aims to meet 'the housing, care and support needs of older people, while helping them to maintain their independence in their own private accommodation' (Netten *et al.* 2011: 4). ExtraCare's mission is 'to give older people an independent, safe and secure future in a network of inspirational communities' (www.ExtraCare.org). Giving care is part of what ExtraCare does and, indeed, residents in receipt of care frequently demonstrate high levels of satisfaction with care provision.[2] At ExtraCare, this includes care packages paid for by residents (or where applicable by the local government or the English National Health Service), ranging from support for washing, cleaning and preparation of meals, to more intensive support for activities of daily living, and, in some cases, nursing care. Care need is assessed on entry and is designed to adapt to changing need. It also includes on-site wellbeing nurse-led support which is available to anyone. The balance between those who live with and without care varies. In ExtraCare's larger villages, some of which may have up to 450 residents, the average age of residents is 74, and a sizeable minority are in receipt of care. In some of its smaller locations (known as schemes), the average age of residents is 84 and those receiving care may be a majority. Every ExtraCare location has a wellbeing advisor (a nurse), who offers health and wellbeing checks by appointment and/or drop-in. This focuses on general health, falls prevention, managing long-term conditions (e.g. blood pressure monitoring, blood glucose testing for those with diabetes), lifestyle advice (diet and physical activity) and advice on cognitive functioning (including dementia onset). There is also a 'locksmith',[3] whose function is to 'unlock' the potential for wellbeing in individuals with early signs of dementia (Brooker and Woolley 2007). Each location has an activity co-ordinator, whose job is to facilitate the implementation of ExtraCare's schedule of activities – such as singing, painting, knitting, word work, games and quizzes, and entertainment.

Residents in ExtraCare are encouraged to take care of their physical and cognitive health. Disability is also catered for: doors are wide enough for wheelchairs; bathrooms, both private and communal, are large enough for wheelchair manoeuvre and all have grab rails and emergency alarms; doors are double-hinged for emergency entry and exit; and signs are given in Braille and text. The possibility of corporeal ageing and disability is, thus, anticipated, but autonomy and self-sufficiency are strongly idealised. This is most evident in purpose-built villages where the ideal is written into the physical layout of the buildings: communal areas on the ground floor look like streets, with a café, village store, gymnasium, hairdresser,

restaurant and bar. Apartments face out on to wide corridors ('streets'), with their own front doors, outward-facing kitchens and customised frontages. The smaller schemes cannot offer the full range of facilities but most have gymnasiums, or at least some provision for physical exercise, and all have restaurants. Extra-care housing, thus, seeks to balance independence and activity (Katz 2000) with care, support and accessible housing provision. As was evident from the focus groups we carried out, people move to ExtraCare for a variety of reasons such as health or bereavement, and for some it is a lifestyle choice in retirement. What is also notable about ExtraCare is its avowedly *socially* inclusive nature. In providing a range of tenures, it seeks to be accessible to residents of all income brackets. Thus, while ExtraCare communities are a positive choice for many of their residents, in many ways, they are challenging environments, both to manage and to live in. It is these challenges that are the focus of this paper.

Previous studies of extra-care housing, and ExtraCare specifically, have examined features of provision, but relatively few have explored the challenges residents face in negotiating community life and identity within extra-care communities. The exceptions have acknowledged the considerable benefits of extra-care housing relative to other types of provision but have also registered a tendency for social isolation to persist even in the context of a more socially accessible community (*see* Bernard *et al.* 2007, 2012; Biggs *et al.* 2000; Evans 2009; Liddle *et al.* 2014), mirroring research from retirement communities in general (Bernard *et al.* 2007). Some of these studies were carried out when the extra-care concept was relatively new to the UK and others have noted how still little is known of life in British retirement villages (Bernard *et al.* 2012). It is, therefore, timely to examine these questions of identity, community and affect.

Research methodology and preliminary focus group themes

The qualitative data were gathered from 14 ExtraCare sites (*see* Table 1) and consisted of: semi-structured interviews with six new residents (*see* Shaw, West, Hagger and Holland forthcoming), repeated at three intervals over 18 months; focus groups in all 14 communities, open to all residents; detailed observations drawn from four ExtraCare communities; and insights from conversations with managers and general immersion in the life of ExtraCare. While we have drawn on all of the data to reach a general understanding of the ExtraCare communities in our study, for the purposes of this paper we draw mainly on the focus groups. In order to preserve the anonymity of both residents and ExtraCare staff, we have given all participants and locations pseudonyms and, in some cases, we have slightly altered some descriptive details.

TABLE 1. *Overview of qualitative data*

	Focus groups[1]		Interviews and case studies[1]		Gender	Age
	N	N groups	N	N interviews		
Schemes	7	9	3	10	14 men	62–91
					34 women	69–98
Villages	7	15	5	12	30 men	58–84
					53 women	60–93
Total		24		22		

Note: 1. Focus groups: N = 122; interviews and case studies: N = 13; four residents took part in both.

