

Making Institutional Bodies: Socialization into the Nursing Home

by

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ABSTRACT

Making Institutional Bodies: Socialization into the Nursing Home

In recent years, research related to older adults and long-term care has been growing. Although much research in the past was focused on biomedical issues, more recent research has examined psychosocial issues faced by older adults within the long-term care setting. Despite the increase in literature and research on aging, long-term care, and dementia, there are still many gaps in our understanding of these phenomena. The concepts of body, self-identity, and place have received some attention over the last decade or so, but little systematic attempt has linked these concepts together, especially with relation to older adults and long-term care. In addition, the adjustment process of older adults into the long-term care facility has been examined, but the socialization processes have not been systematically examined. The purpose of this phenomenological study was to examine the process of socialization for new residents into the long-term care culture and environment, specifically focussing on how identities, bodies, and place are constructed and reconstructed by residents.

Three residents were recruited for this study from a home for the aged in northwestern Ontario. Participant observation and three interviews over a six-month period with these residents focussed on concepts of place, self, and the body, as well as adjustment. Fifteen staff were also interviewed initially to gain an understanding of the long-term care environment and culture. Thirteen staff and two family members were interviewed at the end of the six-month period to gain an understanding of their perceptions of the resident's transition into the long-term care facility.

The findings indicate that a dismantling of the self occurs prior to coming into long-term care. Life in long-term care was described as living an altered life. Once admitted to the home for the aged, two types of socialization processes occurred— institutional and (inter)personal. Institutional socialization processes consisted of placing the body, defining the body, focussing on the body, managing the body, and relating to the body. Placing the body refers to the placement within the physical and social environment, residents' adjustment to a new place, and how space within the facility was used. Defining the body refers to the assessments that were used just after admission which were focussed on the body as dysfunctional and limited. Focussing on the body occurred through the institution's focus on body care, as well as the residents' focus on their aging and unpredictable bodies, with a greater awareness of mortality and the immanence of death. Managing the body occurred through routines, risk management, and waiting. Finally, relating to the body referred to the boundaries of relationships that were defined, both resident relationships and staff relationships. The (inter)personal socialization processes capture the ways that residents internalized the institutional socialization processes. Internalizing the body refers to being a number and being a burden. Accommodating the body suggests ways in which residents complied to the institutional socialization processes. Accepting-resisting the body refers to the struggle residents had in accepting and fighting becoming a body, body limitations, and life in the institution. Re-creating the body illustrates ways in which residents reclaimed the body and alternative identities. All of these processes came together to create institutional bodies.

These findings lead to a greater understanding of the ways in which body, self and identity, and place are intertwined. The institution served as a container for life, defining each of the lifeworld existentials. Lived space became institutional space, as personal space was redefined by the institution. Lived time also became structured by the institution, as temporal dimensions were defined by institutional time. The lived other became the institutional other, as staff became institutional brokers, attempting to balance the needs of the residents while adhering to the rules and regulations of the institution. The lived body also became the institutional body. The care encounter brought these dimensions together, and was the site for the production of institutional bodies. The findings of this study invite a rethinking of conceptions of the body and old age, particularly within the context of institutionalization, with bodies viewed as repositories of memories and containing both youth and age, rather than age as a 'mask'. Residents exist within paradoxical rhythms of life, and thus, old age and institutionalization are not easily defined or theorized, but rather, reflect the complexity of lived experience.

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There is a time for everything, and a season for every activity under heaven:

*A time to be born and a time to die,
A time to plant and a time to uproot,
A time to kill and a time to heal,
A time to tear down and a time to build,
A time to weep and a time to laugh,
A time to mourn and a time to dance,
A time to scatter stones and a time to gather them,
A time to embrace and a time to refrain,
A time to search and a time to give up,
A time to keep and a time to throw away,
A time to tear and a time to mend,
A time to be silent and a time to speak,
A time to love and a time to hate,
A time for war and a time for peace...
He has made everything beautiful in its time.*

~Ecclesiastes 3:1-8, 10 NIV

DEDICATION

This thesis is dedicated to my son
Gabriel Jakob Alerick Lemelin-Wiersma

To the boy he is now

And to the man he may become

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CHAPTER ONE: INTRODUCTION

In recent years, there has been an explosion of research related to older adults and long-term care (e.g., Gubrium, 1993; Paterniti, 2000; 2003; Phinney, 1998). Although much research in the past was focused on biomedical issues, more recent research has expanded to include psychosocial issues faced by older adults, including persons with dementia residing in long-term care settings. The population growth of older adults as well as the growth in incidences of dementia may have contributed to this increase, but so has the increasing professionalization and “disciplinization” of the field of gerontology (Katz, 1996). Despite the increase in literature and research on aging, long-term care, and dementia, there are still many gaps in our understanding of these phenomena. In particular, the concepts of self, body, and place have received limited attention over the last decade or so, and little systematic attempt has been put forth to link these concepts together, especially with relation to older adults and long-term care. The focus of this study, then, is to examine the process of socialization into nursing home culture and life, focussing on these three concepts—self, body, and place. There has been much research examining the impact of long-term care settings and adjustment of residents to the long-term care environment. However, how older adults become socialized into this new culture has not been examined, and more specifically, what role the self, body, and place play in the process has been neglected. For the purposes of this study, adjustment and socialization are two different concepts. Adjustment refers to adaptation to a particular environment or set of relations (Colman, 2001). Socialization, on the other hand, is the process by which we learn to become members of a society, by performing social roles and internalizing the norms and values of the society (Marshall, 1998). Adjustment is a

part of socialization, which is a much larger concept. This study, then, examines socialization as a larger concept rather than simply examining adjustment to the long-term care setting.

1.1 Setting the Stage: The Social and Cultural Context of Aging

Critical inquiry stresses the importance of understanding historical and social contexts of specific issues (Kincheloe & McLaren, 2000). Issues connected to aging also warrant a discussion of historical and cultural contexts. By examining the social and cultural context of aging, it is possible to see how power operates through the medical system and through capitalism to oppress and marginalize older adults.

Aging has become increasingly biomedicalized in the last few decades (Estes & Binney, 1991). Biomedicalization is a paradigmatic perspective focusing on individual organic pathology, physiological etiologies, and biomedical interventions (Estes & Binney, 1991). Biomedicalization has two dimensions—the social construction of aging as a medical problem, and the praxis of aging as a medical problem and associated behaviours and policies (Estes, Wallace, Linkins, & Binney, 2001). Estes and Binney (1991) explain:

The construction of aging as a medical problem focuses on the diseases of the elderly—their etiology, treatment, and management—from the perspective of the practice of medicine as defined by practitioners. This means that the elements of the medical model—with its emphasis on clinical phenomena—take precedence over, and in many cases define the basic biological, social, and behavioural processes and problems of aging (Estes & Binney, 1991, p. 118).

The biomedicalization of aging also influences public opinion and the tendency of the public to view aging negatively (Estes & Binney, 1991).

The biomedicalization of aging might not seem like such a negative process until the role of medicine as an institution of social control is examined (Zola, 1990). Medicine has the cognitive and social authority to describe our bodies (Wendell, 1996). In this way (and in others), the institution of medicine and the medical profession is powerful.

Biomedicalization defines behaviour as a medical problem and mandates the medical profession to provide some form of treatment for it (Bond, 1992). Biomedicalization also increases the range of social phenomena within the institution of medicine, and extends the range of social phenomena mediated by concepts of health and illness (Crawford, 1980). As one example, behaviour surrounding dementia has now become mediated through the discourse of the disease (Bond, 1992). Gesler (1999) states, "...[p]ower is not external to health care, it is part of it, intrinsic to the relationship between carer and cared-for" (p. 18). The notion of expert enhances the power imbalances in the relationship. One of the aspects of biomedicalization is expert control, in that professionals have monopoly over the knowledge about anything related to disease, illness, or treatment (Bond, 1992). Responsibility is placed on the individual for health and wellness (or lack thereof), and the individual is often seen as morally lacking if s/he becomes ill (Crawford, 1980; Zola, 1990).

...[M]edicine is becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law. It is becoming the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts. And these judgments are made, not in the name of virtue or legitimacy, but in the name of health. Moreover, this is not occurring through the political power physicians hold or can influence, but is largely an insidious and often undramatic phenomenon accomplished by "medicalizing" much of daily living, by making medicine and the labels "healthy" and "ill" *relevant* to an ever increasing part of human existence. (Zola, 1990, p. 398).

The biomedicalization of aging has led to the medical-industrial complex and the aging enterprise. A political economy approach to aging emphasizes structural forces and processes that contribute to the constructions of old age in addition to social policy (Estes, Mahakian, & Weitz, 2001). The medical industrial complex refers to the multibillion dollar enterprises whose primary function is profit, and whose secondary function is research and education (Estes, Harrington, & Pellow, 2001). This aging enterprise recognizes that institutional action and the role of the state extends into all arenas of aging-related activities even beyond health (Estes, Harrington, & Pellow, 2001). Both the medical industrial complex and aging enterprise centrally focus on the commodification of health and health care (Estes, Harrington, & Pellow, 2001). The incentives are to maximize profits rather than improve health, resulting in a medicalization of old age and exacerbated dependency (Estes, Mahakian, & Weitz, 2001). The health care system is promoted by capital interests and the role of the state in reinforcing and promoting market-driven delivery systems (Estes, Harrington, & Pellow, 2001). The privatization of long-term care and health care decreases government expenditures and shifts responsibility from the state to the individual (Estes, Harrington, & Pellow, 2001). The state, then, is dependent on income it does not organize. Interests of the state are centered on facilitating private growth, since the state is responsible for the state of the economy (Estes, Wallace, Linkins, & Binney, 2001). The state must also be concerned about social welfare and alleviate the conditions and problems generated by the free enterprise system (Estes, 2001). According to Estes (2001), the state is in constant tension between the demand for the two different types of expenditures—business and social welfare. Economic determinism, then, cannot be separated from other

forms of power and domination, since social policies and the state (in addition to a number of other factors, including ageism, gender, race and ethnicity, social class, and ideology, according to Estes, 2001) are also implicated in power and domination.

Publicly, there are also many negative stereotypes of aging that often define older adults. Culture is the domain of struggle where production and transmission of knowledge is a contested process (Kincheloe & McLaren, 2000). The postmodern consumer culture (Rojek, 1993) marginalizes the identity of older people by emphasizing youthfulness (Powell & Longino, 2001, 2002). The body, particularly the aging body, is socially constituted and fashioned within and by culture.

Dominant culture teaches us to feel bad about aging and to start this early, reading our bodies anxiously for signs of decay and decline. We breathe in this toxicity daily. Narratives of decline have replaced all other forms of meaning and interpretation of the body in later years, so that other more humanistic or plural readings become impossible...Consumer culture is quintessentially youth culture in that it presents and promotes youthfulness as the ideal; and this has profound consequences for how we experience aging in high- or postmodernity. The bodies featured in the media are never old; and the emphasis on perfectionism and the visible eradication of age is reinforced in the growing industry of age denial. Consumer culture is increasingly targeted on those in their middle and later years, particularly those with money and leisure to consume, but a large part of its activity is concerned with selling of youth and youthfulness (Twigg, 2004, p. 61).

As the above quote emphasizes, culture emphasizes youthfulness as an ideal, and as such, those who are aging, especially those over age 75 years (the Fourth Age), are seen in direct contrast to youthfulness. "These old remain eternally Other, and that sense of them as wholly separate and as a fundamentally different category of being lies at the heart of how ageism operates" (Twigg, 2004, p. 64). Because the Fourth Age (or over 75 years old) is generally seen as the onset of infirmity, the Fourth Age tends to be about nothing but the body (Twigg, 2004). As such, since the body is portrayed negatively as broken, frail, and undesirable, those in the Fourth Age are seen as only the body, which is a

tremendously negative stereotype, and is continually contrasted against youthfulness (Powell & Longino, 2001, 2002).

Aging, then, is set in a cultural context in which youth is valued and productivity is emphasized. Biomedicine has the extraordinary power to define and to manage the lives of older adults. As such, aging in current North American culture can pose many difficulties, especially for those with chronic illness or disability.

The move to long-term care settings often exacerbates issues of ageism and negative perceptions of age. The long-term care setting is premised on a biomedical model (Henderson, 1995), which makes the assumption that as people age, illness and disability are inevitable. Narratives of decline pervade long-term care settings. Bodies are viewed as broken down, frail, and undesirable, and residents are often viewed as their bodies (Twigg, 2004).

In order to understand the context of institutionalization and the changes that occur upon admission to a long-term care institution, the cultural relevance of old age and institutionalization need to be set within a wider socio-cultural context. Many of the issues within the long-term care institution can be traced back to wider societal and cultural issues relating to old age, such as biomedicalization, negative stereotypes of old age, the privatization of health care and long-term care and the commodification of health and age, as well as narratives of body decline. Thus, understanding the socio-political context of old age and aging helps us to situate the long-term care facility within this same socio-political context.

Situating the research also includes situating the researcher within the research. Thus, how I came to do this research is important in contextualizing the research. I have

spent many years working, volunteering, and involved in long-term care facilities. I started working in long-term care when I was 19. After taking numerous courses at the college level, I pursued my university education. I continued working in long-term care until I started graduate school full-time. During this time, I became very aware of the issues in long-term care, such as staff's workloads, lack of time, demanding regulations, lack of support for staff, uncaring attitudes, and sometimes unsupportive management. I witnessed many incidents where residents were treated very poorly. I saw the emotional distress and trauma that many residents experienced, and felt helpless to ease or comfort them. I also worked in a very progressive facility, and saw how good care and caring relationships between staff and residents could impact quality of life. These personal experiences have had a profound impact on me as a person and on me as a researcher. They have influenced how I think about long-term care and fuel my commitment to improving the quality of life of residents living in these settings. Because of these personal experiences, my research has focused on issues and experiences in long-term care and led me to this examination of how residents come to be socialized into the long-term culture.

1.2 Literature Review

Because this study focuses on a number of different concepts, in the following three chapters, I delineate and discuss each of these concepts, and then discuss how these concepts might relate to each other, ending with a discussion of how these concepts relate to older adults living in long-term care settings. More specifically, Chapter Two describes research related to nursing home life. Chapter Three discusses the body and social theory.

Chapter Four discusses self and identity, and Chapter Five focuses on theoretical conceptualizations of place. Before the theoretical discussion on concepts of the body, self and identity, and place, however, I shall discuss briefly some of the research conducted on older adults with dementia and long-term care and the state of long-term care today.

CHAPTER TWO: NURSING HOME LIFE

It is no secret that to most people, nursing homes carry very negative perceptions and connotations (Groger, 1995). Goffman (1961) and Hazan (2002) have identified and theorized specifically about what characteristics seem to create these negative perceptions.

The nursing home has often been likened to Goffman's (1961) descriptions of total institutions (Dupuis, Smale, & Wiersma, 2005). Goffman (1961) described a total institution as "...a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered way of life" (p xiii). Goffman also includes institutions established to care for persons who are seen to be incapable and harmless as total institutions. Goffman (1961) defines four characteristics of total institutions. First, all aspects of life are conducted in the same place. Second, all daily activity is conducted in the company of others who are all treated alike. Third, all activities of the day are rigidly scheduled. And finally, the activities are all designed to fulfill the official aims of the institution.

Hazan (2002) describes nursing homes as cultural enclaves and cosmological voids. Older adults are produced as decontextualized others by anthropology and gerontology. There is an equation of old age with death, and each individual by virtue of age represents that symbolic space. Because of the erosion of belief in afterlife existence, non-life is now contrasted with life. Old age homes replace the missing symbols of the fine line between the two. Othering is a solution for people to deal with this discomfort.

A decontextualization of personhood occurs both in childhood and old age. “Old age homes are cosmological niches where subversive agents of nonmodernity can be contained until they are removed and processed to become controllable ‘others’” (Hazan, 2002, p. 341). Old age homes are cosmological voids beyond which lies the symbolic unmentionable.

2.1 The Nursing Home from an Organizational Perspective

The nursing home has been examined on an organizational scale or from a macro perspective by a number of different scholars, many of them using an ethnographic approach (Diamond, 1992; Foner, 1995; Henderson, 1995; Paterniti, 2000; 2003). These studies have examined the culture of nursing homes, staff and resident relationships, structures and routines of nursing homes, and everyday life.

Paterniti (2000) examined life in long-term care in her ethnographic study in which she spent four months employed full-time in a chronic care institution. She describes the residents as being a type of labour, “bed and body” work. Because of the time-table and the number of tasks to be completed, most staff have little time to attend to residents’ psychosocial needs. Residents are viewed as routine work, and the routines are scheduled by the workers’ agendas. The staff must define the residents as deficient in order to construct their work schedules. As such, any self-definition by the residents tended to be dismissed.

Paterniti’s (2003) article expanded further on her ethnographic study by expounding on the constructions of residents by the staff. Staff related to residents by their specific categories of deficiencies. Paterniti (2003) explained, “Residents became a

particular type and amount of staff labor and were labeled as such” (p. 62). Some residents were seen as time consumers by demanding staff help. Others who needed help eating were labeled as feeders. “Troublesome” behaviours were those residents who increased the work burden, increased tasks, and usually involved extra time. Because of the need to keep information and documentation on the residents and staff tasks, residents were viewed as bed-and-body information.

Henderson (1995) also conducted an ethnography in a nursing home. He found that psychosocial care was dehumanized within the nursing home. In the medical culture, time was a commodity, not just a tracking tool. Because of the pressure of time and task, a superficial type of social interaction between residents and staff occurred. The task-oriented nature of the nurses’ aide work was derived from the medical values of time conservation, and as such, care was focused on physical tasks. Staff generally seemed to be unaware of residents’ real experiences of nursing home life, as reflected in patients’ daily need to get their meal when it is appropriately hot or cold. In addition, psychosocial care was mainly found to come from housekeeping staff, not from the nurses’ aides or from activity staff. The net effect of a “cult of time and task” was a lack of psychosocial care.

Diamond (1992) also conducted an ethnography in a nursing home where he worked as a health care aide. He described in-depth life inside a nursing home, where residents’ identities were erased as they were documented.

To be sick, frail, confused, disabled, or old is not the same as to be a patient. In becoming a patient in a nursing home one enters a social organization, patient emerges in the meeting of person and institution. Day and night as boxes got checked and records reviewed, these people were entered into the administrative language and codes of what services were rendered to them. In turn, these terms and categories and codes came to be viewed by many staff and outsiders as the

ultimate reality itself, rather than a small part of it. The status of patient begins only in sickness...These documents did not merely reflect needs, they defined certain needs as well, and they erased others. Most basically, they erased the identity of the people whom they described as being social actors. The women and men living here did not write in these documents, nor did they read them. They did not speak in the charts. They were spoken about. (Diamond, 1992, p. 126-127)

The emotional and social work of the staff for the residents was discounted as their jobs were made into a series of tasks to be ticked off at the end of the shift, thereby erasing the work of the staff in addition to erasing the identities of the residents. The government and bureaucracy were evident in what Diamond (1992) calls a “documentary power of presence” (p. 192). The authorities gave the facilities money in exchange for reports. The events of everyday life were made countable, and external control was exercised.

Residents, then, as people, were fused with beds.

This procedure had the consequence of molding the formal records of residents’ lives into a history of progressively separate, isolated individuals: reduced to the status of those acted upon, from social relations to individuals, from individuals to patients, to sickness, to units of health service, and ultimately to objects. All these components went together to make up the bed. The leap from person to bed was thus not direct. It followed an ideological pathway: from socially contextualized person to isolated individual, on to patient and disease categories, to bodies and behaviours and tasks done to them, then to the records to code them. “Beds” came into the logic at the end of this conceptual conveyor belt, fully accomplishing the fusion of person and bed, resident and commodity. (Diamond, 1992, p. 210)

Kaufman (1994) described the role of geriatric assessments in the construction of risk and surveillance with older adults. The idea of assessment implies supervision of the elderly by other members of society. Supervision enables more effective management of the elderly patient. The geriatric assessment emerged out of risk discourse associated with the biomedicalization of aging. The comprehensive assessment redefines old age as a medical problem and broadens the scope of diseases that characterize aging. The discourse of geriatric assessments not only reconstructs the dependence of older adults

and medicalization of old age, but legitimates the field of geriatrics as a separate and necessary medical field of specialty. Assessments in long-term care tend to be similar to geriatric assessments conducted on individuals still living in the community. In fact, many long-term care residents have had a geriatric assessment conducted on them at some point in time. The notion of the construction of risk and surveillance are primarily what the assessments in long-term care are designed to do. The discourse and language surrounding care issues, assessment, and documentation, although perhaps conducted with the best of intentions, essentially remove the residents from any power over the discourse surrounding their lives and erase their identities, their histories, and their social contexts.

There are numerous studies that have described staff relations in long-term care. Wiener and Kayser-Jones (1990) conducted research over three years in three nursing homes, interviewing physicians, nursing staff, nursing home residents, and family members, as well as observing life in the facility. These researchers found that physicians held extremely negative perceptions of the facilities. These perceptions included views that the nursing home was physically abhorrent, psychologically demoralizing, and that it was an unwelcome rehearsal of the impairments of aging. Physicians also viewed the facility as deficient in support services. Staff felt demoralized because of the barriers to getting their work done. Nurse administrators felt their jobs were hard work because of juggling demands over staff shortages while attempting to overlook the issues that conflicted with their standards of good nursing care. Nursing assistants felt dispirited by the short staffing, and felt that they were denied any sense of working on a health care

team. The teamwork in a nursing home seemed to be unavailable, while each staff group felt oppressed by the conditions in which they worked.

Foner (1995) conducted an ethnographic study in a long-term care facility, examining work in a facility from the nursing aides' perspective—those staff who directly care for the residents' bodily needs. The nursing aides were on the bottom of the nursing hierarchy in the facility. The aides often took their frustration out on the residents, including psychological abuse such as making jokes about the residents, ignoring the residents, indifference and apathy, and being insensitive to the residents' privacy rights. The nursing aides, however, were abused by the residents through racist and derogatory comments. Many aides, however, were kind to the residents, talked to them, helped them to be more independent, and calmed them when they were upset.

Nursing homes are institutions that aim, in a sense, to bureaucratize or rationalize affective care. Administrative rules regulate staff who, as part of their jobs, are expected to provide personal attention and sympathetic care to patients. Bureaucratic rules can come into conflict with workers' emotions and personal relations with patients, and patients are often the ones to suffer (Foner, 1995, p. 53).

Diamond (1992) also examined issues related to staff in his ethnography of a long-term care facility. Diamond (1992) found that most of the nurses' aides in his study were poor women, often immigrants, who were single mothers with young children at home. Many of these women worked two jobs to provide for their children and make enough money to make ends meet. Because these nurses' aides were on the bottom of the nursing hierarchy, they were viewed as expendable.

The women and relatively few men who have done caretaking work in earlier times, have done so as family members or as nurses, servants, or nuns. As caretaking gets continually moulded into a capitalist industry there emerges a change in the definition of its labour. Earlier, as now in families, more hands meant lighter work and therefore were intrinsically valuable. When workers come

under the business logic they are defined as labour costs to the owners and managers, to be cut back wherever possible. However discordant with caregiving as a responsive mode, the industrial mandate is for more work to be done by fewer workers, as a consequence of the drive toward managed productivity. (Diamond, 1992, p. 183-184)

2.2 Adaptation to Nursing Home Life

While limited research has been conducted on the process of socialization into nursing home life, much research has examined the process of psychological adjustment of residents into the nursing home. In addition, much of the research that has examined the transition to long-term care has examined it from families' perspectives (Davies & Nolan, 2003), and so little is known about the transition process from residents' perspectives.

In one of the few studies that has been conducted, Schoenberg and Coward (1997) found that older adults have both positive and negative perceptions of nursing homes. Older adults stated that nursing homes can be beneficial if one's physical condition demands it. Nursing homes have the potential of offering a better quality of life than an older person could have if they remained in their home. Nursing homes were also reported to be a good option if the care was good. Negative attitudes about nursing homes were common as well. Some perceptions were that nursing homes were bad places to live, and that nursing homes were places to die. Others thought that nursing homes were a big adjustment and infringed on independence. The older adults stated that nursing homes were a good option if others cannot care for someone, while others stated that family has an obligation to care for other family members. Nursing homes, however, were seen to be preferable to over-burdening one's family. Most participants stated that people who "suffered" from extensive physical and mental incapacities and who lacked familial

support were good candidates for nursing home care. The attitudes of older adults and their families toward nursing home care can impact the transition experience and adjustment period after individuals enter the nursing home environment (Flynn-Reuss, Dupuis, & Whitfield, 2005; Kahn, 1999).

Kahn (1999) conducted a nine-month ethnographic study of a nursing home to examine the adaptation to the dual nature of the nursing home as an institution and as a home. The nursing home was a definite reality to the residents, but the environment was symbolic as well as physical. The phrase, “making the best of it” was widely used by the residents. Because it was used so often, its obscurity reflected the ambivalence that most residents felt towards their situation. Residents felt ambivalent about their living situation and ambiguity toward the nursing home setting. Four dimensions of “making the best of it” were apparent: (1) the nursing home symbolized both losses and powerlessness, but also a place of shelter and respite; (2) residents tended to minimize the negative aspects of their present living situation; (3) because residents believed they had no other options for living situations, they were determined to reconcile themselves to living in a nursing home; and (4) residents believed they had to make their minds up to live with the situation and make the best out of it. Residents, then, adapted to the nursing home environment by determining to make the best of it.

Porter and Clinton (1992) found a number of adjustment approaches in their study of newly admitted long-term care residents. Reframing was a willful decision to view the move as satisfactory. Getting used to it referred to living in the facility while time passed. Residents often went along with things and passively accepted nursing home life. Emotional responses to change brought about by nursing home life reflected confronting

change. Extending or engaging in facility-sponsored activities or initiating involvement with residents and staff was another approach used by residents. Some residents tried to fit in by purposefully meshing with the circumstances of nursing home life, while others tried to fit in by not fitting in, or expressing personal idiosyncrasies or engaging in familiar self-focused activities. Residents expressed that they gave their best effort, as they would in other circumstances, to adjust to nursing home life. Others renamed the facility, or considered the facility as home or the staff as family. Some remained quiet about the personal impact of nursing home routines, and some obeyed or acquiesced to the staff. Residents often used a combination of adjustment approaches or strategies in different situations and contexts.

Porter and Clinton (1992) identified four adjustment influences as determinants of residents' successful adjustment to nursing home life. First, the circumstances pertaining to the transfer played a large part in residents' perceptions of the home. The extent of control over admission, limitations in pre-admission functional status, and congruence between admission and perceived need all impacted adjustment. Second, residents' life histories played a part. Similarities or differences between the nursing home and their life histories, and congruence between admission and their life plan impacted adjustment. Third, residents who had been exposed to nursing homes throughout their lives were more likely to have a positive attitude towards the nursing home and adjustment. A person-environment mesh also impacted adjustment. Interpersonal and environmental influences played a large part. Bringing items from home helped facilitate adjustment. A personal history with the facility also helped adjustment. Finally, the belief that the only option was nursing home care led residents to adjust and make the best of things. As

evidenced by this study, adjustment is not a simple construct in which one can predict who will adjust and who will have difficulty. Past history as well as other present factors play a large part.

Wilson (1997) interviewed and observed older adults who were recently admitted to nursing homes. The major theme of adjusting to nursing home life was about protection and maintaining a façade of normalcy. Residents would often hide their feelings to protect their families and significant others. Wilson (1997) found three phases in the transition to nursing home life: overwhelmed phase, adjustment phase, and initial acceptance phase. The overwhelmed phase was characterized by a focus on self. Emotional responses such as crying often accompanied this phase, and residents described feeling lonely. The adjustment phase began when residents began to internalize nursing home admission and began to develop a positive attitude. They began to establish new social networks and realized they had a future. The initial acceptance phase was characterized by a focus beyond self, a sense of well being, developing new social networks, and taking control of the situation. Older adults whose admission was planned reached this stage earlier than older adults whose admission was unplanned.

While little research has been conducted on the actual admissions process, one particular study did focus on this process (Nussbaum, 1993). Nussbaum (1993) described the admission process as "...a highly structured, government regulated event that often occurs in a hurried atmosphere of heightened stress" (p. 241). The researcher was present during an admission and the initial meeting with the resident and family, and was able to observe the process. The researcher described the process as having a quick and professional nature. The resident was an observer throughout the process, and most of the

talk was directed toward the family. When talk was directed toward the resident, the staff were explaining procedures that were not negotiable. “Information flowed from the staff and the submissive potential resident quietly listened” (Nussbaum, 1993, p. 244). The result of the interactions was the reinforcement of dependence, and the author concluded that the outcome of resident-staff interactions prior to admission indicated that to a new resident, a move into a nursing facility meant a move to total dependence.

2.3 Relationships in Long-Term Care Settings

The isolation and loneliness in long-term care is yet another aspect of the environment that may influence the socialization process into long-term care. Much has been written about social isolation and loneliness in long-term care (e.g., Donnenwerth & Peterson, 1992; Slama & Bergman-Evans, 2000; Thomas, 1996), but there have only been a few researchers who have examined social interactions specifically in long-term care settings (Applegate & Morse, 1994; Golander, 1995; Powers, 1995; 1996). Research has also been conducted on family-staff relationships, but few studies have examined resident-staff and resident-resident relationships. Much work remains before we have a thorough understanding of social relationships and networks in long-term care settings.

Powers (1995; 1996) described four different types of social networks that seem to exist in long-term care facilities. *Institution-centred networks* were small networks with few outside contacts as compared to institutional contacts. *Small-cluster* networks were variants of institution-centred networks that contained close groups of residents that regularly interacted with each other. *Kin-centred networks* were those in which residents had family members and other relatives who visited and talked with them on a regular

basis. These emotional ties to family made it difficult for some individuals to accept relationships with others in the institution. Finally, *balanced networks* were the largest type of network found in the study. In this type of network, a wide range of contacts including residents, staff, family, and outside friends or acquaintances provided interaction and support.

Research has also examined the relationship between staff and family members. Duncan and Morgan (1994) found that families expressed a desire to maintain an ongoing relationship with staff members, and desired emotionally sensitive care for their loved ones, not just physical care. When families had negative interactions with staff, they perceived significant improvements in the facility were needed (Ejaz, 2002). Vinton, Mazza and Kim (1998) found that staff perceived families to often be unrealistic in their expectations of what staff should do for the residents and that family members were difficult to please. Finally, Gladstone and Wexler (2000) found that families valued specific things in relationships with staff—care and attention given to residents, attention to family members, information given to family members, and opportunities to engage in joint problem solving. When these elements were present, families had good relationships with staff. Gladstone and Wexler (2000) proposed three types of family-staff relationships—detached relationships where families have little involvement with staff, cooperative relationships where families seek information from staff but do not provide information in exchange, and collaborative relationships that are characterized by open communication.

Powers (1996) examined the social interaction patterns of women in particular living in a nursing home setting. She found that elderly institutionalized women

established interpersonal ties with one another. However, there were some women who resisted relationships with others in the institution. Their resistance to relationships was based on fear and a need to avoid upsetting behaviour, as well as a feature of their personalities. Daily contact with other residents in the institution often provided opportunities for social exchange, but most women were selective and cautious in forming relationships. The women with balanced networks were the least resistant to forming and maintaining ties with other residents, but also actively resisted relationships that caused them distress and were selective in choosing close friends.

Golander (1995) found that social interaction among residents on the ward of a nursing home was characterized by indifference, competition, and hostility. Residents with dementia were physically, socially, and emotionally avoided by all other residents. Few personal friendships were formed on the ward except for instrumental attachments. Residents commented on the "...boring unstimulating company of no ones, wailing elders, looking to take your place or food from you" (Golander, 1995, p. 69). Relationships between residents and families as well as residents and staff, however, were characterized by personal attachment and involvement.

Applegate and Morse (1994) observed that residents were treated by staff and by each other as friends, strangers, or as objects. The most striking feature of the unit of the nursing home which they observed was the absence of conversation. When residents interacted as friends, they demonstrated a genuine interest in other residents and recognized their individuality, although this occurred infrequently. When interactions between residents and staff were personalized, residents appreciated staff and perceived them to be more than individuals responsible for their care. A common interest often laid

the foundation for a friend relationship among residents and staff. When staff viewed residents as friends, they attempted to view the resident in a broader social context, beyond the identity as a resident in an institution. When residents interacted with each other as strangers, they were indifferent to those who shared the facility with them and did not acknowledge individuals near them. Resident-staff interaction characterized by indifference was predominantly associated with care activities. Residents appreciated the staff only as long as their own care needs were met. When staff interacted with residents with indifference, staff members viewed themselves only in the context of their roles as caregivers, rather than viewing the resident as a person. Finally, when residents interacted with each other as objects, they regarded other residents without consideration for their humanness or frailties, and treated them as if they were objects with no redeeming qualities. This was most evident in interactions between residents who were not cognitively impaired towards residents who were. In interactions with staff, residents viewed their relationships with staff members as a master-servant relationship and as a means of getting something done. When staff treated the residents as objects, they did not demonstrate kindness, compassion and understanding, but saw them as tasks to be completed as quickly as possible. There were various ways in which residents interacted with each other and with staff, including both positive and negative ways of interacting.

Hubbard, Tester, and Downs (2003) examined social interactions between residents in long-term care settings. This ethnographic study explored the perceptions of quality of life of frail older people in long-term care in four settings—a dementia care unit, a floor of a nursing home for older adults with physical impairments, another nursing home, and a residential home. For residents who were able, talking was an

important part of communication. However, hearing impairments often prevented verbal conversations. Humour was common among verbal and non-verbal resident interactions, often in relation to their own and others' physical frailties. Residents also joked with each other and played practical jokes. Joking was evident both in verbal and non-verbal interactions. Humour also focused around sexual relationships, such as when a female resident said she wanted a man with money. Flirtation was evident between the women and men residents, and was often a sign of affection. Some residents disliked each other, and told each other so. The behaviour of some of the residents with cognitive impairments aroused hostility in others, and these residents became labeled as idiots, stupid, clowns, funny types, mental, and confused. The residents who labeled these individuals often distanced themselves from these residents. As Hubbard, Tester, and Downs (2003) state, "[t]heir [residents] social interactions reveal the older person making sense of the presence of others, interpreting behaviours, and showing an awareness of 'self'" (p. 109).

