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Q1 The need for a social revolution in residential care

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A B S T R A C T

Loneliness and depression are serious mental health concerns across the spectrum of residential 21
 care, from nursing homes to assisted living and retirement living. Psychosocial care provided to 22
 residents to address these concerns is typically based on a long-standing tradition of 'light' social 23
 events, such as games, trips, and social gatherings, planned and implemented by staff. Although 24
 these activities provide enjoyment for some, loneliness and depression persist and the lack of 25
 resident input perpetuates the stereotype and stigma associated with residents as passive 26
 recipients of care. Social calendars are filled with these events while residents continue to report 27
 lack of meaning and influence in their lives, limited opportunities for contribution and frustration 28
 with paternalistic communication styles. Those living with dementia face additional discrimination 29
 resulting in a range of unmet needs including powerlessness and lack of belonging—both of which 30
 are associated with interpersonal violence. Research suggests however that programs fostering 31
 engagement and peer support provide opportunities for residents to be socially productive and to 32
 develop a valued social identity. The purpose of this paper is to provide a re-conceptualization of 33
 current practices. Using social identity theory as a foundation, we argue that residents represent a 34
 largely untapped resource in our attempts to advance the quality of psychosocial care. We propose 35
 an overturning of the current activity practice that focuses on entertainment and distraction, to one 36
 that centers on resident contributions and peer support. We offer a model—Resident Engagement 37
 and Peer Support (REAP)—for designing interventions that advance residents' social identity, 38
 enhance reciprocal relationships and increase social productivity. This model has the potential to 39
 revolutionize current psychosocial practice from resident care to resident engagement. 40

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Introduction

Q5

Vera is an 82-year widow living with early-stage dementia, 50
 newly admitted to residential care home. Until her diagnosis, 51
 five years previous, she loved volunteering and playing violin 52
 in her community orchestra. Now, no longer able to play her 53
 violin, Vera spends her time alone listening to classical music 54
 on the radio. She has little interest in the activities provided, is 55
 not able to find a way to continue volunteering, and is having 56

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57 difficulty connecting with others. During an interview, Vera
58 shared her loneliness and sense of loss at how her life has
59 changed—from doing so much to doing so little. Asked how she
60 is adjusting to living at the home, Vera responded: “I think my
61 room is at the end of the world.” (Theurer et al., 2012). We will
62 return to Vera towards the end of the article.

63 Vera's failure to find meaningful connections exemplifies
64 growing concerns about the critical rates of loneliness in resi-
65 dential care (Brownie & Horstmanshof, 2011; Prieto-Flores
66 et al., 2011; Bekhet & Zauszniewski, 2012). Residential care is
67 defined as congregate living with various levels of support
68 including long-term care or nursing homes as well as assisted
69 and retirement living (Schafer, 2014), and loneliness is present
70 across this spectrum of care. A study of residential care homes
71 in northern Sweden and western Finland revealed that 55% of
72 residents in care homes experienced loneliness (Nygqvist et al.,
73 2013). Assisted living residents are at high risk for loneliness and
74 social isolation (Tremethick, 2001), and a descriptive compara-
75 tive study examining loneliness in elders living in retirement
76 homes found that among the total sample (N = 314), nearly 29%
77 (n = 91) reported feeling lonely (Bekhet & Zauszniewski, 2012).
78 Loneliness is linked with depression (Bekhet & Zauszniewski,
79 2012; Heikkinen & Kauppinen, 2004; Cacioppo et al., 2006;
80 Hagan et al., 2014) and impaired mental health among older
81 persons (Wilson et al., 2007). Indeed, longitudinal studies of
82 loneliness and depression suggest that they are associated
83 yet separate constructs which have a reciprocal relationship
84 (Cacioppo et al., 2006; Barg et al., 2006).

85 Although most residential settings provide programming
86 such as social gatherings designed to address psychosocial
87 needs (Ice, 2002; Knight & Mellor, 2007; McCann, 2013; Evans,
88 2009), there is little evidence for the effectiveness of these
89 programs to remediate loneliness (Victor, 2012) and interven-
90 tions for depression which simply increase social interaction,
91 have produced mixed results (Cruwys et al., 2014a). Those
92 living with dementia have trouble making connections due to
93 increased difficulties in communication (Alzheimer Disease
94 International, 2013) and those without cognitive impairment
95 can also have difficulties connecting socially without support
96 (Cipriani et al., 2006). This paper investigates the troubling
97 underpinnings of the social environment fostered in residential
98 care. The main aims of the article are three-fold: (1) to explore
99 the need for change in current psychosocial approaches and
100 examine the impact of these approaches on residents' identity
101 and well-being; (2) to examine the potential of using social
102 identity theory, social productivity and peer support to enhance
103 our understanding; and (3) to offer a re-conceptualization of
104 the role of psychosocial care and a revolutionary model for
105 designing interventions to advance residents' social identity,
106 enhance reciprocal relationships and increase social produc-
107 tivity and well-being.