The original intention for the focus groups was to limit them to new residents who were already participating in the main, quantitative study, since the research overall was primarily aimed at residents' experiences of transition into ExtraCare. It readily became apparent that long-standing residents also wished to participate and that the qualitative element of the research also needed to focus on their needs and issues. Focus groups were, therefore, publicised and open to all residents who wished to participate. A majority of them were carried out by at least two researchers. We had a set of broad themes we wanted to explore – reasons for choosing ExtraCare, satisfaction with care and facilities, participation in activities and volunteering – but within and beyond those, residents were free to discuss the issues that were important to them. Data were analysed in three interrelated phases. The first was synoptic; immediately following the focus groups we exchanged feelings and perceptions, and made notes or audio-recorded those conversations. From these we derived general themes and 'problems'[4] that we wanted to analyse further, but several features of a number of the focus groups struck us in particular: the mixed feelings of residents about life in ExtraCare and the high level of emotional intensity and complaining in certain focus groups. These we have termed 'islands of over investment' (Glynos *et al.* 2014) and it is to these that our attention turns in this paper. In a second phase, we read across the focus groups for fantasies, a concept to which we will return, in operation. For now, we can think of these as scenarios or narratives that reappeared across focus groups. In a third phase, we returned to particular focus groups, in which these fantasies seemed to be especially marked in residents' accounts, for more detailed analysis. The account that we give here follows the logic of retroduction (from observation to possible explanation) (Glynos and Howarth 2007), in which we start with certain phenomena – ambivalent accounts on the part of residents of the life and values of ExtraCare and excessive complaining and anxiety –

and then seek to develop a hypothetical explanation of those phenomena, drawing on relevant theory and concepts. The explanation of the phenomenon that we proffer is, from a retroductive perspective, not proof, but a type of conjecture that takes 'a perfectly definite logical form' (Peirce, in Glynos and Howarth 2007). Before we set out our theoretical framework and more detailed analysis of the focus group data in that light, we first give a preliminary account of the dominant themes.

In brief, focus groups showed that ExtraCare was a positive choice for many who no longer wanted the burden of home maintenance, could no longer manage stairs or access community facilities, and who felt threatened or isolated living in the external community, corroborating previous research (Bernard *et al.* 2007; Biggs *et al.* 2000; Netten *et al.* 2011) and indeed, strongly supported by evidence from our own quantitative research (*see* Holland *et al.* 2016). Furthermore, it was evident that ExtraCare had given new residents not only a renewed sense of independence, but also a renewed sense of belonging. Residents who had seen their horizons of possibility shrink before moving to ExtraCare saw them opening up again. Whereas they had begun to see themselves as no longer useful, becoming a drain on family, in ExtraCare, they were included, useful, and had the possibility of active participation and meaningful new relationships. These themes surfaced in particular when residents were asked to recall their reasons for moving to ExtraCare or among those who had relatively recently taken up residence. But, alongside these highly positive assessments, residents also communicated disappointments: that standards of care and service had slipped; that too many frail older people were being admitted; that management were placing too many restrictions on their capacity for self-organisation; that there were too many people using mobility scooters; or that too many other residents had withdrawn from collective life, preferring instead to remain within their own apartments. These complaints tended to dominate in some focus groups where there was a preponderance of long-standing residents. Several responses are possible here. We might simply dismiss them as irrational in relation to the 'facts of the matter', or we might simply note them as the marginal accounts of a disgruntled fringe. We chose neither of those and instead took our cue from Alemàn (2001), who argued that while from an ageist standpoint, complaining among older people is 'a dispreferred interactional form', from an anti-ageist perspective, it represents an important window on the ways in which older people manage the various dialectics of dependence and independence in institutional contexts. Moreover, this group of liminal (Grenier 2012) residents (between independence and dependence), although a (sizeable) minority among our participants, nonetheless represent a growing cohort of residents in ExtraCare and other extra-care communities,

as existing residents 'age in place'. Unlike Alemàn, however, the dialectics that these liminal residents are negotiating, we posit, are not merely those of independence and dependence, but the more culturally and historically specific dialectic of the third age and the fourth age as recently posited by Higgs and Gilleard (2015), and previously by Gilleard and Higgs (2010). In order to examine the ways in which this dialectic plays out at the level of the community and of the individual, we place it within a post-structuralist discourse theoretic/Lacanian framework, as this provides us with a means of connecting socio-cultural discourse with individual and group discourse and identity formation.

Connecting residents' complaints with the third age/fourth age dialectic

Alemàn's insight is that complaining among older residents in retirement communities is a productive communicational form, which facilitates the negotiation of their identities in and around the various dialectics of dependence and independence, is a very useful starting point for examining how residents negotiate their identities in ExtraCare communities. However, the more recent work of Gilleard and Higgs seems to us to pinpoint more accurately the contemporary dialectic of ageing in general, and of institutionally mediated ageing (Holstein and Gubrium 2000) in settings like ExtraCare, in particular. Gilleard and Higgs' work is well known, so we will give only the briefest account here. The gist of their argument is that the 'cultural rejection of agedness' (Higgs and Gilleard 2015: 12) on the part of the so-called 'baby-boom' generation, or those currently enjoying a healthy and active older age (the third age), while hugely beneficial in releasing later life from the old institutionalised lifecourse, has also served to marginalise, and engender fear of, deep old age and frailty (the fourth age). As Gilleard and Higgs have stressed, the third and fourth ages are neither chronological categories nor designations that can easily be indicated by physical (dis)abilities. What characterises the third age is a will to eschew age as the primary marker of identity, the active embrace of life's possibilities and 'the active exclusion of agedness' (Gilleard and Higgs 2010: 122). This third age possibility, however, perpetuates and persists in the shadow of the fourth age, 'a social imaginary' whose genesis lies in the 'institutional densification of long-term care' (Higgs and Gilleard 2015: 14) and the nightmare scenario of 'the nursing home', signifying despair, decrepitude and abandonment. This dialectic is, we argue, far more complex than the general dialectics of independence and dependence posited by Alemàn, because dependence has become so marginalised in public and policy discourse in favour of success-based models of ageing (Grenier 2012), and because the strength

of this social imaginary of the fourth age is a function of society's investment in the ideals of the success-based third age (West and Glynos 2015). This latter point implies that, although this dialectic is part of the contemporary cultural landscape, to some extent, its effects can be amplified or mitigated by the discursive practices of institutions like ExtraCare.