As evidenced by the above studies, there are many ways in which relationships among residents and between residents and staff are described. Not every relationship becomes a friendship, or is necessarily antagonistic. Because individuals carry themselves with them into the nursing home environment, patterns of interaction established throughout their lifetimes are not erased. Bringing many people together in a small space can enhance both positive and negative interactions and ways of relating throughout one's life.

2.4 Leisure, Socialization, and Long-Term Care

Although some research suggests that leisure can play an important role in the adjustment to long-term care, there has been little research on the role of leisure in the socialization process for any age group, but especially for older adults. Discussions of the role of leisure in the socialization process is typically limited to children and the role of play in socialization and development (Mannell & Kleiber, 1997). The role of leisure in providing a means of adjustment, as a socialization agent, and as a site for resistance have been discussed by few, if any, scholars. It seems possible, though, that continuity or discontinuity in valued activities and patterns of life, including leisure, may play an important role in the socialization process.

There have been various studies on activities, recreation, and leisure in long-term care settings over the past few decades. For example, Geiger and Miko (1995) interviewed thirty residents of a nursing home to explore the meanings of recreation and leisure activities. Through interviews and observation over a seven-month period, four common themes of meanings were identified: a sense of continuity and security; a desire to learn and to be mentally challenged; a desire to interact with others; and a sense of helping others. These valued aspects of recreation programs demonstrate the importance of community access programs, particularly in addressing the need for continuity but also to help seniors feel a sense of contribution to others.

Pedlar, Dupuis, and Gilbert (1996) found that leisure can help individuals residing in institutions to regain valued roles they may have lost because of institutionalization. Using an action research approach, they focused on integrating a male resident into community leisure activities. The researchers interviewed and observed Eric in integrated

community recreation over the period of ten months. Three patterns emerged through the process of integrating Eric into a community woodworking program: (1) identifying common enthusiasms in leisure; (2) opportunity to contribute; and (3) demonstrating capabilities. Eric had an interest in woodworking throughout his life. Because of Eric's woodworking abilities, other participants in the program began to ask him for advice on their work, giving Eric an opportunity to contribute. Throughout this integration process, Eric was able to resume a valued role that he had lost upon institutionalization.

Other studies have examined the ways in which residents of nursing homes spend their time. Voelkl, Winkelhake, Jeffries, and Yoshioka (2003) examined the ways in which the nursing home environment was used by residents and staff. They found that residents were most frequently observed in eating or drinking, or in no observable behaviour. Data from the focus group indicated that resident characteristics and the facility schedule impacted the time residents spent in the common areas of the nursing home.

Much of the research on leisure in long-term care settings has examined the impact of leisure on various aspects of residents' lives (e.g., Buettner, 1995; Fitzsimmons, 2001; Rabinovich & Cohen-Mansfield, 1992; Ward, Kamp, & Newman, 1996). McGuinn and Mosher-Ashley (2000), for example, conducted a qualitative study examining the effects of participation in activities on the perceptions of life satisfaction. Residents who reported initiating activities with others were more satisfied with their lives in the facility. Female residents as well as those who were involved in their decision to enter a long-term care facility were more involved in recreation activities than others.

The findings of this study would suggest that there is a link between self-generated activities with others and satisfaction with life in the facility.

Despite some of the positive aspects of activities, recreation, and leisure in long-term care facilities, a number of studies have highlighted the lack of activity in long-term care settings. Ice (2002) followed 27 residents throughout their day, and found that 66 percent of their time was spent in passive activity. Only twelve percent of the time was spent in social or expressive activities, including talking, activities, and visiting. Residents were engaged in structured activities only three percent of the day. The majority of these activities were large group activities.

Dupuis and Smale (2003) examined the nature of recreation and leisure in long-term care settings in Canada. They found the majority of the recreation and leisure offerings provided in long-term care facilities are “in-house” recreation programs and that far less than fifty percent of residents participate on a regular basis in these programs. Thus, residents have little opportunity to participate in recreation programs with others in the community, and opportunities are mainly provided to participate with other residents.

Other studies have highlighted the different meanings of activity programs for residents compared to staff. Hall and Bocksnick (1995) found that residents viewed activity programs as helping to deal with boredom rather than as beneficial. In contrast, staff believed that residents participated in recreation and leisure programs to enhance health and well-being. Residents felt that although they were not physically forced to participate in programs, they felt a sense of discomfort or guilt when they were asked to attend but declined. The authors suggested that residents are often manipulated by guilt to participate in programs.

Despite the research conducted on recreation programs provided in long-term care, much of it is sporadic and inconclusive, with a number of studies directly contradicting the findings of others. For example, freedom of choice is seen to be key to leisure and is often espoused for recreation programming in long-term care facilities (McGuinn & Mosher-Ashley, 2000). However, Savell (1991) found that choice in an activity or selecting an activity from activity alternatives had no influence on perceived physical well-being, subjective well-being, or leisure satisfaction, and others found that organized leisure activities in long-term care settings did not enhance life satisfaction (McGuinn & Mosher-Ashley, 2000). As such, it is imperative that research continues to examine the phenomenon of leisure and recreation in long-term care facilities so we can develop a thorough understanding of the experiences of residents in leisure, and subsequently improve the provision of recreation and leisure in these settings. This research is also important in order to identify the role leisure may play in the relocation process to a long-term care facility.

Leisure, typically defined as perceived freedom (Mannell & Kleiber, 1997), is a concept that is not necessarily applicable to the long-term care environment. Because autonomy and self-determination are seen as attributes of perceived freedom, and autonomy and self-determination are often denied in residents in long-term care (Lidz, Fischer, & Arnold, 1992), the notion of leisure as perceived freedom is unattainable at best, or simply irrelevant, in long-term care settings. In the words of Hemingway (1996), leisure is an illusion, particularly in long-term care settings. In addition, the notion of leisure has not often taken into account the tremendous impact of place. Place is the context for leisure, and as such, defines leisure experiences (Wiersma, 2003). Therefore,

in a place such as a long-term care facility which is typically confining, the leisure experience tends to also take on these characteristics of confinement (Wiersma, 2003).

This being said, however, the possibility of resistance and the agency of nursing home residents cannot be ignored. Wearing (1998) talks about leisure as a ‘heterotopia’ (based on Foucault’s ideas). A heterotopia is a counter site or compensatory site to those of everyday activity. Wearing (1998) suggests that leisure is a heterotopia—a personal space for resistance to domination, where there is room for self to expand beyond what it is told it should be. Much of the work on identity experimentation and resistance has been done from a feminist perspective. Shaw (2001) states that “[r]esistance is seen to occur when women adopt behaviours or express themselves through activities which provide personal empowerment and which, at the same time, reflect a challenge to dominant restrictive or constraining views of femininity, sexuality, or motherhood” (p. 191). To that end, Wearing (1998) states that:

...leisure does not signify non-work time, activity, or experience or space—it is resignified to mean personal spaces, physical and metaphorical, where women can explore their own desires and pleasures, and perform acts which allow them to become women in their own right, to constitute diverse subjectivities and femininities which go beyond what women have been told they should be (p. 149).

This literature suggests that leisure can provide opportunities for resistance and safe spaces in which residents can resist the identities ascribed to them by the institution, yet these ideas have yet to be fully explored in the leisure literature or elsewhere.

Leisure has also been described as a form of social control (Hemingway, 1996; Reynolds, 1991; Rojek, 1995). Because leisure and ‘perceived freedom’ are treated as social psychological constructs, the emphasis is on the individual within the social context. If we use the subjective definition of freedom, then we use

knowledge/power/influence not to change reality, but to change people's perceptions, which provides powerful reinforcement for the status quo (Goodale, 1990). When the focus is on the individual, the assumption is that the individual has an ability to control his or her perceptions, spiritual condition, and subjective thoughts independent from external influence (Hemingway, 1996). Therefore, if an individual is not 'truly' experiencing leisure, s/he is responsible since s/he has control over perceptions and thoughts. In modern society, leisure is seen as a function to be fulfilled if society is to remain in order (Rojek, 1995). Leisure as freedom is potentially "...a mirage that serves to screen the interests of controlling elites" (Kelly, 1999). Leisure's function is to contribute to the well-being of the individual and society (Rojek, 1995), and the emancipatory potential of leisure is largely ignored (Hemingway, 1996).

The notion of leisure as social control is also prevalent in long-term care. Much of the research on leisure in long-term care has examined the benefits for residents. While the purpose of leisure in long-term care has never been explicitly stated in policy documents on long-term care, research on leisure, recreation, and activities in the long-term care environment has focused on the instrumental ends of leisure. For example, Buettner (1995) and Rabinovich and Cohen-Mansfield (1992) examined the role of therapeutic recreation in reducing agitated behaviours in persons with dementia, as did Ward, Kamp, and Newman (1996). Other research has examined the role of exercise and fitness programs in increasing the functional abilities and psychological well-being of residents (Brill, Jensen, Koltyn, & Morgan, 1998; Buettner & Fitzsimmons, 2002; Burns, Cox, & Plant, 2000; Fitzsimmons, 2001; Payten & Porter, 1994). The impact of recreation programs on residents' psychological well-being (Boyd & McGuire, 1996;

Gerdner, 2000; Gielow & Hobler, 1986; Katsinas, 2000; Rosling & Kitchen, 1992; Shary & Iso-Ahola, 1989) and on discourse and social interaction (Moss, White, & Sunderland, 2002; Smith-Marchese, 1994; Trzinski & Higgins, 2001) has also been documented. In fact, one paper actually described leisure in terms of its cost-effectiveness in long-term care (Lilley & Jackson, 1990).

While examining the benefits and functional outcomes of leisure is an important part of research, it is disturbing that little research (perhaps with the exception of a few studies such as Geiger & Miko, 1995; Pedlar et al., 1996; Sullivan, Pedlar, & Miller, 2003) has focused on the meanings of leisure as well as other issues that may impact the leisure experience for individuals. Leisure in long-term care, as it is currently conceptualized, appears to be focused on functional outcomes rather than on the experience itself. Such a conceptualization illustrates how leisure can potentially be used as a form of social control. Leisure opportunities are provided to residents to help them adjust to life in the facility, as behaviour control, and as diversion from boredom (which is seen to be negative for residents) and to keep residents busy. While these functions are not wrong in and of themselves, if these functions are the primary focus of leisure opportunities, then leisure can become a form of social control to effectively manage residents, to placate them, and to avoid dealing with larger structural issues of the institution that compromise quality of life and demand attention. “Convincing people to feel contented avoids the far messier and more difficult problem of providing substantive opportunities for authentic accomplishments so people have something in their lives worth feeling good about” (Sylvester, 1991, p. 447). Since residents are not often involved in the design and implementation of programs, programs are not geared to meet

residents' needs (Dupuis & Smale, 2003). Service efforts focus on the adaptation of the resident to existing conditions, which exerts a form of social control (Reynolds, 1991).

If all existing values of society are embraced as a given, service efforts will center around the adaptation of the "client" to existing conditions thereby exerting a form of social control. Our professional interventions tend to be "time limited" and "technological" and treat the symptoms of discontent within the "client" rather than dealing with the fundamental environmental sources of the person's discomfort (Reynolds, 1991, p. 299).

Leisure, then, can have different roles and functions, including a function of social control as well as a space for resistance.

Nursing homes as total institutions, then, are premised on a biomedical model, and often neglect the psychosocial care of the residents. The organization of staff in long-term care facilities is hierarchical, with those who directly care for the residents being at the bottom end of the nursing hierarchy, which can sometimes lead to neglect of residents' needs. Research on adaptation to long-term care has documented various adaptation and adjustment techniques of residents to the long-term care environment, and residents often hide their feelings to maintain a façade of normalcy. Varying findings on social interaction of residents in long-term care have been documented. Some research has found that interaction among residents was characterized by hostility or indifference (Golander, 1995), while other research found that residents did develop relationships with each other (Powers, 1996). The impacts of leisure and recreation on residents' lives have been documented in long-term care settings. How leisure is implicated in the socialization process of residents into nursing home life and culture, however, remains to be seen, and it is the goal of this study to examine this further.

CHAPTER THREE: THE BODY AND SOCIAL THEORY

The concept of the body is important to consider when discussing residents' transitions to the long-term care setting and their socialization into this new environment. Because the long-term care environment is focused on "bed and body" work (Gubrium, 1975; Paterniti, 2000; 2003), the body is implicated in many staff-resident interactions. The body as frail and broken down (Twigg, 2004) becomes a focal point of care. Routines in long-term care are focussed on the bodily needs and routines of the residents. While the notion of body work has been discussed relating to older adults and particularly staff (Twigg, 2004), little work has examined what the embodied experiences of residents might be, particularly in the time of major change, such as when older adults are admitted to long-term care facilities.

In recent years, the body has received much attention in sociology and social theory (Ahmed, 2004; Csordas, 1994; Featherstone, 1991; Featherstone & Hepworth, 1991; Leder, 1990; Lupton, 1998; Shilling, 2003) and in medicine (Kontos, 2003, 2004). The body, up until the last decade, was absent in sociology and in most other social science disciplines (Shilling, 2003). Shilling (2003) attributes this to the concerns of establishing a disciplinary field that was distinct from and irreducible to the natural sciences. The rise in the study of the body in sociology began with questioning of divide between society and nature (Shilling, 2003). Nettleton and Watson (1998) suggest that the growing emphasis on the body is related to a number of factors: the politicization of the body; demographic factors (graying of the population); the changing nature of disease burdens (increasing illness as people live longer); the rise of consumer culture; advent of

new technologies related to the body; broader social transformations that are associated with a move from modernity to late or higher modernity; and the body as a project (unfinished biological and social phenomenon that is being transformed).

Even with the discussions emerging about the body, there is still often a mind/body dualism (Howson & Inglis, 2001; Leder, 1990; Merleau-Ponty, 1962), or a separation of the body and self (Featherstone & Hepworth, 1991; Shilling, 2003) that persists with sociology. Some suggest that current discussions often serve to continue to reproduce dualist approaches to the body as being structured by society and power relations and the body as experienced (Shilling, 2003). Kontos (2003) suggests:

Scholarship in social theories of the body, in many of their discursive formulations, have critically explored how cultural and social practices elaborate and construct the human body in significant ways. However, the proliferation of postmodern discourse with its radical (de)constructionism has brought discourse/power so far into the body that the existential nature of embodiment is rendered inconsequential...Consequently, while the paradigm of embodiment has emerged with increasing sophistication and insight, scholars objectify the body as a material substitute on which culture operates, which excludes the body from primordial participation in the domain of culture. (p. 43, 45)

In addition, Nettleton and Watson (1998) state that:

...the sociology of the body has, by and large, ignored the voices that emanate from bodies themselves. This is mainly because this sphere of study tends to suffer from theoreticism, a condition which implies that attention is limited to theory, which in turn is not grounded in the empirical domain... (p. 2)

The tension, then, seems to be between foundationalists who assume a biological basis of the body which impinges on our experience of the body, and anti-foundationalists who assume that the body is simply an effect of discursive processes or contexts (Nettleton & Watson, 1998).

The importance of examining the body and embodied experiences cannot be stressed enough. All experiences in life are mediated through our bodies (Shilling, 2003).

Indeed, Nettleton and Watson (1998) explain:

Everyday life is therefore fundamentally about the production and reproduction of bodies. Given the centrality of the body to everyday life, and the fact that it is something that all humans share, it is perhaps surprising that there has been so little empirical investigation into the body as it is experienced by human beings, who both *have* and *are* bodies (Nettleton & Watson, 1998, p. 2).

The body is also the site of the interface between a number of different domains, including the biological/social, collective/individual, structure/agency, cause/meaning, and constraint/free will (Berthelot, 1991). Because of this, the body is everywhere as we experience and live in the world.

At the risk of reproducing the theoreticism of the body, I shall discuss some of the main theoretical discussions surrounding the body, before suggesting my views of the body and the ways in which they are informed. I first discuss phenomenology and the body, the dys-appearing body, the social construction of the body, the development of bodies, and the body and power. I will then discuss the body and self-identity, as well as the body in medicine and age.

3.1 Phenomenology and the Body

One of the main theorists to discuss phenomenology and the body is Merleau-Ponty (1962). Merleau-Ponty perceives the body as one of the objects of the world, that “[t]he body is our general medium for having a world” (Merleau-Ponty, 1962, p. 145).

Humans exist in the world, and it is only in the world that we can know ourselves.

The theory of body image is, implicitly, a theory of perception. We have relearned to feel our body; we have found underneath the objective and detached knowledge

of the body that other knowledge which we have of it in virtue of its always being with us and of the fact that we are our body. In the same way we shall need to reawaken our experience of the world as it appears to us in so far as we are in the world through our body, and in so far as we perceive the world with our body. But by thus remaking contact with the body and with the world, we shall also rediscover ourselves, since, perceiving as we do with our body, the body is a natural self and, as it were, the subject of perception. (Merleau-Ponty, 1962, p. 206)

Perception, then, is independent of reflective thought, but instead is part of existential understanding. The body acts in the world without necessarily having reflective thought or understanding. We do not need to look for our body or cognitively think about where our bodies are in the world, because we intuitively know this already. The body remains marginal to perceptions because it is not really in front of us; it is the thing we do not observe. This of course is not to deny consciousness and reflective thought in some of our actions. However, by completely intellectualizing our experiences, perceptions, and bodily actions, everything that separates us from the real world is reduced to the status of mere appearance. Merleau-Ponty also discusses the 'intersensory unity of a world' in that our senses are a way of entering into relationship with objects. Various parts of our body are known to us through their functional value only, and their actions are not learned.

Experience, then, gives us 'access to being':

We must choose between the behaviourist course of refusing all meaning to the word 'experience', and trying to build up perception as a product of the world and of science, or else we must concede that experience too gives us access to being, in which case it cannot be treated as a by-product of being. Either experience is nothing or it must be total. (Merleau-Ponty, 1962, p. 258)

Therefore, to summarize, Merleau-Ponty's theories suggest that experience and existence is 'being-in-the-world' and it is only through the world that we know ourselves.

Perception and experience, then, are independent of reflective and reflexive thought. The body knows how to act without cognitive consciousness because the body is known

through its functionality. Pre-reflective embodiment requires deep immersion by the researcher into the setting of the participant. The findings of this research indicate that embodiment is also a reflective process, as evidenced by the ways in which residents discussed embodiment. Thus, embodiment occurs on both a pre-reflective and reflective level.

3.2 The Dys-Appearing Body

Leder (1990) based his discussions of the absent body on much of Merleau-Ponty's theories of phenomenology and perception. Leder (1990) suggests that the body is characterized by absence, even though it is the most inescapable presence in our lives.

Insofar as the body tends to disappear when functioning unproblematically, it often seizes our attention most strongly at times of dysfunction; we then experience the body as the very *absence* of a desired or ordinary state, and as a force that stands opposed to the self. (Leder, 1990, p. 4)

Leder describes five types of bodies—the ecstatic body, the recessive body, the dys-appearing body, the immaterial body, and the threatening body. The ecstatic body refers to the sensorimotor experience of the body. Our perceptions are not “bare concatenations of sense-data but reveal what is other, a realm of external objects” (Leder, 1990, p. 15). “One’s gestures, facial movements, and sounds do not call for explicit thematization by self or Other—they phenomenologically recede to permit access to the message they convey” (Leder, 1990, p. 21). The body thus projects outward from its place of standing. The body is a field of immediately lived sensations.

As I go through the day, my extended body ebbs and flows, now absorbing things, now casting them back onto shore...I live in bodies beyond bodies, clothes, furniture, room, house, city, recapitulating in ever expanding circles aspects of my corporeality. As such, it is not simply my surface organs that disappear but entire regions of the world with which I dwell in intimacy. (Leder, 1990, p. 35).

The recessive body refers to hidden organs and processes as well as the depth of myself as an experiencer. This recessive body is unavailable to the conscious awareness and command. Interoception refers to sensations of the internal organs of the body, while exteroception refers to the five senses that are open to the external world. As an ecstatic body, the body projects outside itself into the world, but as recessive, the body falls back from its own conscious perception and control. The dys-appearing body refers to the body's own tendency toward self-concealment that allows for the possibility of its neglect and deprecation. Body pain calls us back from ecstatic engagement to focus on the state of one's own body. In the dys-appearing body, the body appears as a focus of attention, but only in times of dysfunction or problems. The body then appears to explicit awareness. The body also becomes aware through the social, "...out of experiences of the corporeality of other people and of their gaze directed back upon me" (Leder, 1990, p. 92). The body comes to explicit awareness as an object through the Other.

As long as the Other treats me as a subject—that is, experiences *with* me to the world in which I dwell, mutual incorporation effects no sharp rift. But it is different when the primary stance of the Other is highly distanced, antagonistic, or objectifying. Internalizing this perspective, I can become conscious of myself as an alien thing. A radical split is introduced between the body I live out and my object-body, now defined and delimited by a foreign gaze. (Leder, 1990, p. 96)

The body, then, is a place of vulnerability to social and political forces.

The immaterial body refers to the functional roles of the body surface and depth which cannot be easily exchanged. Bodily functions often occur without conscious knowledge of these functions. However, when body function becomes problematic, surface and depth disappearance can give way and the body can emerge as a thematic

object. Therefore, when an individual's bodily functions that are typically hidden are breaking down, such as an ulcer, the body emerges as an object for that individual.

Finally, the threatening body is the last of Leder's (1990) defined bodies. This is when the body becomes philosophically associated with dysfunction, such as the aging body. The body is seen as having the ability to disrupt thought. The body needs to be restricted, and is equated with mindless passions and passive automaticities. "For when dysfunctioning, the body seems most Other to the self, a force opposed to the understanding and will" (Leder, 1990, p. 133).

Bodily practices and interpretations always occur within social and cultural contexts, and as such, the body cannot be defined apart from these contexts. "The human body shapes social practices, and social practices shape our use and understanding of the body" (Leder., 1990, p. 152). The body, then, according to Leder (1990), is known to us subconsciously, but becomes an object to our awareness when we experience pain, dysfunction, or the foreign gaze that is distanced, antagonistic, or objectifying.

3.3 The Social Construction of the Body

There are many theorists who have taken a social constructionist approach to the body. Here, I discuss Goffman's concepts of the presentation of self, symbolic interactionism and the body, Bourdieu's concepts of the habitus, and Frank's discussions of the body as related to social forces and relationships.

3.3.1 *Goffman and the Body*

Much of Goffman's work is related to the body as integral to human agency (Shilling, 2003). The body is seen as playing an important role in mediating the relationship between people's self-identity and their social identity (Goffman, 1959). The body is not produced by social forces, but the meanings attributed to it are determined by discourse which is not under the control of the individual. Goffman (1963) describes body idiom as a way in which the body is used to create and is ascribed meaning. Body idiom refers to bodily communication which is seen in bodily appearance and personal acts. Body idioms are conventionalized normative discourse. Expectations are held of a certain presentation, and most individuals possess some knowledge of the same vocabulary of body symbols. The individual makes information available to others through his or her body idiom. Individuals then modify activity based on others' reactions and when aspects of the activity are available for others to perceive.

3.3.2 *Symbolic Interactionism and the Body*

Symbolic interactionism, as defined by Blumer (1969), rests on three premises: i) humans act toward things on the basis of the meanings that things have for them; ii) the meaning of such things arises out of social interaction; and iii) these meanings exist within an interpretative process used by the person in dealing with the things s/he encounters. While symbolic interactionism does not discuss the body explicitly, this theory can help to explain the body and embodied experiences. Because symbolic interactionism focuses on social interaction and the meanings which arise in social

interaction, the body plays a central role as it is how we experience and mediate social interaction, whether face-to-face or not. Social interaction is a process that forms behaviour rather than being an arena for expression of behaviour (Blumer, 1969). Blumer (1969) also describes three types of objects which humans attach meaning to—physical objects, social objects, and abstract objects. Humans live in a world of objects, and actions are formed around objects. Human bodies, then, can be both physical and social objects, depending on the meaning that is attached to the body. Objects become social products when they are formed and transformed by the defining processes that take place in social interaction (Blumer, 1969). “Human group life on the level of symbolic interaction is a vast process in which people are forming, sustaining, and transforming the objects of their world as they come to give meaning to object” (Blumer, 1969, p. 12). Bodies become infused with meaning as humans interact with the world. Human behaviour is not a result of outside forces, but a result of how people act towards their world, interpreting their worlds and organizing their actions on the basis of interpretation. While Blumer (1969) does not account for primordial perception or phenomenology as does Merleau-Ponty (1962), he does provide an explanation and account for the agency of humans, and provides an account of the ways in which bodies can be infused with meaning.

3.3.3 Bourdieu and the Habitus

Bourdieu (1990) discussed the body from a social constructionist perspective. The habitus is defined as principles that generate and organize practices (Bourdieu, 1990). It can also be defined as a system of cognitive and motivating structures formed in the

context of people's social locations which structures their worldview, and reproduces existing social structures (Shilling, 2003). The practical world is always constructed in relationship with the habitus. Bodies become imprinted with the marks of social class. The structures of the social world and bodies are linked, and bodies are formed through their participation in social life (Shilling, 2003). Structures characterizing a class of conditions of existence produce structures of the habitus, which, in turn, are the basis of perception and appreciation of all subsequent experiences. The habitus is limited by historically and socially situated conditions of its production, and generates all reasonable, common-sense behaviours. Bourdieu (1990) distinguishes between class habitus and individual habitus, but individual habitus is always seen to reflect class habitus. Habitus incorporates history by structuring new experiences in accordance with the structures produced by past experiences.

...all the schemes of perception and appreciation in which a group deposits its fundamental structures, and the schemes of expression through which it provides them with the beginnings of objectification and therefore of reinforcement, intervene between the individual and his/her body. (Bourdieu, 1990, p. 73)

The modus operandi that defines practical action is transmitted through practice without rising to the level of discourse, therefore, individuals are not conscious of these modus operandi. Implicit in the techniques of the body is a system of social values.

3.3.4 Frank and the Typology of the Body

Frank (1991) views the significance of the body as related to social forces and social relationships. Frank (1991) suggests that bodies exist among discourses and institutions.

Discourses imply cognitive mappings of the body's possibilities and limitations, which bodies experience as already there for their self-understanding...these mappings form the normative parameters of how the body can understand itself. These parameters are, to be redundant about an important point, not fixed limits but fluid resources, not necessarily requiring specific bodily techniques but providing for variation and improvisation of these techniques...Institutions, on the other hand, have a specificity within body space and time....the point of a sociology of the body is not to theorize institutions from the body up. Rather than postulating more about institutions now, it is preferable to let them emerge from the actions of bodies.... (pp. 48-49)

The body is constituted in the intersection of institutions, discourse, and corporeality.

The body must also address four issues—dimensions of control (how predictable the performance will be); dimension of desire (whether the body is lacking or producing); relatedness to others; and the dimension of self-relatedness of the body. Frank then goes on to describe four types of bodies. The *disciplined body* makes itself predictable through regimentation, understands itself to be lacking, and isolated in its own performance. The body is disassociated with itself. The *mirroring body* remains predictable as the objects are made available. This body is open to the exterior world but appropriates that world. The *dominating body* refers exclusively to male bodies, and is characterized by anxiety, fear, and a sense of lacking. When dyadic other-relatedness is combined with a sense of lack, the body turns to a domination of the other. Finally, the *communicative body* is in the process of creating itself. It participates in shared narratives, community rituals, and caring relationships. While Frank's (1991) model describes discourse and institutions and how they act on the body, little of his theory is necessarily applicable to people's daily experiences.

3.4 The Development of Bodies

Elias' (1978, 1983) work needs to be included in the discussions on the body since he is one of the few theorists who frames the body in terms of relevance to historical transformations in behavioural codes and affect control. While the historical changes in conceptualizations of the body do not need to be discussed here, the processes of change in perceptions of the body, or how conceptualizations of the body have changed, is what is applicable. Elias (1978, 1983) views the body as the bearer of value. His central idea is that bodies are unfinished entities which develop in social contexts and are in a constant state of change. The social contexts are not determined by individuals or by social structures that are beyond the reach of people. Instead, social figurations or social norms, which individuals then internalize, shape social contexts. Elias views the body as being both biological and social. The body, from being closely associated with nature, becomes socially managed and organized, and is transformed into a location and expression of codes of behaviour (Elias, 1978; Shilling, 2003). Body behaviour and management, thus, becomes internalized and is perpetuated. Elias suggests that the development of civilized bodies involves a progressive socialization, rationalization, and individualization of the body (as summarized by Shilling, 2003). Socialization involves hiding away natural functions and transforming bodies into a location for and expression of codes of behaviour. Rationalization of the body refers to the strengthening of the boundaries between consciousness and drives. People, therefore, become self-reflective about their actions and do not act on impulse. Individualization of the body means that individuals tend to conceptualize themselves as separate from others, with the body

acting as a container for the self. These three techniques, then, contributed to the development of bodies and of bodily actions in present society.

3.5 The Body and Power

Foucault (1975; 1980) discusses the notion of power. In his views, the body is not only given meaning through discourse, but is fully constituted through discourse.

Discourse is viewed as sets of principles reflective of the meaning and values which underpin relations between discourse, thought, and the external world (Shilling, 2003).

The body is present as a topic of discussion but absent as a focus of investigation (Shilling, 2003). However, much of Foucault's work illuminates the body within a sociopolitical context. Foucault (1975) views the body as an object and target of power.

The human body was entering a machinery of power that explores it, breaks it down and rearranges it. A 'political anatomy', which was also a 'mechanics of power', was being born; it defined how one may have a hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus discipline produces subjected and practised bodies, 'docile' bodies. Discipline increases the forces of the body (in economic terms of utility) and diminishes these same forces (in political terms of obedience). (Foucault, 1975, p. 138).

Panopticism is a system of surveillance under which the pathological must be constantly centralized (Foucault, 1975). An increasing system of surveillance on the body produced binary divisions and branding, such as mad-sane, normal-abnormal, and dangerous-harmless. "All the mechanisms of power which, even today, are disposed around the abnormal individual, to band him and to alter him..." (Foucault, 1975, p. 200). The phenomenon of the social body consists of power operating on the very bodies of individuals (Foucault, 1980). New mechanisms of power are exercised through

surveillance and disciplinary power (Foucault, 1975, 1980). Power produces knowledge, and the knowledge of the body has been produced by an ensemble of disciplines (Foucault, 1980). According to Foucault, then, the body is produced through power operating on the body through surveillance and discipline.

3.6 Feminist Theory and the Body

Much feminist theory focuses also on issues of power and the body. In particular, Grosz (1994) and Birke (1999) are feminists who have written about the body and feminism from different perspectives. Grosz (1994) takes a perspective of the body as socially constructed and inscribed, while Birke (1999), a biologist, incorporates the biological body into the cultural construction of bodies.

Grosz (1994) describes three different positions of feminism to the body. Egalitarian feminism views the female body as a limitation on women's access to rights and privileges accorded to men, and also views the female body as a unique means of access to knowledge and ways of living. Women's oppression is a result of the containment within an inadequate body. This position is seen in the works of individuals such as de Beauvoir. According to Grosz (1994), the social construction position on the body is eschewed by Mitchell, Barrett, Chodorow, and Marxist feminists. The body is not seen as an obstacle, but as a biological object whose representation and functioning is political, marking male and female as distinct. This position shares the notion of a biologically determined, fixed, and ahistorical body, and retains the mind/body dualism. A distinction is made between the "real" biological body and the body as an object of representation. Finally, the position of sexual difference is espoused by Irigaray, Butler,

and others, according to Grosz (1994). The body is seen as crucial to understanding women's psychical and social existence. This position is concerned with the lived body, the body as represented and used in specific ways in particular cultures. The body is seen as a cultural interweaving and a production of nature. Rather than seeing sex as essentialist and gender as a constructionist category, these scholars undermine these categories altogether.

Grosz (1994) views the body as products of the social constitution of nature itself.

I hope to show that the body, or rather, bodies, cannot be adequately understood as ahistorical, precultural, or natural objects in any simple way; they are not only inscribed, marked, engraved by social pressures external to them but are the products, the direct effects, of the very social constitution of nature itself. (Grosz, 1994, p. x).

Grosz views bodies as being colonized through the discursive practices of natural sciences, particularly biology and medicine.

...in all cases, how bodies are conceived seems to be based largely on prevailing social conceptions of the relations between sexes...bodies provide a neuralgic locus for the projection and living out of unreflective presumptions regarding the sexes and their different social, sexual, and biological roles (Grosz, 1994, p. x)

Grosz does not embrace either biological determinism or social constructionism, but views the body as peculiar, not quite reducible to being merely a thing, nor does it ever quite manage to rise above the status of a thing. The body is both a thing and a nonthing, an object able to take itself and others as subject. The specificity of bodies needs to be understood in its historical rather than biological concreteness.

Birke (1999) takes a similar perspective to the body, although from a slightly different viewpoint, being that her background is as a biologist. She claims that the biological body is peripheral to much feminist theory because of the necessary rebuttal of biological determinism. She contends that this has obscured what goes on inside the

biological body, and is now only explained through the language of biomedicine. She makes the link between the biological body and its gendered construction, and makes explicit how assumptions about gender are read onto nature, including the insides of our bodies. The division between the biological and social has meant that whatever was assigned to biology was seen as inaccessible to cultural analyses. Social theory has focused on the exterior of the body on which culture becomes endlessly inscribed, which implies that the biological lies outside social theory. While the body is seen as socially and culturally constructed, it is also material, also flesh. Birke (1999), therefore, bridges the divide between the body as material and the body as constructed, and shows how the body's materiality is constructed and how specific narratives structure the way we understand biology.