108 Exploring the need for change in psychosocial care

109 The need for change in psychosocial care within residential
110 settings is long-standing as reports of loneliness and depression
111 in residential care have not improved in over 50 years. In the
112 late 1950s and early 1960s, Townsend (1962) conducted an
113 extensive survey of residential institutions and homes for the
114 aged in England and Wales. He described a variety of negative
115 effects associated with institutional relocation including loss

of occupation, isolation from family, friends and community,
tenuousness of new relationships, loneliness, loss of privacy
and identity and the collapse of self-determination. The same
concerns and issues are still prevalent today and in some ways
have become compounded and magnified within institution-
alized settings with the increasing frailty and chronic health
conditions of residents (Baumbusch, 2008). Residents report
frustration around their lack of influence and independence
(O'Dwyer, 2013; Timonen & O'Dwyer, 2009), and paternalistic
communication styles among staff (Baur & Abma, 2011).

126 We are proposing that conditions for a social revolution
127 continue to grow in response to the psychosocial care provided
128 in residential settings. A social revolution has been described as
129 'a dramatic and wide-reaching change in the way something
130 works or is organized or in people's ideas about it' (Revolution,
131 2015). A social revolution is a change process that can happen
132 on different levels (Duthel, 2008), such as the contributions
133 from many innovators within the current culture change move-
134 ment in the United States that seek to improve quality of life
135 in elder care (Weiner & Ronch, 2003). By social revolution in
136 residential care we mean adopting a different approach through
137 an overturning of the long-standing tradition of psychosocial
138 care that is centered on superficial social programming—a move
139 from providing 'recreation' to providing opportunities for emo-
140 tional and meaningful social engagement. A social revolution in
141 residential care could be akin to the civil rights movement in
142 mental health which rejected the basic premise of traditional
143 care within the medical model, seeing it as a broken system
144 that fosters stigma and discrimination (Adame & Leitner, 2008).
145 The need for a social revolution is a response to the pervasive
146 influence of this deeply entrenched tradition, the biomedical
147 focus (Doyle & Rubinstein, 2013) and its impact on the
148 residents' social identity (Shulman, 2014; Ferrand, Martinet,
149 & Durmaz, 2014).

150 Current approaches to psychosocial care

151 Current psychosocial programming provided in residential
152 settings is a concern for a number of reasons. Many disciplines
153 are involved informally in socially supportive care, but thera-
154 peutic recreation is specifically mandated to maintain or im-
155 prove physical and mental health status, functional capabilities
156 and psychosocial quality of life (Leitner & Leitner, 2011). In
157 the United States the Centers for Medicare and Medicaid
158 Services include recreational therapy in the mix of treatment
159 and rehabilitation services mandated for skilled nursing and
160 residential care facilities (American Therapeutic Recreation
161 Association, 2009). However due to a combination of heavy
162 workloads for staff (Knight & Mellor, 2007), pervasive ste-
163 reotyping (Sherwin & Winsby, 2011), and the complex health
164 conditions of residents (Alzheimer Disease International, 2013)
165 recreation programming is frequently inappropriate or inac-
166 cessible and activity participation rates are low. For example,
167 a study in the United States found that 45% of residents with
168 dementia participated in few or no activities, 20% participated
169 occasionally and 12% attended activities that were inappro-
170 priate to their functioning levels or incongruent with their
171 interests (Buettner & Fitzsimmons, 2003). Another study found
172 that aside from time spent receiving care, residents spent only
173 2 min within a six-hour period interacting with other residents
174 or staff.

Residents are provided a variety of social programs (Knight & Mellor, 2007), but typically these programs are planned and implemented using a 'task-oriented' scheduled approach (Katz, 2000), without input from residents. An analogy has been made between living in residential care and flying in an airplane, with comparable restrictions, mandatory use of restraints, regulation and lack of choice (Andrews et al., 2005). A similar analogy that speaks to steady diet of light social events typically provided is the 'cruise ship living' approach to programming (McCann, 2013). Cruise ship living in residential care is based on being entertained and chore-free—somewhat like a continuous vacation, but according to McCann (2013), it lacks opportunities for, and hinders, meaningful connections and personal growth. Indeed, residents complain of lack of meaning (Knight & Mellor, 2007; Choi, Ransom, & Wyllie, 2008) and limited opportunities for reciprocity (Rash, 2007) or contribution (Van Malderen, Mets, & Gorus, 2013).