Theorising from post-structuralist premises

Gilleard and Higgs' third age/fourth age dialectic, while not without its critics (*see* Grenier and Phillipson 2013; Lloyd *et al.* 2014), has become a significant focal point for thinking the politics of identity in later life. We argue, though, that in order to connect it to the empirical world of ageing, it requires a certain conceptual anchoring. In order to do this, we draw on post-structuralist discourse theory and the further Lacanian concepts of desire, fantasy and enjoyment.

What we take from post-structuralist discourse theory is the idea that discourses are constitutive of communities and identities. The 'we' of a community is constructed in relation to its 'others' in 'logics of equivalence and difference' (Glynos and Howarth 2007; Laclau 2005). In Gilleard and Higgs' third age/fourth age dialectic, the discourse of the third age articulates certain discursive elements – independence, autonomy, choice, fitness regimes, preventative medicine, healthy ageing strategies, empowerment and participation, *etc.* – into a chain of equivalence, while other discursive elements (associated with the fourth age) – dependence, frailty, withdrawal, senescence, geriatric medicine, nursing homes, *etc.*, are excluded. Identities, or rather contingent 'subject positions' (Laclau and Mouffe 1985) are made possible within these discourses. Subjects orient to certain discourses ('the Other') and daily practices are, thereby, signifying practices, lending a degree of subjective consistency that would otherwise be lacking. But, 'the Other' is never complete and can never confer a completely stable identity. In certain moments, this incompleteness (impossibility or lack) – both of the symbolic order of the Other and the imaginary order of the individual subject – reveals itself. This is the Lacanian 'Real' – 'an originary lack or void at the heart of subjectivity' (Howarth 2004: 260), which both provokes anxiety, but also potentially opens up the possibility of forming new identities. In Lacanian terms, then, the Real simply stands for that which cannot be symbolised (Žižek 2008). It is a purely ontological category. For our purposes, though, we might think of this Real in terms of Gilleard and Higgs' fourth age 'black hole' and the 'event horizon', the point where one imagines being stripped of all agency (Gilleard and Higgs 2010) and drops out of the symbolic order of the third age.[5] Higgs and Gilleard (2015) themselves posit this as a social

imaginary that stalks all stages of the lifecourse, but arguably it takes on a more definite shape and has greater resonance in later life, where 'functional limitations and increasing social losses of old age bring finitude to the fore' (Nicholson *et al.* 2012: 1426), where one stands at 'the intersection of age and impairment' (Grenier 2012). In this state of 'persistent liminality' (Nicholson *et al.* 2012), one may experience both its 'gravitational pull' (Higgs and Gilleard 2015) as well as the will to resist it. But, what is crucial here, and the key contribution that Lacanian theorising can make, is that there is more to a subject's relationship with this fourth age Real than fully conscious fear. On the contrary, as we have known since Freud, the first recourse when identity is in question is to repression. This, we argue, is key to understanding how residents negotiate identities in communities like ExtraCare, in which some may be experiencing a sense of 'persistent liminality', between the third age and the 'gravitational pull' of the fourth age Real. Albeit from a rather different theoretical perspective, this is what Alemàn seeks to capture in the idea that complaining is a mechanism for the negotiation of fragile, liminal identities in older age that requires a certain non-literal reading between the lines of these complaints. For us, though, the Lacanian concepts of *desire, fantasy* and *enjoyment* better capture what is at stake. These we will illustrate with reference to the third age/fourth age dialectic.

Enjoyment in the third age

In order to function as subjects of, in this case, the third age, to fit into a community which appears to value the third age (as evidenced, for example, by its artefacts, injunctions and daily practices, such as strong encouragement to maintain physical and cognitive health, to pursue lifetime ambitions and the volunteer, the presence of gymanisums, *etc.*), its members have to desire what this third age Other desires. They have to like themselves, and to be liked, from the standpoint of the (third age) Other (Žižek 2008). But, as it is nothing more than a contingent symbolic fix of an unmanageable world, the Other's desire is ambiguous. Does it want community members to pursue hedonistically post-retirement ambitions or does it want them to spend their time exercising and being active so as to avoid ill health and becoming a burden? There is uncertainty about what it wants, that they are giving it what it wants and, moreover, as they experience the gravitational pull of the fourth age (this sense of persistent liminality), they do not know if they even want what it wants. The third age Other, we might say, has no clear object, and they have no clear desire, but to remain subjects of the third age, they have to desire it nonetheless. This provokes uncertainty and anxiety. A common response to this (Real)

anxiety is to seek to give the Other's desire a clear object, to turn desire into demand (Fink 1987) (to convert impossibility into mere difficulty; Glynos 2008). The feelings that this provokes are, of course, nothing more than a vague sense, and what we have described here are no more than translations of this into a more cognitive register.

Fantasy's role, here, is to explain why there is no ultimate satisfaction. Subjects, thus, stage a fantasy scenario that objectifies the Other's desire and explains, above all, why they are not satisfied in the realm of the Other. Fantasy is a 'discursive element' (Glynos 2014: 5) which comes from the Other, which is partially *enjoyed*, but which also promises the recovery of full enjoyment[6] (Glynos 2014; Stavrakakis 2007), thereby maintaining a subject's identification with (desire in) the third age Other. This partial enjoyment can take many forms: guilt, shame, scape-goating others for our failing desire, repulsion at others' frailty and so on. This pursuit, reification, denial or transgression of some symbolic element is not an extraordinary or shocking occurrence, but something that occupies the whole of our psychic life (Fink 1997; Rose, cited in Butler 1997: 97). However painful it may be, on some level it is *enjoyed* because it gives partial relief from Real anxiety (Fink 1997); in this case, the fourth age. '[E]njoyment is thus linked to an impossibility and its fantasised overcoming' (Glynos 2008: 681). It indexes an individual's over-investment in an ideal or object (Glynos 2014) beyond the function of inter-subjective communication (Glynos 2014) and the community-building function of narrative. In this way, residents' complaints, can be read in three ways: as representations of material facts; as narratives that co-create communities (*e.g.* as the study of narratives in extra-care communities of Biggs *et al.* 2000); *and* symptomatically as fantasies and the enjoyment they procure for liminal subjects, whose desire in the third age Other is called into question. What we seek to demonstrate now is how residents' complaints can be understood as fantasies and the implications of the enjoyment in these fantasies for individuals and the collective. We then draw on excerpts from certain locations and focus groups, which seem most clearly to demonstrate how residents' complaints function as fantasies.