The fear that many feminists have of falling into biological determinism, then, have been addressed by feminists such as Grosz (1994) and Birke (1999), who advocate both an understanding of the construction of the body and the materiality of the body. What still remains, however, is an understanding of embodied subjectivity, of psychical corporeality (Grosz, 1994). Given that language is often inadequate to express these embodied experiences, it remains to be seen how this will play out (Shapiro, 1999).

3.7 The Body as Subject/Object

The body and self are intertwined. The self is inseparable from the body, but not identical to the body (Gadow, 2004). The body can be seen both as subject and object. The body as subject is the experiencing body. The body as object is the inscribed body. The question is, where is the self in this? Gadow (2004) suggests levels of relation

between the body and the self. *Primary immediacy* is the lived body as a mode of orientation of the self, a way of being in the world. The relationship between the body and the self is immediate since the body is an aspect of self. When the focus changes inward, the immediacy of the lived body gives way to self-distinction and divides the self and body. *Disrupted immediacy* is when primary immediacy is ruptured by incapacity and constraint. The rise of the internal distinction gives meaning to “constraint” (the self) and the part (body) which is the origin of the constraint. There is an implicit struggle between the body and the self, and the body becomes an object. The object body is as much a part of the world as it is a part of the self. There is then an attempt to recover the concrete unity of self and body. *Cultivated immediacy* is the reuniting of the self and body by transcending the struggle of the body and self as mutually limiting.

The subject body is a part of the self, but only a part. A new relationship between the self and subject body is described by Gadow (2004) as one of intrasubjectivity, in that the self recognizes the body as another manifestation of selfness. When the relationship is intrasubjective, neither the self nor the subject body is object or is subjugated. Instead, one may simply appear less immediately accessible than the other.

In the one-sidedness of concern for only the object body, the consideration which is missing is the body as a being in its own right. It is that body, the subject body, which may emerge in illness and aging. It is only by complementing the mastery of the object body with equal attentiveness to the subject body that an enduring and dialectically complete unity can be achieved, one which does not require continuing conformity of the body to self. (Gadow, 2004, p. 77)

Shapiro (1999) describes the body as the mediator of experience, and that coming to know is an embodied experience. Any approach that is committed to human liberation must address the body as a site for both oppression and liberation. Embodiment is the process by which the body becomes a vehicle for socialization.

The forming of our being grows out of our experiences. Experiences are perceived in coordination between our minds and bodies—that which forms our being. This forming is the historically situated, culturally inscribed “reality” in which we live. (Shapiro, 1999, p. 26).

Early feminist work has advocated the inseparability of body knowledge and issues of power. Deconstructionism, however, places the body nowhere as it dislodges the body from any particular location and any possibility for unity. The woman’s body is positioned in a way that it becomes the focal point of identity. Women construct identities in relation to the socially constructed notions of female beauty.

Embedded within perceptions and interpretations are personal experiences understood through a hegemonic consciousness that suspends us in the contradictions between a dominant and a resistant consciousness. From this space between domination and resistance is where meaning is found, securing the living body as the material that holds both. Ideas do not exist somewhere outside of this living material. What we know is at times attached to bodily knowing, whether as tacit knowing or as conscious knowing. What we know speaks with and to our bodily memories of living. Both mind and body mingle together in a continuous informational stream creating the interpretations we call knowledge (Shapiro, 1999, p. 32-33).

According to Shapiro (1999), in feminist and postmodern discourses, the body’s place is reconceived, and is “...reconceptualized as a material presence that relativizes perception and thought as it fixes the knower in time and space” (p. 78).

3.8 The Body in Old Age

In gerontology there has been a reluctance to tackle the aging body (Twigg, 2004). Concerns are expressed that by embracing the body, it can take us back to biological determinism and narratives of decline (Twigg, 2004). Currently, because we live in a youth culture, the only reading of the body in old age is narratives of decline (Twigg, 2004). Closely connected with youth culture is the consumer culture (Hepworth, 2003). This consumer culture inscribes certain meanings on the body, and categorizes the

body into the inner and outer body (Featherstone, 1991). Within consumer culture, however, the inner and outer body become joined, and the inner body is thus defined by the outer visual body.

The mask of aging is a popular theory in gerontology (Featherstone & Hepworth, 1991). Older adults are seen to conceal and mask inner feelings, motives, attitudes, and beliefs. As such, old age as revealed in the body is a mask which conceals the identity of the person underneath. Aging portrays the body as pathological and deviant, while the inner self remains. The changes in appearance and the body are seen to be separate from the self, which is more enduring. This reading of the body still continues to reinforce the Cartesian dualism of mind and body, assuming that the self is separate from the body.

Gubrium and Holstein (1999) view the nursing home as a discursive anchor for the aging body. The leading questions “...have become *how* and *where* does the body as a corporeal presence serve as a surface for the assignment of personal meaning and an organizing principle for social interaction?” (p. 520) The nursing home as a discursive anchor “...provides an increasingly common institutional basis for assigned meanings to the body” (Gubrium & Holstein, 1999, p. 520). The nursing home guides body talk relevant to disease, caregiving, and dying, and encourages the appropriation of aging characteristics. The aging body is discursively anchored in relation to organizational practices. The deprivatisation of experience exists because of the power of the institution to define the body and discourse.

Embodiment links together both broadly cultural and circumstantial usages, the body taking on its meaning at the intersection of narrative, culture, and social interaction. The nursing home, in particular, not only draws these usages together in relation to the aging body, but, in turn, it is itself productive of related body talk, reflexively acting both as discursive anchor and as an anchor for discourse. (Gubrium & Holstein, 1999, p. 536)

Golander (1995) describes the experiences of nursing home residents of their bodies. Residents described the “betrayal” of their bodies, and how they had to renew their knowledge of their own bodies after changes to the body because of chronic illness and the aging process. They pursued “new modes of somatic attention” (p. 65) related to their bodies, referring to pain management, body listening, and self care. Despite residents’ physical conditions and distress, they rarely talked about it among themselves. However, they were able to determine what was good and bad for their bodies, and adjust their lives to this, including eating, sleeping, and daily rhythms. Residents also invested time and effort into training the staff the ways of their bodies. Changes in bodily functions, then, involved a reorganization of expectations and adjustment to physical changes.

Beyond the body, however, is still the notion of self. Kontos (2003) conducted an ethnography on an Alzheimer’s unit. Using Merleau-Ponty’s (1962) phenomenology and Bourdieu’s (1990) notion of habitus, she examined the selfhood of the residents, and suggested that an understanding of embodied intentionality defined the participants as persons and sustained their selfhood despite cognitive impairment. She found that residents were self-reflective about their body through appearance, cleanliness, expressions of preference, and creativity and self expression. Sociability was evident through social etiquette, caring, sharing, friendships, singing, dancing, and orchestrating, social talk, conflicts, and gestural communication. Finally, embodied intentionality was evident through ritual and ceremony. She suggests that the self resides in the pre-reflective body, which invites a rethinking of selfhood as not simply located in the conscious will, but also in the visceral depths of the body. Kontos’ (2003) work is

revolutionary in that it challenges the Cartesian dualism of mind and body as well as the loss of self that is presumed to accompany dementia. “Etched in the facial lines and marked by the flaccid skin are the experiences of a life: pain, joy, anger, pleasure, concern, have all seeped into the flesh representing a knowing through living” (Shapiro, 1994, p. 72).

3.9 Body Work in Long-Term Care

The discussions of the body would not be complete without discussing body work specifically related to long-term care. Wolkowitz (2002) suggests that the concept of body work incorporates those whose paid work involves the care, adornment, pleasure, discipline and cure of others’ bodies. Twigg (2004) states that bodywork is a character of carework, and that “[b]odywork entails working on or through the bodies of others, handling, manipulating, appraising bodies which become the object of the worker’s labor” (p. 67). Many social processes are involved in creating specific niches of bodywork (Wolkowitz, 2002). Higher status occupations tend to deal with the bounded body, whereas the lower status occupations deal with what is rejected, left over, spilled out, and polluted (Wolkowitz, 2002). The higher one rises in an occupation, the more removed they become from the “dirty work on bodies” (Twigg, 2004, p. 68). “...the worker is employed as much to carry dirt’s stigma as to labour, and is metaphorically racialized by her association with dirt” (Wolkowitz, 2002, p. 502).

In addition, there are many gender connections with body work. Women tend to often perform bodywork (Twigg, 2004). There is also a wider cultural association of women with the body as representing the unmarked, silenced categories of the body,

emotion, and nature (Twigg, 2004). Women then are equated with the body and nature, and contrasted with the rationality of men (Twigg, 2004). By a complex set of processes, women find themselves located in bodywork. Carework is also perceived as unskilled in that there is a perception that it does not require education or training to do it, and consequently is low paid. The skills are seen to come naturally to women (Twigg, 2004). Women are also not seen as a sexual threat as caregivers since they are viewed as nurturers, whereas men are perceived to have ulterior motives when caregiving (Twigg, 2004).

The notion of bodywork is important to discuss to provide a more comprehensive understanding of the nature of carework in long-term care and the nature of staff-resident interactions, most of which focus around the body. Bodywork is a set of processes that marginalizes and dominates, in addition to giving power to other groups. It is not a simple matter of caregivers in a position of power over residents, but as caregivers who are themselves marginalized, giving care to residents who are marginalized. Therefore, the dynamics of domination and marginalization are complex and implicit, rather than simple and explicit.

In summary, then, there has been much discussion on the body in the last few decades. Different approaches to the body, such as phenomenology, the social construction of the body, historical developments of the body, the body and power, feminist approaches, and the body as subject/object have permeated the literature. The body has also been discussed in relation to old age, where the body is viewed as frail and broken down, yet the self is still seen to prevail. Old age, then, is seen as a mask which conceals identity (Hepworth, 2003). Bodies are also discursively constructed, as

described by Gubrium and Holstein (1999). Finally, Kontos (2003) found that self resides in the body, and invites a rethinking of selfhood as located not only in the mind, but also in the body. Bodywork is also discussed related to long-term care (Twigg, 2004), in that both residents and staff are marginalized and dominated, as well as dominating, illuminating the complex relations in long-term care. The body, then, as a potentially important part of the socialization process in the long-term care environment must be examined.

After reviewing the immense body of literature focused on the body, I take various theories and apply them to my perceptions of the body. Recognizing that the body is both acting and acted upon (Bourdieu, 1990; Foucault, 1975; 1980), I also recognize that the body is a biological entity, yet socially constructed (Birke, 1999). Embodied experiences provide a unique means of access to knowledge and ways of living (Grosz, 1994; Shapiro, 1999). The body is a mediator of experience (Shapiro, 1999). As such, the self is an inextricable part of the body (Kontos, 2003). Old age provides a unique set of challenges to the body and embodied experiences, as perceptions of the body are focused on frailty and decline (Twigg, 2004). However, older adults, and specifically in this study, residents in long-term care settings, provide a site of unique knowledge of their embodied experiences and what it means to be “old” in particular settings. Therefore, to summarize, I view the body as both acting and acted upon, as a biological entity, yet socially constructed, as a physical entity, yet as the self, and as a site for access to unique and often silenced knowledge. The findings of my research suggest that the body, both as inscribed and disciplined by the institution as well as experienced

by the residents, is not only the primary site for the socialization processes into long-term care, but is also the end result of the socialization processes.

CHAPTER FOUR SELF AND IDENTITY

Self and identity are important components of the socialization process. Because the long-term care environment can be so foreign to older adults prior to and during admission, the adjustment to long-term care can potentially have a tremendous impact on the self. As Paterniti (2000; 2003) found, residents often have identities imposed on them by staff and institutional routines, yet in many ways resist these identities and also provide alternative identities to the ones assigned to them. How identities become assigned to residents when they are first admitted to the long-term care setting and if and how they accept or resist these identities has yet to be examined in the literature. In addition, how these identities impact a sense of self has not been examined in the literature. Therefore, this study will focus on self and identity as a potentially important part of the socialization process into long-term care settings.

The notions of identity and the self have been central to numerous ongoing projects over the years (Leary & Tangney, 2003). Scholars have not yet come up with a single, universally accepted definition of self (Leary & Tangney, 2003). There are five distinct ways in which the self is used: as the total person in common everyday language; as personality; as the experiencing subject; as beliefs about oneself (self as the knower and known); and as an executive agent (Leary & Tangney, 2003). Ultimately, self refers to the human capacity for reflexive thinking (Leary & Tangney, 2003).

Mead (1934) was one of the first modern theorists to discuss the notion of self. Mead viewed minds and selves as social productions. The self arises in the process of social experience and activity. Mead distinguishes between the self and body, and

suggests that the body can operate without a self being involved in the experience. The self can be both subject and object to itself. This corresponds to Mead's "I" and "me". "The 'I' is the response of the organism to the attitudes of others; the 'me' is the organized set of attributes of others which one himself (sic) assumes" (Mead, 1934, p. 175). Because the self is social, individuals experience themselves from the standpoints of others in the same social group, or from the generalized standpoint of the social group. An individual enters his or her own experience as a self by becoming an object to him or herself by taking the attitudes of others towards him/herself within the social environment or context of behaviour. Mead (1934) suggests a unified self that can be broken up within the communities to which we belong. The unity and structure of the complete self reflects the unity and structure of the social process. There are various elementary selves which constitute a complete self, and these various aspects of the self are parallel to the structure of social processes as a whole. Because the self arises in a social process, the interaction of individuals within the group is implied.

One of the criticisms of Mead's theory of the self is the separation of the mind and body, which has been criticized by various scholars (Howson & Inglis, 2001; Kontos, 2003; 2004; Leder, 1990; Merleau-Ponty, 1962). In addition, the self is seen not to exist without the social interaction of others, and that the self arises only out of adopting others' views and attitudes toward oneself. The notion that individuals can resist others' constructions of themselves and create new constructions of the self is not taken into account.

Giddens' theory of structuration (1984; 1991) takes this perspective of self. Human agents and actors have the capacity to understand what they do while they do it

inherently. The reflexive capacities of individuals are involved continuously in the flow of day-to-day conduct. The notion of the self as agent is often criticized for not taking into account structural issues, which is what Giddens's theory attempts to do. Social structure is seen as a set of rules that facilitates and constrains human action. It does not make people do one thing or the other, but individuals decide what to do by drawing on the structure, thereby manifesting agency. Individuals have the need for security, and to sustain this, individuals act to reproduce specific social systems as they exist, which is how systems persist. Giddens effectively tries to marry the self as a reflexive agent within social structures.

Self-identity...is not something that is just given, as a result of the continuities of the individual's action-system, but something that has to be routinely created and sustained in the reflexive activities of the individual. Self-identity is not a distinctive trait, or even a collection of traits, possessed by the individual. It is the self as reflexively understood by the person in terms of her or his biography. Identity here still presumes continuity across time and space: but self-identity is such continuity as interpreted reflexively by the agent. This includes the cognitive component of personhood. To be a 'person' is not just to be a reflexive actor, but to have a concept of a person (as applied both to the self and others) (Giddens, 1991, p. 52-53).

Gergen (1991) has also written about the social self. Gergen suggests that the process of social saturation, that is, the expansion of social worlds and the inability to "get away" from obligations and demands, is producing a profound change in our ways of understanding the self. Because of this social saturation, we are being furnished with a multiplicity of incoherent and unrelated languages of the self. In this world, we no longer experience a secure sense of self. The populating of the self leads to the acquisition of multiple and disparate potentials for being. Social saturation produces imitative assemblages of each other, and each of us becomes the other. Committed identity becomes a difficult achievement as new and disparate voices are added to one's being.

Gergen still holds to the idea of a singular concept of self that can exist if one can only fight off the forces of social saturation.

Gubrium and Holstein (2001) do not dismiss the concept of a singular, authentic self, but suggest instead that the self is "...produced in proliferating and variegated panorama of sites of self-knowledge" (p. 96). The self is essentially a social structure, which unfolds in and through social life. Discursive environments function to assemble, alter and reformulate our selves. These discursive environments provide many options for who we could be. These environments set the conditions of possibility for subjectivity. As a result, the world is increasingly populated by institutional selves—those selves that are formed and reformed in the discourse and practice of the institution. No single environment determines who and what we are, so the individual has multiple and diverse options for self-construction. Within these discursive environments, narrative practice lies at the heart of self-construction (Holstein & Gubrium, 2000). Interaction and communication are the basis for the social self (Gubrium & Holstein, 2001). We, therefore, have institutional identities, which:

...are locally salient images, models, or templates for self-construction; they serve as resources for structuring selves. But as ubiquitous, prominent, and varied as troubled identities have become, the process of assembling them into institutional selves is anything but a matter of simply picking and choosing. Making connections between the personal self and a troubled identity involves a great deal of interpretive activity, work that is conditioned by the setting in which it is conducted (Gubrium & Holstein, 2001, p. 11).

A number of studies have used varying definitions of the concept of self. Sabat and Harré (1992) state that the self of personal identity is "...experienced as the continuity of one's point of view in the world of objects in place and time. This is usually coupled with one's sense of personal agency, in that one takes oneself as acting from that

very same point” (p. 455). Personae are selves that are publicly presented in the episodes of personal interaction in everyday life (Sabat & Harré, 1992) or co-constructed roles that individuals take on in various social contexts (Small, Geldart, Gutman & Clarke Scott, 1998). Usita, Hyman, and Herman (1998) did not explicitly define self in their study, but the assumption and argument was made that language is a reflection of self, and that information and stories are told through narrative. Cohen-Mansfield, Golander, and Arnhem (2000) used an operational definition for the concept of self-identity in dementia that included “...roles, identities, attributes and preferences which an individual attributes to him/herself, and which therefore reflect selfhood” (p. 383). Kitwood (1997) defines personhood as “...a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect, and trust” (p. 8). This definition of personhood is based on individuals living in relationships, and therefore is bestowed upon individuals by others. As such, personhood is a much different concept than self, since personhood depends on the definitions of the individual by other individuals surrounding him or her. Charmaz (1983) in her classic study of the loss of self in the chronically ill, uses a symbolic interactionist perspective indicating that the self is fundamentally social in nature and is developed and maintained through social relationships:

When I speak of self-concept, I mean the organization of attributes that have become consistent over time. Organization is the key to understanding the self. Though the self is organized into a structure, ordinarily that structure ultimately depends on the processes to sustain it. In other words, for most individuals, maintaining the organization of the self—that is, self-concept—means empirical validation in daily life (p. 170).

Kelly and Field (1996) state that “self is a cognitive construct that is constantly being reconstructed and which is expressed in the various narrative and autobiographical accounts which are offered by the individual in self-presentation” (p. 245).

For the purposes of this study, I will be using the definition of self as posed by Sabat and Harré (1992), that is, the continuity of one’s point of view in the world as well as the sense of personal agency. I believe that self is evolving and constantly constructed and reconstructed depending on the situations or circumstances we find ourselves in (Kelly & Field, 1996). Self can be expressed in many different ways, including in our narrative and the autobiographical stories we share with others (Kelly & Field, 1996). Personae will refer to those aspects of self an individual chooses to project into the public arena, essentially the social self. This is the publicly presented image of self that is regulated by the individual, or how the individual chooses to portray him or herself in a social setting. Finally, identity will refer to “...public and shared aspects of individuals. Identity establishes what and where the person is within social structures, thereby linking self to social structure...Identity defines a person as a social object locked into group memberships and social relationships” (Kelly, 1992a, cited in Kelly & Field, 1996, p. 245). Further defined, identity will also refer to the public and shared perception of the individual, or the responses of others to the presentation of personae. Thus, identity is similar to Kitwood’s (1997) definition of personhood as a status that is bestowed on an individual by others. Identity also establishes a person within a social network through the assumption of roles.

I also recognize Gubrium and Holstein’s (2001) and Holstein and Gubrium’s (2000) discussions of the discursive self, in which the self is produced and defined

through discursive environments that provide many options for who we can be. In addition, individuals can choose to resist and create alternative identities and self in opposition to dominant discourse. Narrative practice, however, is the key to the heart of self-construction (Holstein & Gubrium, 2000). In addition to these definitions of self and identity, I also incorporate Kontos' (2003) notions that the body and self are entwined. Since the body and the self cannot be separated, when the self is discussed, the body is often implicitly referred to as well.

4.1 Self, Identity and Long-Term Care Facilities

Nursing homes and other long-term care settings can have a drastic effect on residents' identities and perceptions of self. Golanter (1995) describes the deselfing process that happens to nursing home residents. The stereotypes of aging and the incongruence in self and social conceptions can blur older adults' identity. The structural nature of the institution also increases the homogeneity among residents, which further serves to erase what might have been left of residents' individuality and identity. As individuals become residents, social and personal identity become one. Despite this, however, residents can resist these inscriptions of identity.

Gubrium (1993) reminds us that “[m]undane as the stories are, they inform the reader that quality of life and quality of care, in residents' voices, are not so much rationally assessable conditions, as they are horizoned, ordinary, and biographically active renderings of lifelong experience” (p. xvi). The use of narratives, as will be illustrated, provide opportunity for the residents to portray images of self and resist constructions of self by others (Paterniti, 2000, 2003).

Paterniti (2003) suggests that residents do not define themselves solely in institutional terms. In her study, she found that different strategies were used by residents for resisting institutional identities. For some, storytelling was used to allow the residents to transcend the institutional rhythms structuring their lives. Some used musical instruments and talents to lay claim to a distinct identity. Residents also viewed others as different from themselves—as older, more dependent, and more troublesome. Staff often accepted the residents' alternative identities, but these strategies could also backfire on the residents if they demanded too much of staff time. Paterniti's research highlights that residents are not passive subjects in the nursing home, but are active agents in establishing their own identities and resisting institutional identities.

Paterniti (2000) further describes the role of narrative accounts in functioning as a principal tool for establishing an alternative definition of the situation in the institution and to authenticate personal identity. Residents' narratives provide a self that is usually unrepresented in medical records and discourse. By providing an alternative narrative, residents provide a different means of personal identification and other bases for interaction with staff. Residents who emphasize their illness as an identity marker conform to the staff-defined identities of them. Staff and residents often have conflicting interests:

As a result of different demands on their time, residents and staff have conflicting interests: the former have a desire to promote a “noninstitutional” self-identity in the otherwise regimented, mundane, and sometimes inhumane circumstance, and the latter have an interest in fulfilling occupational timetables, using routine identity and work as a means for occupational accomplishment... While one set of actors, the resident patients, tries to make institutional life interesting, the other set, the staff, attempts to control the chaos (Paterniti, 2000, p. 109).

Gubrium (1993) illustrates different identities that residents take on based on their biographical linkages. He suggests that life narratives are communicated lives. He interviewed 58 residents; 33 residents who participated in three interviews, and 25 residents who participated in two interviews. The life narratives of some residents highlighted worry and disappointment. Other residents were making the best of their life in the nursing home, and the nursing home's quality of life was a narrative extension of what life had always been like. Some residents overrode concern with fate. They wondered how it was possible that life had come to this, where they felt they had no purpose in life. For others, features of the earthly life took on meaning in connection with the life beyond. These residents were strongly religious, and felt this was a stage in the journey to heaven. Finally, the vigilant had typically been independent throughout their lives and felt an ethic of distributive justice. They felt that their personal space had been infringed upon by other residents and staff. Gubrium (1993) illustrated in this study that residents' views toward the nursing home and quality of life should only be interpreted within a historical and biographical context. This of course indicates that the experience of living in a nursing home is also mediated by the historical and biographical context.

Assumptions are often made that residents simply conform to the rigid structures and confines of nursing home life, but as is evidenced here, there are many ways, both actively and passively, that individuals resist the pressure of conformation to the routines and the structure of institutions. While some scholars considered dementia as paramount to a loss of self (Cohen & Eisdorfer, 1986), other scholars have suggested that the self continues even into the late stages of dementia. Sabat and Harré (1992) found that individuals continue to refer to themselves in the first person and express their

experiences throughout the course of the disease. In research conducted by Tappen and colleagues (1999), it was found that individuals have a sense of self even into advanced stages of dementia. Participants in this study frequently referred to themselves in the first person, and talked about their characteristics and experiences both in the past and present. They also indicated that they were aware of the cognitive changes that were occurring. Harris and Sterin (1999) found that the impact of dementia on self-concept involved a changing sense of self, multiple losses, and emotional reactions linked to efforts to maintain a sense of self. Participants stated that self was not lost in Alzheimer's disease, but that the sense of "who one is" is often in a state of flux. Even in dementia, the sense of self is still intact. While this study is not specifically focusing on residents with dementia, this research highlights the impact of illness and disability, as well as the impact of long-term care settings, on individuals' sense of self.

To summarize, self and identity are important considerations when discussing long-term care residents. Various theorists, such as Mead, Giddens, and Gubrium and Holstein, have discussed self and identity. Recognizing that the self is constructed in discursive environments (Gubrium & Holstein, 2001), individuals also have agency to accept or resist these identities (Giddens, 1991), and to construct and reconstruct new identities. Self, as well, is not seen as exclusive of the body, but instead is seen as dwelling within the body (Kontos, 2003). Research examining identity in long-term care settings have found that the institution often serves to define residents' identities (Diamond, 1992; Paterniti, 2003), yet residents often resist these identities and provide alternative definitions of self (Paterniti, 2003). The role of narrative accounts is the principal tool for these instances of resistance. The notion of self, then, is a reflexive

concept that is both constructed by others and society as well as constructed and reconstructed by individuals. The findings of my research point to a sense of self and identity that increasingly becomes defined by the institution, yet residents still find ways to resist institutional identities and maintain a personal identity that is not solely defined by the institution.

CHAPTER FIVE THEORETICAL CONCEPTUALIZATIONS OF PLACE

Since the socialization process occurs within the framework of the long-term care facility, place is an important concept to consider. Because place is a constituting element of social life, it is significant in all studies of social life (Gieryn, 2000). Therefore, socialization into a particular culture occurs within the context of place. In addition, the body and self are formed within particular places and are influenced by place. Place, then, is an important component of the socialization process and is linked to body and self.

There are many different discussions on the concept of place and space in the literature. In most of the discussions, however, place and space are distinctively differentiated. Space is often defined as the physical characteristics of the environment while place refers to psychologically and socially constituted meanings of the environment (Dixon & Durrheim, 2000; Giuliani & Feldman, 1993; Low & Altman, 1992; Rubinstein & Parmalee, 1992; Stokowski, 2002). While space and place are most often differentiated in this way, others have defined them opposite to above—place referring to physical location and space referring to the way place is used and the meaning made out of place (Gustavson & Cytrynbaum, 2003).

Relph (1976) describes space as intangible, something that cannot be directly described or analyzed. There are different understandings and a wide range of meanings of space. The meaning of space, according to Relph (1976) arises from immediate experience. Space becomes place because experiences have attracted and concentrated our intentions and are set apart from surrounding space while remaining a part of it.

Tuan (1977) states that the meaning of space often merges with that of place, but that space is more abstract. What begins as undifferentiated space becomes place as we get to know it better and endow it with value. Space is organized around the body and is a symbol of openness and freedom. We have a sense of space because we can move. Place, on the other hand, is a calm centre of established values, and we have a sense of place because we undergo phases in life. When space becomes familiar, it becomes place. Place offers little outside the human bond, and is focused on relationships and roles. Place is a static concept of an organized world of meanings.

Gieryn (2000) describes place as having three significant features. First, place is a geographic location, and is the distinction between there and here. Second, place has physicality. "It is a compilation of things or objects at some particular spot in the universe" (Gieryn, 2000, p. 465). Third, place is invested with meaning and value. Place needs to be named, identified, or represented by ordinary people in order for a place to be a place. Place, according to Gieryn (2000) is not only physical, but given an identity as well.

I, however, refer to space as either a physical or abstract location which is defined in reference to other objects around it and has the potential to be used in a specific way by individuals. Space is defined in reference to the ability of an individual to move (Tuan, 1977), and is often measurable. However, space is also often used in colloquial terms to refer to abstract locations, such as "cyberspace" or personal space. I refer to place as the physical environment (Relph, 1976), both built and natural, as well as the social environment. In addition, place incorporates the identities assigned to it by individuals and is endowed with value (Gieryn, 2000; Tuan, 1977). Space and place can

at times be used interchangeably, but there are some spaces that cannot be places (e.g., cyberspace). Relph (1976) suggests that places are the elements that order our experiences in the world. Place, although being endowed with value (Tuan, 1977), must also be a physical geographic location (Gieryn, 2000). I refer to sense of place as the ways in which people have constructed meaning out of place. Although “place” as a concept incorporates identities assigned to it by individuals, a sense of place incorporates much larger notions of meaning and representation of place. Some scholars have used place to refer to a sense of place, and have included both the physical environment as well as meanings and interpretations (Gieryn, 2000). However, sense of place as I am using it in this context incorporates not only meanings and interpretations, but also includes experiences of place, the notion of self in place as well as how the self is revealed and concealed in place, the history of the individual as it shapes meanings and interpretations, and relationships and role expectations in place (Wiersma, 2003). Sense of place is a fluid and changing concept because interpretations, meanings, and experiences are always changing (Wiersma, 2003). Sense of place, then, incorporates much more than meanings and interpretations, but also incorporates the various other aspects delineated above.

Rodman (1992) conceptualized place as multilocality and multivocality. Multilocality assumes a decentred analysis, and looks at places from the viewpoint of Others. It also refers to the reflexive relationships with place. Multilocality also shapes and expresses images of place for different users—a single place may be experienced differently. Multilocality also refers to the comparative or contingent analysis of place—that activities arise from actions of multiple agents in different places. Multivocality

refers to listening with all of one's senses. Places bespeak people's practices, history, conflicts, and accomplishments. "By joining multilocality to multivocality, we can look "through" these places, explore their links with others, consider why they are constructed as they are, see how places represent people, and begin to understand how people embody places" (Rodman, 1992, p. 652). Rodman (1992) sees places as socially constructed. "Places are not inert containers. They are politicized, culturally relative, historically specific, local and multiple constructions" (Rodman, 1992, p. 641). Essentially, there is an inseparability between people and place, and identity is grounded in place.

Many concepts are apparent in theoretical discussions of place (for a brief summary, see Manzo, 2003). Concepts such as sense of place, place attachment, place dependence, and place identity are used. Sense of place tends to refer to the meaning making process of place (Steele, 1981; Wiersma, 2003). Place attachment refers to the bonding process of people to places (Low & Altman, 1992). Place dependence refers to the strength of the association between a person and specific places (Manzo, 2003). Place identity refers to dimensions of self that develop in relation to the physical environment (Tigger-Ross & Uzzell, 1996). Despite the definitions of these concepts, many of them overlap and the connections between them remain unclear (Manzo, 2003). For the purpose of this discussion, I shall briefly discuss place attachment, place identity, sense of place, discourse and place, old age and place, and criticisms of the concepts of place. I then summarize my own conceptualizations of place.

5.1 Place Attachment

As mentioned earlier, place attachment refers to the emotional attachments to place, and is often described as a complex phenomenon (Giuliani & Feldman, 1993). Place attachment is the bonding of people to place (Low & Altman, 1992). According to Low and Altman (1992), there are a number of assumptions with place attachment:

- (i) place attachment has interrelated and inseparable aspects;
- (ii) the origins are complex and varied;
- (iii) place attachment contributes to individual, group, and cultural self-definition and maintenance (see p. 3).

Low and Altman (1992) have contributed significantly to the theorizing of place attachment, and suggest that it is an interplay of affect and emotions, knowledge and beliefs, behaviours and actions in relation to place. The primary target of the bonding is to the physical environment, but can incorporate other people and social relations. Place attachment is often measured with quantitative tools such as surveys (Brown, Perkins, & Brown, 2003; Williams & Vaske, 2003). Place attachment can also contribute to the identity of an individual, group, or culture. As such, place attachment often overlaps concepts of place identity.

5.2 Place Identity

Twigger-Ross and Uzzell (1996) posited a number of characteristics of place identity. First, they distinguish between place identification and place identity. Place identification refers to a person's expressed identification with a place. Place is then considered as a social category. Place identity is another aspect of identity that describes

socialization with the physical world. These authors, however, suggest that all aspects of identity have place-related implications to a greater or lesser degree. Twigger-Ross and Uzzell (1996) suggest four principles of place identity. First, place is used to satisfy the desire to maintain personal distinctiveness or uniqueness. Second, the continuity of self-concept implicates place. Place-referent continuity is the maintenance of a link with a specific place that provides a sense of continuity to identity. Place acts as a referent to past selves and actions. Place-congruent identity refers to the maintenance of continuity through generic and transferable characteristics of a place. In other words, people look for places to live that represent their values. Third, self-esteem as an aspect of identity refers to the positive evaluation of oneself or the group with which one identifies. Self-esteem can be impacted by the qualities of place. Finally, self-efficacy is affected if the environment facilitates or hinders everyday lifestyle. Based on their empirical research, these authors conclude that there is evidence for the establishment and use of place in the maintenance of continuity of self and the use of place to create, symbolize, and establish new selves.

Hormuth (1990) described the ecology of the self, which consists of others, objects, and environments. Others are seen as sources of direct social experience. Objects are symbols and representations of social experiences. Environments are settings for social experiences. Self-concept, according to Hormuth (1990) develops in interaction with its social and physical environment to form the ecological system for self. If change happens, people try to preserve their ecological system or resist changes in the environment. Social commitments are central to the self as they involve and tie people together in social relationships. Changes in central social commitments can cause

individuals to reinforce or question their self-concept. Self as a process and self concept as a product are linked to the individual's social situation as well as the larger social and cultural context. Place, however, as both social and physical environments, and experiences within place, can have a significant impact on the sense of self, self concept, and even how people define the identity of a place.

5.3 Sense of Place

Steele (1981) has delineated in detail the notion of a sense of place, and views a sense of place as a transactional view of relations with the environment. A transactional view means that people take something from and give or do things to the environment. A sense of place is an experience created by the setting in combination with what a person brings to it. Steele (1981) describes two aspects of place—a sense of place and a spirit of place. A sense of place, as described already, is a particular experience of a person in a particular setting. The spirit of place is the combination of characteristics that gives some locations a special “feel” or personality. Sense of place, then, is not simply about the setting, but is about the individual as well.