In this paper, we use "institutionalized recreation" as a term to describe the formally administered approach to psychosocial programming in residential care that, while providing elements of enjoyment for some, underscores the marginalization and stigma associated with residents. In this approach activities are rigidly scheduled (Wiersma & Dupuis, 2010) and are often intended to entertain and distract, rather than foster meaningful connections or engagement (Timonen & O'Dwyer, 2009). The issue is critical and not unique to nursing homes. Similar concerns regarding recreational programs are found throughout senior living. In an ethnographic study within an adult day program in Australia older adults expressed objections to the social programs stating that the activities were "childlike" (Tse & Howie, 2005). Katz (2000) examined activities in an independent retirement community in the United States where residents objected to what they described as the rigidity of recreation programming and the patronizing approach to its provision.

The focus on distraction and entertainment is complicated by the concept that in order to keep residents 'functional' they need to be kept busy (Katz, 2000) and that requires non-stop activity programming. According to Katz (2000) having too many activities every day can mask an emptiness of meaning. Staff feel pressured to show evidence of activity attendance, furthering the notion that simply being at an activity promotes better quality of life. In a thirteen-month-long ethnographic study Henderson (1995) described the inability of the nursing home staff to visualize life through the residents' eyes:

...activities were undertaken, but they were of the simplest kind and were accompanied by the attitude that a mere charade was sufficient. It was in the psychosocial care domain that there was the greatest staff blindness to what quality of life in long term care should and could be.

[Henderson (1995), p. 38]

A task-oriented approach provides a smoke screen for what is really needed, which is a space where residents can speak and be heard (Nouwen & Gaffney, 1976). The need for substantial change of the culture within these settings is clear (Bowers, 2011). According to Nouwen and Gaffney (1976), providing older people entertainment and distractions avoids the painful realization that most do not want to be entertained, but rather sustained with hope and purpose.

Psychosocial care for those living with dementia

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Dementia is increasingly prevalent throughout the residential care spectrum (Alzheimer Disease International, 2013) and these residents in particular face additional discrimination which may contribute to erosion of their identities (Kelly & Innes, 2012). Residents with dementia are typically cast as passive recipients of care (Bartlett & O'Connor, 2010) because their ability to understand information, communicate and independently participate in typical social activities deteriorates over time (Alzheimer Disease International, 2013). Pre-existing social and cultural influences and expectations have an impact on residents over time, as many become accustomed and resigned to maintaining a passive role and keeping their social interactions superficial (Knight & Mellor, 2007), and this is especially significant for those with dementia.

Those residents living with advanced dementia who display aggressive behaviors are often treated inappropriately with antipsychotics (Coon et al., 2014). Treating these behaviors with chemical or physical restraints is regarded as an indicator of poor quality of care and the use of antipsychotics is controversial (Konetzka et al., 2014). Although some forms of physical restraints for responsive behaviors have been reduced, antipsychotic use has increased (Konetzka et al., 2014). All behaviors have meaning and aggressive behaviors have been reframed as responsive as they are not unpredictable or meaningless (Ontario Behavioural Support System Project Team, 2010) but rather a response to something frustrating or confusing and a fundamental struggle for identity (Behuniak, 2010; May, 1973). Kontos (2011) emphasizes the need to identify responses as meaningful self-expressions rather than aberrant behavior in need of restraint. She advanced the concept of *embodied selfhood*, the idea that bodily habits, gestures and actions are a means used by those with advanced dementia as a source of self for social engagement (Kontos & Martin, 2013). Thus there are inherent difficulties in using antipsychotic drugs for treatment of behavioral responses and depression. Furthermore research suggests that such drugs are ineffective and in some cases harmful for those with dementia (Coon et al., 2014; Kirshner, 2011).

Lack of control, loneliness and responsive behaviors

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One of the barriers to finding solutions to responsive behaviors is a tendency to understand them as a single discrete episode rather than a series of actions embedded within a complex social milieu (Pillemer et al., 2011). Behavioral responses such as repetitive verbalizations, physically hitting out and pacing may be a response to unmet needs rather than a symptom of the disease itself (Zeisel, 2009; Cohen-Mansfield, 2013). Depression, for example, has been linked to behavioral responses among those living with dementia (Canadian Institute for Health Information, 2010). However, addressing both depression and loneliness becomes increasingly difficult in the later stages of dementia, as these constructs become more challenging to assess and treat (Snowden, 2010).