ExtraCare and the third age

As is evident, ExtraCare consists of both public spaces, in which people socialise, engage in physical activities and access ExtraCare's wellbeing services, and the private spaces of residents' apartments. These latter may be configured in any number of ways – as habitats for those pursuing entirely independent, even working, lives or as sites for the provision of formal,

institutionally arranged care, but it is in ExtraCare's public spaces that residents are seeking social contact, social approval and fulfilment. In these public spaces, third age themes of choice, independence and self-fulfilment through activity were dominant, which is consistent with previous research (Biggs *et al.* 2000). From the focus groups, it was evident that while living a private life in one's own apartment is a right to be upheld, being an ExtraCare citizen means being an active participant in this third age public space. Volunteering is very much encouraged and, to a degree, expected. Many services and activities would not function without the input of resident volunteers, and across the focus groups, we were regularly told that even participation in the focus groups was both a kind of civic duty and a democratic right. The following excerpt from one of ExtraCare's smaller schemes, Ivy Court,[7] is indicative here. The focus group facilitator asks for clarification of the role and membership of the residents' forum and asks why focus group members thought it might be that attendance was so poor.

Facilitator:	Is that because people don't want to come or because they can't?
John:	No, I wish you'd find out for me!
Rosie:	They're more than happy in what they do, aren't they?
John:	I'm not being rude but you see the same old, I was going to say old people (laughter among the group), same people come down for everything … There's one man here, truthfully I've seen him once and I've been here 18 months, but he chooses to be in his flat on his own, which is *own right.*
Rosie:	It's his choice.
John:	It's his choice, his own life, what a life he must lead!
Rosie:	I mean there are *things that you've got to do.*
John:	Wouldn't it be better if he came and joined in with us.
Rosie:	There are things that you've got to do in your own flat like you would at home.

Here we can see how being independent, exercising choice about what to do with one's time, but also joining in with community life, are valued by residents. John is ambivalent here on the question of whether residents should be cajoled and encouraged to participate in communal events, whereas Rosie is more definite that people have their own lives and affairs to organise and may choose to spend their time differently. There is, nevertheless, a persistent concern about residents who do not 'come down' (an oft-repeated phrase as we shall see) and participate in public life. As Rita put it about her recently bereaved friend:

Of course when he died she'd got nobody else; never made friends nor nothing. So she, she sits in a two-bedroomed flat across there all on her own all day long. Don't even come down for dinners.

But not everyone can readily access this public, third age space. Here we turn to one of the focus groups in Woodland Village, a large and relatively new village. This focus group consisted of two women, Joy and Molly, and two men. Of the men, one was approximately 80 with no visible physical disabilities or cognitive impairment, the other was a younger man with multiple physical disabilities, able to walk with sticks but also using a mobility scooter for longer distances, and very active in village life, as evidenced by the number of residents who came to him seeking information about events once the focus group had finished. Both of the women, Joy and Molly, used mobility scooters and had visual impairments. Joy had experienced a gradual decline in her health over a period of many years. She previously lived in private sheltered accommodation, but she found she could no longer use a self-propelled wheelchair. Joy found her mobility scooter difficult to use in her previous sheltered housing home, in her words:

Joy: I just became totally isolated. I couldn't get around. I've got no families [*sic*], but coming here has just made a huge difference to my life. [Before moving here] I was going weeks and weeks without seeing anyone. When I fell over, I had nobody to call. (Pause) I have been lonely here.
Facilitator: Have you been lonely?
Joy: I must admit, I do at times. I have been lonely, but a lot of the time, I shut myself away because of my health. I prefer to be alone when I'm not feeling well. I don't mind it's a different kind of isolation here because it's self-imposed. If I want to go out, I do.

Joy has the facility, at least, in ExtraCare to access a social life if she feels up to it. Later in the conversation, though, she admitted to struggling with community life and accessing the activities in the village. Joy wanted a social life, but something more intimate:

I had visualised it as a smaller group having a light coffee morning. I said 'I'm happy to entertain six people in my flat'. I always had, the girls always came to me, we always used to screech with laughter, the neighbours said that they never heard anything but laughter from my place. And I had visualised that, we'd all get to know each other through smaller groups.

This had not, so far, materialised and Joy could not see a way to bring it about by herself. For her, events for meeting new people, such as the organised singles club nights. were not appropriate to her needs. She was by no means unhappy in Woodland Village, but could see the possibilities of a social life that merely revolved around scheduled activities slipping away from her. Joy's comments here echo those of some managers, who were concerned that there was a tendency (among both staff and residents) to routinse and render activities goal-oriented, such as the knitting group or the singing group.

Molly's first 12 months in Woodland Village had not yielded any significant friendships. She felt shut off and with very different needs to those of what she perceived to be the mainstream community. She thought that Joy was 'the nearest I've met to anybody that's like me'. She was experiencing great difficulties in integrating. One excerpt is indicative. The conversation was about a group of single women who meet for lunch and coffee in the communal areas. One of male participants described this as 'the witches' coven'.