Relph (1976) also discusses the notion of a sense of place. While he describes place as a multifaceted phenomenon of experience, he states that some assessment can be made of which properties of place are essential to our sense of place and experience. He suggests that places have identities that distinguish them from other places. The essence of a place lies in the experience of belonging and identifying with the place, of an ‘inside’. A sense of place, however, is the ability of individuals to recognize different places and different identities of place. An authentic sense of place, according to Relph

(1976), is the genuine experience of the identity of a place and an awareness of places for what they are. This suggests that place has an identity or an essence that is interpreted by individuals.

5.4 Discourse and Place

The ways in which we talk in everyday language are often routinely spatially marked (Keith & Pile, 1993a; 1993b). Dixon and Durrheim (2000) discuss the role of discourse in the creation of place. Because place is socially constituted and constituted by the social, place identity is created together through talk.

It is through language that everyday experiences of self-in-place form and mutate; moreover, it is through language that places themselves are imaginatively constituted in ways that carry implications for ‘who we are’ (or ‘who we claim to be’)” (Dixon & Durrheim, 2000, p. 32).

Stokowski (2002) suggests that people actively create meaningful places through conversation and interaction; therefore, language is central in the formation of a sense of place.

Thus, the systems of speaking and writing (documenting, inscribing, remembering) our social, natural and cultural landscapes do not only mirror or represent an objective reality. Instead, these communicative behaviours are actively employed to create place realities (Stokowski, 2002, p. 373).

The role of discourse in creating a sense of place, then, reveals the social origins of place identification (Dixon & Durrheim, 2000).

5.5 Social Aspects of Place

Place is a multi-faceted phenomenon (Relph, 1976), and so place cannot be discussed without mention of the social environment. How people make meaning of

place depends, to a large extent, on other people present within place. Place defines the roles and expectations of people, and the built environment clarifies social roles and relations (Tuan, 1977; Wiersma, 2003). How one acts at home is often different from how one acts in the work environment. People actively create meaningful places through conversation and interaction (Stokowski, 2002), and there are social origins to place identification (Dixon & Durrheim, 2000). Place also incorporates other people and social relations (Low & Altman, 1992). The social relations in long-term care facilities consist mainly of staff and other residents. Residents are viewed by staff as “bed and body work” (Gubrium, 1975; Paterniti, 2000); therefore, place has defined the roles of staff and residents. The long-term care facility has also been described as a place of social isolation and loneliness (Slama & Bergman-Evans, 2000; Thomas, 1996). Residents are cautious in developing relationships with each other (Powers, 1996) and some relationships are characterized by hostility or indifference (Golander, 1995). The place, routines, and expectations of social roles all create a social environment in the long-term care facility that is not often conducive to supportive relationships, caring, and personal attachment.

5.6 Old Age and Sense of Place

Place attachment is a process that continues throughout life (Rubinstein & Parmalee, 1992), a way of keeping the past alive. Feelings about one’s experiences in or of key former places may be an important part of remembering one’s life course and, thus, of organizing and accessing a lengthy life span.

Attachment to key former places is one way of keeping the past alive and thus relates to the later-life tasks of maintaining a sense of continuity, fostering identity, and protecting the self against deleterious change. Second, attachment to a current place may be a way of strengthening the self...Third, attachment to a

current place may be a way of enacting or representing independence and continued competence. (Rubinstein & Parmalee, 1992, p. 140)

In old age, place attachment is in the past and in the current day, and consists not only of each, but of the relation between the two (Rubinstein & Parmalee, 1992). Howell (1983) suggests five general principles of the meaning of place in old age:

1. The attachment of meaning to life, to self in relation to events, people, and place is a *continuous reweaving process*.
2. Places are affectively *redefined* in the course of utilizing them in reminiscence, self-concept reviews, problem solving, social rule maintenance, and other operations.
3. A way of conceptualizing the meaning of place would be to attempt to evaluate the roles of place in self- or identity reconstructions.
4. ...in environmental memory and the meanings attributed to place, much more of *self* is invested with other forms of memory, and place elements get unevenly (and at this time juncture unpredictably) attached to other selective self-in-time and space components of recall.
5. Attributes of self-concept may psychodynamically function *parallel* to attributes of place, and thus we should consider that the meaning of a place attribute may, for the individual, change over time or be different from one group of people to the other (depending on how group is defined) (pp. 99-100).

As is evident from the above discussions, a sense of place is formed not only based on affective bonds with the environment, but with the memories and past experiences of the individual. As Howell (1983) reminds us, "...natural (including built) environments remind me of what I choose or reject about myself" (105).

Because of the importance of place to identity, discussions of home and long-term care institutions are appropriate here. Rowles (1987) suggests that home is a protective environment, a place of withdrawal from the outside world. Home also refers to a sense of identity, security, and belonging. There is an interweaving of self and place through the length of residence and the accumulation of life experiences (Rowles, 1987). Because of the attachment to home, disruptions to place attachment can be extremely difficult. If

place attachments are integral to self-definitions, then place disruption can threaten self-definitions (Brown & Perkins, 1992). Place disruptions are often about more than identity, however; they are multi-faceted and multi-scaled, meaning they can consist of many different dimensions and to differing degrees (Brown & Perkins, 1992). Because of the potential extent of place disruptions, the impact on individuals can be significant.

Disruptions are difficult to deal with because the ties that bind people include multifaceted connections, occurring at multiple levels, that provide a taken-for-granted orientation to the world. A disruption means that individuals must define who they are and where they are going without the benefit of the tangible supports that formerly bolstered such intangible understandings. (Brown & Perkins, 1992, p. 301)

Stafford (2003) suggests it is the "...liminal, betwixt-and-between status of nursing home that engenders a collective discomfort on the part of our citizenry" (p. 121). Because the nursing home is often associated with negative perceptions, the transition may be difficult. In addition, the disruptions in place attachment, the loss of home, and the loss of personal possessions that also represent self may impact the transition (Giuliani, 1991; Stafford, 2003). As one resident stated (as quoted in Savishinsky, 1991): "*Home*. That is a very distinguished word, and no nursing institution can be that. Here, instead of paintings, age hangs on the walls." (p. 74). The nursing home attempts to re-create home through symbolic representation, which often trivializes the notions of home (Stafford, 2003).

Groger (1995) examined residents' perceptions of the nursing home as home. She found that residents' abilities to consider the facility a home was related to the circumstances of their placement, including previous experiences with nursing homes, criteria used to define home, and the degree of continuity they achieved after placement. If residents defined home as social and family relationships, then they were more likely

to consider the facility a home. However, when home means independence and autonomy, residents were not likely to consider the facility as a home. Continuity of aspects of residents' earlier lives can create external continuity and help transform the nursing home into a home. Therefore, the possibility of adjustment and reconstructing the institution as home depends on how residents define home throughout their lives.

The nursing home as an abstraction embodies the polar opposites of home. Although its purpose is benevolent, its structural arrangements make it a total institution like a mental hospital or prison...If "home" defines and maintains the self, institutionalization attacks and mortifies the self through multiple indignities and losses: loss of role; sometimes loss of name; loss of possessions and thus loss of self-affirming context...*As a concrete place where people live*, however, even the total institution offers possibilities for compromise and adjustment (Groger, 1995, p. 138).

Dobbs (2004) conducted a four-month ethnographic study in an assisted living facility based on Groger's (1995) work. She found that home was constructed as a memory. Home encompassed social relations, family and life experiences, roles performed, and autonomy to do the things one liked. Home was related to dress and appearance, and the facility could not be considered home because residents felt they needed to dress up as they were on public display. Family and friends were an important part of home in contrast to the strangers they lived with. The choices that were associated with home, such as going shopping and choosing meals, were missing. Dobbs (2004) concluded that there was continuity in the concrete meanings of home for residents, but little continuity in the abstract meanings of home. The socially constructed meanings of home and definitions of care are embedded in the institutional structure of the assisted living setting, while abstract, symbolic meanings elude residents (Dobbs, 2004).

For my master's thesis, I (Wiersma, 2003) examined the experiences of long-term care residents in two different places—a veteran's hospital and a summer camp. The

experiences of residents were different in these different settings. The findings suggested that residents interpreted the characteristics of the environments, and then made meaning of their lives incorporating the characteristics of the environment. An emerging theory from the research suggested a comprehensive theory of the sense of place. This sense of place is constructed by the individual through the meaning making process. The individual brings his or her interpretations and meanings to the place to construct a sense of place. The interpretations and meanings of place that are made by individuals are shaped by the context of their values, ethics, ideals, and biographical experiences. Place also has a reciprocal relationship in the definitions of relationships and role expectations. In addition, place has a reciprocal relationship with leisure experiences. The sense of place impacts the ways in which self is revealed and concealed to others, which also, in turn, impacts the sense of place. The self is present in all aspects of the experience. Agency is evident in that the individual actively makes meaning and sense of his or her experiences. Sense of place is a fluid and changing construct because interpretations and meanings are always being shifted and reconstructed.

5.7 Criticisms and Challenges to Theoretical Constructions of Place

There have been a few people who have challenged theories of place (Keith & Pile, 1993a; 1993b; Manzo, 2003; Stokowski, 2002). Much of the research and theory on place is based on the mythology of home, which is seen as a metaphor for belonging, comfort, joy, and protection (Manzo, 2003). Because of this, much of the research is focussed on positive aspects of place. The negative experiences of home, and therefore

place, have not been addressed, even though meaning is made through both positive and negative experiences (Manzo, 2003).

In addition to the mythology of home (Manzo, 2003), the politics of exclusion are rarely addressed (Keith & Pile, 1993a; 1993b; Manzo, 2003). While people create a sense of place, most times access to place is unequal. Therefore, opportunities to make meaning of place are limited for some. Keith and Pile (1993) discuss locations of struggle, communities of resistance, and political spaces, although the politics of place and identity are rarely discussed elsewhere. In addition, the assumptions and social practices that go into the act of making places are unobtrusive and hidden (Stokowski, 2002), making power relations invisible.

5.8 Further Conceptualizations of Place

Much of the discussion regarding place has assumed the neutrality of physical environments (Howell, 1983; Rubinstein & Parmalee, 1992). Place, then, is neutral, simply awaiting for people to attach meaning to it. Meaning, then, exists for individuals, rather than for the environment itself. I would argue, however, that even in place, even before people create a sense of place, space is imbued with meaning. The physical characteristics of a built environment are not necessarily neutral, but carry with it specific meanings because they are built for specific purposes. Much of this meaning is determined in the physical construction and planning of the environment. Given that much research has been done in environmental psychology on how physical environments impact people, it is evident that meanings are constructed into physical environments because they are built by humans for intentional purposes. I will use the

example of the building of a new nursing home to illustrate this point. The rooms within nursing homes convey specific meanings. First, they convey the meaning of a residence—beds are available for people to sleep in. Second, they convey a class distinction—some rooms are private and some are ward rooms. Those who can pay, then, have access to the private rooms. The nursing station indicates a place for working through the use of desks and chairs. It also indicates a separate working area for staff, and gates enclosing it signal that it is off limits for residents. The set-up of hallways ensure that they are always visible from the nursing station (or camera monitors are set up), indicating surveillance of the residents. A separate staff room again indicates the separation of staff from residents. Locked doors and units indicate confinement. The physical space of environments, then, are already imbued with meaning. While this meaning does not necessarily mean that once people are within these places that they will create these meanings, but this is a function of agency. Even if they take on some of the meanings of place, they construct it within their own experiences. Place, then, is created for specific purposes, which imbue that place with meaning, albeit not always consciously. "...the spaces and places of our everyday lives are taken for granted and 'naturalized'; with little need for interpreting what geography can tell us about society and culture" (McHugh, 2003, p. 166).

In addition to the challenge of the neutrality of place, the notion of critical spaces and resistance is important to recognize (McCorkel, 1998). If we only focus on the positive aspects of place, we cannot recognize acts of resistance and agency. Goffman (1961) suggests that individuals develop a sense of self through accepting and rejecting organizational constructions of identity. McCorkel (1998) conducted research in a state

prison for women. She suggests that there are two types of spaces—physical space and conceptual space. “Physical and conceptual spheres are interdependent in that social controls are simultaneously directed at controlling both meaning frameworks and actions in order to transform the core self” (p. 238). These spaces, through surveillance and authority structures, are meant to transform definitions of self. Critical space, then, is an area that is unregulated by staff and not under surveillance.

...critical space occurs at the intersection of physical and conceptual spheres. Physically, residents must have access to locations where their actions and conversations will not be reported to staff. Frequently, this means meeting other residents in the crackhouse [a reference term to a room in the prison] when staff are not looking, although critical space is not necessarily connected to a specific physical location. Clients can construct critical space in any area of the facility so long as they perceive surveillance to be weakened (McCorkel, 1998, p. 243).

The development of critical space has four properties according to McCorkel (1998):

1. It is one form of resistance to organizational controls and identity definitions.
2. Alternative conceptual frameworks to identity challenge predominant organizational discourse and individuals can interpret life experiences in ways that provide alternative definitions of self. This is conducted through interaction among residents.
3. Critical space has a temporal dimension.
4. Critical space is not a uniform feature of institutional life, but expands and contracts in response to surveillance and authority structure.

This critical space is evident in everyday life since there are instances which mimic the process of identity transformation and resistance found in the institution. People, then,

construct critical spaces in everyday life when there are power imbalances in relationships.

Heidegger (1958) discusses the relationships between the ontological dimension of being and the political structure of human existence. People are involved in place in two dimensions—horizontal, which is determined by political relationships; and vertical, which refers to the dimension hiding the uniqueness of Being. Place then reveals the bounds of human existence while at the same time revealing the depths of freedom and reality. Each dimension is grounded in the other, yet different. The state dominates the horizontal dimension, while the vertical dimension, or ontological place, is revealed through existential place. Estrangement refers to the shock of the absence of freedom when an individual is a tool of power, and results in the hiding of the vertical dimension and the destruction of the meaning of place. The tension of human situations is manifested in the vertical and horizontal dimensions of place, yet humans are estranged. The vertical dimensions of place both guarantees the claims of the horizontal and reveals their limits. Therefore, the political structure can impact the ontological dimension of being, but its limits are also revealed. Place reveals the uniqueness of individuals and the conditions of human activity. Ontological place defines people before they enter existence and delineates how they enter the existential realm, as well as establishing structures with the existential realm. Heidegger's philosophies of place, then, recognize both the political structures of place, but also recognize the agency and resistance of individuals in their ability to create ontological dimensions of place—the vertical realm. "A political order is limited in its activities to the preservation of the ontological nature of

'place'. The disregard of the ontological nature of 'place' is the obliteration of human freedom. To have 'place' is to be free" (Heidegger, 1958, p. 26).

Further conceptualizations of place, then, need to not only examine how individuals create a sense of place, but how place affects self. While place attachment, sense of place, and place identity have been conceptualized to some degree, power relations within place need to be recognized and explicitly examined. The political structure of human existence and place is an important part of the theorizing of a sense of place. Therefore, my conceptualizations of place suggest that the physical environment can be imbued with meaning and imbued with the physical, social, and political structures of power. In addition, positive meanings may not always be attached to place. In fact, dialectical or contradictory meanings of place may exist at the same time. The notions of resistance and critical space need to be recognized. Therefore, place becomes much more than an experience, but becomes a socially constructed entity in which the power relations in social structures and society are inherently a part of place.

Place and space, then, as defined in the literature, are often confusing concepts. Place, for the purposes of this study, incorporates the physical and social environment, as well as the identities assigned to place. Sense of place is a much larger concept examining meanings and representations of place, as well as experiences in place and the self in place. Different concepts have been attached to place, such as place attachment, place identity, sense of place, and discourse and place. Some literature has addressed the sense of place in old age and the importance of home (Howell, 1983; Rowles, 1987). There have also been some challenges and criticisms to notions of place, especially to the focus on positive aspects of place (Manzo, 2003). Place, as indicated by the findings of

this research, is a structuring element of social life, and provides the context for the construction of the body and identity. Place is also a significant part of the socialization processes into the long-term care environment and culture.

CHAPTER SIX: BRINGING THE BODY, SELF, AND PLACE TOGETHER

Despite the lack of theory tying the body, self, and place together, there has been some work on these three concepts. Here I present some of this work and tie these concepts together to present a framework which will guide my research. I make assumptions of the oneness of body, self, and place, which may be separated conceptually but not experientially. I first describe the link between the concepts of body, self, and place, and then describe the dual approach I take to the body/self/place relationship as both lived and acted upon.

First, there has been research to demonstrate that the self and body, while perhaps two different entities, are inseparable and indivisible. The aforementioned work by Kontos (2003), for example, suggested that selfhood is not only found in the conscious will or the mind, but is found in the depths of the body. This conception of self, then, denies that self can be lost during the process of dementia or illness, but instead suggests that it still exists within the body. To clarify in my further discussions, then, when I refer to the body, I refer to the physical body. Body-self refers to the self and the body as an inseparable entity. Body-identity refers to the identity that is ascribed to the body by others and in interactions.

As mentioned earlier in Chapter Three, Kontos (2003) views the self and the body as inseparable. The self is seen to not only be located in the mind, but to also be located in the body. The Cartesian dualism of mind/body is disregarded, and the mind and body are seen as indistinguishable and inextricable, as opposed to privileging the mind and

rationalism over the body. I adopt this perspective of the mind/body relationship for this research.

What has been less explicated than the self and body connection, however, is the link between body and place. Nast and Pile (1998), one of the few authors who discuss place and the body, suggest the urgency of examining place and body relationships, since the way we live out place/body relationships is political.

Bodies and places, then, are made-up through the production of their spatial registers, through relations of power. Bodies and places are woven together through intricate webs of social and spatial relations that are made by, and make, embodied subjects. (Nast & Pile, 1998, p. 4)

It appears, then, that it is imperative to examine the body and place, but how is this relationship conceptualized? The body has rarely been brought into recent theoretical discussions about place at all, with the exception of Nast and Pile (1998) and a few feminist authors (Grosz, 1999; Rose, 1999). Because every experience of the world is mediated through our bodies, the body is the focal point of the experience of place. Place becomes part of our habitus, of our experiential world. We develop habits and relationships with place, according to Merleau-Ponty (1962). Our bodies know the place (Stafford, 2003). Every experience of place, then, is mediated through our bodies. As such, every attachment we form to place, every meaning we make of place, every interpretation of place, is mediated through our bodies. We can experience place subconsciously (Relph, 1976; Tuan, 1977) as Merleau-Ponty (1962) suggests we experience our bodies. We have spatial knowledge (Tuan, 1977). The phenomenological basis of geography, knowledge that is not explicit and self-conscious, suggests an understanding of the realities of everyday life that is unselfconscious (Relph, 1976). Places are incorporated into the intentional structures of human consciousness and

experience (Relph, 1976). As such, place identity cannot be distinguished from the body and neither can a sense of place. Our embodied experiences of place do not just consist of issues of competence and accessibility within place, but of all of our bodily sensations experiencing place. The body, then, cannot experientially be separated from place, since our bodies exist in place, in the experiential world, and place mediates all of our embodied experiences.

The body is also seen in relation to space (Crossley, 1996). For Merleau-Ponty, the body in relation to its environment creates a functional space around it. For Foucault, the body is organized and controlled through the organization and control of space. Stafford (2003) suggests that the wandering of residents with dementia is a bodily sensation of place, and recreates home for individuals.

When reduced to its most primitive and skeletal form, the path, the rhythm of to and fro, presents as the wandering behavior of the patient with dementia. The meaning of the wandering, as *professionally* constructed, misses the point again. “She’s searching for home” is the typical explanation for the behavior. (True, it is often expressed verbally as such by the patients themselves.) Home, again, is taken to be some cognitive representation, a mental entity. Yet, recognizing that the path itself *is* home, can we not reinterpret the behavior as a kind of homemaking, in and of itself? The behavior is persistently repeated, not because home is *not* found but because it *is* and is constantly being re-created in the journey from there to here. (Stafford, 2003, pp. 147-148)

The body, then, is implicated in the experiences of place, and as such, must be included in the theoretical discussions of place. Currently, this connection is often overlooked in the literature.

Kontos (1999, 2003, 2004) has done much work on the body and self in dementia and long-term care. Kontos (1999) criticizes body theory for the assumption that self is capable of dissociating from its own corporeality. She argues that culture and biology are interrelated and have a dialectical relationship. Critical gerontologists, however, have

rendered the body silent and invisible. A main tenet of local biology is that the body is linked with place. However, in gerontology and in other social sciences, the body has not been incorporated in a discussion of place.

Local biology sets the agenda for an exploration of the body which integrates lived bodily experience with a concern for political and professional discourse about the construction and manipulation of individual bodies. It provides the means to articulate a range of bodily experiences while taking into account the larger social context in which these experiences take place. Experience, corporeally constituted, is the lived conjunction of mind and body, body and culture, body and physical and social surroundings. To this effect, aging occurs not only in the body but in time, in place, in history, and in the context of lived experience...It provides a conception of the body as a material phenomenon without eliding its materiality with a fixed biological essence. (Kontos, 1999, p. 687).

Rose (1999) also suggests that bodies are central to time-geography.

...the social constitution of different identities may also imply different kinds of social space. This implies that everyday space is not only self evidently innocent, but also bound into various and diverse social and psychic dynamics of subjectivity and power (Rose, 1999, p. 365).

Grosz (1999) suggests that the city is one particular ingredient in the social constitution of the body, indicating that place is an important part in the constitution of the body.

Place as referred to here incorporates not only the physical environment but the social environment as well. Since place defines social relations (Dixon & Durrheim, 2000), the social environment is inextricably a part of place. In social interactions within place, the body also mediates every social experience. In addition, social relations can have a profound effect on the sense of self and identity (Mead, 1934; Holstein & Gubrium, 2000). The discursive environments which shape identity and provide a multiplicity of selves (Holstein & Gubrium, 2000) is created by place—both the physical and social environment. Therefore, place as a social environment, in addition to the physical environment, is inextricably linked to the body and self.

One more important aspect of the body-self-place relationship is the ways in which these phenomena are disciplined. According to Foucault (1975), the body is disciplined through surveillance and the application of power. Since the body cannot be separated from the self, the self also becomes disciplined through these various techniques. This surveillance comes through place, or occurs within the place, and thus the meaning of place can often take on the limiting aspects of place (Wiersma, 2003). As such, it is important to consider the culture and aspects of power when discussing body-self-place relationships because culture and subsequently, power, are an inherent part of these relationships and form and define these relationships. Therefore, taking an approach that recognizes the ways in which the body-self-place is disciplined and the ways in which power defines these phenomena is crucial to understanding the phenomena.

I take a dual approach to the body/self/place relationship as both lived and acted upon. Crossley (1996) suggests that the notion of the body as lived and the body as inscribed are not incompatible ideas, but instead are complementary. Crossley examines Merleau-Ponty's phenomenology of the lived body and Foucault's work on the discipline of the body. Merleau-Ponty (1962) rejects the notion of an inner mental realm that is separate from actions; embodied actions, instead, are based on habits which are drawn from the habitus or social stock. Humans are not in a subject-object relation with their world; but instead belong to their world as an active part of it. In contrast, Foucault's ideas (1975) focus on a body that is imprinted by history. For both of these authors, according to Crossley (1996), embodied behaviour is historical. One difference is that Merleau-Ponty understands historical behaviours as ways of being-in-the-world, while Foucault understands them in terms of political history and functions. Crossley (1996)

also suggests that for both of these authors, the body is seen as both a locus of action and a target of power.

Crossley (1996) suggests that the body is both acted and acted upon and that the works of Merleau-Ponty and Foucault are not incommensurable, but complementary. “This tension, I contend, is precisely what constitutes the human body qua socio-historical being. The body as a mastered and self-aware being is, as I have argued, formed in this interstice” (Crossley, 1996, p. 114). The two poles of the tension are relational dimensions of a single structure. “We must resist the ‘either/or’ temptation and study body-subject and body-power as twin aspects of a single structure of action-upon-action” (Crossley, 1996, p. 115). It is this recognition of the relational dimensions of a single structure that I adopt for my research.

This study, then, not only takes an experiential phenomenological approach to understanding people’s experiences of the socialization process into long-term care and to the body-self-place, but also takes a critical approach to the ways in which culture and power define and discipline the body-self-place. The assumptions or understandings underlying this study are that the body, self, and place are intertwined, and that culture and power discipline these phenomena in addition to individuals being active agents.

6.1 Purpose and Rationale for the Study

While there is an abundance of research on long-term care and older adults, as well as a body of literature focussing on the adjustment of older adults to life in a long-term care facility, little research has examined the socialization process of new residents into long-term care culture and life, as well as how these new residents actively construct

and reconstruct their perceptions of life in long-term care and how they participate in the socialization process. Psychological and social psychological adjustment to nursing home life has been examined (Groger, 1995; Porter & Clinton, 1992; Schoenberg & Coward, 1997), and research on residents' experiences and stories in long-term care (Gubrium, 1993) have been emerging. Ethnographies have also been conducted examining nursing home structure and organization (Diamond, 1992). However, scant research has examined the socialization process of residents into nursing home life or the role that staff play in the socialization process of new residents to nursing home life and culture.

Kontos (1999) suggests that there is a significant connection between bodies and place:

Biological and physiological aspects of the aging process deny universality by virtue of their constant interaction with physical and social surroundings. Yet it is more than the impossibility of a placeless body which gives the body its localized character; the body roots itself in, is appropriated by, and appropriates its locality (p. 686).

In her further research, Kontos (2003) suggests that

...selfhood resides in the pre-reflective body...the primordial level of experience where selfhood emanates from the body's power of natural expression which manifests in the body's inherent ability to apprehend and convey meaning (p. 156).

In other words, Kontos' (2003) argument is that the self not only resides in the mind or in cognition, but also resides in the body. The concept of place has often been left out of the research entirely except with reference to the physical structure of the institution. But, according to Kontos (1999), the body appropriates and is appropriated by its locality. Based on Kontos' research, it is evident that there are links between the body, self, and place, which provides the support for my focus on these three concepts. With the exception of Kontos (2003), no research has examined residents' embodied experiences

or how residents frame and reframe their self and identities, their bodies, and place upon admission and throughout the first few months living in a nursing home.

The purpose of this study, then, is to examine the lived experience of the process of socialization for new residents into the nursing home culture and environment, specifically focussing on how identities, bodies, and place are constructed and reconstructed by residents and staff. The specific research questions guiding this study are as follows:

- I. What is the lived experience whereby new residents are socialized into the nursing home culture and environment? How does this socialization occur and through what processes?
- II. What roles do body, self, and place play in the socialization process?
- III. How do new residents experience their sense of self or identities, bodies, and their sense of place throughout the socialization process?
- IV. What techniques do staff use to socialize new residents into culture and life in the nursing home?
- V. What role does leisure play in the socialization process, if any?

CHAPTER SEVEN: METHODS

This research was conducted in partnership with Ridgemount Long-Term Care Facility¹, a local homes for the aged in northwestern Ontario. A partnership was formalized with Ridgemount for data collection in May 2005. A description of the facility is provided in Section 7.2.1.

7.1 Epistemological and Methodological Assumptions

This study was conducted within a hermeneutic phenomenology paradigm according to Van Manen (1997). Hermeneutic phenomenology is a study of people's lifeworlds. From a phenomenological point of view, to do research is to question the way people experience the world, to want to know the world in which people live as human beings. Phenomenology is the study of the life-world, referring to the world as we immediately experience it, and aims at a deeper understanding of the nature or meaning of people's everyday experiences (Van Manen, 1997). It is studying the lived world as experienced in everyday situations and relations. Because phenomenology attempts to uncover the internal meaning structures of lived experience, it offers us insights that bring us into a greater understanding of the world.

Phenomenological human science is the study of lived or existential meanings; it attempts to describe and interpret these meanings to a certain degree of depth and richness...phenomenology attempts to explicate the meanings as we live them in our everyday existence, our lifeworld (Van Manen, 1997, p. 11).

Hermeneutic phenomenology also offers the possibility of understanding social structures through understanding individuals' lived experiences within the backdrop of social

¹ Pseudonyms have been used to protect anonymity.

structures and settings. "...phenomenology attempts to explicate the meanings as we live them in our everyday existence, our lifeworld" (Van Manen, 1997, p. 11). Because I was attempting to gain a deeper understanding of residents' experiences of the socialization process into long-term care through an understanding of the body, self/identity, and place, a hermeneutic phenomenological perspective was appropriate to gain an in-depth understanding of residents' lived experiences through this phase in their lives. I was not necessarily attempting to understand and describe the institution, but to understand residents' lived experiences coming to live in an institution. Hermeneutic phenomenology is based on the premise or belief that we can best understand human beings from the experiential reality of their lifeworlds.

Van Manen's (1997) descriptions of hermeneutic phenomenology suggest that we know things not only

...intellectually or conceptually, we also experience things in corporeal, relational, enactive, and situational modalities. Thus, hermeneutic phenomenological method tries to "explicate" meanings that in some sense are implicit in our actions. We know things through our bodies, through our relations with others, and through interaction with the things of our world (p. xiv).

Thus, a challenge with hermeneutic phenomenology is representation. Since language is our main form of representation, challenges are posed in representing experience.

One answer is that language is simply inadequate in describing experience. Ultimately words miss the fullness and the uniqueness of our private worlds. Words fall short because language is essentially social. It is only through the collectivity of language that we can access experience, the experience of others as well as our own. And so the essentially unique and private qualities of inner experience will ultimately be beyond our linguistic reach. But while our spoken or written words may never coincide with the actual sensibility of our lived experiences, it may still be possible and worthwhile to try to emulate or prereflective life by means of lifeworld-sensitive texts (Van Manen, 1997, p. xiii).

Van Manen (1997) suggests that there are fundamental existential themes which are part of all people's lifeworlds, regardless of historical, cultural, or social situatedness. He refers to these as "existentials" (p. 101). There are four existentials which belong to the lifeworld. The first lifeworld existential is lived space or spatiality. Lived space refers to felt space. The experience of lived space is largely pre-verbal (Van Manen, 1997) and pre-reflective (Merleau-Ponty, 1962). Yet space can significantly affect how we feel and make meaning. The second lifeworld existential is lived body or corporeality. This refers to our bodies in the world, or 'being-in-the-world' (Merleau-Ponty, 1962). Our bodies are mediators of the world and of knowledge (Shapiro, 1999). The third lifeworld existential is lived time or temporality. This is subjective experienced time as opposed to objective clock time. Lived time refers to our perceptions of time as well as temporal dimensions of past, present, and future. Finally, the last lifeworld existential is the lived other or relationality. This is the lived relation we maintain with others in the interpersonal space that we share (Van Manen, 1997). Each of these four lifeworld existentials are important, but given that this research is focussed on concepts of the body, self/identity, and place, I shall focus on understanding lived place and the lived body, as well as understanding self and identity within the context of relationality. Each of these phenomena will be a focus within the lived experience of coming to live in a long-term care facility.

7.2 Setting

In order to provide context and thick descriptions of the experiences of residents, it was important for me to gain a comprehensive understanding of the setting and the facility. There were various ways in which I was able to gain an understanding of the

facility. First, my interviews with management provided me with background information on the facility as well as a historical context, and some of the routines and procedures of the facility. Second, observations of life in the facility provided me with in-depth understanding of how the facility operated on a day-to-day basis, staff morale, and staff-resident interactions. These observations provided me with understanding of the “corporate culture” of the long-term care facility. Third, by examining documents relating to policies, procedures, and other information about the facility, I gained an understanding of the values, mission, mandates, and culture of the organization.

7.2.1 Description of the Setting

Ridgemount Long-Term Care Facility was a Home for the Aged that was owned and operated by the City of Ridge Mountain. Ridgemount was 11 years old at the time I started my data collection. The building itself was fairly modern. It was licensed for 150 residents. There were four floors. Two floors were locked units for residents with dementia and residents who may wander, while the other two floors were the “extended care” floors. Each floor had one dining room, one activity room, and two lounges. Coming off the elevator, the nursing station was centrally located, with two hallways branching off to either side. These hallways followed a square pattern at the end, with rooms located on either side. As such, the complete hallway was not visible from the nursing station, so cameras were installed in order to provide nursing staff with a view of every area of the floor. A monitor was installed at the nursing station, with a feeding rotation of these cameras. A lounge was located down each hallway, while the activity room was located across from the nursing station to the right, and the dining room located across from the nursing station to the right.

Upon walking into the facility, one entered into a large lobby with ceilings two stories high. Carpets and large armchairs and couches were situated to the left of the main entrance, while on the right, a cafeteria was located. Just past the sitting area, a children's day-care was located. The day care was not accessible from the nursing home (unless the proper code was had for the locked door), but there were windows so residents, staff, and visitors could watch the children. The lobby narrowed straight ahead, and residents' living areas were located through two doors that were most often propped open. The elevator was located on the right and stairs on the left (although toward the end of my data collection, the stairs were locked and only able to be accessed by staff who had an access card). Walking straight through the hallway past the elevators and stairs, one would end up directly in front of the nursing station, with hallways branching out to either side. The Administrator's office and business office were located on the third floor, as was a large auditorium that was used for many of the large group programs for the whole facility.

Because Ridgemount was a Home for the Aged, staffing levels were somewhat higher than a nursing home. Research has demonstrated that many for-profit homes have lower staffing levels than not-for-profit and public homes (Aaronson, Zinn, & Roso, 1994; Harrington, Wollhandler, Mullan, Carrillo, & Himmelstein, 2001; Hillmer, Wodchis, Gill, Anderson, & Rochon, 2005). A Home for the Aged has a different designation by the Ministry of Health of Ontario (MOH) than a nursing home, has separate legislation (The Homes for the Aged Act and the Nursing Home Act), and is owned and operated by a municipality. The MOH requires that each municipality operate a home for the aged, the number of beds depending on the population of the municipality.