Two key factors that influence responsive behaviors have been identified: lack of control and loneliness (Catanese & Tice, 2005; Gardner, Pickett, & Knowles, 2005; Twenge, 2005). Behuniak (2010) suggests that lack of control engenders a sense of powerlessness and argues that those with dementia

are especially vulnerable. According to Behuniak (2010), as individuals lose their cognitive and physical abilities their sense of self is eroded leaving them powerless, often with the inability to act autonomously or effectively communicate their needs. It can be argued that behavioral responses stem from a fundamental struggle for the power to be an included and influential member of their community. Loneliness or unmet belonging needs is linked with numerous negative consequences, including interpersonal violence (Gardner et al., 2005; Talerico, Evans, & Strumpf, 2002), however even simple positive social interactions can be enough to reduce aggressive responses (Twenge, 2005).

Diminishing social interactions, including the inability to communicate needs, is often of a direct result of the stereotyping and the ways the person with dementia is negatively positioned and treated by family and staff rather than a symptom of the disease itself (Zeisel, 2009; Scholl & Sabat, 2008). This negative positioning often results in misinterpretations of behaviors and dysfunctional social treatment (Scholl & Sabat, 2008). According to Scholl and Sabat (2008), stereotyping also fosters excess disability which can be heightened by anxiety in social settings.

From resident care to resident engagement

According to Alzheimer Disease International (2013), key standards of care for those living in residential care are not being met. These standards include enabling residents to have control, have a voice, maintain and develop relationships, and contribute to society. A conceptual shift from resident care to resident engagement is supported by a movement towards 'culture change' that speaks to the quality of life in residential care and the need to rethink values, assumptions and practices currently in place (Brownie & Nancarrow, 2013; Canadian Healthcare Association, 2009; Canadian Institute for Health Information, 2013; Kane, 2001, 2010; Koren, 2010). Shura, Siders, and Dannefer (2010) argues however that some culture change modifications still come from the 'outside-in and the top-down', rather than with involvement from residents. In gerontology there is a growing interest in productive activity to counteract the stereotype of the frail older adult as an unproductive member of society. Here, we focus on social productivity or contribution, as one of the aspects most threatened by aging, especially for those who are relocated to a residential care setting.

Enhancing social identity through social productivity and peer support

Social productivity is conceptualized by Siegrist, von dem Knesebeck, and Pollack (2004) as an "interpersonal social exchange based on the principle of reciprocity." Being productive has a positive effect on resilience, health and well-being (Jung et al., 2010; Jetten, Haslam, & Haslam, 2012; Schwartz, 2007; Kim & Ferraro, 2014), and loneliness and depression in particular (Cruwys et al., 2014a). Peer support is a form of social productivity and is an emerging movement that is gaining attention in aging policy (Mental Health Commission of Canada, 2012a,b) reflecting a shift from 'advice from on high to support from next door' ((Department of Health, 2004 p. 103)). Peer support (i.e. helping others) is an example of a

socially productive contribution that fosters social identity (Finn, Bishop, & Sparrow, 2007).

We are proposing social productivity and peer support as pillars of a social revolution—mainstays that are increasingly recognized as having a pivotal role in helping those in residential care to live well (Keyes et al., 2014; Yeung, Kwok, & Chung, 2012; Snyder, Jenkins, & Joosten, 2007; Roberts & Silverio, 2009). Residents with and without dementia are capable of being socially productive in their communities and of helping and supporting their peers when supports are in place (Skrajner et al., 2014; Theurer & Wister, 2010). Increasing attention is being paid to the role social relationships play in well-being of people with dementia (Morhardt & Spira, 2013) and there is a growing literature on the friendships they develop (de Medeiros et al., 2011; Harris, 2011; Sabat & Lee, 2011). Friendships play a key role in social connectiveness and some residents are able to maintain long-term friendships in the early stages of dementia (Harris, 2011). Sabat and Lee (2011) point out that there is a danger of positioning those living with dementia as incapable of developing relationships with others on their own. The decreases in social interactions have been attributed more to the social dynamics involving staff and family than to dementia (Sabat & Lee, 2011). However, the concept of facilitated friendships through staff has also been proposed that acknowledges a potentially important role that staff can play in enabling peer support (Ward et al., 2011). Indeed, Ward et al. (2011) highlight the importance of friendship facilitation in producing a collective agency with those living with dementia.