I asked those people once. I said 'Do you mind if I join you?' They said, whether they were joking I don't know, 'We don't know you'. (Molly)

This experience had been upsetting for Molly and had made her wary of seeking other opportunities to join in:

I should love to go to the quiz evening. I'm not walking in there on my own and have everybody ignore me and sit there on my own. (Molly)

So, Joy and Molly are both single women, both have severe physical limitations related to visual impairment and mobility. In Joy's case, the fluctuating nature of her health makes it difficult for her to keep up with programmed events. For Molly, her early experience of being shunned, together with her shyness, has made it difficult for her to access the public spaces of Woodland Village. Her need for regular visits from a nurse also prevented her from participating in scheduled activities. Neither of the men in the focus group was especially sympathetic. For them it was a case of ignoring hostile comments and muscling into community life. But, for Molly and Joy, things are not that simple. They face multiple physical impairments and challenges and cannot commit to regular attendance of goal-oriented activities, but they are not ready to retreat from communal life either. They are neither securely of the third age, nor, clearly, are they of the fourth age. Their status is liminal.

We can see, then, that third age values are dominant in the public space of ExtraCare. Residents' choices to stay out of the public space are endorsed, but, at the same time, being a full citizen (or subject) of ExtraCare means active participation in organised events. But, we can also see how, for some residents, these values are hard to live up to. As relatively new residents, Joy and Molly were in the process of negotiating what life in ExtraCare would mean for them. We now want to turn our attention to more established residents; residents, we posit, who have taken full advantage of all that ExtraCare has to offer, who are still very much in the thick of community life, but whose satisfaction in it appears to be waning. Here the narrative is not so much about accessing ExtraCare's public space, but, rather, about whether a public space would continue to exist at all. Here we suggest that a somewhat more complaining narrative of 'keeping

the show on the road', while partly a representation of objective material conditions, also shows signs of being a fantasy support for liminal identities.

A fantasy of keeping the show on the road

In the more established and smaller schemes, we encountered a certain anxiety among residents about the ebbing away of community events. We came across small groups of residents of long-standing who had evidently been very active volunteers – organising social activities and residents' committees. Now, with waning energy, they sought to keep these activities going in spite of what appeared to be a lack of enthusiasm or interest on the part of other residents, which, in their view threatened their viability. A lot of time was taken up in focus groups speculating about why it was that other residents never seemed to 'come down' to organised events. Excerpts are from a focus group in Mountain View, a smaller scheme with a relatively high number of established residents. This consisted of three women all over the age of 75, Sally, May and Elizabeth, and a fourth, Janet, a much younger resident with multiple disabilities.[8] It became apparent that their participation in the focus group itself was also bound up with their wanting to turn back what they saw as a tide of apathy. The focus group was seen as part of their democratic duty. The first excerpt concerns their Street Meetings, a participatory forum in which residents can air their views about life at Mountain View:

Elizabeth: They [other residents] won't come down.
Sally: They're terrible for coming down. It's always the same people. We've got, what, 42 flats, but they won't come down. There's a lot of people don't join in anything you see.

[…]

Sally: It's their choice. I mean you can't force anybody … all you can do is ask them. It's up to them whether they want to come down … We have a meeting. Call it a Street Meeting don't we with Tony, the manager…
Elizabeth: If you get 12 down you're lucky. Same ones aren't they, same people as here … the manager will come in here on a Friday, there's only me and Sally comes. Nobody else comes. Two of us!

Here we see residents on the horns of a third age dilemma, similar to that already noted in Ivy Court. On the one hand, there is a feeling that other residents are letting the active community (and them) down in their non-participation, but, on the other hand, their right to choose not to participate is affirmed.

Some ten minutes later, the discussion becomes less condemnatory and more focused on the practicalities of ageing in place, and what practical

steps are taken to seek to ensure that new residents, at least, are given a sense of being part of an active collective.

Sally: But you see we're ten years on and health deteriorates and you can't expect things to be the same now as what they was when it first opened.
Elizabeth: You see they were more active, the people, when we first came.
Facilitator: But what about the new people coming in, are they not more active?
All: No.
Sally: What happens when we have new people, right, for about a fortnight residents see them when they're in, see if they've got any problems or do they want anything, then I go in for about a fortnight, you know not *every* day to see if they're alright…

A little later, the facilitator asks what kind of things there are to do. Again, residents concerns about losing an active collective life come to the fore, as well as some of the strategies they deploy to compensate for this apparent decline and to maintain some kind of active identity.

May: There was ceramics, but the lady don't come now.
Sally: We have cards and every Monday we have a quiz. Monday afternoon, but that's fell through hasn't it now. Choir, we had a choir for a bit (laughs), but that's dropped more or less, you know, off … We have flower arranging and in the morning, we've got one of them Wii games. We put it on Tuesday afternoons and anyone can come down. The one we've been playing is on bowls and it's been brilliant. It's good, it's really, really, you know, good.
Elizabeth: Tuesday night bingo, Sally.
May: I used to like ceramics but we don't get it now, because she don't come (adamantly). So we don't get that … We have a knitting night but I'm crocheting on me own because nobody else comes.
Sally: Yes, but you haven't been down for a long while have you.
May: I *do* come down Sally, *every night*! Every night I come down. I walk round the corridors because there's nought else to do.
Sally: No I didn't mean that. I meant for activities at night, not your walking around at night.
Elizabeth: I come in here to play a game if there's gonna be anybody there, but there's never anybody 'ere (plaintively). I come down to pampering, but there's only two staff so they can't do it.
Sally: They don't do it when there's three members of staff!
May: I come down for knitting every Wednesday night, but I come down to crochet, I don't knit.
Sally: That's why a lot things don't get done, because the numbers of people coming down have gone more or less right down till some of them don't exist do they.