Ridge Mountain owns and operates three Homes for the Aged. A home for the aged operates under the Homes for the Aged Act, rather than the Nursing Home Act, although much of the legislation is similar. What is perhaps most different between a Home for the Aged and a nursing home is the history. Homes for the Aged were often for residents who were at a higher functioning level and who required minimal assistance, while nursing homes were for residents who needed much more care (Julie, initial interview). Given the changes in long-term care policy, legislation, and care needs in the community, Homes for the Aged have become virtually indistinguishable, in my opinion, from nursing homes (with the exception of ownership and management). However, many Homes for the Aged, because they are public and not-for-profit, tend to have higher staffing levels as well as use more professional nursing staff rather than health care aides (Aaronson et al., 1994; Harrington et al., 2001; Hillmer et al., 2005).

At Ridgemount, very few health care aides (HCAs) work on the floor and give direct care to the residents. Many of these staff are registered practical nurses (RPNs), or RPNs who work in an HCA job. Therefore, the staff at Ridgemount are higher educated who give direct care to the residents, and the staffing levels are topped up. (Staffing levels are usually determined by a Case Mix Index funding formula determined by the government, but facilities can choose to top up this funding if they wish. Many not-for-profit homes do this) (Ontario Health Coalition, 2007).

7.3 Participants

7.3.1 New Resident Sampling and Recruitment

Participants were recruited from Ridgemount home for the aged. Purposive sampling was used (Patton, 1990). The following criteria were used in order for new residents to be eligible to participate in this study:

- (1) The resident had to be admitted to the facility during the time of data collection;
and
- (2) The resident had to possess the ability to verbalize and answer questions, and have an adequate grasp of the English language to facilitate free-flowing communication.

The initial intention was to recruit two to four residents as participants for the study. Because this study was focused on the in-depth experiences of new residents over a longer period of time, an immense amount of data for each resident was collected. Therefore, any more than four participants was not feasible for this research and timelines of this study. Three participants were recruited in total. All participants lived in the same facility. This was important to understand how the culture of the facility impacted residents' experiences coming into the facility, and since each facility might have a somewhat different culture, it was important to recruit residents from the same facility, both from a practical and theoretical standpoint.

The participants had not yet entered the nursing home at the beginning of data collection since I spent a few months in the facility getting to know my way around and understanding the institutional culture. The Administrator contacted me as soon as the possibility of a resident being transferred to the facility was probable. Since I was already

collecting data at the facility in person when a new admission was occurring, she gave me a brief description of the resident and the date and time of admission. I approached two participants on the day of admission into the facility, and the last participant was approached within three days of admission. The study was described to the residents, and the information letter and consent form were given to the participants (see Appendices C and D for information letters and consent forms). All participants were able to give their own informed consent to participate in the research. I gave them an opportunity to peruse the information materials, but all participants signed the consent forms when first approached after reading the materials and having the study explained to them. Recognizing of course that the admission period can be a very traumatic time in both the resident's life and the families' lives, I was sensitive to this and approached them at the most appropriate time. The Administrator introduced me to the first two participants when they came into the facility and told the family and resident about the study, and asked for their permission for me to be present during the move and help out in any way I possibly could. Each participant was very interested in the research, and readily agreed to participate. The participants are described below.

Edward and Maybelle

Edward and Maybelle were admitted to Ridgemount Facility toward the end of September, 2005. I met Valerie, their daughter, on moving day along with Edward and Maybelle. Maybelle had dementia, and was placed on one of the locked units, while Edward, who was more independent, was placed on another unit. This was the first time in their married lives that they had to live separately. Edward and Maybelle were both in their nineties, and had been living in a seniors' apartment prior to coming to Ridgemount

Facility. It was because of Maybelle's dementia and her requirements for care that they moved into Ridgemount Facility. Edward and Maybelle lived most of their married lives in a small town a few hours east of Ridge Mountain. Edward owned his own company and was often gone on trips for days on end. They had two children—Valerie and Jerry. Valerie's daughter was also expecting about the same time as I was due, and her son (Edward and Maybelle's great grandson) was born five days after Gabriel (my son).

Rachel

The second participant, Rachel, was also admitted to Ridgemount Facility toward the end of September, 2005. When she came into the facility on moving day with her family, I recognized her granddaughter from prenatal classes. She was due with her first child shortly after I was. Because of this, my conversations with Rachel often focussed on her granddaughter's and my pregnancies, as well as the babies after they were born. (Her granddaughter had a baby girl about three weeks after Gabriel was born). Rachel had a stroke a year prior to coming to Ridgemount Home, and had been in the hospital for a few months and then at a transition facility that had been opened for people who were waiting placement to long-term care. She had been living in institutions for a year before she came to live at Ridgemount Facility.

Rachel spent most of her adult life in a very small town a few hours north of Ridge Mountain. She had two sons. Her two adult grandchildren, Teddy and Deborah, were actively involved in her care. Her relationship with her grandchildren, particularly her granddaughter, was very close. Rachel was always very involved with children. In addition to raising her son and grandchildren, she often babysat the neighbourhood children. She and her husband owned a store at one point in time, and she also worked in

public service. Rachel was working up until the day she had her stroke (she was in her mid-seventies when she had her stroke), and was very independent and active prior to her stroke, according to her granddaughter. Rachel's husband died when she was in her sixties—fourteen years prior to this research.

Brian

The last participant, Brian, came into Ridgemount Facility the beginning of February, 2006. Brian had been living at home before coming to Ridgemount Facility, although he had spent some time in respite care at two other facilities before his admission. Brian's wife was still living at home when he came into the facility, although she was admitted to hospice shortly after Brian came to live at Ridgemount Facility, and she died a few months later. Brian also was a dog owner and had a dog when living at home. His dog was euthanized shortly after he came to live at Ridgemount. His house, which he had built and lived in for 40 years, was sold about four months after he came into the facility and just shortly after his wife died. Brian had Parkinson's disease, and the disease progressed rapidly just prior to his admission, hence the reason for his admission. Because the disease had progressed so rapidly and so unexpectedly, Brian stated that he was not prepared for admission into the facility.

Brian grew up in eastern Canada, but came to Ridge Mountain when he was a teenager, and had been living there ever since. He worked in the pulp and paper mills as well as the shipping industry. He was an avid hunter and fisher, and knew much about the land and nature of Ridge Mountain. Brian became friends with my husband, Harvey, because of their mutual love for the land and Brian's historical knowledge of the land and the community.

7.3.2 Staff Sampling and Recruitment

Staff at Ridgemount were also approached to participate. Initially, I intended to interview the Administrator, Director of Nursing, the Recreation Coordinator, and a couple of nurses and health care aides prior to recruiting residents. By interviewing management staff initially, I wanted to gain a better perspective of the transition process and the policies in the facility. By interviewing direct staff initially, I wanted to gain a better perspective of the transition process and how the policies of the facility directly impacted the ways in which staff interact with new residents. The Administrator was also asked to give consent for the facility to participate in the research study (see Appendices A and B for the information letter and consent form), and informed the staff of my project and my data collection. The Administrator, Director of Nursing, and Recreation Co-ordinator were asked to participate in a general interview describing the procedures of admission and their perceptions of the transition process for residents. Nursing staff, health care aides, and recreation staff working directly on the floor were also made aware of the study, and permission was obtained from them to participate in initial interviews regarding their perceptions of the process of transition into nursing homes for residents (see Appendices E and F for information letters and consent forms for recreation and nursing staff). Fifteen staff in total participated in the initial interviews. Three staff were management, four staff were recreation staff (including social work), and eight were nursing staff (RNs, RPNs, and HCAs). I had not intended to interview so many staff initially, but the recreation staff were very excited about the research, and felt strongly

that more nursing staff should participate in the project. Thus, they actively recruited nursing staff they felt I should speak to.

Throughout the course of the study, it became apparent that I should interview other staff who came into regular contact with the new residents involved in my study (i.e., the subsequent interviews). Permission was obtained from staff and family to participate in interviews (see Appendices G and H for information letter and consent form). Therefore, I subsequently interviewed eight nursing staff, three recreation staff, one housekeeping staff, and the resident counsellor about the residents after the data collection period with the residents was completed. These staff were chosen to participate since they had developed close relationships with the residents. The purpose of these interviews was to discuss the transition process from his or her perspective for the participant with whom they had developed a relationship. Because qualitative studies often evolve during the process of collecting data, I left myself open to possibilities of interviewing these staff members and to the structure of the research changing somewhat throughout the process.

7.4 Research Design and Data Collection Strategies

This research study employed three methods of data collection to gather information from participants. Participant observation, interviews, and documentation analysis were employed to obtain data. These methods of data collection were utilized throughout the first six months after admission. This enabled me to examine the adjustment and socialization process over a period of six months post admission, and to

examine key issues, changes, and factors involved in the process over the first few months after admission.

7.4.1 Participant Interviews

In-depth semi-structured and unstructured conversational interviews were used at various stages in the data collection. Interviews can help the researcher learn about people's sense of self and identities, and how they maintain, transform, or challenge their sense of self and identities (Kleinman, Stenross, & McMahon, 1994). Interviews can also provide access to feelings people fail to display in field settings (Kleinman et al., 1994). The researcher can access the participants' self-reflexivity, become privy to identities that may remain hidden in the field setting, understand how a person's identity in one sphere of life might affect other spheres, and explore how non-present others can impact identities (Kleinman et al., 1994).

Interviews were conducted with distinct groups of residents and staff at various stages throughout the study. A general interview was conducted with the Administrator, Director of Nursing, and Recreation Coordinator to gain an overall idea of the process of admission and the involvement of the nursing department in the admission and socialization process (see Appendix J for the interview guide). As mentioned earlier, initial interviews were then conducted with eight nursing staff (including health care aides) and four recreation staff (including the resident counsellor) to gain an overall idea of their perspectives of the process of admission and their involvement in the admission and socialization process (see Appendix K for the interview guide). Because nursing and recreation staff had the most interaction with residents, I assumed that the practices of

these departments impacted residents significantly. Therefore, by understanding how these departments operated and their roles in the transition process, a thorough understanding of the socialization process became evident. These interviews with staff lasted approximately twenty minutes to three hours each. These interviews were designed to gather information similar to those interviews conducted with management.

At the end of the data collection period with each resident (i.e., six months post admission), I interviewed a number of staff members and family members. The staff members were typically those who had developed a close relationships with residents participating in this study or who had significant contact with them. These staff were determined in conjunction with input from the recreation and nursing staff. These interviews took place at the end of the six-month data collection period for each resident, and focussed on staff's perceptions of the residents' adjustment into the facility, any significant incidents that occurred, and changes in the resident (see Appendix L for the interview guide). I interviewed two nursing staff and two recreation staff regarding their perceptions of Edward as well as his daughter Valerie. I interviewed three nursing staff, a housekeeper, and two recreation staff regarding Rachel along with her granddaughter. Brian did not have any children and did not wish for me to contact his extended family, so I did not conduct any family interviews regarding his experiences. I did, however, interview two nursing staff and two recreation staff. Some of these staff had participated in the initial staff interviews, but others had not.

A series of interviews were conducted with the residents moving into the facility during the six month period after admission (see Appendix I for the interview guides). These interviews ranged between thirty minutes and two and a half hours. There were a

number of times where residents were unable to complete an interview in one sitting due to interruptions, other commitments, visitors, and body limitations. In these instances, I returned within a couple of days to complete the interview (with a few exceptions, which will be noted below). These interviews were fairly unstructured and conversational, and were conducted at a time and place of the resident's choosing. The interview guide was slightly revised based on what arose during the interviews. The first interview covered aspects of the transition, how the resident came to live at the facility, how the transition had been so far for the resident, and how things had changed since coming to live at the facility. The second and third interviews covered aspects of life in the facility, the process of the move and admission, changes in life and routines, self and identity, social interactions, and routines and staff assistance.

My initial plan was to interview the participants within one week of admission, after one month, after three months, and after five months of admission. However, there were some concerns raised by my committee and the facility that I may not be able to conduct an interview within the first week of admission. I therefore changed my data collection plan to three interviews—one interview within the first month (preferably within the first two weeks), one interview in the third month, and one interview in the fifth month. The revised plan was actually much more suited to the residents' needs than the initial plan. The first week was often quite chaotic and difficult for the residents, with furniture being moved, paperwork and assessments being completed, clothes and possessions being labelled, and adjusting to the place and routine.

The data collection process changed from my initial plan, but was also somewhat different for each participant due to a number of factors. The birth of my son, quarantine

of the facility, sickness of participants, and refusal to participate in interviews were just a few factors that led to the variability in the data collection. Since the process was variable for each participant, I describe the data collection procedures for each of them below.

Data Collection with Edward and Maybelle

I conducted one interview with Maybelle. Maybelle was very quiet, and had difficulties articulating her thoughts and finding her words. As such, I decided to focus on Edward, rather than on Edward and Maybelle. I learned a lot about the adjustment and socialization process for Maybelle through Edward, my participation in life on the locked unit, and through their daughter Valerie's accounts. However, my primary focus was on Edward. I was able to spend time with both Edward and Maybelle and observe their interactions and life in the facility. I conducted three interviews with Edward, although they were sporadic.

I was able to conduct one interview with Edward within the first two weeks of admission, which occurred at the end of September. The second interview was conducted the beginning of December, two and a half months after admission. This was mainly due to the birth of my son, as well as Edward's lack of availability. I had much difficulty with the third interview. Edward was sick and in the hospital in January, and in February, the facility was closed for two weeks. When I was finally able to see Edward again, it was March. I approached him numerous times for the interview, but he stated he was either not feeling well or unavailable. I was finally able to get part of the interview finished with him at the end of March. Unfortunately, that interview got interrupted, and again after approaching him numerous times, he was either unavailable or not feeling well. I

was finally able to get the rest of the third interview finished at the beginning of May, seven and a half months after admission.

Edward spent much of his time in his room, walking around the facility, visiting Maybelle, and participating in programs. After his sickness in January, Edward didn't attend recreation programs as much, and often spent time on his own or informally with other residents visiting. Because he was so often out of his room visiting Maybelle or unable to be found, I wasn't able to visit as much with him toward the end of the observation period (end of March, 2006). I did not wish to intrude on his visits with Maybelle, particularly since Edward was not extremely welcoming when I saw the two of them together (and I wanted to be respectful of their time together), so if I came to chat with them and they were visiting together, I stopped in to say hi and went on my way. Edward sometimes had his room door closed, and out of respect for his privacy, I did not intrude on his time alone. Edward also often went for walks around the facility, and at times I was unable to find him. As such, observations toward the end of the data collection period were somewhat difficult.

Data Collection with Rachel

Data collection with Rachel occurred according to plan. I was able to interview her within her first two weeks at Ridgemount Home. The second interview was conducted just after two months at the facility, and the third interview, conducted on two separate days, occurred just after Rachel had been in the facility for five months. Rachel's interviews were typically conducted while I was painting her nails, since keeping her nails neat and painted was very important to her. Since Rachel's granddaughter had a baby at around the same time that I did, many of our conversations centred around the

babies. Since I brought Gabriel into the facility with me during the data collection period, Rachel became quite close to him, and called herself his “grandma”. I visited Rachel every time I came into the facility, and she was often full of newsy events that were happening around the facility. My visits with Rachel occurred in her room as well as during recreation programs and in the dining room.

Data Collection with Brian

Because Brian was often in pain because of his Parkinson’s disease, interviews did not occur originally as planned. The first interview was conducted within the first two weeks after admission (middle of February), although because of his pain, the interview was cut short. I was not able to sit down to finish the interview with him until a month later. The second interview occurred around the middle of April, about two and a half months after admission. The third interview was conducted in July, about four and a half months after admission, although this interview was also cut short, and the second half was finished at the end of July.

My observations with Brian consisted of visits in his room. Brian did not attend any of the recreation activities in the facility, and the only time he left his room was for mealtimes and for his daily walk around the unit. The length of my visits with him often depended on how tired he was or whether he was in pain.

All interviews were tape-recorded upon permission from all participants. An appropriate, quiet room was utilized for all staff interviews. Residents were given the choice to have the interview conducted in their rooms, in a quiet room in the facility, or downstairs in a coffee shop or other common area, although all interviews were conducted in residents’ rooms. All participants were reminded that information was

confidential and participation was voluntary. They were also reminded that should they feel uncomfortable answering any of the questions, they could refrain from answering the question or have the tape recorder turned off. A couple of staff members requested that the tape recorder be turned off, and comments be made “off the record.” Memos and notes were written after each of the interviews, including perceptions on how the interview went, the interpersonal dynamics of the interview, emotions throughout the interview, and beginning interpretations to provide context for the interviews and begin to analyze how residents were experiencing life in Ridgemount.

7.4.2 Participant Observation

Participant observation was also utilized as a data source. There are many benefits to utilizing participant observation that cannot be obtained from simply using in-depth interviews. Field workers are able to observe the dominant culture of a group, roles within this culture, and how members reproduce or resist that culture (Kleinman et al., 1994). Individuals are also sometimes constrained by the meanings of the worlds they live in, and sometimes this is not possible to understand unless observation is used (Kleinman et al., 1994). In addition, participant observation can provide access to things participants are unwilling or unable to talk about during the interviews, and can provide a better contextual setting of the institution (Patton, 1990).

I was a participant-observer in the setting. Because I was focussing on specific participants, I was “hanging around” them for much of the data collection. This meant that I participated in life with them. I participated in recreation activities with the participants, engaged in informal conversations with the participants, was around in the

hallways when the participants were not actively engaged in activities, and generally was around during the day. For the most part, however, I visited with the residents, participated in recreation programs with them, and had informal conversations with the residents. Much of my observational data came from my informal conversations with the residents and my observations of them.

Specific things were noted in the observations (see Appendix M for the sensitizing framework). I observed daily patterns of activity. I attended recreation programs. I was aware of social interactions and behaviours. I observed how residents used the space in the facility; that is, where they spent time within the facility. I observed various conversations with staff and with other residents to examine identities and selves that residents portrayed. I also observed staff interactions and activities with the residents to determine how specific routines and regulations became socialized for the residents. In addition, I examined residents' use of their bodies—facial features, gestural communication, body manners and other relevant body uses—to understand how the body in the place is a part of experience.

Participant observation took place between one and three days a week for six months for each resident participating in the study. I spent time with each resident every day I was present at the facility for six months. Because the facility was large (150 residents), some residents were not living in the same areas, which meant my time at the facility was spread out over different units. Two participants were on the same floor, and one participant was on another floor. Therefore, I planned to focus my observations on specific residents rather than spend days on the unit simply observing. In total, I spent

one year at the facility observing the residents since participants were not recruited at the same time.

Field notes were used to record my observations. All of the aspects of life, as described by the sensitizing framework, were documented in the field notes. A reflexive journal was also kept with my insights, interpretations, relationships with the residents, feelings about the facility and residents, and anything else that was not included in the field notes.

I had also originally planned to spend much more time at the facility observing the residents. Again, the birth of my son changed my plans somewhat. Prior to Gabriel's birth, I was able to spend three full days a week at the facility observing the residents and participating in life with them. After Gabriel's birth, I went into the facility approximately two to three days a week. I brought him in with me once or twice a week for a half to a full day, and then went in on my own for a couple of hours once a week in between his feedings and care.

Gabriel spent much of his first eight months in the facility, and first was exposed to the facility when he was ten days old. The staff and residents loved having him there, and there was no resistance to our visits. The nature of my observations and visits also changed quite significantly after Gabriel's birth. I spent much more time talking and visiting informally with the residents, rather than being a passive observer. Incidentally, this approach was where I gained much of my in-depth data and observations. Often, thoughts were shared with me during our visits that were never discussed during the interviews. In addition, the presence of Gabriel changed the dynamics of interactions. I was approached much more by staff and residents, and interactions were more frequent.

Residents with dementia remembered Gabriel and would ask me where he was when I visited on my own. When I brought him in, residents with dementia would ask if the baby was Gabriel. Edward, Rachel, and Brian asked where Gabriel was when I visited on my own, and each of them have pictures of him in their rooms.

My official observations in the facility began in August, 2005. I spent a month becoming accustomed to the facility and its culture, getting to know the staff, and conducting the initial staff interviews. I officially completed my observations of the last participant at the end of June, 2006. At the time of writing this section, I still visit the participants and staff approximately once a week with Gabriel.

Because I was “hanging around” the facility, and in particular, the participants, there were both positive and negative aspects to this. First, my presence may have helped the new residents to adjust to life in the long-term care facility since I spent much time with them and (hopefully) provided emotional support. One of the participants, Brian, mentioned to the recreation staff how a “girl” was interviewing him, and made him reflect on his life and think about things he had not thought about before. My presence may also have had an impact on the socialization process and the way in which the residents adjusted to the facility. Residents adjusted in a different way and the socialization process may have been somewhat different for these participants since they had a visitor one to three days a week. However, given that I was not at the facility or spending every day all day long with the residents, I do not think that I could have changed the socialization process, although the adjustment process may have been impacted. Because I was a part of the social environment and may have an impact just as other aspects of place (both social and physical) have an impact, my presence shaped

experiences to some degree. Since I do not think it was possible to obtain the depth of information from the residents that I did without having a close relationship, the only choice was to develop a close relationship and spend much time with the individual. My reflections on our relationships and the process of becoming part of life in the facility are included in Chapter Nine: Discussion and Conclusions.

7.5 Data Analysis and Interpretation

Data was analyzed using Van Manen's hermeneutic phenomenological approach (Van Manen, 1990). Phenomenological themes are essentially the structures of the experience (Van Manen, 1990). All data was read through numerous times first to ensure familiarity with the data and the transcripts. Van Manen (1990) suggests three ways to isolate thematic statements—through a wholistic or sententious approach, a selective or highlighting approach, and a detailed or line-by-line approach. Staff interviews were analyzed separately from the residents' interviews and the participant observations.

Staff interviews were analyzed using the detailed or line-by-line approach. This approach essentially means that the researcher looks at every sentence or line, and asks, what does the sentence reveal about the phenomenon or experience being described (Van Manen, 1990)? A set of themes surrounding staff's perceptions of residents' experiences coming into long-term care were then identified. These were the essential structures of the phenomenon (Halldorsdottir & Hamrin, 1997). These structures of the phenomenon were compared back with the original transcripts to determine whether they fit the data (Halldorsdottir & Hamrin, 1997).

Resident interviews and observations were analyzed together using the selective or highlighting approach. Statements or phrases that seemed to be particularly essential or revealing about the phenomenon or experience being described were isolated (Van Manen, 1990). Essentially, these statements or phrases focussed on the body, self or identity, relationships, and place. The statements or phrases that reflected each of these concepts were then analyzed more in-depth and notes and themes were written down in the margins. These beginning themes were compared between residents' experiences and throughout the six-month period of data collection. Once the essential structures of the phenomenon were identified, they were compared again with the original transcripts to determine if they fit the data and if there were other themes that had not been developed (Halldorsdottir & Hamrin, 1997).

Finally, the findings of the research were discussed with a number of staff, including two recreation staff, a resident counsellor, as well as one of the participants. In this way, the essential structures of the phenomenon were verified by the participants (Halldorsdottir & Hamrin, 1997). While much discussion ensued about the themes, all of the participants were in agreement that these themes represented the socialization processes into the long-term care facility.

The themes between the staff interviews and the resident interviews were very similar, so the focus for this dissertation was mainly on the residents' experiences as data. The main reason for focussing on the residents' experiences as data was to privilege their voices and ensure that their voices were heard. In addition, by focussing on the residents' voices and using the staff quotes as supplementation to the residents, repetition of themes was avoided. The staff interviews provided much of the content and provided more

understanding about how the socialization process played out in this particular long-term care facility. The staff interviews provided more of the context of the structure of the institution, and also supported the residents' perceptions of their experiences throughout the socialization process. Thus, the process of socialization as a phenomenon was viewed through different lenses (i.e., staff and residents), but the essential structures of the phenomenon remained the same.

7.6 Crystallization and Criteria

The notions of trustworthiness and validity have been incorporated into the concept of crystallization, as proposed by Richardson (1997).

The central image is the crystal, which combines symmetry and substance with an infinite variety of shapes, substances, transmutations, multidimensionalities, and angles of approach. Crystals grow, change, alter, but are not amorphous. Crystals are prisms that reflect externalities and refract within themselves, creating different colors, patterns, arrays, casting off in different directions. What we see depends upon our angle of repose. Not triangulation, crystallization (Richardson, 1994, p. 522).

Crystallization allows for multiple realities without needing convergence on truth and values heterogeneity (Richardson, 1997). Because we all have partial and situated knowledge (Haraway, 1988), crystallization provides researchers with a lens through which to view and evaluate research. Crystallization suggests that there are far more than three sides from which to view the world (Richardson, 1997). When judging qualitative research, especially alternative representations of research, different criteria than the typical criteria of validity and reliability is needed to judge whether a text is good or not (Bochner, 2000). Rather than being methodological, criteria about what is good is tied to values and subjectivities (Bochner, 2001). Crystallization recognizes heterogeneity,

multiplicity, and messiness, which in essence is what “real life” is all about (Ellis, 2004; Richardson, 1997).

One of the main characteristics of crystallization is reflexivity. Reflexivity is demonstrated through how open, honest, and self-conscious the researcher is. Reflexivity calls for a demanding standard of ethical self-consciousness, where the researcher shows concern for the people who are part of the story, for how a person evolves or changes in the telling of the story, and the moral commitments and convictions that underlie the story (Bochner, 2000). In addition, researchers must come clean at the hyphen (Fine & Weis, 1996; Fine et al., 2000). “Coming clean at the hyphen means we interrogate in our writings who we are as we co-produce the narrative we presume to collect” (Fine & Weis, 1996, p. 263). Researchers reflect on their place in relationship with the Other, or their participants (Clough, 2000). Researchers also reflect critically on themselves as researchers, and the selves and identities that are brought to the research and the text (Lincoln & Guba, 2000). Researchers are a part of the world as involved participants, and must examine in their texts what that means (Ellis, 2004). In Chapter Nine, I reflect on my experiences throughout this research.

In addition to reflexivity, multiple layers of meaning are evident in the analysis. Meaning is not simply found by the researcher, but is created together with participants. Richardson (1997) says “We ply our sociological craft within--not above--broader historical, social, and intellectual contexts” (p. 13). Meanings change and evolve over time. In addition, individuals can have contradictory and conflicting meanings at the same time. The meanings in texts need to be “messy”, reflecting real life. Researchers

also need to be explicit about how meanings emerged throughout the analysis and storytelling, and how these interpretations of events came to be.

Multiple voices are also included in the text, including the researcher's. To whom the researchers speak influences the voices chosen for the researchers themselves and the voices for participants (Lincoln, 1997). Because multiple selves are part of research and texts (Lincoln, 1997; Lincoln & Guba, 2000), multiple voices must also be evident in texts. Hearing silenced voices in the text provides opportunities for empowerment and challenges dominant hegemonic discourse. Not only do researchers need to hear silenced voices, but they need to include their own voices. "Separating the researcher's story from the people's story implies that the researcher's voice is the authoritative one, a voice that stands *above* the rest." (Richardson, 1997, p. 18). Including the researchers' own voices in the story implies that researchers are a part of the story. This research included residents' voices, staff members' voices, and family members' voices, as well as my own reflections. These voices are all different frames, or lenses, through which to view the process of socialization (Pamela Wakewich, personal communication, May 2006).

Multiple and partial interpretations are also characteristic of crystallization. Many interpretations of the meanings of stories are possible, given that individuals and social life are complex. Meanings are also produced in interaction and within cultural contexts. The meanings of the past are always incomplete and are revised according to present life circumstances (Ellis, 2004). Harding (1991) suggests that all scientific knowledge is socially situated. Therefore, depending on where one is situated, interpretations may be different. In addition, Haraway (1988) suggests that partial perspective allows researchers to become answerable for what they learn how to see. "The knowing self is always partial

in all its guises, never finished, whole, simply there and original; it is always constructed and stitched together imperfectly, and therefore able to join with another, to see together without claiming to be another” (Haraway, 1988, p. 586). Therefore, knowledge and interpretation is always partial, because every individual only has partial perspective depending on social situation.

The purpose of the research is also multiple. While research most certainly enhances academic careers, the purpose of research is not solely for this. The purposes are for political, social, and cultural change, as well as for transformation. Texts become sites of resistance where politics and identities are negotiated, and where researchers are seeking to make the world a better place (Denzin, 2000). My hope is that this research will ultimately be used to influence and change long-term care policies.

Finally, verisimilitude is a characteristic of crystallization in that the story is like real life and is believable (Denzin, 2001). The experiences that researchers depict must be believable, lifelike, and possible (Ellis, 2004).

These characteristics of crystallization guided my research and my data collection. By attempting to propose these characteristics of crystallization, it provided guidance for how the research was conducted, as well as for how data was analyzed. Instead of discussing notions of triangulation and of validity, I used crystallization as criteria.

The present study used these characteristics of crystallization. I have already mentioned the importance of reflexivity in this research. I want to be transparent and honest as a researcher. In addition, recognizing that meaning is created and not ‘found’ provides a partial and situated perspective of the research (Haraway, 1988). Multiple

voices, from residents, staff, text and documents, as well as my own voice, are presented in the text. The purposes of this research are not merely for intellectual advancement or to complete my Ph.D. dissertation, but also for social change. I believe it is important to understand the ways in which residents learn to become part of the long-term care environment (if indeed they do) and the ways in which meaning becomes created and recreated in this environment. By explicitly focusing on bodily and phenomenological knowledge, traditional intellectual knowledge is challenged. Multiple interpretations of the data are provided, as are thick descriptions. The research is also presented as believable. By staying as close to life in long-term care as possible, recognizing my own partial perspective, a better understanding of the long-term care environment and of residents' experiences in this environment can be advanced.

CHAPTER EIGHT: MAKING INSTITUTIONAL BODIES—RESIDENTS’ PERSPECTIVES OF COMING TO LIVE IN A LONG-TERM CARE ENVIRONMENT

This section is based on the findings from the three residents who participated in the study—Edward, Rachel, and Brian. Three interviews conducted throughout a six-month period, as well as participant observations and informal conversations, constituted the data upon which this analysis is based. The findings from the initial staff interviews, as well as the staff and family interviews regarding the individual participants are included here to supplement the findings from the residents’ interviews. In essence, most of the themes emerging from the residents’ interviews were similar to the staff perceptions of residents’ adjustment and socialization into the long-term care facility. Thus, staff quotes are used only to supplement the findings, in order that the residents’ voices might be heard. Pseudonyms are used to refer to all names and places from hereon in.

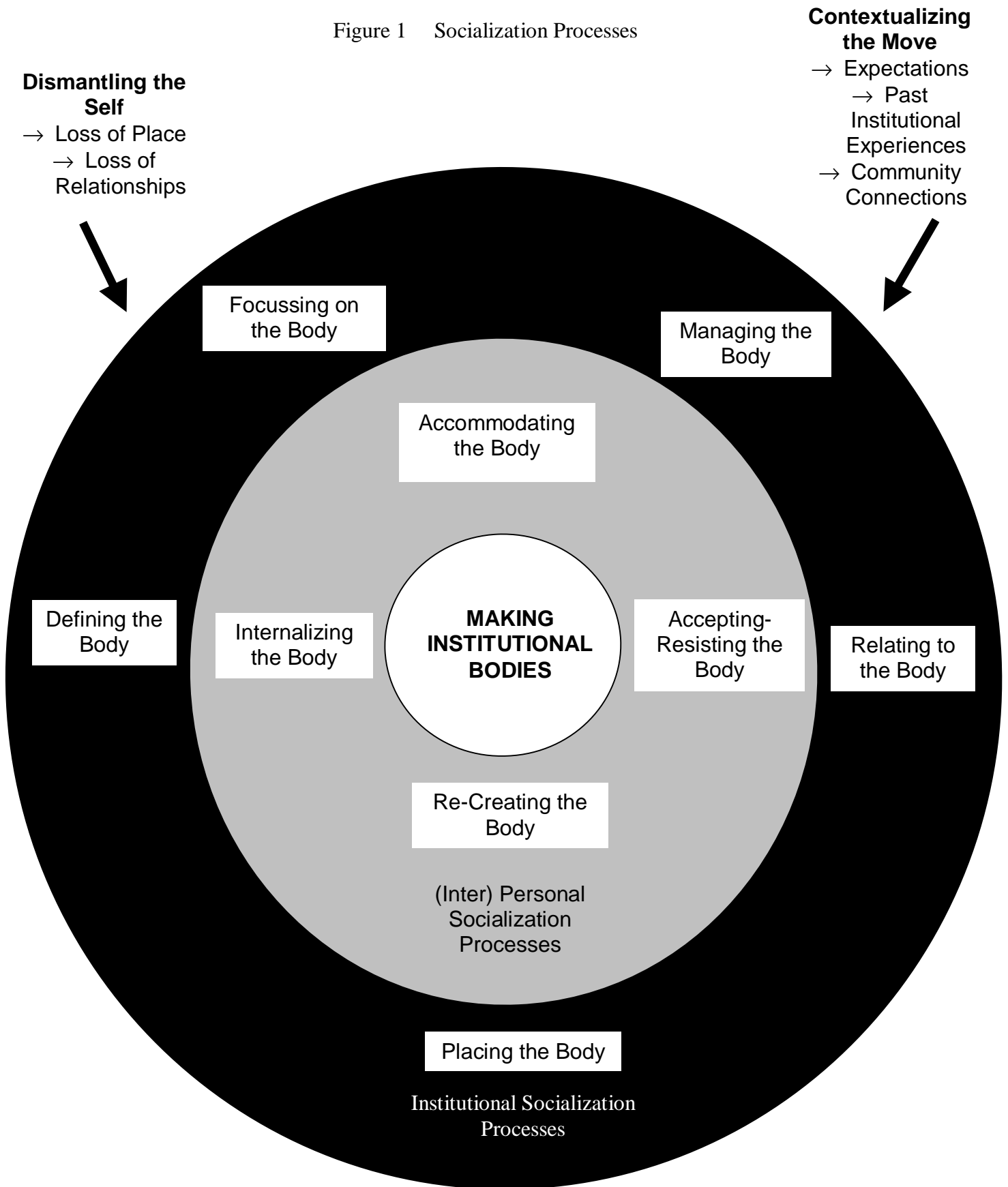
My time with Edward, Rachel, and Brian illuminated a dynamic process of socialization into long-term care. Figure 1 reflects to some degree this socialization process into long-term care. Although the figure suggests a somewhat deterministic process of socialization, the process is complex and is anything but simple and linear. Thus, as is the case with many diagrammatic representations of experiences, the figure does not adequately represent the complexity of the participants’ experiences, nor does it adequately represent the uniqueness of each participant’s experiences throughout the socialization process. As the following findings will demonstrate, how the participants experienced and construed their experiences moving to a long-term care facility and the socialization into long-term care reflected a much more complex and complicated set of

interconnected processes. In addition, there was a tension between residents' descriptions of their experiences and hearing and respecting their voices, and the processes of socialization by the institution itself. Thus, it was imperative to be aware in what situation these experiences were embedded, and recognize that understanding the residents' experiences more fully necessitated understanding the long-term care setting and culture within which the socialisation processes were played out.