Social identity refers to how we see ourselves in relation to others by what we have in common, and social identity theory posits that an individual's sense of self is created through participation as a member of relevant social groups (Haslam, 2014). Once an individual has developed a sense of social identity within a group, that person will go out of their way to 'advance' the group, that is, care for its members and keep it positive and sustainable. Research indicates that empathy-induced altruism may provide the motivation behind helping behaviors (de Waal, 2008). This results in strong emotional bonds even for those who have diminished cognitive abilities. Thus peer support has a positive social effect rooted in identification with others who share a common experience (Keyes et al., 2014). For example, people with mild to moderate dementia participating in peer support groups report positive socialization and an improved ability to cope with symptoms (Snyder, Jenkins, & Joosten, 2007). This may reflect Post (1995) construct of moral solidarity—striving for the common good—which aims at mutual reliance as an antidote to being cared for in a manner that oppresses autonomy. Moral solidarity highlights the importance of *being with* rather than *doing to* in reducing excess disability (Post, 1995). A sense of shared identity is developed through these social interactions, for example, through an exchange of viewpoints about a topic of concern (Postmes, Haslam, & Swaab, 2005) or sharing experiences of personal loss, challenges and success.

As depicted in Fig. 1, research suggests that peer support provides opportunities to be socially productive by actively helping others and through these actions develop a valued social identity (Finn, Bishop, & Sparrow, 2009). Having a sense of shared social identity with others and being productive has positive consequences for mental health (Jung et al., 2010), and

Peer Support → Social Productivity → Valued Social Identity → Improved Mental Health

Fig. 1. The development of social identity through peer support and productivity.
Adapted from Finn (Finn et al., 2009)

a positive impact on loneliness and depression (Cruwys et al., 2014b). For example, an intergenerational, therapeutic gardening program in a care home in Australia found that helping children led to decreased depression and agitation and improved quality of life scores among residents (McDonnell & Merl, n.d.). Peer support and productivity can be used to create a sense of shared identity, which can be the foundation for change in residential care.

Social identity theory predicts certain behaviors based not only on a sense of self as an individual but also as a member of a social group (Tajfel & Turner, 1979). The large body of research informed by this theory focuses primarily on the nature of the mind, intergroup relations and conflict (Haslam, 2014). The social identity approach (SIA) however, incorporates both the social identity theory and self-categorization theory (Turner et al., 1994, 1987). Self-categorization theory is described as a distinctive process in which group members see themselves less as individuals and more as a prototype or an example of their 'in-group'. SIA has become a dominant social-psychological model and is well-established as an approach to enhance social and psychological functioning, but it is seldom used in residential care practice (Haslam et al., 2010). SIA has potential to provide psychological benefits or 'resources' for the needs that residents have, such as support, influence, meaning and belongingness (Jetten et al., 2012). Loneliness and depression can be understood as conditions that result from the lack of these social identity resources (Cruwys et al., 2014a).

According to SIA, individuals develop an awareness that they belong to a particular social group through a comparison process, finding either perceived similarities or differences between themselves and others in the group (Haslam et al., 2009). This awareness happens over time and triggers a process that produces behaviors in which individuals favor in-group versus out-group members, along with associated values, empathy, emotional significance and a sense of shared identity (e.g., a self-definition as 'us' as club members over 'I' and 'me' as an individual). SIA highlights the benefits of increased identification with others (Postmes et al., 2005) leading to potential opportunities of increased social responsibility shared within a group whereby group members look out for one another (Evans, 2009).

Research exploring identity has advanced our understanding of the social culture of institutional care. Social identity is multifaceted as individuals simultaneously self-categorize themselves into multiple groups (Schmid et al., 2009). Furthermore, the social identity of people with dementia varies considerably depending on various factors. Among younger individuals, identity within the workforce, as a family member and a social and sexual being may be more salient (Harris & Keady, 2009). According to Cheston (1998), those living with dementia have psychological and emotional needs resulting from the social consequences of the loss of identity (Cheston, 1998). Basting (2003) however argues that identity is not tied to memory alone and that those with dementia retain an identity despite the progression of the disease. Identity exists in a social context and is shaped by culture and interactions with others.

An ethnographic study within an institutional setting revealed that residents and staff produced shared meanings within the social structural and cultural contexts, and that the *culture of self* was connected to one's perceived usefulness in society (Hubbard, Tester, & Downs, 2003).