[All agree.]

Elizabeth: I just play games with the staff sometimes.

Despite these complaints and concerns, all residents, when specifically asked, said they were happy and grateful to be in Mountain View compared to alternatives that they saw as available to them – residential care or living with other family members. But what this demonstrates, more starkly than in Ivy Court, is the importance of third age ideals of self-sufficiency, choice and active participation. On the one hand, residents want to keep a social and democratic life going but worry that it is slipping away ('we used to have'; 'we don't have that anymore', *etc.*). On the other hand, there is exasperation at the perpetual organising, cajoling and worrying about others' motivations. Sally saw it as her job to look out for newcomers, in the hope they would participate in public Mountain View life. She was fairly pragmatic about collective life not being the same as it was ten years ago, but she nonetheless took on a leadership role (evidenced by the number of times others look to her for affirmation). Throughout she is ambivalent about this role, oscillating between pride and exhaustion. Later on, when the discussion turned to volunteering in the garden, her exhaustion becomes more evident. With a heavy sigh, she asserts: 'They expect too much don't they'. The 'they' here is not specific; it could be management or other residents, perhaps it is also more generally addressed to the third age 'Other'. Elizabeth, although somewhat frustrated at the apathy of the other residents, sought the company of staff for *ad hoc* social interaction. Maybe she is more willing to let go of the idea that social interaction must take place in and through programmed activities and instead to look directly to staff to meet her individual needs. Janet, we were told, spends much of her time socialising outside ExtraCare, regularly frequenting the local bingo clubs. May was the least vocal, but perhaps, being the most frail of the group, has the most difficult relationship with ExtraCare's ideals. There is a suggestion that she does not 'come down' as much as she thinks she does, at least not for the organised events. Her identity is nonetheless tied up with being an active participant and part of the organising crowd – her participation in the focus group demonstrates this – and her failure to get the satisfaction she once had as a member of the Mountain View collective is, in her view, down to the failure of others to participate and organise.

We can begin to see how the third age ideals of self-sufficiency, choice and active participation penetrate life at Mountain View. When gradually residents withdraw through ill health or frailty, it comes down to a remaining handful of residents, who themselves have aged in place, to uphold the ideal on their behalf – to keep the show on the road. But we can also see how this ideal is also a fantasy, which is *enjoyed* in a number of ways. Janet, despite multiple disabilities, appears to be less dependent on Mountain View for social fulfilment. Elizabeth appears, to some extent, to have found new ways to support her identity that are perhaps not as bound up

with ExtraCare's ideals. Perhaps she is more willing to retreat from community life. Sally, although perhaps ready to give up on the ideals and settle for non-approved and non-goal-oriented games like Wii bowls, nonetheless sees it as her responsibility to uphold them, a responsibility she both welcomes and finds exhausting. May, on the other hand, has a tendency to scapegoat the failures of others rather than face her own declining capacity. These ideals take their toll, both intra-psychically (as in the case of Sally's internalisation of it) but also inter-personally when it comes to laying the blame with others (as with May's projection of failure on to others). This latter mode of enjoyment we see even more clearly in the cases of Bishops Court, another small scheme, and Hilltop Village. Here we witnessed more vehement modes of complaining. Again, the narratives may be read as a representation of changing material conditions and also as narratives that bolster and sustain a friendship group, but they may also be read as a fantasy – in this case, we posit, a fantasy of rejuvenation.

A fantasy of rejuvenation

As already discussed, ExtraCare caters to a very broad spectrum of need – from those who have no apparent care needs to those whose needs are complex. What ExtraCare promises, and indeed its ethos of self-sufficiency and resident volunteering requires, though, is the maintenance of a rough balance across that spectrum. In general terms, the age profile of ExtraCare locations will match the needs of the local community. Ideally about a third of residents in each location will be in receipt of a care package and the rest will manage independently.[9] In practice this varies from one location to another and at different times. Currently, fewer residents are in receipt of care than the target level, although interestingly, the perception of some residents is that numbers on care have increased. As Harry, a resident of another village, put it to us:

But I … well look at the figures Bob [ExtraCare general manager] gave us. There are 386 people here, 15 per cent use scooters, 15 per cent have got care packages. So all the others must be like me. I manage, you manage.

We are not so much concerned in this paper with whether or not these proportions are a true reflection of the composition of ExtraCare communities. What is interesting is the way in which this ideal of rejuvenating the collective becomes a fantasy. Harry's comment is a common narrative across ExtraCare communities, and a manifestation of a more recent policy of giving new residents a realistic picture of the diversity of need that is being catered for and periodically reminding existing residents of that

fact. For Harry, though, a new resident, having been recently widowed and with no obvious care needs, these statistics were important to his feeling satisfied that he had made the right decision to give up his family home. His use of the narrative points to a potential to read it not so much as a reality check, but as a kind of guarantee that that is how things will remain. We take this up first in Bishops Court, another small scheme. The focus group involved three long-standing residents,[10] two women (Joan and Iris) and one man (Roger), who, like those of Mountain View, had maintained an active role in the organisation of social and democratic activities. They were united in their condemnation of the disengagement of others, but also tended to blame what they saw as the indiscrimination of management in taking in new residents. As Roger said: 'They just seem to take them off the street as far as I can see'. This, for Roger, was a dereliction of management's duty to ensure adequate replacement of the frail with the fit.[11] For this group, there was enjoyment in complaining about management's failures. The wheelchair, in this instance, became an object of frequent discussion. Not the self-propelling kind or mobility scooters (often the object of irritation in ExtraCare villages), but the kind that requires a pusher. They described these wheelchairs queuing up in corridors while residents waited to be transported to their destination, and people in wheelchairs being abandoned because of inadequate staff coverage or the failing lift. Frustration arose because health and safety regulations were perceived as prohibiting them from helping out with pushing the wheelchairs, which, ExtraCare management assured us, was not the case. Management was, thus, admonished not only for its failure to adequately rejuvenate the population but also for preventing them, and Roger, in particular, from helping wheelchair users, and, thereby correcting this failure. We do not know their exact health status, but none of our participants appeared to be without health issues. Joan, who, during the focus group we perceived to be the one the others looked to, had recently had serious health issues and now used a walking stick. Iris also confessed to increasing health problems. So, we see here three residents who have been very active organisers in Bishop's Court. We can read their frustration at management and the perceived inflexible health and safety regulation *literally* as a demand to management to do something about altered material conditions. We can read it as an exercise in bolstering the cohesion of their own friendship group. But, we could also read it (psycho-socially) as a fantasy that explains their waning satisfaction and promises its overcoming on the removal of health and safety barriers.