Dismantling of the self occurred prior to and during residents' admission and life into long-term care. This included *loss of place* and *loss of relationships*. Losses included the many losses of home and possessions as well as relationships that residents experienced before and during their admission to long-term care. The move into long-term care was *contextualized* by the preparation to come into long-term care. Preparation included expectations (for when they would be coming into the facility as well as what the facility would be like), past institutional experiences, and community connections that they had in the facility. Coming to live in a long-term care environment was described by residents as living an *altered life*. This altered life consisted of socialization processes on two levels—*institutional processes* and *personal processes*. The institutional processes consisted of *placing the body*, *defining the body*, *managing the body*, *relating to the body*, and *focussing on the body*. The personal processes included *internalizing the body*, *accommodating the body*, *accepting-resisting the body*, and *re-creating the body*. These processes all came together to form what residents become in long-term care—*making institutional bodies*, as described in Figure 1.. Again, for the purposes of this discussion, I use bodies to refer to physical bodies, which is the meaning and identity assigned to

residents from an institutional perspective—that of being a physical body. Body-self refers to selfhood existing in the body as well as the mind.

Figure 1 Socialization Processes



THE STRUCTURE OF THE INSTITUTION

Living an Altered Life

8.1 Dismantling of the Self

Dismantling of the self focused on the losses that residents experienced, both prior to and after admission to Ridgemount. In a sense, these losses were part of the process of relinquishing a life in the community and accepting an altered life in long-term care.

More so, however, these losses reflected a dismantling of the self, where the resources by which they identified themselves were eliminated. The three residents participating in the study—Edward, Rachel, and Brian—experienced multiple losses both prior to coming to Ridgemount and after admission to Ridgemount. These losses centred around two main areas: loss of place and loss of relationships.

8.1.1 Loss of Place

Each of the participants experienced the loss of place either immediately prior to coming to Ridgemount, or years before. Edward had already given up his house that he and his wife lived in when they moved away from their small community of Smithville a number of years ago. Despite this, admission into Ridgemount Facility constituted a reliving of that loss of home.

Then he started talking about his house in Smithville and how everything was sold and everything was gone from there. He said, "I guess it's no use to me at my age now. I replied, "That must be hard." "Yes, it is", he said. [Field Notes, September 28, 2005]

The loss of community was also difficult for Rachel. This loss, however, happened the year before when Rachel had her first stroke and was hospitalized. Her granddaughter, Deborah, stated,

She comes from a small little town. And that if anything is an adjustment that she doesn't know too many people in Ridge Mountain. Her fifty years in Longhill, you get to know every person.

Because Brian had to give up his house after he was admitted to Ridgemount, he experienced his loss during the data collection period and discussed it in great detail with me. He had built his home himself and he and his wife lived in it for over forty years. For him, the loss of his home as well as other losses were all tied in with the adjustment process to the facility.

*Elaine The house is the last of everything?
Brian Yes. When that's gone, it's gone.
Elaine How do you feel about that?
Brian At first I felt a bit lonesome, but then as it wore on, it got to be
 more of an aggravation. [Interview One]*

When I asked Brian if it was sad to have his house sold and to see it without furniture, he replied, "It feels kind of hollow. It makes me feel lonely." [Field Notes, August 15, 2006]

The loss of possessions was also significant and very much tied in with the loss of home for Rachel. Even though Rachel's loss happened a year ago, she still stated,

I miss my plants. My living room was full of plants and my office. And Deborah gave them all away. Gave my dog away. Well, nobody could look after him. Miserable little bugger. I could look after him because I'd holler at him and he'd listen. [Interview One]

Again, the loss of possessions was extremely difficult for Brian because his home was sold during the course of the data collection. All of his possessions had to be emptied out of the house before it could be sold. As such, he was not just selling his house, but was giving away a lifetime of possessions. He had little control over what happened to his possessions during this process.

At first I felt a little bit lonesome, but then as it wore on, it got to be more of an aggravation. What was lonesome was all of the stuff that you accumulated over the 52 years we were married. I say they pick my bones for it. Like we had a set of lamps that the wife, she renewed one of the shades on it. It cost her \$120. She renewed the shade on it. Then my sister come in from Jonestown. She said I'll

*take those two lamps. She never asked me or anything. She just took them away.
[Brian, Interview Three]*

Brian's family had come from out of town to assist with selling the house and disposing of his possessions. He described the loss of his house and the loss of possessions as memories stopping.

Brian Yeah, after you get used to your stuff missing, there's things that you'd like to give to somebody. Somebody else comes in and claims them. It all stayed in the family, but ah, I hated to see some things go. But I can't have them all here.

Elaine But they all have meaning, don't they?

Brian Everything has meaning.

Elaine Like somebody could look at it and see just a thing, but for you,

Brian Yes, for me, it's something. We talked last time about memories, and I never thought about memories until this stuff started to go. And we got to, she was buried, my sister from Jonestown was up here. And I knew, I say about her, she'd pick the pennies of a dead man's eyes. And I knew that when she came up, she's 84 years old, and her husband's 70, no, he's 83. Something like that. He's a year younger than she is. And they drove up from Jonestown to here. And I knew when they were bringing the car, they were bringing it for something. She got her share. Oh, there's things I'd like to have, but I can't have them. I can't have them here, so I've got to give them up. You get used to it.

Elaine I can't imagine that it would be easy though.

Brian Can't imagine which?

Elaine That it would be easy.

*Brian No, it's not easy. Not easy. It's ah, you have to watch. With only two adults in the house and no children, it gets a lot of treasures. ... You take this, you take this and that. And then, that's what memories are made of. Can't go on forever. It's got to stop. And it stopped. I'll sell the house. The house is going to be more of a lonesome spot than anything. Because I built it right from scratch.
[Interview Three]*

One of the most difficult losses for Brian, however, was the loss of his workshop.

He went to his house, and his workshop where he made his guns was empty. "That was my sacred space. That's where I went to relax." Apparently, his family had divided up his gun collection and took it all without telling him. "I know I can't have it here, but I have to come to that decision myself. If I really think about it, I know I can't have those things here," he said. [Field Notes, September 2, 2006]

Brian Part of my freedom was working in my workshop. It didn't really matter whether I got the job done in a day or got the job done in ten months, it was something I could do to take up my time. And all of a sudden something happens in the latter part of your life, but if you really didn't, you knew it had to come. But you were not accustomed to that kind of life, so you live the life that you had normally lived. Then all of a sudden, somebody cuts that off.

Elaine Because you described your workshop as being your sacred space, right? I think those were the words you used.

Brian Yes. Then all of a sudden, somebody at the door says you're done. And my workshop is scattered all over. There's saws up in Fort Church, and there's a drill press in Mackery. The family got the whole thing and they spread it around. [Brian, Feedback Interview]

Another aspect of the loss of place was the loss of the outdoors. Rachel spoke mostly about this aspect of institutionalization. She was not allowed to go outside by herself at the past facilities she had lived in, so she was happy to have access to the outdoors at Ridgemount.

You can go outside if you like. Like I haven't gone out that much because it turned cold after I got here. Wait 'til summer comes and I'll be out. [Interview Two]

You can get out here. Like once summer comes, we'll be able to go and sit outside. [Interview Three]

The staff also recognized the depth of losses that residents experienced, particularly with the loss of place—both through a loss of home and a loss of possessions.

When you think about leaving your whole home and all your furnishings and coming to one room and you're allowed to bring what, two things? I think it's pretty hard on most of them. [Mary, Nursing]

And how do you choose? How do you choose if you? I mean people who have a whole home, they have to choose from their whole home the few limited things. And even that makes a statement about who they are. What things do they choose to bring with them? Versus the other things that we don't even see in their home... I can see from people's apartments, I mean, I try to call them apartments, um, pictures, family pictures, lots of family pictures, um, not a lot of trinket things. Maybe the odd one of where they've been somewhere, like because it tells a story. Because everything we have tells a story. Like where did you get that?...And if

you ask people, there's a story behind and that is their identity. [Karen, Recreation, Initial Interview]

8.1.2 Loss of Relationships

The loss of relationships was also very significant for all three participants.

Rachel lost her husband 14 years ago, and still talked about him and their life together.

Rachel My husband and I were married for, well we got married in 1950 and he died in 1992.

Elaine So 42 years.

Rachel Yeah.

Elaine It must be hard being used to having that person there all the time and all of a sudden they're gone. My husband and I have been together for almost four years, and I can't imagine not having him around.

Rachel Yeah, it's hard. I miss him. I had three brothers die around the same time. It was really difficult. He would have loved his two great-grandkids. [Field Notes, December 14, 2005]

Edward's relationship with his wife, Maybelle, had changed significantly over the years because of her health changes and her dementia. While he hadn't lost her physically, he had lost the relationship that once existed between them.

Elaine Now you were saying too that Maybelle doesn't talk as much as she used to either.

Edward Oh, no. She doesn't.

Elaine So that really leaves you, so who do you talk to then?

Edward Well, that's it. When there's two of us together. I have a hard time to get her to listen to what I'm trying to tell her. And that is hard on me, but, 'cause I'm used to yapping away at different people, you know?

Elaine So you don't have a lot of people to talk to here then.

Edward No. [Interview Three]

Part of the change in the relationship of Edward and Maybelle was a change in roles for Edward when he came into the facility. He was no longer Maybelle's primary caregiver at Ridgemount, as he was when they were living at home.

I know at first it was like you're taking my job away, whenever we did something for her that was, he was like you're taking my job away. He did everything for her. So um, but now when he comes down he basically does nothing. Other than he will spend, if he's lucky, 60 seconds before he's up and he's going again. So I don't know, and then he'll come back again, sometimes half an hour, sometimes two hours, so I don't know if he remembers he's been here to see her. But no...he just comes and goes. [Brenda, Nursing]

Another loss that Edward experienced was the loss of being together with Maybelle.

Edward and Maybelle were not living in the same room together, and were in fact living on different floors. The separation, particularly in the beginning, was very difficult for both of them, since they had never lived apart for long periods of time during their married life.

I asked how [Edward] was doing. He said fine. "I haven't seen my wife for four days," he said. I replied, "You haven't?" He said, "Well, my wife was just up here and she's upset because she said that I hadn't seen her for four days, but I have." I said, "Yeah, you were just there yesterday." He said, "Yeah, I go down to see her everyday." Later he said, "Her mind's not working properly, so she's wondering why I don't come down to see her all the time." [Field Notes, September 28, 2005]

Edward *It was a big adjustment. Yes. It's just Maybelle and I, as far as we're concerned. When we come here, I didn't think we'd be separated. And ah, although I haven't, gotten used to it, I don't think Maybelle has really set her mind on it yet. 'Cause I go down and see her in the evening, you know, and we talk for a while. Then I'll say, well I gotta go. And she'll, why you in such a hurry and so on? I don't want to stay too long, so I have to say, I gotta go. And that parting with her and not seeing her until the next time, it bothers her. Not so much now as it did at the beginning. At the beginning it was terrible. I didn't like it myself, but I had to put up with it. I can put up with things easier than she can.*

Elaine *She didn't really understand why you had to leave, did she?*

Edward *No.*

Elaine *No.*

Edward *I don't think she knows yet just why she had to leave. But I've got it from, it was, ah, whatever is taking place, she couldn't be there. Now I don't know what, why the reason for that, but. Because we've been married for I don't know how many years.*

Elaine *Sixty-something? Isn't that right?*

Edward *I think it's sixty-something. Somebody said it was eighty-something. I know it wasn't eighty-something. [Interview Two]*

Brian experienced significant relationship losses as well during the data collection period. Brian's wife passed away about three months after Brian's admission, and this was a significant relationship loss for him, perhaps the most significant relationship loss because he and his wife had no children.

His voice was very hoarse, and sounded like he'd been crying. According to Julie and the nurses, he had been up most of the night. He told me that he hadn't slept most of the night. I asked him if he went to see [his wife] last week, and he said he did. She couldn't talk to him because she was so doped up on morphine. He said she had been calling out for him and for the dogs. He said, "It's God's blessing. At least she's not suffering anymore. But I can philosophize about it all I want." I said, "But it's still your loss." He said yes. Again, he said that the only good thing was that at least she's out of pain and not suffering. He said he was really tired and might fall asleep, so I said that I would leave. [Field Notes, June 5, 2006]

Brian also had to put his dog to sleep shortly after he came to live at Ridgemount. Since he was a dog owner for most of his life, this was also a very difficult loss for him and was a significant relationship loss.

We're going to have to put her down. I can't take care of her. The nurse can't keep her. I don't want her to go to anyone else. She's 12 years old though. She's old for a dog. She's had a good life. She's had birthday cakes. [Field Notes, March 27, 2005]

The loss of friends was also mentioned by Edward and Brian. Although some of Edward's friends had passed away a few years ago, he still talked about them with fondness.

Elaine *So what is life like here for you?*

Edward *Very quiet for me. Of course, maybe I, it's my own fault, 'cause I've always liked to be alone in certain things. Now, I'm alone more often, more often. But it hasn't done any harm. It ah, there's some things I miss.*

Elaine *What do you miss?*

Edward *Just the company.*

Elaine And I know at your other apartment building you were living in, you said you had lots of friends around and lots of people to talk to.

Edward Oh yes. Oh yeah. I had friends there all the time. I don't have that here. I have friends here. Just not the same... But now it's, some of those old friends are gone, and there isn't the new friends to take their place.

Elaine Do you find the same thing for yourself?

Edward Yes, I find.

Elaine Is it lonely here for you?

Edward At times. I haven't the friends here that I had before. Like John Smithies and ah, well, he was an old friend. [Interview Two]

Brian also discussed the loss of friends. He had lost many of his friends prior to coming to Ridgemount, but still often talked about his memories of his friends.

Brian All of a sudden, him and I were the best of friends. Run our dogs together, fished together, just played together. And he told me one day, we were driving out to the [camp] to see a friend. He said I can't drive you. So we take my truck. He said, I got something to tell ya'. I said you, we were talking about cancer, and we were about the age, you know. I said, you got cancer. He said I don't know. But I sure have the symptoms. I said, how often do you get up during the night to go to the bathroom? He said about 20 times. I said, have you been to the doctor? He said no. I said you'd better get to the doctor and get there fast. I said, does your wife? His wife's name is Jane. Does your wife know? He said no. I said at your age, your prostate is gone. So he went to the doctor and the doctor told him, take this antibiotic and come back and see me in six months. I told his wife, there's no way that Mike can wait six months. He's got to go in now. So they took him to McIntyre Hospital. He was dead in six months. He was dead in 3 months.

Elaine So it was cancer.

Brian Right through him. It was hard to take, because we did everything together. We had a coffee club with the retired people from the mill. And we, each one of us had a phone list, and he'd go down there. He made up the list for everyone to phone, you know. [Interview Two]

Ultimately, though, Brian described all of his losses as a loss of freedom.

It's something that you've lived with, oh, for me I've lived with it for 79 years I've lived with the freedom. And all of a sudden, I lost it in six months. If you, if you're like a lot of them that are under the influence of drugs, you don't miss your freedom because you don't know you've lost it. But for a fellow like me that

doesn't like drugs, I like, I still like my freedom. I know what I've lost. It's hard to take, but you have enough time alone to think about it. [Brian, Feedback Interview]

The residents experienced many losses, which they all discussed in great detail, particularly the loss of place (home and possessions), and the loss of relationships. In a sense, these losses were losses of a life and of identity. As such, residents came to Ridgemount having experienced many challenges, and grieving over the many facets of their lives that were now gone.

Many of the staff also understood the loss of a life for residents. This loss of a life was compounded by the dehumanizing aspects of the institution. Many staff felt that residents lost their identity upon coming into the long-term care facility. A decontextualization of the residents' lives as part of the dismantling of the self occurred when they came into the facility.

There's a loss of their life coming into institution. Because as we talked about, they're coming into strangers, and these people that work here don't know them, have no idea who they are, they only know tidbits about this person. So really there, it's almost being like an entity in this building of nothing beforehand. You know, I often make a metaphor of a plane went over and dropped the person off. And not to be disrespectful, but dropped the person off and said here, here's the next person moving in. and that's all you have, you know, and sometimes staff don't want to know anything else about them. Only enough to help with their actual care right now. So, yeah, I think it is like a door closed, this is gone, and now I'm just this, here...[Karen, Recreation]

So I would think it's just the loss of being able to be even who they are. If that makes any sense. [Martha, Recreation]

8.2 Contextualizing the Move into Long-Term Care

The amount and ways in which the residents were prepared to come into the facility significantly impacted the ways in which they adjusted to life within the facility.

There were three significant ways in which preparations were made to come into Ridgemount and in which adjustment occurred. These included *expectations and anticipation, past institutional experience, and connecting with familiar people.*

8.2.1 *Expectations and Anticipation*

This theme incorporated residents' expectations and anticipations about when admission to Ridgemount would occur. Rachel had been waiting for a permanent place to live after spending over a year in a hospital and transition facility, so the move to Ridgemount was anticipated. Edward and Maybelle had moved out of their home and small community to Ridge Mountain and had lived in a senior's apartment with a live-in caregiver prior to coming to Ridgemount. The move to Ridgemount was anticipated because of Maybelle's declining health and progressive dementia. Brian, however, did not anticipate that he would have had to come to Ridgemount so soon.

And it's because of the wife's condition that I came in here. I didn't expect to come in here so early. Maybe this fall. ..So because of her condition, she couldn't take care of me. She wanted to be home. We couldn't both be home. So I came in here. [Interview One]

In retrospect after being in the facility for a couple of months, Brian realized that he needed to have assistance, and perhaps should have come to live at Ridgemount earlier. Thus, his expectations changed upon reflection.

...just the idea that I don't think I should be here. Nobody does, eh? Everybody figures that. I carry on alone when I look back. When I look back, I see that I had to have help at home. My wife needed it. Sick too. You don't realize you're sick until you get sick...To me, I wasn't quite ready. Although if I look back and see the care my wife was given me, I should have been outta her hair. But I didn't expect to have to come in here. Because coming in here is so final. [Interview Two]

One of the nursing staff also confirmed Brian's perceptions of his expectations of admission to Ridgemount.

He didn't understand why he had to come in here when his wife was at home looking after him. But his wife on the other hand was getting tired and burnt out and very sick...But I think even if it would have come when he expected it to, it still would have been too early... When he first came in, he did tell me something. He said it was a gradual disease, but the disease process sped up much faster towards the last two months before his admission. And again, that's what he was telling me where he would freeze up and his difficulty with transferring, and that's where it seemed to be a very big problem for him, is that he had a rapid decline in his health over the last two months period of time, and I think that's why his wife had increasing difficulty looking after him as well. [James, Nursing Staff]

8.2.2 Preparation Through Past Institutional Experiences

The second way in which residents were prepared for life at Ridgemount was through past institutional experiences. Rachel had many past institutional experiences at St. Mary's Hospital in rehabilitation after her stroke, and at McIntyre Hospital, a transitional facility while waiting for long-term care placement.

I think the fact that she was in a facility before, that helped her to adjust quickly. I think that had a lot to do with it. [Sarah, Management]

Brian also had experience in an institution since he had been in respite care two times prior to coming to live at Ridgemount.

Because of my first two experiences being in respite, I didn't have too many apprehensions. They told me with the room, there's a good-sized room. And as I say, I didn't think too much bad of it. I come in, I haven't been disappointed. [Interview One]

Elaine Did you find it difficult when you moved in here to get used to the different staff when you moved in here? I guess it's only been a couple of weeks so I guess you're still getting used to the different staff.

Brian Not really. I had the experience in respite. A little bit of background. [Interview One]

These past institutional experiences helped them learn about what life is like living in a facility, and prepared them for their admission to Ridgemount. These institutional experiences allowed them a glimpse into institutional life and what the experience was like living in a facility.

8.2.3 Connecting with Familiar People

A final factor that provided context for residents' lives at Ridgemount and helped them to adjust was connecting with familiar people inside the institution. Because Ridge Mountain is a medium-sized northern town, many people knew each other. Even those individuals who came from out of town knew others from their small communities.

Edward met two women also living at Ridgemount who had lived in the small community where he and Maybelle spent most of their married lives.

On elevator, [Edward] met Dorothy. She said, "I should know you." He couldn't remember, but it turns out he knew her husband. After yoga, Dorothy introduced another resident who had also lived in Smithville who knew them. [Field Notes, September 22, 2005]

Rachel knew many of the staff working at Ridgemount because of her past experiences in St. Mary's Hospital and McIntyre Hospital. In fact, many of the staff at Ridgemount worked at both McIntyre Hospital and Ridgemount.

Rachel Then I have the girls that come over from McIntyre. They always pop in and say hello to me.
Elaine Oh, that's nice. Now do they work here?
Rachel Yeah. And they take messages back and forth from McIntyre to, the nurses to me and me to the nurses.
Elaine So you're still able to maintain some links.
Rachel Yeah. I'd like to be able to get back over there for a visit. To both places. I will when I get feeling better.

Rachel also met another resident she knew growing up who came from the same small town in Manitoba as she did.

Elaine But you said yesterday you've met quite a few people?
Rachel Yes I have. I think I've met pretty near all on this floor. I met Ruth.
Elaine That was so funny that the two of you grew up in the same town.
Rachel Her dad was a mailman. My dad was a fireman. We lived three miles west of Harbourview. And she lived... quite a ways from us, and then they moved to town.
Elaine So did you, are you okay? [coughing]
Rachel I knew her two sisters, Bernice and Vera. Vera was old fashioned, she was. [Interview One]

Some of the nurses also knew Rachel's son from her hometown of Longhill.

I'll have to see if my nurse comes back tonight. She should be in tonight. Her and my son sat here and laughed and talked, 'cause my son knows her dad. They used to party together in Longhill. [Interview Two]

Brian knew some of the residents in the facility because of his days working at one of the local paper mills.

The woman two doors down, she doesn't remember that she worked thirty years at the mill. She doesn't remember me, doesn't remember that I met her the other day. She's a spinster and liked everything her way. They used to call her Granny Grumpy. [Field Notes, February 6, 2006]

Brian I know the old one next door. I worked with her son.
Elaine That's right. Mrs. Koposta.
Brian Mrs. Koposta. The other one down the road, I worked in the same department she did.
Elaine Miss Farmer.
Brian Then the old one down there, Eleanor Watson, she was the manager's secretary.
Elaine Oh, so there's more people that you know then.
Brian Yeah.
Elaine Isn't that interesting? Julie was telling me that Ridge Mountain is a small town, and you'll find that a lot of people in here know each other. And I didn't believe it until I started talking with people, and everybody knows somebody.
Brian Julie used to date a guy who lived next door to me.
Elaine I think you told me that last time, yeah.
Brian He had an orchestra. Not musicians. They just banged on guitars and stuff. They called themselves some kind of musicians. He'd

open his basement window and the wife and I would open our window and have music for supper. She used to date him. Julie. He died in a house fire. The only son that they had. [Interview Two]

These community connections helped create an identity for the residents that was beyond and before their lives at Ridgemount and helped them get to know others and adjust to the facility. Thus, there was some recognition of who residents were prior to admission on the part of those who knew the residents in their prior lives.

Dismantling of the self through losses, then, set the stage for admission into Ridgemount Facility and for the socialization process that occurred after admission. The move was contextualized, at least for these residents, by the expectations and anticipation of long-term care, past institutional experiences, and connecting with familiar people. Coming into Ridgemount was described as an altered life because of the many changes to residents' day-to-day lives that were forced upon residents.

8.3 The Structure of the Institution

While this research did not focus on staff and their own socialization into the long-term care environment, comments from both the initial staff interviews, subsequent staff interviews, and field notes described the culture of the institution and indicated that staff felt pressure to conform to the culture of the long-term care environment. As will be indicated in the following findings regarding the socialization processes, this culture of the long-term care environment structured the everyday lives of both the staff who work at Ridgemount, and the residents who live there. Both staff and residents had to conform to the structures of the institution. The structures of the institution included government regulations, organizational culture, and structuring the staff's everyday experiences. In

essence, staff felt like they were constrained in their work by the regulations and organizational culture. Making the residents into institutional bodies, that will be described later, was not necessarily something that staff wanted to participate in, but the structure of the institution made it difficult for them to resist this. My purpose here is to provide a description of the facility and of some of the issues going on in the facility in order to further contextualize the lived experiences of moving into Ridgemoor for these residents.

8.3.1 Government Regulations

Government regulations, and compliance officers as enforcers of these regulations, were the biggest contributors to the socialization into the long-term care environment. The rules and regulations, made by people outside the institution, impacted and structured the institution and the way that staff went about their day-to-day jobs (Diamond, 1992).

It's always the people outside of it that make the decisions. They're not even connected to the facility. They're totally outside of it. They're the people who make the decisions and decide where money goes, and they have no idea what it's like to be here. I mean, I even take in the people who designed this building. There could have been a lot better ways to design it. But they're not here. They don't live here. And we had, we had a team created to talk about the retrofit that happened to this building. I doubt that anything that was on that retrofit happened. From the people who actually work here. [Karen, Recreation, Initial Interview]

While regulations were enforced by the government, funding was also described as a significant issue. There was not enough funding for staff to do everything that the government required of them, and lack of staffing was a common theme.

Oh yeah, so in those first days sometimes I'll hear you know "We thought this was the Taj Mahal and you're supposed to be the Cadillac and you know dadada" and

I says "Well we're still funded, we're still funded for long-term care so we may be a new building and we may smell nicer you know than some buildings but we're still funded the same envelope you know, and so that's kind of a view that comes in. [Marlene, Management, Initial Interview]

The changing standards of the Ministry of Health, along with a lack of staffing, were perceived to contribute to the structure of the institution.

Well staff have a hard time sometimes adjusting to the Ministry standards. They're changing, there's no staffing for the changes. But the demand is great. The demand is you know you have to be supervising offering food every two hours. There's not enough time to really, the staffing that we have now it's unrealistic...The Ministry standards are great they're actually awesome if you have the staffing for them. I mean I don't think it's good enough to change Ministry standards because you know in long-term care it's not right that residents are sitting for four hours and not being turned. I think you should be providing the staffing for that. The hours they should be looking at some sort of feasibility study and taking those standards and talking the individuals you have and see exactly what kind of staffing pattern you need. It's just to me it's not realistic. So now you have to, a resident wants to eat in their room with their spouse and you're telling them they have to eat in the dining room 'cause you can't eat in your room 'cause I have to supervise you and sit here and watch you eat. And to me it's routine. You know it's part of our routine. We have, you know lunch has to be at a certain time you know the Ministry tells you when lunch is supposed to be, when supper's supposed to be and we have to get into the routine of doing this. It's not always resident-driven even though they say it is...There's been a lot of changes and we haven't been, we're having a hard time coping with the changes. [Eleanor, Nursing, Initial Interview]

The legislation from the Ministry of Health required residents to conform to these rules.

There's Ministry guidelines that are more or less for the nurses. I don't know if there's really, yeah there is expectations I guess because you know we kind of expect them to go to the lunch room. If they feel like today I don't feel like it I'd like to eat in my room well that's not an option 'cause one of the things the Ministry says is they need to all be in the dining room and you know yourself at home a lot of these people, younger generation have been raised eating in front of the TV. So I don't know, what's going to happen in the future will be quite interesting. [Belinda, Nursing, Initial Interview]

...so that legislation is really binding. Really is binding. And I got in more than one debate, I'll say. With the Compliance Advisor over her opinion and mine and what's a risk and what isn't so. They usually win, you know, so then it's up to the staff to come up with a creative way that we can still help the resident continue on with what they're used to doing with their lifestyle...and not pose any risk to

anybody else so. Those situations are hard. Yeah, those situations are really hard. [Colleen, Management, Initial Interview]

Staff knew there were repercussions if rules and regulations were not followed, despite the lack of funding and staff available to follow these rules and regulations through. An example of this is the recreation assessment. The recreation assessment had to be completed within 21 days of admission, otherwise the facility was cited by the compliance officers.

And again, on my floor I don't talk to the residents because I can't get that information from them, so I have to contact the family. So sometimes it goes beyond 21 days because you can never connect with the family. I think I got cited the one, Ridgemount got cited for that one. [Martha, Recreation, Initial Interview]

Life was regulated for staff, as it was for residents.

But no, it's very regulated...and as we are, as staff we are. As what, as recreationists, our role, we're very regulated as to when we do it, time, how often, yeah. [Martha, Recreation, Initial Interview]

The enforcers of these regulations viewed residents as bodies and tasks, and so the regulations were structured around this view. Some staff, particularly staff working outside of nursing, found this frustrating.

Well you know what? I find that a lot of them, not knocking nursing, but a lot of the compliance officers or managers that we get are all coming from a nursing background. So you find a building, you're going to know that there's a lot of supervisors with that. Because they're totally task oriented. They think that they're seeing the residents' focus, but they're not. They are totally seeing the task. We gotta get all these people up. They gotta be up by 10:00 or whatever time, blablabla. And um, God, this is a home. You know? [Joyce, Recreation, Initial Interview]

The policies of long-term care, rules, and regulations structured the environment in which the residents lived and staff worked. As such, the structures of the institution shaped not

only the residents' day-to-day experiences, but also shaped the staff's day-to-day working experiences at Ridgemount Facility.

8.3.2 Organizational Culture

Ridgemount Long-Term Care Facility was in a period of change during my data collection, and the organizational culture was reflective of this. Because of decisions made by bureaucrats, the care of residents in this community was increasingly being transferred to the private sector. As such, the long-term care community in Ridge Mountain was in a state of transition. At the time that I started my data collection (July, 2005), the decision had not yet been made to transfer care to the private sector, but by November 2005, politicians had made a decision to transfer care to the private sector. This put the employees at the homes for the aged, who had worked for considerable years in the public long-term care sector, in a position of potentially losing jobs and being transferred to work in the private sector. As such, the environment was often palpable with tension, both among management and staff.

Another change throughout the data collection period was increasing surveillance. Access to the stairs was restricted, and only staff with access cards were permitted to open the door to the stairwell. There was a cited concern about thefts in the building, so there was talk about installing more security cameras in staff areas, although this has not yet occurred to my knowledge. The back entrance to the facility was also locked toward the end of my data collection period, and only staff with access cards could come and go through that entrance. Staff did not have a time clock where they punched in and out before and after shift, but management began to monitor use of access cards through the

back entrance (which all staff were required to use). Management turnover also occurred. Two Directors of Care left during the time I was involved with the facility, and the Assistant Director of Care position was not filled for most of the data collection period. In short, Ridgemount was in a state of change, and this state unsettled both staff and management alike, resulting in increasing surveillance, resentment toward others (particularly management), and an organizational culture that was unsettled and tense.

The unsettled environment and state of change was also reflected in management-staff relationships. Staff commented on some of the conflicts and tensions between management and front-line staff. There were comments made to me “off the record” after interviews were conducted regarding management and some of the conflicts between management and staff. These comments, of course, are not recorded here. However, there were many observations and comments during the interviews about management issues.

And that's about the power structure of institutions and systems. And will that ever change? No because somebody always needs to have the power. And feel the power. And to me there's a difference between having power and having leadership. Leadership is not about power. Power is an entity and it's usually very negative in itself. And there are some people I really feel that are dangerous when they have power and don't have any leadership skills. And I know that happens in this facility too. [Karen, Recreation, Initial Interview]

Part of Karen's frustration was the inability to change the culture in any way because of management and organizational structures.

...and it's always so difficult, because for me when I read things like Eden Alternative philosophy of care, I get excited when I read it, and I think oh, you know. And then I get depressed because I'm welcomed again to the reality of like you know, and I do dislike my mindset of it's never going to change. It's the same thing. You know, but I took a seven-month leave of absence and came back to the identical, very same nothing changed. Maybe I'd hoped in seven months a few little things that I know could be changed, are not. And that's, that's difficult. So I think being a resident and knowing that too, day by day by day, and then we wonder why people do get depressed? I mean yeah. Probably every person in this

*facility is depressed and have been depressed. And does that surprise me? No.
[Karen, Recreation, Initial Interview]*

Staff, then, felt incapable of changing the organizational culture.

Organizational structures are complex, and Ridgemount was no exception. A union culture, issues between staff and management, and increased surveillance of staff all contributed to this complex structure. This organizational structure, however, was part of the culture of Ridgemount, and in this way, structured the existence of the staff's working environment, which also filtered down to residents' day-to-day experiences.

8.3.3 Structuring Staff's Everyday Experiences

The government regulations and organizational culture structured staff's everyday experiences. Some staff found that they had to ignore their ideas of what was right and their ideals of how residents should be treated in order to function in the day-to-day work environment and the structures of the institution. If they were to meet the requirements both of the Ministry of Health and regulating bodies, as well as management demands, they had to compromise resident care and relationships.