Cruwys et al. (2014b) outline three key premises that form the foundations of SIA which we will apply to individuals in residential care. First, social relationships restructure an individual's self-concept and influence their behavior. For example, when a resident participates in an emotionally supportive group they develop a sense of belonging and the group provides an ongoing basis for social identification (e.g., I am a member of the group). This social identity helps give people a place in the community and a sense of purpose. Second, the subjective experience of belonging structures an individual's self-concept and social behavior. When the group, and especially individual group members, matter to them and the feeling is reciprocal, it results in a higher sense self-esteem and behaviors that support the well-being of the individual and of the group as a whole. Third, social identification is a fluid process that is enhanced by accessibility (e.g., having support to regularly attend groups and participate actively), and fit (e.g., having a sense of fitting in and having strong ties with other members). Thus, social identification is not an end point, but rather a process that can be influenced and strengthened over time. Furthermore, social identity is a matter of degree such that a person can have more or less of it and contributing has considerable potential to increase a sense of shared social identity (Haslam, 2014).

Research indicates that with support residents living with dementia are capable of contributing to programs—even facilitating group programs themselves (Skrajner et al., 2014). In another example, a study of mutual support groups in Canadian residential care homes found that as more residents took on supportive roles within the group the ability to be of help elsewhere in their home (i.e. outside of the support group) was strengthened (Theurer et al., 2012). According to Cohen-Mansfield (2013), the needs of residents with more advanced dementia can vary daily and therefore interventions are best individually tailored and adapted as the need arises.

Based on this approach we propose that engaging and contributing within a peer group that holds meaning is likely to strengthen social identity and well-being. The focus on groups arises from systematic reviews suggesting that supportive interventions implemented at a group level are more likely to be effective in alleviating social isolation and loneliness than one-to-one interventions (Hagan et al., 2014; Haslam et al., 2010; Masi et al., 2011; Cattan, White, Bond, & Leamouth, 2005). Cattan et al. (2005) suggest that a crucial ingredient in effective interventions that target loneliness is the connectedness (i.e., social identity) that evolves in groups.

A new psychosocial care model in residential care 516

In keeping with the social identity approach we are proposing a model called Resident Engagement and Peer 517 518

Support (REAP) for designing and developing group psychosocial interventions within residential care (see Fig. 2). This model depicts three sequential processes which have potential to reorganize institutional recreation practices. The first process is to assess and clarify what forms of group participation are meaningful for each resident. If that includes continued participation in programs already being provided within the home then ongoing involvement is facilitated/supported. This may also involve examining how residents can actively engage (or re-engage) in the group(s), as well as how they might contribute to them. The second process is to explore participation in extant groups that foster relationships and help promote valued shared identities for the resident or to explore the development of new groups that fulfill that function. The third process is to investigate the development of and participation in groups or membership clubs which focus on being of service and helping others.

This model offers options for developing new programs by and for residents based on what is meaningful to *them* thus replacing the common practice of fitting residents into existing programs. The processes involved may occur during the admission and/or assessment processes individually or in focused group planning sessions with residents, including resident councils. As depicted in Fig. 1, staff help to identify existing or potential groups that are meaningful and also to explore what contributions residents can make (e.g., participating in planning, set-up, facilitation). In addition, as seen in the second and third columns, staff collaborate with the residents on the development of groups that foster relationships (especially peer support groups of their choice), and on groups/clubs that offer opportunities to help or contribute. It is recognized here that not all residents are comfortable joining groups, however they can be encouraged to consider other options such as helping with the functioning of a group. Once personal relationships develop it is easier to sustain active participation in a group.

We return to Vera to illustrate the hypothetical application of this model in practice. The staff and Vera (as a newly admitted resident), work together to explore how she might become engaged in her new community. They consider which community groups she has participated in previously and

whether there are any similar groups in the home that might provide a sense of comfort and security to help her develop new connections. An obvious choice would be existing music groups that appeal to her, but the key aim is that that she develops meaningful social relationships with her peers in whatever group(s) she chooses. Once involved, Vera can share her experiences and group members can empathize with and support her, and eventually she can empathize with and support others as well. These emotional bonds become the foundation of Vera's engagement with her new community, strengthen her sense of connectedness and social identity, help her cope with the losses and changes she is experiencing and provide comfort and inspiration for her to engage in other activities.