In the case of Hilltop Village, we see a different kind of enjoyment of the fantasy of rejuvenation, one that takes on a far more obvious 'othering' tone. Here we have Donald and Edna, among the original residents of

this established village, who have 'aged in place', and two much younger, newer residents, Diane and Julie. Donald and Edna were vociferous in their complaint at management's failure to rejuvenate the resident population as they had understood to have been promised when they moved in. This complaining came to crowd out the far more upbeat assessment of life in Hilltop Village among the newer residents. Part of the focus group discussion was about whether Hilltop Village should and could accommodate both those living independently and meet the needs of the less independent. There was a stark difference of opinion between, on the one hand, Diane and Julie, who felt that, moving into Hilltop Village had been timely and had given rise to new interests and friendships. They accepted that extra care meant both facilitating independent living and providing care when it is needed. Donald and Edna, on the other hand, felt that the village was being swamped by people in need:

It's all, kind of, mixed up. And, from my point of view, those that have got independent living [and] people that have assisted living or are disabled in some way, and they have a perfect right to be there, absolutely, but it can be very depressing. (Donald)

For Edna, this was not just depressing, but she suggested that too high a proportion of people with needs risked a kind of contagion. Edna talks about her friend, Maureen, who she believes to have been tainted in this way:

That's what's happening to Maureen … And that's what happens. You see … Definitely right, that is. Because she comes and sees all them round us, with sticks or whatever and she says, 'Well, I'm 80, I'm one of them now'. But she's not. It's in here because it's all around us. Everybody is talking about what they've got, she imagines. Today, 'I think I've got an ulcer coming', only because she's *seen* them.

In this focus group, the mobility scooter became the object of frustration. In Donald's and Edna's views, there were too many of them and they were unnecessary. Their use to make the journey from apartment to village easier signalled, for them, that residents had capitulated too readily to corporeal ageing.

In the case of Hilltop Village, this negative view about the failure of rejuvenation is not exhaustive; there is a positive view of life there too. Diane, one of the newer residents, explained:

It took me a good six to eight months [to settle in] and in the meantime I met Julie. She came in about a month after me, we've been good friends since. It's the best thing ever.

In the case of Mountain View, a wave of praise came at the end of an hour-long focus group which otherwise consisted of nothing but complaint. Joan, in particular, was keen to point out how much support she had had in caring for her now deceased husband, Philip:

No, no, it's the best thing we ever did. I came here with my husband. Unfortunately, I lost my husband, but it's the best thing we ever did, because I did get a lot of help with Philip. He suffered with Parkinson's and he needed 24-hour care. I got the care with …, he got the care, he loved it here and was a very *private* man. I thought, he's not gonna like being dressed and washed and bathed, but he was quite happy, *very* happy, but it just … doesn't seem to be the same.

But, rather than characterise the more critical comments as aberrant cases of collective hysteria in an otherwise harmonious life, we argue that these 'islands of over investment' index something important about the way in which identities are negotiated, and how discursive elements become fantasies that are variously enjoyed. We cannot know for sure what animates this enjoyment, since this would require intimate familiarity with the specific discourse of the subject (Lapping 2013; *see also* Frosh 2010) and focus groups, although intense and emotionally charged, can only offer but a cursory insight here. For some, the presence of frailer residents poses no threat to them; for others, though, we might argue that the perception of a failed promise to rejuvenate the collective has become something of a fixation which procures a kind of enjoyment. For some, this provokes shame at their failure to remain the fit, active and non-ageing subjects of the third age, and for some the presence of visibly ageing others risks a general contagion of fourth age frailty and a compulsion to police the boundaries of ExtraCare's public third age space.

Discussion and implications for theory and practice

Our research across 14 ExtraCare communities has shown that there are many ExtraCare residents whose horizons and possibilities have been extended and who are manifestly enjoying (in the sense of ordinary pleasure) a third age life in ExtraCare. In the harsher external world, where the alternatives are often seen as being left to struggle on their own in unsuitable accommodation or becoming dependent on family or residential care, the independence and autonomy that ExtraCare affords is welcome. But, on the other hand, residents 'age in place' in ExtraCare. For some of these, but by no means all, discursive elements that were once experienced as liberating can start to be experienced as constraint and frustration. But, at the same time, there is resistance to slipping out of public third age life and into an imagined fourth age oblivion, be that in a nursing home or within the four walls of one's ExtraCare apartment. Here *enjoyment* of the third age can take on a different tone. Its discursive elements can become fantasies, enjoyed in the modes of self-recrimination, hostility to management or the ostracism of frailer others. We have focused here on residents'

ambivalence, anxieties and complaints about life in ExtraCare, not because we think that is all there is to life in ExtraCare communities. Far from it. ExtraCare is a welcome addition to older people's post-retirement housing and care options. Rather, we have focused on what might be perceived as somewhat more negative views, because, following Alemán, we feel that to dismiss them would be a form of ageism and would miss an opportunity to understand how older people fare in the current climate of active, positive and healthy ageing.