Joyce But um, yeah, that's so hard because you're finding that your morals, or what you believe, sometimes you have to walk away from. And that's really hard to deal with. Yeah, like seeing somebody that's really in need and that needs something, but you have to be somewhere else and everyone's in a room, starting a program in the auditorium at 2:00. And you want to bring this one person but this one person has something that they need or they need a sweater or something, I don't know, anything, and it's like okay, if I go do that, I'm going to be late. And then I have all this room of people that I've let down to get this one person there but the one person would really like to go to this music or whatever it is. So it's really a catch-22.

Elaine It's trying to balance the needs of the group versus the needs of the individual and you can't always do that.

- Joyce *And then you feel bad because you're. And Julie and I said this a long time ago. Because you're, there's not a lot of days where you can go home and say I met everybody's needs today. And maybe that's an unrealistic expectation of yourself, but you like to be able to go home and say well you know, everybody had a good day, and I felt like I really helped the people I'm supposed to work with today. But most of the time it's like okay, well I should have seen so and so today but I didn't get a chance because I had to do this. But so and so's really sick today. It's, yeah.*
- Elaine *I know when I was working too, most often days you'd go home and you'd accomplished the programs on your calendar, but you felt like you didn't do much and you felt like there's so much more you wished you could have done.*
- Joyce *Exactly. [Joyce, Recreation, Initial Interview]*

Oh, it is. I mean, I don't understand what the ministry is trying to get at. I mean I know yeah. People should get up. And there are the extremes of people that um, don't want to ever leave their room. Well you've got to kind of work it so they are still getting out and about. But trying to get everybody up so they're eating breakfast in the dining room? That to me is against residents' rights. If they all their lives depending on their morning routine. Like for me, I'm not getting dressed until after, if it's a Saturday or a Sunday, I'm in my pajamas until noon. I'm drinking coffee and I don't want to eat until I have lunch. So if I had to come in and get up early every single day and be dressed before I even get to eat or drink coffee and have one or two cups of coffee, no thank you. And if this is the last stop, let's make it as best as it can be for them. [Joyce, Recreation, Initial Interview]

There were many staff, including nursing staff, who disagreed with the regulations imposed by the institution and government regulations, and the ways in which residents were forced to conform to the structures and routines of the institution. To question the government or compliance officers, however, was not in the hands of front-line staff, but instead was left with management. Challenges to government regulations, though, could result in repercussions, such as citations against the facility, difficulty with annual inspections, or unannounced visits from compliance officers. What happened in the interactions between compliance and management is beyond the scope of this study, but the nature of the long-term care system is such that there are repercussions for not

following the “regulations”. These repercussions include citations and loss of licenses and funding, among other consequences. The structure of the institution, with its rules and regulations, and organizational issues, socialized staff into the long-term care environment by teaching them to suppress parts of themselves, and contributed to the making of residents into institutional bodies.

8.4 Living an Altered Life

Residents described life at Ridgemount Facility as a *new life* or a *different life*. This life was an *altered life*, significantly different from their lives in the community. Since Rachel had been living in institutions for a year prior to her admission to Ridgemount, she had experienced this different life already. For her, she described having a stroke as her world coming to an end. “*Your whole world comes to an end. In a matter of a few minutes. You lost all your independence*” [Interview One]. Rachel’s world had drastically changed since her stroke, and coming to live at Ridgemount was one change in a series of life changes since her stroke. “*She said she lost her life when she got sick, she gave up her whole life. She had a stroke a year ago September 15, and everything changed since then.*” [Field Notes, October 4, 2005]

Edward also described his experience at Ridgemount: “*It’s a different type of life from what you’re used to*” [Interview One]. Brian, in particular, described in great detail how coming to live at Ridgemount was a new life for him. Brian went back to his house to visit a couple of times just after his admission to Ridgemount. He stated,

The first time you do it [go home], it’s heartbreaking. After a while, you get to realize that that’s it. The end of the life that you knew is here. You’ve gotta live a new life. And although you accept it, although you live it, you never accept it. [Interview One]

He also described life at Ridgemount as “...not the most exciting life in the world” and stated, “I’m starting to live another life” [Interview One]. When I asked him what he meant by living a new life, he stated,

You have to give up what you left behind. You can’t be in the before space. You gotta live in what’s coming. And you can’t take your whole life in with you. When you lock the door to go out, you’ll never unlock it again. It just doesn’t work that way. So you begin to get a new life and you have to watch yourself because you can fall into a rut. [Interview One]

In his second interview, Brian stated, “As soon as I get myself, my brain organized, I’ll start living the life that I should be living here. I can’t change it.” In different ways, the participants described coming to live at Ridgemount as a new and different life. During Brian’s feedback interview about the findings when he was reflecting on his past year in the facility, he stated,

First of all they have to get you in a room and let you be. They don’t hover over you like a mother would. They let you get used to it. Then as things go on, especially in the first three months, it’s a different bed. A different life that you haven’t accepted it because you don’t know what you’re doing.

Confinement to this altered life, particularly for Brian, was difficult. This was not completely due to the facility or the policies of the facility, but a combination of a number of factors, including the facility and the failing body.

Elaine *So how would you, you described this space as a confined space because you’re kind of confined to your room?*

Brian *Yeah, it’s not the fault of the place here. It’s just that my legs are not that strong, and everything happened so suddenly...And maybe then I’ll get out and walk around. Until then, I’m confined. You can only watch so much TV...This is like solitary confinement in jail. [Interview One]*

Gee, here, you’re tied to the four walls. You don’t walk, you feel like you can walk. My legs, I can’t walk that far anymore. [Interview Two]

Brian, then, described the facility as a new life, but also as a life that he was confined to without choice. This confinement, again, was not specifically because of the facility, but also about the confinement of the body.

- Brian* *What you don't like about it is you're confined. People in a wheelchair who've accepted their fate, it's not confining to them. It's confining to me yet. Take me a while to get over that.*
- Elaine* *Well, I'll tell you Brian, I go nuts if I'm at home for a day and I don't get a chance to get out. So I can't imagine how it must be to be in here looking at the same four walls for as long as you do*
- Brian* *Well, as a comparison, if your baby wasn't getting older than today, and he was going to cry like he cried today, try living with that for the rest of your life. It wouldn't be very pleasant.*
- Elaine* *I don't think I could handle it. I really don't.*
- Brian* *If they said to you, now you've got muscular dystrophy and you're going to be in a wheelchair in six months, that's the same as it is here. You're here 'til you die. Or there's no cure it's all maintenance. As I say, if ah, your young lad had cancer and you're waiting for him to die, you're confined then to that life. And as it is now, you never think about those things. [Interview Three]*

The new life that the residents were referring to at Ridgemount Long-Term Care Facility was a life that ultimately made the residents into institutional bodies. In many different ways, the residents were taught to become, and forced to become, bodies. This socialization process occurred in many different ways, mainly through institutional processes and personal processes. The institutional processes included *placing the body*, *defining the body*, *managing the body*, *focussing on the body*, and *relating to the body*. The process of making residents into bodies was so complete that by the end of the data collection, residents had *internalized the body* and *accommodated the body*. However, there was also *acceptance-resistance of the body* and the *re-creation of the body*. The tension between accepting and resisting the body was constant, and was still not completely resolved by the end of the data collection period. Residents re-created the body in different ways by defining an alternative identity for themselves. In these ways,

residents showed that they were able to resist these socialization processes to some degree and that residents exhibited some degree of agency within the structure of the institution. The making of bodies, though, was their primary identity in interactions with the staff and others within the institution. Being an institutional body, however, did not constitute the fullness of the self, as will be described in some of the personal socialization processes. Thus, being a body was created in interaction with others in the facility, mostly staff, but did not constitute the whole of residents' perceptions of the self. Residents became known through and by their bodies, without context or identity, and were in many ways forced to accept this identity of a body.

8.5 The Institutional Processes

8.5.1 Placing the Body

In addition to being placed within the structures of the institution, the body was also *placed* within the physical and social environment. Placing the body was about becoming accustomed to the institutional environment as a new environment and conceptualizing meanings of this environment. It reflected residents' experiences of where they were located physically. Placing the body happened at a number of different intervals in a number of different ways. Most importantly, however, placing the body occurred when residents first came into the facility. Residents had to adjust to a new physical and social environment. Residents described not sleeping well and being nervous the first few days they spent in the facility.

*She also stated that she was sweating, maybe because she was nervous.
[Field Notes, October 2005]*

And Elaine, it does not get scary after a while. When you first come in here, you get a little fearful that you know, if you have any common sense at all, you know what's going to happen. [Brian, Feedback Interview]

The participants also had to learn place, that is, learn the physical place in which their bodies would be residing. They had to learn their way around. This was especially difficult for Edward, since he not only had to learn his floor and the places he needed to be (such as the dining room), but he needed to learn how to get downstairs to visit Maybelle.

As the other ladies were talking, I overheard [Edward] say to Maybelle, "How are you getting along?" "Fine," she said. "It's hard to find your way around. It's so big," he replied. [Field Notes, September 21, 2006]

Edward said he has a bad memory. He is having trouble getting used to the place. He wanted to go down and see Maybelle, but couldn't go down the hall, get the elevator, go down, and find her room.

Elaine It must be hard to move to a new place.

Edward Yeah. I wished I didn't have to move, but this is the way things ended up. [Field Notes, September 23, 2006]

Part of learning place was also getting used to the sights and sounds of the facility.

When first talking to Rachel, I asked how her first night here was. "Not very good. I didn't sleep very well," she said. I asked, "Was it noisy in the halls or what?" "No, just a new place, I think," she replied. [Field Notes, October 4, 2006]

While we were chatting, a call bell went off. It was really loud in the dining room. "Oh, that bell", said Rachel. "It's enough to drive you crazy. I wish it'd stop." The dietary aide also commented on the bell.

"Why do they have the bell in the dining room?" I said. "That doesn't make any sense."

"Because the nurses are in here to feed," Rachel said. The bell continued to go off, and Rachel continued to make occasional comments about the bell. I asked her if it was like that in her room. She said it was. [Field notes, December 8, 2006]

Having a roommate was also an adjustment. Rachel was the only participant residing in a semi-private room.

Rachel told me again how she didn't like her roommate. "She's really loud. She keeps me up all night. I've been missing programs because I'm so tired during the day that I fall asleep because I'm up all night. She's moving out. They're moving her to a different room because she's so noisy." [Field notes, December 8, 2005]

The altered life occurred in a place that was not defined as home by any of the participants. The residents made meaning of the environment in which their bodies were placed, and this meaning was not reflective of home. While Edward and Brian did not discuss much related to the notion of "home" (except to discuss their past homes), Rachel did talk about the facility and the notion of "home". Since Rachel had been "homeless" for the last year, that is, living in acute care or transitional health care institutions, coming to Ridgemount, a place that was a permanent place to stay, was comforting for her.

She [another resident] says, don't call this home because this isn't home to her. Well, this is our home now for a long time, and we just have to make the best of it. [Field Notes, October 11, 2005]

Ridgemount had a feel to it that, according to Rachel, was different than the hospitals she had previously stayed in.

Elaine How are you adjusting to being here so far?
Rachel Good. Good. Better than I did at either one of the other places. It's more homey here. Like over there, they both felt like hospitals. Well, they were.
Elaine And this doesn't?
Rachel No. [Interview One]

Despite now living in a permanent place, Rachel could not describe the facility as home.

Elaine So what's it like to be a resident here? What's it like to live here?
Rachel It's not bad. It's not home, but it's not bad [Interview One]

Elaine Now you were saying that this is more homey than McIntyre Place, but still not home?
Rachel Still not home.

Elaine *What makes home home?*
Rachel *Your friends and your family and*
Elaine *Your own stuff?*
Rachel *Yeah. Cause I've got quite a bit of my own stuff here now.*
Elaine *Which is really nice. It's made the room look really nice.*
Rachel *My son bought me the writing desk and the bookcase. [Interview One]*

In comparison to the past hospital environments she had been residing in, Rachel did find Ridgemount “more like a home”, although it was still not home for her.

Elaine *So other than being able to get outside, is there anything else that's different about being here?*
Rachel *It's a nicer place.*
Elaine *The décor and the environment?*
Rachel *Yeah.*
Elaine *Because McIntyre was pretty old, wasn't it?*
Rachel *McIntyre felt more like a hospital. This feels more like a home, like you know? A home environment.*
Elaine *And what makes it feel like that?*
Rachel *Because I got a lot of my own stuff here. Pictures and...*
Elaine *Is your room bigger here than it was?*
Rachel *I had a private room at McIntyre.*
Elaine *Oh, did you? Was it bigger than this one?*
Rachel *Yeah. But I didn't have my desk or my bookcase or my little table there. Those are all stuff they brought to me since I come here.*
Elaine *Now was that 'cause it was only temporary at McIntyre Place?*
Rachel *Yeah. [Interview Three]*

While Rachel referred to the facility as “homey”, Brian and Edward did not describe the facility as home. When I talked with Brian about his feedback on my initial findings, we discussed the notion of the facility as home. When I asked him if he would refer to the facility as home, he answered with an unequivocal “no.”

I don't think that the refusal to refer to it as home is deliberate. I think it's something that happens. Like there was four of my friends came to see me last week. They said how do you like it here? My first words were it ain't home.

Staff discussed how residents did not view the facility as home. Many of them felt the residents viewed the facility as an institution or hospital, but did not attach meanings of home to the facility.

[W]e are a home , but we're also a facility and when the reality that yes this is their home then it's also a large organization. You know, they have rules and regulations that you know probably don't fit what we would interpret as home...I should ask permission, but like I say there's, there's a lot of sections of my staff a lot of other, you know, rules that kind of make it very organization to follow, schedule and times for things and so I think it's still kind of difficult to say this is their home you know they have to, you know embrace that, you know we respect that anything they do it's in their home-like environment 'cause it isn't, I don't think at least absolutely the way they see home life. So I think we try to meet their needs of making it as home-like as possible but still recognize that it's a facility. And some rules and regulations that don't fit what they would think of as being their home... That breakfast, lunch and supper's are the same time and we kind of can stretch that yes you can come at a different time, but if everybody did that you know it would be chaos, so it's a home within some guidelines and schedules it's as home as you can get. [Darlene, Management, Initial Interview]

Some of the staff did not think that the facility could be referred to as home at all.

And we're supposed to say this is your home. But I think they learn quickly this is not your home. And I think that's where depression comes in. And I don't think it's a very long time period for that to happen. This isn't home. When we talk about ah, adjustment, um, what if people just don't want to adjust? What if they have chosen not to adjust? Because it can be a choice, depending on people. And I know people we have talked about that have said, I don't want to adjust to this. I will cope the best I can, but I don't want to adjust because this is not home. So yeah, I think it changes. [Karen, Recreation, Initial Interview]

It is in this context, then, that residents become socialized into—a place that isn't home or away, a place that is the liminal betwixt and between (Stafford, 2003).

Placing the body was also evident in the bedroom as a site for making the body and for resisting this. The bedroom was described as “homey” or “more like home” because of the personal possessions residents brought into the facility (although they did not refer to it as home). For Brian and Edward, the bedroom was a private site where they spent much of their time. Brian, in particular, spent most of his time during the day in his

bedroom reading the paper, watching TV, having a nap, and visiting. This space, in many ways, was defined as personal through the use of space and the display of personal artifacts that made it “homey”. Yet because body care took place in the bedroom (with the exception of baths), the bedroom was also the site for the interactions with staff and the institutional processes that *made institutional bodies*. Rachel’s case, in particular, was an example of this. She needed assistance with transferring, so she was not able to go to the bathroom independently. Staff used a commode with her instead of using the toilet. Because there was no bar in the bathroom for her to use to transfer herself, she had to use the towel bar in her bedroom. The staff then put her on the commode, but did not move the commode to the bathroom where she could complete her bodily functions. Instead, she was forced to urinate or defecate on the commode in the bedroom.

- Deborah* *Oh, she does have issues with the commode. She wants to have privacy in the bathroom as opposed to standing up in her room.*
- Elaine* *Fair enough.*
- Deborah* *And I told her, I said Grams, why can’t they wheel you to the bathroom, get you to stand up at the rails, and then get you to sit down? There’s different angles so she could sit on the commode. She doesn’t have to sit on the toilet. She said she was going to run that by them, and I thought, I don’t know if they just don’t want to because she can’t walk? Maybe they feel insecure? But a lot of them won’t use her belt, her safety belt that she has. [Deborah, granddaughter]*

Discussions with Brenda, the housekeeper, also focussed on Rachel’s requests for a bar in her bathroom so she could use the commode in her bathroom instead of her bedroom.

Brenda recognized in her interactions with Rachel that this was very important to her.

- Brenda* *I don’t know if this should be in this interview, but Rachel had asked for a bar to be put in her toilet. Did she ever get it? I tried to get it for her.*
- Elaine* *You know what? I don’t even know, because as far as I know, she’s still on the commode.*

Brenda Yeah, she was still going to use the commode, but she wanted a bar in the bathroom so she could go in there privately rather than having to use her room.

Elaine Oh, using the commode in her room. I don't even know.

Brenda I had tried to get it for her and.

Elaine I'll have to ask her about that. I know Deborah was mentioning something about that.

Brenda Because that was very important to her. That was her um, privacy. She felt her privacy was taken away. But otherwise I've never heard her complain about anything.

Elaine But your room is where you live. And you wouldn't go to the bathroom in the middle of your living room, I mean, it's only normal you would think

Brenda That they would automatically do it.

Elaine Yeah.

Brenda Because she had to use the towel rack to stand up. She had to use the towel rack.

Elaine And that's in her room, right?

Brenda That's in her room. And she had asked for a bar in the bathroom and someone had told her it couldn't be. And I said I don't see why it couldn't be.

Elaine Now I'm remembering a conversation with her now that someone had told her she can't do that.

Brenda And I can't see that.

Elaine So she'll get on the commode in her room. Will they bring her to the bathroom or does she just sit in her room?

Brenda I think she must sit in her room because she needs the towel bar to get up.

Elaine So they don't wheel her to the bathroom, let her go there, wheel her back and then transfer?

Brenda I have no idea how they do it. But I know she needs that towel bar.

Elaine I'll have to ask her about that and see if anything was done.

[Brenda, Housekeeping]

Placing the body also incorporated notions of privacy. Privacy was not just about having one's own space or having control over that space, but also about control and access to the body. Residents did not have much body privacy, since staff had access to their bodies whenever they demanded it. There were numerous examples of the lack of body privacy.

Rachel said the other night two nurses came to put her to bed, and decided to take her to the bathroom. The one nurse, "a bigger girl", picked her up and carried

her to the bathroom, “bare bum and all.” She was worried someone might see her, but the nurses said no one would see her. When she brought her back to bed, the lock wasn’t on the bed, and she fell into bed with her. “The nurses just toss me into bed.” They laughed so hard that another nurse came into the room to see what was going on. [Field Notes, December 29, 2005]

During the feedback interview with Brian, I asked him about his room and privacy. The notion of privacy had not been brought up explicitly in past interviews, and I wanted to explore this further with him. We discussed privacy in great detail, and Brian felt that privacy became a very different concept in the context of long-term care than it was in the context of home.

Brian *Now I’m stuck for words, I’m talking to a lady. You have to remember at all times, that the bathroom door has to be shut. And it’s only necessary to shut it when strangers are coming. Like very seldom, very very seldom do people come to visit in the morning although visiting hours are at all times. So you put it in your mind that this, 2:00 in the afternoon until 6:30 at night are visiting hours. And you play a different game than you do the rest of the time.*

Elaine *So you don’t need privacy with staff but with visitors you do.*

Brian *But it takes you a while to get used to that, Elaine.*

Elaine *Yeah, I bet. I can’t imagine.*

Brian *It takes a while to get used to it, and after a while, there’s no embarrassment at all. Like I made a joke the other day, I was in the bathtub. I was tired. I was groggy for some reason. And they went to give me a bath, and I was sitting on the chair in the bathtub. They sink you down in. I think I dozed for a couple of minutes. I woke up and holy jumpin’, there’s five girls in the bathroom. I said, this is something a man always dreams about... He’s sitting naked in the bathtub with five girls around... They laughed and went out. Then I think it must be as embarrassing for them the first time they get in that situation as it was for me. But you soon lose that. You see privacy in a different way. Like I didn’t like television when I had my workshop, because you had to watch the television and with the radio, you could listen to the radio and do your work. And if I was doing a particular job and one of my friends walked in, and I thought of this lots of times, the interruption in that privacy was worse than this. And the older you get, the more you realize something like this is going to happen. So without thinking about it, if you just allow it to happen, you very soon get accustomed to it. The word privacy doesn’t have the same*

meaning here as it had at home...Everybody needs his privacy to himself. Like you say, the time. Yeah, I don't know how to say it. It's a different form of privacy here than it is at home... Here, privacy is different. Now you notice that the one girl came with the cookies and whatnot? Really what they're doing there, they're trying to find out something about your life. Whether you just want to be alone in the afternoon or not. I wasn't a desperate loner. I learned when I was tugboating that you could stay alone for a while. But I was more gregarious. I like company. Privacy is not the same here as it was there. Because you can adapt to anything if you put your mind to it.

Brian stated that he had become accustomed to the lack of body privacy that is afforded residents in long-term care, although it was a transition for him at first.

So they come in here, they're all welcome in here. I know what's going on. They open the bathroom door and ask me if I need anything. At one time it was embarrassing, but now, [laughter]. [Feedback Interview]

Like I say, at first I was like you. I was an older person and I was mortified. All my life I had my privacy. All of a sudden you have to give it up. They come in now in the morning and they're actually welcome to come in. You don't think you're slowing up, but your arms are stiffer. And you go to wash your face and the back of your neck is far away. So they come in and give you a good wash, and you're happy about it. And you joke about it every morning, but you wonder, though, what their life is like. They're looking at you, you think they're looking at an animal. [interruption] They think they're comparing you to an animal, but they're not. Because an animal doesn't have any privacy, does it? And you have the same privacy here that an animal does. You're fed. And what they have to feed you, it's not a restaurant... But you get used to it. Like I said, if you go with the flow, you get used to it. Don't try to fight it. [Feedback Interview]

Brian also referred to privacy as “...tak[ing] time for yourself and give thought to life.” In this way, he was able to find some privacy in the facility. Privacy was not necessarily regarded as having one's own space to control, but as time for oneself to think. Brian redefined a new but altered sense of privacy. In this way, privacy was redefined to fit within the context of Ridgemount.

...sometimes I sit here and I wake up at 3:00 in the morning and I can't get back to sleep. I think about it. But you know damn well that no one's going to come and

bother you. And you have time to think and do what you want to do. [Feedback Interview]

While Brian did not discuss issues surrounding the bedroom and privacy in his earlier interviews, there were incidents that occurred for Brian in the bedroom that reinforced the bedroom as a site for making the institutional body. As will be described later, Brian did not want to sleep in his bed at night when he first came into the facility but preferred to sleep in his chair. Staff did not want him to sleep in his chair, and this caused significant conflict in the first few weeks after Brian's admission. Thus, there was conflict over the way that Brian wished to use his space, and how staff wanted him to use his space.

The tension between the bedroom as a private place for residents to conduct their affairs and as a site for care and the making of bodies is one that cannot be resolved in long-term care. In the initial staff interviews, staff discussed the lack of privacy that residents need to become adjusted to upon entering long-term care.

...sometimes your caregiver doesn't really appreciate the amount of privacy that you need and you deserve, and that kind of thing, so they come here and they're bathed by a stranger. They're, they might have an incontinent product changed by a stranger. They're dressed by a stranger. Maybe in the past they've been dressed by their husband or something like they've assisted them, somebody familiar. So they now have to come in and they need that care and it's a strange face looking after them. Over time, that changes and I don't know if that's good or bad that over time it changes, because maybe they don't think they need as much privacy as they felt they did initially but, or maybe they're just the caregivers now just become their extended family in their view for providing care, but that that's really hard to accept... many nurses to them it's a task and you forget there's a human being on the other end of that task that might not want to be exposed or might not want you having them see you naked or whatever if they need assistance to dress. Yeah so I think that's very, very difficult to overcome for most people that come into the home, really difficult. [Colleen, Management, Initial Interview]

In essence, it is the claim of residents over this space as private, personal space, and the claim of staff over the space as part of an institution with structures, rules, and routines

that need to be observed. In this sense, the body is *placed* within the structures of the institution. The bedroom, within the institution, and as a site for the body, is a contested site. Yet residents attempt to redefine notions of privacy to fit within the context of long-term care.

8.5.2 *Defining the Body*

While residents did not discuss the process of defining the body in great detail, staff felt that this was a significant part of coming into the facility. When residents first came into the facility, there were a number of tasks and assignments that staff were required to complete with the residents. The residents may have been focussed on learning the routines and getting adjusted to the facility, and potentially the tasks of nursing at first may have been forgotten in the initial stages of settling into Ridgemoor. The staff, however, discussed in detail the necessary tasks related to the body that they were required to complete after admission. The body was defined as impaired through the process of assessment and paperwork. The assessments and documentation focussed on assessing, evaluating, and documenting the body as impaired. There were different types of assessments that were used, but they were all focussed on various aspects of the body.

When they come I, of course I get introduced to them or I introduce myself and orientate them to the room, take them around the unit if there's nobody else available. Then I call the doctor and I look up all the history to do all the, there's a lot of admission forms. There's a choking risk assessment and a falls assessment, multidisciplinary form that's on their cultural needs, their background, their diagnosis, weight gain, likes and dislikes for dietary. It's a real multipurpose form. And then the care agreement is the last one that we do, what they can do for themselves. As we get to know them what they need help with and now what the usual pattern is what they can do for themselves and what they need help with, and then we get them to sign the back. [Mary, Nursing, Initial Interview]

Elaine Are there any policies that the facility has for tasks that you have to do within the first few days or weeks the residents move in?

Stacey Oh, yes there are. There's like, we have to monitor their meals. And I know the RNs, there's some, like there's TB skin tests, stuff like that, that they have to do when they come in.

Elaine So monitoring their meals

Stacey And you have to do a total body assessment when they come in, like for bruising, or, that's when their first bath comes in. That's why we try to do it as soon as possible. [Stacey, Nursing, Initial Interview]

One of the nurses described Brian's reactions to the assessment process.

Initially when he [Brian] got settled in? We did our assessment, do our history, do the physical exam, and again he seemed to be quite accepting, but he really wasn't sure about why we're doing these physical exams, why we're asking all these questions. And that's quite normal for someone who's newly admitted, especially when they have their wits about them and they're quite alert and orientated to what's going on around them. So it took a little bit longer for him to open up. So we got the initial stuff that we had to, the basic stuff, and as time went on, then we were able to complete the admission protocol. [James, Nursing]

Residents were made aware from the beginning of the admission process that the body was the focus of the attention of the staff in the facility. Brian, during his feedback interview, mentioned that "...they're unconsciously measuring your habits. To find out what you're trying to do, what you'd like to do." While the assessment of recreation staff did not focus on the body, body limitations, or body care, it was typically completed after the resident had been in the facility for a couple of weeks. In addition, since it was only one assessment among many that focussed on the self rather than the body, the message of the focus on the body seemed to be evident. The focus of all other assessments and conversations focussed around the body and body care. In this way, the body as a focus was defined from the outset of admission.

Because of the paperwork and other tasks associated with an admission, often staff viewed a new admission as paperwork and tasks, rather than as a person.

Well, most of us will look at the paperwork prior to [admission]. And honestly, if we see that they're really heavy care, we're not happy. [Glenda, Nursing, Initial Interview]

I think some staff look at them as just a, oh no, here comes, they have a task to do, these jobs to do, and especially if the resident takes has these expectations or want stuff done whenever, they see it as a real chore for them. Some staff do. And I will admit too, feeling that way a little bit myself at times if I have a whole bunch of orientations to do. If there's been a lot of deaths and you just don't have the time to give to these people, depending on what's going on in your job. So sometimes it can be a little overwhelming. [Julie, Recreation, Initial Interview]

8.5.3 Focussing on the Body

Focussing on the body was a function of both residents and staff with the intent of maintaining the body. Staff of course focussed on the body through body care. Residents focussed on the body through the experiences of an aging and unpredictable body. They also discussed the immanence of death and the awareness of their own mortality. These issues were not necessarily directly related to the institution, but in many ways, the institution and interactions with staff solidified an aging and unpredictable body, as well as the immanence of death.

In terms of body focus, staff focussed on the body through care. Brian described the different attitude that the doctor had towards him because he was older.

Brian *And when you're pretty near 80, you know that, you can tell the different attitude the doctor has toward your health. Now, he's not being mean or anything. He treats you in a different way. My blood sugar is 5.7, 5.8. That's what they call cracker jack. He's got me on a diabetic menu. Now it's not so much that I've got diabetes. It's a healthier way to live.*

Elaine *So it's just having to watch your sugar intake.*

Brian *Yeah. They try to, not cure anything. They tell you there's no cure for anything now. It's all maintenance. And what they try to do is to keep you from sliding too far. And I, like I said, I have no regrets. I naturally have some wishes, but yeah. [Interview One]*

Staff also described the focus on the body, particularly through body care. Life occurred around the body and around body routines and body care. As such, the body was a primary focus of life.

It consists of eating, sleeping, changing, toileting. Like I think about the conversations I hear in this facility. That's what they're about. Bowel movements, incontinence, sleeping, hoyer lifts, that's the conversation that you hear. [Karen, Recreation, Initial Interview]

And it's funny, on a humorous note, it's very interesting, I remember a resident moving in one time, and it's that whole idea about everybody going to see this person as they moved in from every discipline, and I remember going to see a gentleman, and he said, so are you here to find out whether I pooped today or not? [laughter] No, I really don't need to know that. It's okay if you tell me, but I'm not coming to ask. Because that's what their day revolves around. Everybody wants to know if I'm having a bowel movement. And it is interesting because lots of my conversations with people is about that. Because that's the focus of their life. It's like the focal point of people's lives becomes around bodily functions. And because they're being asked about input and output. What goes in and when it comes out. How did it come out? And why is it not coming out? Why is it? So yeah. Usually it's just a small portion, but it's just interesting that that becomes part of a conversation too. [Karen, Recreation, Initial Interview]

One way that Brian described the focus on the body is how staff adapted to each individual. Since each individual's body and body needs were different, staff had to adapt to the resident. This adaptation didn't necessarily happen in significant ways, but in day-to-day, mundane body care tasks with each individual. While residents were forced to conform to the routines and structure of the institution, there were little ways during care that staff adapted to the individual. Staff focussed on the body through the various tasks they had to perform as well as figuring out residents' bodies so they could accomplish tasks easily without having resistance from residents.

They know me now and I know them... That's something that's unconsciously, you don't think about it all the time. but what means a lot to me is that they are doing things automatically. They are doing things in advance of your thoughts. They're coming around, dinner's at a quarter to twelve. They come around at quarter after, half past 11. Saying, they come and get you. If you can't make it, they bring

you a tray. But they know what you're going to eat. They've got you figured pretty well. And rather than think of them doing it, you think of yourself. I've been here long enough for them to know my habits. So that's another few months off my life. You have to accept what's going on. [Feedback Interview]

Residents also focussed on their bodies in a number of ways. Many of my conversations with the residents focussed on how they (their bodies) were feeling that day. When I asked residents how they were doing, their typical response was focussed on the body, rather than other aspects of their lives. While feeling ill or feeling well is a significant part of life, residents seemed to assume that when I asked them how they were doing, I was asking about their bodies. Conversations were focussed around the body and interpreted through a focus on the body.

I asked [Edward] how things were going, and he said fine. "The other day I had a bad day. I was feeling so bad, ready to throw it all in and leave here. I laid down and had a good sleep, and woke up feeling better today. Almost 100%." I asked him if he was feeling sick or just under the weather. He said he had been sick to his stomach the other day. He said he had been worried. I asked him what he was worried about. "It doesn't take much to get me worried." [Field Notes, November 16, 2005]

Elaine Hi. How are you?

Brian Okay. I think the disease is manifesting itself. I'm freezing. I'm not able to move. [Field Notes, February 13, 2006]

8.5.3.1 The Aging Body

There were two types of bodies that the residents focussed on—the aging body and the unpredictable body—which are significantly interconnected. The first type of body was the aging body. Residents reflected on aging and growing older, and in particular, what this meant to their bodies as they aged. Brian especially discussed aging in a philosophical manner and had obviously been reflecting on aging throughout his life.

As he was attempting to move around the bed (he had hands on the bed, facing bed, shuffling somewhat sideways), he said, "Growing old is for the birds. But the alternative to growing old isn't so good either." [Field Notes, March 13, 2006]

Brian described slowing down as an inevitable consequence of growing old.

Brian And you never think that I'm going to be 80 in the 16th of June. And you think you're 80 years old, you're bound to be slowing down. As I said earlier, the years do take their toll. And if ever you think that they're going long, you'd better slow down. Everything goes like the day is today. And I could tell you, I'm slowing down. Yeah. But, I have no regrets, you know. If I could live it over, I'd do the same thing again, probably.

Elaine And how many people can say that, right? Lots can't.

Brian You think when you're growing up, and you're about 30. 35 years old and someone retires, you think you're going to retire and you're going to do this and that. What you're doing is trying to put a 35-year old mind in a 65-70 year old body, and there's just no fit. Not a match.

Elaine Yeah. Yeah. So you can never anticipate what it's going to be like.

Brian No. Everything's today. [Interview One]

Brian also described slowing down and getting sick as part of the process of aging.

Elaine I asked if you felt your age. Do you think of yourself as being almost 80 years old?

Brian Realistically yes. See [you ask me if I] feel 80, you can't. The things that you do that you take for granted. You don't take for granted any longer. Yeah, I feel older. You don't know what you're supposed to feel like when you're growing up. So you can't really say yeah, I feel 80. I don't know just what 80 means. And you always look back and say that we, you always look back and say, if I hadn't gotten sick, I would have done this. Getting sick, that's just part of the process of aging. And you have to accept that, though it's tough. You know you can't go on forever, but you don't want to let it go. [Interview One]

Body habits had to be re-evaluated and altered as Brian got older. Altering body habits was one way in which age was felt by residents.

Brian You see, my father never had a wrinkle. And they tell me I don't have a wrinkle.