For those living with more advanced dementia an adapted REAP model applies. Group interventions are set up on a smaller scale (3–4 residents) and are designed to foster a sense of shared social identity. Residents with dementia provide distinct cues that indicate their preferences (Sabat & Lee, 2011; Power, 2010) and staff sensitivity to these cues can help prevent them from being overlooked (Sherwin & Winsby, 2011). So although these residents may not be able to participate in sharing or helping the way that Vera could, there are creative alternatives that can help them contribute. Examples might include inviting residents to participate in a peer support group even though they may not be able to share in typical ways. Research indicates that participants with advanced dementia do track conversations that have an emotional component even if they are not able to verbally participate (Theurer et al., 2012). With help residents with advanced dementia can connect with their fellow residents through a simple handshake or a hug, or inviting them to help push an activity cart to bring a cup of tea and a hug to a co-resident socially isolated in their room. These are all feasible actions that exemplify a shift in focus from passivity to social productivity and peer support. This approach facilitates simple positive interactions between peers, making it possible to explore what is meaningful and enjoyable to residents while remaining alert for indicators of preferences and giving them as much control as possible (Zeisel, 2009; Knight, Haslam, & Haslam, 2010). Providing opportunities for residents with advanced dementia to support and help one another can be an ongoing

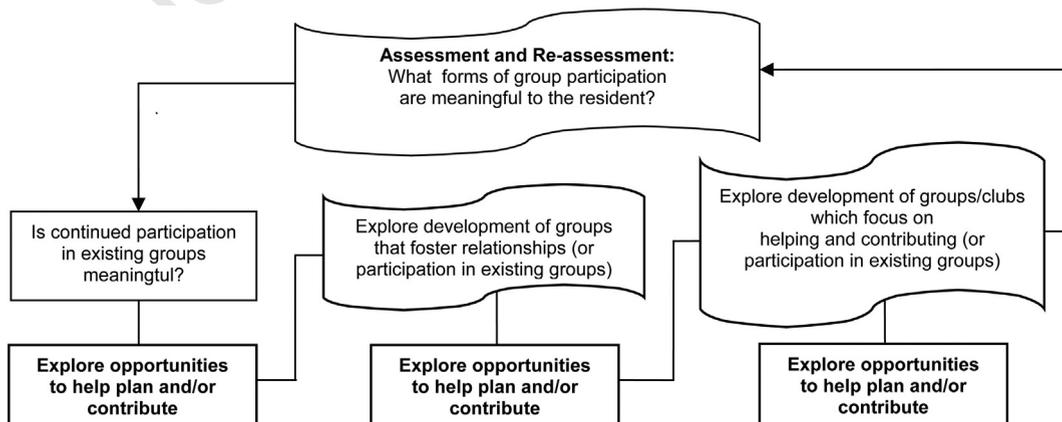


Fig. 2. Resident engagement and peer support (REAP): a model for enhancing meaningful engagement and contributions of those living in residential care.

601 intervention and preventative treatment to address unmet
602 needs (Cohen-Mansfield, 2013).

603 Conclusion

604 Despite advances in policy and programs loneliness and
605 depression in residential care remain critical problems,
606 highlighting the need for change. Contributing to the problem
607 is what Kitwood (1997) calls a 'malignant social psychology' in
608 our society—a social positioning that results in a loss of status
609 for those with compromised function or cognitive capacity.
610 As well, in planning and implementing programs with effi-
611 ciency and safety, staff over-protect and resist attempts at self-
612 direction from residents (Ruggiano, 2012). What the REAP
613 model offers is a foundation for a fundamental change in a way
614 of thinking about psychosocial care, with residents at the
615 center of the process.

616 Those seeking to incorporate social identity, productivity
617 and peer support principles within an institutional environ-
618 ment will likely confront obstacles (Haslam, 2014). Literature
619 indicates that due to apprehension about potential liability
620 associated with autonomy, administrators tend to focus on
621 safety (Kapp, 2012). Health professionals may be slow to
622 endorse the REAP model as an approach to reducing loneliness
623 and depression as it deviates from the still dominant biomed-
624 ical approach that focuses on task completion and body care
625 (Doyle & Rubinstein, 2013). In an ethnographic study in a
626 United States dementia care setting, Doyle and Rubinstein
627 (2013) revealed that despite training, the traditional biomed-
628 ical focus and the cultural process of 'othering', (classifying
629 those that are different in a negative way), prevented staff
630 from providing more holistic and individualized care. New
631 programs can be challenging for staff to implement for those
632 with memory impairment (Alzheimer Disease International,
633 2013) as in practice, staffing levels and staff competence with
634 non-pharmacological alternatives, ethical concerns and the
635 wishes of distressed family make implementation of alterna-
636 tives difficult (Coon et al., 2014). Residents themselves may
637 find it challenging to tolerate and embrace diversity and
638 dissent among their peers (Abrams & Hogg, 2004). Other
639 barriers have been identified by Stone and Bryant (2012) that
640 include lack of dedicated educational funding, low wages, and
641 difficult and demanding work, all of which limit the incentive
642 for change.