Now, it may be objected that this mode of theorising and analysis is itself ageist and patronising in its failure to acknowledge the material foundations of residents' complaints. We are not, however, suggesting that complaints have no basis in material facts. We have, indeed, observed how ExtraCare has been challenged by austerity and a rapidly changing policy environment, and we do not doubt that these material conditions can be the triggers to the complaining we have commented upon throughout the paper. Residents' complaining narratives could also be read as a mechanism for co-creating and bolstering the identity of a collective in a more straightforwardly sociological sense. We are not suggesting that either of these readings would be incorrect, but we are arguing that there is an over-invested quality in these complaints that ought to alert us to a certain *enjoyment* in complaining that goes beyond simply imparting knowledge about changed material conditions or the inter-subjective construction of group identity. Moreover, thinking about complaining in psycho-analytic terms of enjoyment lends a firm theoretical basis to the intuition of critical gerontologists that current socio-cultural and policy discourses of later life are ill-suited to later-life experience (*see e.g.* Biggs *et al.* 2006; Grenier 2012; Holstein and Minkler 2007). It enables us to name the fantasies to which the discourse of the third age gives rise and to pinpoint the modes of enjoyment they procure for liminal subjects who find themselves betwixt and between the third and fourth ages. This has certain practical implications to which we now turn.

Supporting liminal residents

What we have been trying to show through this brief survey of the ways in which residents come to identify with ExtraCare is that there are alternative ways of listening to residents' complaints. These are not simply complaints to be countered with 'the facts of the matter', nor just demands for improved services and activities. They are also manifestations of difficult subjective transitions, which require other kinds of support: support to build new relationships that do not revolve around scheduled and goal-oriented activities (Molly and Joy); support in coming to terms with

altered capacities (Roger, Joan, Iris, Donald and Edna); or the death of loved ones (in Joan's case, for example, her perception of life going downhill at Mountain View seems to coincide almost exactly with the death of her husband); or simply, perhaps, permission to be less responsible for keeping the show on the road (Sally and May).[12] Listening in this way also has implications for how wellbeing is understood. ExtraCare has a deep and long-held concern for residents' wellbeing, and offers all kinds of support for the prevention of frailty and cognitive decline, but perhaps there is scope to broaden the remit of these to take greater account of emotional wellbeing, enabling residents to process anxieties, fears and losses. Again, there is variability here. Some locations do have an appreciation of wellbeing as more than just physical and cognitive health, in others the latter facets of wellbeing are, perhaps, over-emphasised. We suggest that what is required is not necessarily more intensive inputs from staff, but simply more active listening and the facilitation of peer-to-peer support. We are by no means suggesting that tensions can be entirely eliminated from community life, nor, from a post-structuralist discourse theoretic perspective, would we consider that an appropriate aim. We do, however, want to suggest that there is a need to listen differently, and to respond differently, to the complaints of liminal residents, a cohort that can only grow in importance as residents age in place within these kinds of environment. We see possibilities in some of the practices that are already evident in some of ExtraCare's communities. Where the discourse of the third age covers the entire ground, however, we would argue that for those on the margins of the third age, who are dependent on the public space of ExtraCare for their social being and for whom the fourth age Real is all too proximate, enjoyment in the third age is likely to mean far more than just ordinary pleasure.

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wellbeing advisor (nurse), carers or family, researchers contacted interested residents by telephone to discuss the study and arrange a meeting. Interviews were undertaken with new residents only, whereas focus groups were open to any resident who wished to take part. Focus groups were held in a room within the village or scheme. Interviews were held at the participant's place of residence. The focus groups took approximately one and a half hours, including 15 minutes for introductions, participants' questions and consent. Volunteers were informed that they were welcome to ask for a break at any point and that they were free to withdraw at any point during or between visits. Reasons for withdrawal were recorded where available, but ethical procedures stipulated that people were free to withdraw without giving a reason. All focus groups were carried out by at least two researchers.

NOTES

1 The research was commissioned and funded by the ExtraCare Charitable Trust and we are most grateful to them for their generous support and to the residents who generously participated in the study.
2 ExtraCare carries out annual care satisfaction surveys, the most recent of which was conducted in 2015 (ExtraCare Charitable Trust Quality Team 2015).
3 Locksmith is a term taken from the Enriched Opportunities Programme designed to care for people with dementia. Locksmith refers to the possibility of unlocking the potential for wellbeing in individuals with dementia (*see e.g.* Brooker and Woolley 2007).
4 Here we understand problems in a Foucauldian sense of puzzles or issues in need of problematisation (*see* Glynos and Howarth 2007).
5 The meaning of the Real in Lacan's work is a keenly debated topic, but interestingly for our purposes, Chiesa (2007) refers to it as 'the undead'.
6 Translated from the French *jouissance*, the term enjoyment is misleading since it really is not about ordinary pleasure, but about injurious and painful repetition. For a discussion of the insufficiency of its translation into English, *see* Fink (1997).
7 All ExtraCare sites and residents have been given pseudonyms to preserve anonymity and some details have been changed.
8 Janet was much younger than the other residents and because of a speech difficulty we were not able to transcribe her contribution to the focus group.
9 Personal communication from ExtraCare senior manager.
10 Length of residency ranged from 6 to 12 years.
11 We encountered this in other ExtraCare communities too in the frequent scanning on the part of residents of communities for the 'correct proportions' of the fit and the frail.
12 *See also* Glynos *et al.* (2014) for a fuller discussion of these points.

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