643 Based on a growing body of literature on resident en-
644 gagement and peer support we believe that despite these
645 challenges, the REAP model can be successfully adopted in
646 residential settings. The model lays the groundwork for
647 additional research that examines the effectiveness of this
648 approach, beginning with a systematic exploration of the
649 processes and associated barriers involved, challenges staff
650 would face with licensing and organizational requirements, as
651 well as the inevitable resistance to change (Cohen-Mansfield
652 et al., 2012). If implementation of the model proves to be
653 effective at reducing loneliness and depression it will have
654 important policy implications. An example of this would be
655 integrating culture change ideals into policy decisions, such
656 as standardizing peer support as a mandated program within
657 residential care. The REAP model focuses on residents as
658 experts of their everyday experience and engaging them in
659 reform and change processes, and this is one of the central

660 goals of culture change (O'Dwyer, 2013). New policies and
661 programs surrounding this model will need to be investigated
662 and education modules developed and tested.

663 Viewing the ongoing issue of loneliness and depression
664 through the lens of the social identity approach can reform
665 institutionalized recreation and provide a new social order
666 to help address the fundamental needs of those in residential
667 care. We offer the social identity approach as a way to re-
668 conceptualize our understanding of psychosocial care in
669 residential settings and propose the REAP model to revolutionize
670 current practice. We have argued that institutionalized recrea-
671 tion is inadequate and contributes to the problems of loneliness
672 and depression in residential settings. Using the social identity
673 approach helps us to appreciate the importance of designing
674 interventions in residential care to effectively develop and
675 manage social identity resources. It encompasses a fundamental
676 and radical shift for staff in two ways. First, it provides a new
677 understanding through which staff can view their role and
678 the role of the residents. This understanding has potential
679 to motivate them to use the REAP model in determining and
680 developing appropriate activities that engage residents and
681 improve psychosocial care and quality of life. Second, it signifies
682 a shift from providing calendars dominated by light social events
683 to collaborating with residents on the development of group
684 programs that provide meaning and strengthen shared identi-
685 ties as well as opportunities for contribution.

686 As a model, REAP represents a promising re-conceptualiza-
687 tion of psychosocial care in residential settings. Notwithstand-
688 ing the challenges of implementing change, it is expected that
689 the use of this model can contribute new understandings of
690 culture change in residential care and advance the academic
691 literature. In addition, although the actual costs of delivery of
692 this model needs to be formally evaluated, the anticipated low
693 cost and scalability of peer support coupled with its associated
694 positive effects (Pfeiffer et al., 2011) make REAP a potentially
695 viable and vital option to help address the psychosocial needs
696 of the rapidly increasing numbers of those living in residential
697 care (Keyes et al., 2014). In the presence of high resident to
698 staff ratios, residents remain a largely untapped resource for
699 improving psychosocial care (Skrajner et al., 2014). Further-
700 more, the importance of including residents as collaborators in
701 research has been identified as a key aspect to helping us better
702 understand their subjective experience, as well as enhancing
703 their self-worth and identity (Sabat, 2003). The benefits are far-
704 reaching as not only are group peer interventions sustainable
705 within growing fiscal constraints, but they represent an optimal
706 approach to building better mental health (Jetten et al., 2014).

707 This re-conceptualization has important implications and
708 brings with it a responsibility. The biggest challenge residents
709 face in their struggle for social identity may stem from the most
710 difficult and prevalent issue—the ageist stereotyping within
711 the larger culture of senior living. However, the challenge also
712 provides an opportunity for a social revolution to eradicate
713 the pervasive discourses that disenfranchise those living in
714 residential care through a presumed inability to contribute.
715 Like all revolutions, this needed change can only happen
716 from the bottom up. As residents are given the support to
717 have a voice—to move from care to engagement, and when
718 those caring for them see this new structure in action, ageist
719 perceptions will change. Kitwood (2013) argues that even with
720 the documented failures and confusion surrounding the culture

721 change movement, there is genuine social change and a growth
722 in responsibility.

723 The uncertainty and lack of direction that provoke so much
724 bewilderment also provide a space for the emergence of
725 a new culture of care. The dismantling of some of the
726 old structures, although deeply unsettling, has created the
727 opportunity for a radical and more benign redistribution
728 of power.

[Kitwood, 2013, p. 9]]

731 Through reaching out and tending to the needs of others,
732 residents may regain a sense of self and purpose, view
733 themselves and their problems from a new perspective and
734 find that they are not alone. With the right supports in place
735 residents can actively engage in their own psychosocial care,
736 thereby improving quality of life for themselves and their
737 peers.

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