Elaine No, your skin is very...

Brian -and I'll tell you something. When you shave, you cut these here. You never knew, you never realize because you're this age, you

never realize that your skin is getting older, so you've got the razor down, you put the razor down as hard as you did when you were 20. Then again it just don't work.

Elaine Well, that's one of the reasons when I first met you that I didn't think you were as old as you are, because you don't look it.

Brian I don't know what I'm supposed to feel like, but I don't feel 80. I have a brother, he's going to be 82 this year. He's still step-dancing. Now he fell the other day and cracked his knee cap. He's in a walker now. They told him, you watch yourself because you're getting old. Some people don't accept it...

Elaine So do you sometimes feel like your body's supposed to be able to do things it used to be able to do when you were younger but

Brian Yes. That is ah, that is the hardest thing to accept. And it only happens once in a while because as you slow down, it's slowing down is a part of nature. And you don't accept that you're slowing down. Accept the same thing in your workshop. You cut 20 pieces of bark yesterday and today you're only cutting ten. Then you realize I'm getting slower.

Elaine So is it like your mind's not catching up with your body?

Brian That's quite a right way to put it. Then all of a sudden you hit it. You realize. You go to do something. You make a move. And it takes you twice as long to do it. You think gee, I used to be able to reach an arm out and get a piece of lumber. I gotta get this lumber, so I can't bend this far. So I move the lumber. Then you say, that's okay. I'll just develop a new habit. But you can't develop a new habit when you're this old. The ah, I'm trying to think of a saying. [pause] When your mind makes a promise your body won't fulfil, you're over the hill, Bill.

Elaine I've never heard that one. [laughter]

Brian It's true. When your mind makes a promise your body won't fulfil, you're over the hill, Bill. You're over the hill. [Interview Three]

Slowing down was measured in terms of activity and body habits. Aging, according to Brian, required forming new body habits that were different than before, and required him to adjust his expectations to account for his slowing body.

When you consciously watch yourself, you see that you're not doing as much today as you did yesterday. You don't realize it. You're watching television more. Like I was not a television man. I watch television more now than I used to. And the reason is I got to fill my time someway. My body doesn't have the energy it had before... No, I don't find that what you had yesterday is left. I don't find it is as important now as it was in my mind when I was using them, with my freedom. And you think if you're a rational thinker... If you're a rational person and you're thinking, you'll know what's happening. When you're in your prime, like young

people are between 20 and 40, you don't notice things are happening. But if you're a sportsman like a fishing man, you go to a lake before and get a limit of fish. You go to another lake and get a different fish. You do that all day. When you're retired you think I'm going to do all these things. What you doing is when you're 20 or 30 years old, you project that body and mind into a 65 year old body, because you don't know what a 65-year old body feels like. I say 65 because that used to be the retirement age. You think you're going to do it, but as the time comes, you gradually wear away. Instead of catching four fish you only catch three. And that satisfies you. And if you think of it, you become accustomed to that kind of life. And if you don't think of it, you become frustrated because you're not enjoying your life. There's a saying go with the flow. You just gotta go with the flow. [Interview Three]

The aging body was also permanent. While the unpredictable body was always in a state of flux, the aging body created an awareness of its permanence.

- Brian* *Because I used to like to go to the marina. And I'd help them take the boats out of the water and whatnot. And as you get older, you can't do that. So you realize, if you're paying attention to what's going on, you realize that hey, all I can do is watch other people and be envious at the other people do, having young people's fun. And you know you're not ever going to be a young person again.*
- Elaine* *So then it's not just, I don't know how to describe it, sadness, not just for what you're losing right now, but for what you're losing in the future too, that you won't be able to do that again.*
- Brian* *It's the knowledge that it will never return. That this is the bitter end. That you're in here for a reason. And the reason is that you can't look after yourself. And if you've looked after yourself all your life and you pay attention to what's going on, you realize that here it is. You know? And somebody lays a hammer down, it's all of a sudden boom. You have to accept these things... And every morning you get up is another day gone. And it's the realization of age if you have any common sense at all and you've got a clean mind, it's the realization that the age is here, you know what's coming but now it's here. It's hit. I realized as soon as I came in here, I knew darn well what's going on. [Brian, Feedback Interview]*

Brian expressed a realization and awareness that the facility was the last stop in the aging process.

Edward also spoke about growing older. Since he was very old, aging for him meant living until he was 100. He had accepted his age already, and had a goal in mind to reach his 100th birthday.

“I think I’m getting old. I’ve learned to accept it. At my age, I can’t remember names anymore,” Edward said. [Field Notes, November 30, 2005]

I said to him, “Growing old isn’t easy, is it?” “No”, he said. “Nobody ever said it would be easy. It definitely isn’t easy for me. I’m not living, well, not day by day, but living until I reach 100.” I said, “Well, time goes by fast, doesn’t it?” and he said, “Well, it might for you, but it doesn’t for me. Time goes by so slow.” [Edward, Interview Two]

Age was not just a slowing body for Edward, but slowing time as well.

Rachel did not discuss aging, although she did occasionally refer to herself as an “old person.”

She said, “It’s hard to move so many times, especially when you’re old.” [Field Notes, October 3, 2006]

She said Deborah was supposed to bring her more Polident strips. Deborah told her she didn’t need them—that she had enough already. “There’s nothing that makes an old person madder than being told you’re wrong when you know you’re right”, she said. [Field Notes, October 14, 2005]

Rachel’s aging trajectory had been interrupted by a stroke, and as such, the stroke was her body’s identity together with aging. Brian, on the other hand, viewed getting sick as part of aging. Brian’s reflections on aging provided a unique insight into the aging process that has not often been afforded me. His discussions of embodied aging and reflection on the aging process provided an insight and a better understanding for me of not only what old age is, but what old age feels like.

8.5.3.2 The Unpredictable Body

Another type of body that residents focussed on, which was related to and interconnected with the aging body, was the *unpredictable body*. Residents' bodies were unpredictable because of the aging and disease process, but bodies were also unpredictable in day-to-day life. From day to day, and indeed, even from hour to hour, residents' bodies were unpredictable and undependable. Edward's body, at 98 and 99 years old (he had turned 100 shortly after the data collection was completed), was often tired. Every day was unpredictable as to how he might be feeling. One day, he felt good while the next day he felt bad.

I went in to see Edward. He was sitting in his chair reading his paper. He saw me coming in with a big smile and said hi.

Elaine Hi, how are you?

Edward Not so good today.

Elaine You look good.

Edward I'm not up to par today. I felt better yesterday. [Field notes, February 15, 2006]

Edward did not know when his body would feel good or bad, and thus, it was unpredictable.

Edward was going for a walk, and saw us in the lobby. "Well," he said. He looked very pale and the tip of his nose was red. Asked him how he was doing. "Better now. I was really dizzy this morning. I was scared even to get up. Then I had a good nap this afternoon and now I feel better." [Field notes, April 3, 2006]

Earlier, Edward said, "I wasn't feeling so good last night. The guy came in, and I told him, I said, I'm feeling stupid today. He checked my temperature and said everything was normal." [Field Notes, April 10, 2006]

Brian's symptoms of Parkinson's disease would often flare up, and his body would freeze, giving him great difficulty in getting movement started. Some days, his symptoms were lesser, but many days, his body would freeze on him. Brian did not know when he would be having a bad day, and when I came to visit him, I often had to come back at a certain time of the day or another day when he was feeling better. Many of our

conversations focussed around the symptoms of his Parkinson's, and much of our visits were spent with me helping him to get comfortable in his big lazy-boy chair. From one moment to the next, Brian's body was unpredictable.

Gabriel and I then went upstairs to see Brian. He was sitting in his chair, feet on floor, brow furrowed, face pale, with chair control in his hand, not moving. I knocked and came in. He had a hard time starting to speak. "I can't move. I'm frozen. The nurse came in and gave me a bath. I was fine then I fell asleep and now I can't move." I helped him get situated in his chair. Then he got up and started for a walk. It took him a few minutes to even get his feet to start moving. [Field Notes, May 6, 2006]

Vulnerability to illness and sickness were also part of the unpredictable body, as they were of the aging body. Edward became quite ill with a bout of pneumonia about three months into the data collection period and was hospitalized. The nursing staff were unsure if he was going to make it. Rachel also had a "spell" where she had a seizure. This was a surprise since Rachel's body, for the most part, was fairly predictable.

I went upstairs to see Rachel. She was lying in bed with the head of her bed propped up. She said she had a spell on the weekend. She went for breakfast, and had a seizure. "My arm felt like it was being pulled back. My leg was out straight. It sure scared my family," she said. I said, "Did it scare you?" She replied, "Oh no. it wasn't like the last time. I didn't black out. I knew everything that was going on the whole time." [Field notes, January 16, 2006]

After the seizure, she was put on medication to control it, which then had a significant effect on her functional level and health because of medication side effects.

I went upstairs to see Rachel. I was quite shocked. She was in bed with pajamas on. She looks like she's lost some more weight. There were dark circles under her eyes, and she had sunken eyes and cheeks. She stirred, so I knocked on door. She opened her eyes, so I came in and said, "Hi Rachel."

Rachel Hi, how are you?

Elaine I'm fine. How are you?

Rachel Not too good.

Elaine No. You look rough. What's going on? Are you coming down with something, or are you just tired?

Rachel I'm not coming down with anything. I don't know what's wrong.

She said that the meds were making her tired, so they put her on two instead of three today. "Hopefully I'll be up again tomorrow," she said. She said she was in bed yesterday and today. She seemed to attribute her health to meds. She said she didn't eat today, and only ate soup this morning.

Rachel Deborah was here yesterday. She said, 'Oh Grandma, you look awful'.

Elaine Well, you don't look your normal self. Your eyes don't look right. I can tell you're not feeling well.

Rachel Yeah. I'm just really tired. I'll rest today and hopefully be up tomorrow. [Field Notes, January 26, 2006]

The unpredictable body was a socialization agent in that residents learned they could not depend on their bodies from day-to-day, and activities and daily life were structured accordingly. In particular, recreation activities were structured by the unpredictable body, and when residents did not feel well, they did not participate in planned recreation programs or in recreation activities in which they needed to depend on their bodies, such as with walking or exercising. As one of the staff members described, the body ruled residents.

I would mention every day, every waking day that doesn't rule me. My body is this and how do I accept that and get through the day? [Darlene, Management, Initial Interview]

8.5.3.3 Immanence of Death and Awareness of Mortality

Having an aging and unpredictable body often brought an awareness of the immanence of death and mortality to the forefront. This was a very close cycle between an aging and unpredictable body and the awareness of death. The aging and unpredictable body was the reason why the residents were in the facility in the first place. The aging and unpredictable body, along with place, brought an awareness of mortality and the end of the life cycle. Each one of the participants discussed mortality. The aging and unpredictable body, particularly living within a long-term care institution, brings

mortality into focus for residents. “When you’re younger, you think about it but don’t think about when it will come to you. Now all of a sudden it’s staring you in the face”

[Brian, Field Notes, Mach 27, 2006]. Rachel did not often discuss mortality, but there were a couple of times when she was worried about her health and what that might mean.

I knocked on Rachel’s door, went in, and said hi. Rachel said, “I had an awful scare the other day. The doctor had to sign my forms for disability benefit, and he left a note saying he wanted to talk to my family. I’d been coughing a lot lately and thought it was about that. But he just wanted them to come to his office so they could pay him for signing the forms.” [Field Notes, March 22, 2006]

When she was really ill, she talked about dying with her granddaughter.

During that time she was really sick and she was talking all, let’s, you know what’s happening, you know? Don’t be foolish. Talking like that was it. Like she was in a rut and not feeling good. [Deborah, granddaughter]

Edward also talked about dying. For the most part, he was fairly independent with his body care. Edward became quite ill about three months after he came to live at Ridgemount. When he was sick and had to be dependent on staff for his personal and body care, he stated that he wanted to die. Edward’s lack of control and frustration over his dependence on staff for body care was linked with his wish to die.

Edward I just want to die. Nobody takes good care of you. Nobody wants to take care of two old cronies like us. I have nothing to live for.

Elaine But you have Maybelle.

Edward I imagine she feels the same way that I do. How are you feeling, Mom? [Maybelle looked at him and then at me, but did not reply.]

Edward They gave me a bath and then they just left me. Nobody takes care of you here. I just want to die.

Elaine I’m going to bring you down for lunch when Joyce comes back.

Edward I don’t want any lunch. I just want a glass of water.

Elaine They’ll have a glass of water, juice, and a cup of coffee or tea.

Edward I don’t want coffee. Look at my lips. I burnt them drinking a cup of hot coffee. I just want to die. I have nothing left to live for.

Joyce said that Edward doesn’t like being in a wheelchair, and staff just left him in his room in the wheelchair after a bath this morning. [Field Notes, January 12, 2006]

Edward had a bad case of pneumonia that had him hospitalized. The nurses did not think he was going to make it, and in retrospect, Edward stated that he was ready to “cash in at times”. Illness brought an awareness of mortality.

- Elaine* *Now, you went through a couple of periods when you were pretty sick here, right?*
- Edward* *Well, the one just before I come in here, I think. I had a, I don't know, some, well I wouldn't call it a disease because it didn't kill me, but it knocked me down quite a bit. I give my former doctor the credit for pulling me through. In fact, he pulled me through two or three times. Just, more or less telling me just what I was, what I had to do to get over this. It was like a flu, only it was more serious than that.*
- Elaine* *Because I think it was after Christmas you were in the hospital for a while, because you were pretty sick?*
- Edward* *Yes, I was. Pretty near ready to [pause]*
- Elaine* *But you made it.*
- Edward* *Ready to cash in at times, but I made it. [Interview Three]*

Brian also discussed his mortality. Since he was very self-reflective, he had reflected philosophically about his life and death. Aging, for him, did not come without a reflection on life and death. In many of our discussions, death and references to his mortality were brought up. The facility was seen as a place to go to die. Coming into the facility brought an intense awareness of death.

You get to know the things that you leave behind. Like your fishing gear. You can't take that to the grave with you. You've got to give it up sometime. You know you're dying and I don't say that in an ignorant way or anything. But you know that each day is a day less to live. And you're in here for that reason. [Brian, Interview Three]

Brian did not simply discuss death philosophically, but had also given thought to what death was like and what might happen after he died.

- Brian* *No, you're never home free. You know, you've gotta be a total imbecile to think you're going to get out of here alive.*
- Elaine* *That's true.*
- Brian* *You just ain't gonna do it. [laughter]*
- Elaine* *You'll never get out of life alive, will ya'?*

Brian That's right. You ain't gonna do it. But you always dream that moment your heart will stop. That little dog of mine. She had a cancer operation. And she, we believe she had it again. That needle, stopped life bingo. [Interview Two]

Brian Some years back I had a case, I had to take blood thinners. Every old fellow's got to take blood thinners. And when you rise from a sitting position, and you're your age, your blood stays with you. When you're my age and taking blood thinners, the blood all pools to your feet.

Elaine So you get dizzy.

Brian And you just flake out. Then you, when you wake up, like you come back to life just bingo. And I fell on the floor twice. And I hit my head hard enough against the wall that I cracked the wall. But you realize that people whose heart stop, you think oh poor them. It's not poor them. They don't know what happened. Yes. I get up from the chair, and my wife was going to church. I got up from the chair in the living room and floop. When I came to I was laying on my back on the floor. I wondered what I'm doing here. There's totally nothing. It's a black world. Just totally nothing. You aren't oblivious to what's going on because nothing's going on. And I think that's what when a person dies, that's the end. There's no thinking about coming back. There's just no thoughts at all. But people who, they talk about dying. But I always say something my father said today. You won't know your value in life 'til you throw a rock and see how fast the water closes in over the hole the rock made in the first place. And I've often times tried it. Throw a rock in. It's true. [Interview Two]

Brian also realized that aging and death were a natural part of the human life cycle.

Brian You cannot prepare for it.

Elaine So you just react to what happens?

Brian It's something you, you don't prepare yourself, it prepares you, it prepares itself to you. Nature says it's going to happen. There's gotta be room for someone else to come along. If it wasn't that way, we'd be an awful society, wouldn't we? You wouldn't be here because I wouldn't let you. I wouldn't die. [Brian, Feedback Interview]

Staff were very aware that residents often thought about their own death and mortality. While death and mortality was quickly hidden from view or a “taboo” topic of

discussion between staff and residents, staff recognized that death was a part of residents' adjustment into long-term care.

... Because they know, this is the last stop. Most people, that's realistic for them. That they're not going anywhere else to live, this is the end of their journey, whenever that will be, but it's the process to the end of the journey... [Karen, Recreation, Initial Interview]

...but you know that it's the end of the road. I think that's what it is. It's the end of the road. [Stacey, Nursing, Initial Interview]

While death was a part of life in the facility and recognized by both staff and residents, it was studiously avoided as a topic of conversation and hidden out of sight.

...my first experience, when I first started working here, I was so upset about the fact that somebody dies, and often times I would find out about it so I would go to the room to see if family was there or if the resident was still there. For me, I just wanted to see them, I just wanted to go in. Especially if it had been somebody I had been working with on different things, and they were gone. The bed was stripped. Like we're talking hours. And nobody ever spoke again, and it was as if that person had never been here. And that was very difficult for me... It's like nobody talks about it. The person's gone and a new person comes in and we don't talk about it. Communication is very little, you know. [Karen, Recreation, Initial Interview]

One of the ways Brian reflected on life and death was through reflection on his father's life and death.

As you get older and you approach my age, you look back and think. My father died of lung cancer. And he was a heavy, part smoker, and chewed tobacco. And I worked with him on the east coast. Twelve hours a day, seven days a week. And he came up here and said, then, he was in business for himself down there. He was approaching 70 years of age. He came up here. Caught me driving up to Deer Falls... And he was working for the government at the time... lung cancer. Told him that he'd come down in February. He got on the bus and came down... It was ah, anemia. There's another word for it. And he went back out to work. The pain didn't go. Cancer in itself, there's no pain in cancer. The tumour spread and it caused the pain. And we're looking at September. We got him. He brought his tools down and everything. He accepted the fact that he was going to die. He was home. You know where Hill Motel is on River Street? You know where the Mountainview Funeral Home is? Right across the street is the Hill Motel. I built that house too with my brother-in-law. My father died there. He learned in September what he had. They said we can put you in the hospital and prolong

your life. My father said to him no. You couldn't cure King George. How do you expect to cure me...He said how long? They said three months. He died February 11. My sister is a nurse. She's old now. She was active then. The doctor told him you're going to have to go to the hospital and have someone take care of you. I can't come and give you a shot everyday. So my sister came up and stayed with him. And at quarter to 2 in the morning of December 11 he woke up in pain. She gave him a shot. Didn't help too much. 2:00 he woke up again. Went back to sleep. 2:15 he woke up and said good-bye to everyone and died. See, morphine didn't help. He was fighting it. His brain knew he was going and he was fighting it. Woke up at quarter after two to say good-bye to everybody and died. You think of those things. I helped carry the body out... And you pay attention to yourself then. You learn. [Brian, Interview Three]

The body as aging and unpredictable was a socialization agent. As the residents described, they became aware of the limitations of their body and of their body as unpredictable. In this way, every daily activity was impacted by the body. Thoughts of mortality became commonplace as the body socialized people into the liminal state between life and death (Hazan, 2002). The impact of the institution, however, focussed all activity on the body. The culture of long-term care is about bed and body work (Gubrium, 1975; Henderson, 1995; Paterniti, 2000; 2003). The body became a focus for the residents, but also became central to life inside an institution where the sole purpose was to treat the body. With an already aging and unpredictable body, life ceased to exist outside of the body, and residents' usefulness and purpose was in their body limitations. Day-to-day experiences and activities were ruled by the body. It is these limitations that are the reason for long-term care institutions, the reasons why staff are hired, and the reasons for government funding. This focus on the body, however, precluded any focus on the emotional and psychosocial needs of the residents, particularly given approaching mortality and residents' awareness of this. The result of this is a body divorced from the mind.

8.5.4 *Managing the Body*

Managing the body incorporated various techniques that staff used or policies of the institution to let residents know the body's place. There were three main ways in which this occurred: *routines*, *risk management*, and *waiting*. Various methods were used in which residents became aware of the importance of their bodies, yet also became aware of the expectations that the body fit into the structures of the institution. A paradox existed in that bodies were considered of utmost importance in certain contexts, such as risk management. Yet in other contexts, such as personal care, bodies were placed at the discretion of staff. Although body care was important, staff schedules and routines were much more important than the body. In this way, while the body was still in focus, it was managed to fit in with the day-to-day routines and structure of the institution.

8.5.4.1 *Managing Through Routines*

Routines were a critical way in which bodies were managed. Daily life was very routinized around body care. Brian and Rachel did not always like some of the routines in the facility, and their comments reflected this. Edward, on the other hand, was fairly independent with his personal care, and the routines of mealtimes were similar to his past routines. "*But he sort of has his own routine and he follows it, and ah, he's got himself into a nice routine.*" [Jennifer, Nursing] In this way, his way of life was not significantly compromised. This, however, was not the case for Rachel and Brian. One of the most important and stringent routines revolved around meals. Staff demanded that residents be in the dining room for all meals. Life in the facility revolved around meals. The only way in which residents did not come to the dining room is if they were sick. From a staff

perspective, of course, this was due to government legislation demanding that residents be present in the dining room at all meals. However, residents were not aware of this and were only aware of the unreasonable demands placed on them by staff to be present in the dining room for every meal.

Brian *One girl she's young married woman. She's just a little bit pregnant. She's whole heartedly pregnant, but she's just little.*
Elaine *She's not very far along.*
Brian *No. she said are you coming for dinner? I said no I don't think so. Not today. She got to a point where she was arguing with me. I pretty near said something, but I held my, I held back. I can't be sarcastic. If I'm sarcastic I feel it myself and I often think about it. And I finally I went for dinner. But I didn't enjoy it. It's not her fault because she's doing what she's trained to do. [Interview Two]*

Here, to go for a meal, they come in and tell you it's mealtime. Are you coming for lunch? You have to think if you are going or not. And they're very strict about whether you're going or not. If I were to miss two or three in a row, they'd say, what's wrong. And this place is not equipped to treat people that are very sick. [Brian, Interview Two]

Because of the requirement to be in the dining room for all meals, Rachel was awakened early in the morning for morning care before breakfast, although she preferred to sleep in.

Elaine *So what are the routines like here for you?*
Rachel *I don't know why we have to get up so early in the morning.*
Elaine *Yeah, you were saying that yesterday. Because they get you up before 8:00 for breakfast?*
Rachel *Yeah. If they could just give us one morning to sleep in. [Interview One]*

Elaine *So what's the routines like here for you?*
Rachel *Good, but I wish they'd let me sleep in once in a while.*
Elaine *I was going to ask you about that because last time you told me they get you up too early.*
Rachel *Yeah. They never let me sleep in. [talk about nails]*
Elaine *So what time do they get you up?*
Rachel *This morning they were in here shortly after 7.*
Elaine *Ew. That's early. [Interview Two]*

By the third interview, however, Rachel no longer complained about getting up too early. She said she had become used to the routines.

- Elaine* *And you were saying that a typical day for you, you get up in the morning. What time do you get up in the morning?*
- Rachel* *They wake us up when the crews change. About 7:30, eh? And they get us up. We gotta be in the dining room before 8:30 or quarter to nine for breakfast.*
- Elaine* *That's early.*
- Rachel* *Umhmm.*
- Elaine* *You were saying before that it's a little too early for you. Are you still finding that?*
- Rachel* *No, not really. I'm getting used to the routine now. [Interview Three]*

It became evident through some of the residents' comments that adherence to the routine was very important for staff, more important than residents' wishes or requests.

And this morning we went for breakfast. And the girl that was on this morning kept saying hurry up. Hurry up. All the time we were trying to eat. [Rachel, Interview One]

It's pretty, I find that in the home, it's pretty well regimented...because you gotta get up for breakfast. You gotta go for lunch. You gotta go for supper. If you're sick, that's different. [Stacey, Nursing, Initial Interview]

At times, adherence to routine created conflict between residents and staff. Brian did not always want to go to the dining room for meals. When he was having a bad day and “freezing”, he did not want to go to the dining room. I suspect that Brian wanted to have the autonomy to leave the dining room when he wished after his meal was completed, and if he was “freezing”, he would require the use of a wheelchair to go back and forth to the dining room, which also meant that he would have to depend on staff for his transportation to and from the dining room. As other research has indicated, mobility symbolizes freedom for many long-term care residents (Bourret, Bernick, Cott, & Kontos, 2002). Brian did not want to come to the dining room in these circumstances, yet

often, staff insisted. Staff expressed their displeasure when residents did not automatically conform to the routines of the facility.

The nurse came in as I was talking to Brian, and asked if he was coming to the dining room for dinner. He said that he couldn't move and was really achy. The chair had "squishy" wheels. "So you're not going to come?" she asked. "Well, I can't walk," he said. "Are you going to have dinner in here?" "Yes," he said. She turned and walked out of the room without a reply. He said to me, "She's one of the most ornery people I've ever met." I stated that it seemed that way. "It doesn't take that much effort to be friendly." "No," he said frowning. "She probably won't even bring me my lunch. She'll get one of the other girls to do it. I've had enough of those people my whole life. If she's going to be like that to me, I'm going to ignore her. I don't like being like that, and I'll never be like that first. But if she's going to ignore me, I'll ignore her. I have no use for people like that." [Field Notes, May 30, 2006]

When Brian was first admitted, staff described some issues with him conforming to the routines as well. Brian wanted to sleep in his chair rather than in his bed, and wanted to go to bed later in the evening. Apparently, some staff had a problem with this.

Well it was like stuff like wanting him to go to bed and him getting up and wanting to go to the bathroom. Just that typical stuff, right? And him being a little bit heavy, like him freezing where he couldn't move, so he's becoming a safety risk on people. [Julie, Recreation]

Brian at first resisted routines but gradually became accustomed and conformed to the routines.

And he took a dislike to some of the evening staff. Because we were trying to figure out, he would sleep in his chair all night. We were trying to figure out why he didn't want to go back to bed. And he, and initially we thought that maybe there was some, a lot of anger, maybe some resentment towards the staff. What we found out is that he was having difficulty at home before he came in, and he wasn't always able to go ahead and get from the chair into bed and vice versa, so he would just sleep in the chair. There was a misunderstanding, so we had to kind of get him into the routine that you have a bed here, we'll help you into the bed. We'll get you ready for the night. And we'll get you settled for the night-time. But some of the evening staff had interpreted it that he was very angry at them. And that's why he wasn't going ahead and getting into bed. It took a while before he sort of revealed that to us. And ah, initially he said that he's staying up in the chair because he's mad at the staff by not meeting his needs and not doing what he wants, and therefore, he's not getting into that bed. But then when we

investigated it further, we found out that there were some difficulties with him ambulating on his own at home, and therefore he would sleep in the chair. So it took a little while before he got to feel comfortable with the staff and our routines and assist him to bed. And after that he was fine... That's why I guess you just have to identify the underlying problem. Once you do that, you're able to fix it and he's able to move on with his life. What I've found is since then he's settled in, he's become more comfortable with the staff, with our routines, with the activities that are going on in the facility, and he seems to have settled in. He seems to have accepted that this is his home now, and this is where he's going to stay. [James, Nursing]

In effect, staff found many ways to let residents know that they must conform to the routines of the facility, from disregarding residents' opinions and desires, to expressing their displeasure when residents did not conform, to simply demanding that residents conform to the routines of the facility. In the end, each of the participants conformed to the routines.

It's a hard routine to get into. Early in the morning you have breakfast, have a shave. That's just to waste time. You have nobody here to look good for. It's just to waste time. And then it's dinnertime. Then after dinner, get up and walk around. At 7:00 it's bedtime. I don't go to bed at 7:00 but last night I went to bed at 4:00 in the morning. [Brian, Interview One]

But there's new people come every day. And you watch them. And you see the lonesomeness in their face. They're looking watching what other people do. How they're going to eat their meal and what they're going to eat and what they're going to choose to eat and everything. And you watch them for a month. They fall into the routine. If they're not fighting it, they fall into the routine. Which is a good thing. You can't fight so go along. [Brian, Interview Three]

When I asked Rachel if her routines had changed during the second interview, she said that she was "...more settled into a routine." [Interview Two] She had conformed to the routines of the facility. Staff viewed residents as not just conforming to the routine, but actually becoming a part of the routines. Becoming part of life in the facility meant becoming a part of the routines.

How do they become a part of life? Well just through some of those regulations and schedules. Like I say, you're a brand new person and you've come to your home but our home and just how they started you know fitting in is maybe the first

get up in the morning you know to working with the nursing staff, to going to a meal. Or just they become part of the routine. And that becomes part of the way they live. [Darlene, Management]

Well, they're sort of taught the routines. This is what time this is, this is what time that is. And ah, and then they just can choose some of that. But some of it sort of is against, or out of their control, so they're needing to adapt to it. [Julie, Recreation]

Boredom was also a part of routines. While some aspects of life were regimented and filled with busyness and tasks, other aspects of life were empty.

I go to bed at 6 or 6:30 in the evening. There's nothing to do in the evenings. They ask me if I want to go to bed, so I say yes. I know they're busy, so I just go to bed. I don't have to, but there's nothing else to do. [Rachel, Field Notes, February 15, 2006]

*Elaine That's early to get up that early every day.
Rachel And you got nothing to do all day. [Interview Two]*

Rachel described how time typically went very slow with nothing to do. When she had something to fill her time with, time went by fast. Boredom and routine impacted perceptions of time.

I was visiting Rachel. When I looked at the clock it was 11:40. "Boy, time went fast," she said. "It must have been because I had company. Usually time drags on for hours with nothing to do." [Field Notes, Saturday May 6, 2006]

Rachel's granddaughter also commented on how bored Rachel was.

*Elaine Has her [Rachel's] mood been different here, from being in her room?
Deborah I think so. More mellow and bored. I'll get five, six phone calls a day opposed to you know, when she was at McIntyre Hospital, at the beginning we heard a lot from her, but towards the end, you'd go visit her, and it was like, I have to go and do this. You gotta leave now. And it's like okay. [laughter] It was good for her. And I don't see that in her now. And I thought it would have happened by now.*

Brian described the boredom and lack of activity as a habit he got into. This sense of boredom did not change for him over the data collection period.

And I get up and wash my face. If I'm going to shave, I take a little shave. Then I go down for breakfast at around quarter to eight. I'm the only one there, and then I have nothing to do actually, then until noon. So I come back and I snooze. I walk around. [Brian, Interview One]

So you begin to get a new life and you have to watch yourself because you can fall into a rut. If you had an active life, a very active life like I did, then you come in here and you sit for three or four days, it gets to be a habit. [Brian, Interview Three]

Part of the routines in the facility included planned recreation programs. An expectation of the residents was that they attend recreation programs or therapy that was offered by the facility. Activities were part of the routine. In this way, residents further became a part of the institution and the routines of the facility.

I always, I used to do this with therapy right or wrong, but call it strong encouragement and with therapy too, you know, where residents were on a program and you'd ask them would you like to do this today "No" well you know I don't really take no for an answer so I'm gonna "No" and then I always call three strikes you're out. Then when I heard the no loud and clear I would respect that. For some residents it's just you know the coaxing and the spending time with that person and then you can kind of work them into doing it and then I always say you know by the third NO, yeah I respect that they have a choice today, you just don't wanna do this and that's OK. And we'll try again tomorrow or the next day. So I think that kind of control is that they still have a choice of, of um being involved or not in long-term. Some, some residents may choose that through eating or not eating or being active or not active or like you say seeing someone or not seeing someone. [Darlene, Management, Initial Interview]

I have been called several times to interact with this person to get them out of their room because they're spending too much time in their room. They're not being social. They're not attending anything. So it's our need, or our own beliefs about socialization, that we think this person needs to, again conform, to....But just how that one instance can create all this oh my God. She's in her room, we've got to get her out of her room. She doesn't want to! And I'm not going to go there. I often think, is that what you're telling me? And of course that's why I'm very conscious of asking people, staff, so what is it you're expecting? Cause if you're expecting me to go down there and pull her out of her room and say, you need to be involved in this, I have no right to do that. [Karen, Recreation, Initial Interview]

The programming yeah you're expected to come, what can we do it's only from two to three. I would hope that they would 'cause they're gonna have a darn good

time. But there are expectations, I think I'm the type too, I encourage them more to come instead of to say "Well if you don't wanna come you don't." I've heard people say well if you don't wanna come stay in your room. Well I still feel we, we need to do our job a little bit to encourage people to come. But those unwritten rules, there are those unwritten rules. [Karen, Recreation, Initial Interview]

Rachel participated in most recreation programs and yet still described being bored and having nothing to do. Brian kept himself 'busy' in his room with napping, reading the paper, listening to the radio, walking, and watching television. Edward attended some recreation programs, visited Maybelle, read the paper, watched television, walked, and chatted with people. Yet each of these residents mentioned having little to do. While there were scheduled recreation programs, the confined environment also left little choice and opportunities for a wide variety of activities in which to participate. Activities may also be meaningless in the institution. Whereas in one's home, there typically was a wide variety of possibilities to keep busy, the institution offered little control and ownership over space, thus leaving little to do. The limited access to the outdoors, particularly in the winter, may have also contributed to a feeling of boredom and confinement, since each of these participants were accustomed to spending much time outdoors. Boredom may also reflect a dependence on the facility to provide for recreation needs for some. Boredom may also be a sign of a lack of meaningful activity. Although residents find things to keep them occupied, these may not be meaningful and may be simply to 'kill time'.

Life, then, consisted of routines around the body—waking up, eating, body care, and going to bed. Outside of these routines, however, residents were left with little to do, resulting in boredom for these participants. Regardless of residents' wishes or desires, in the end, they all conformed to the routines of the facility. In this way, their bodies were

managed according to the institutional structure of the facility. Organizational structures of regulations and routines filtered down to structure day-to-day life for the residents.

8.3.4.2 *Managing Through Waiting*

Another way in which residents' bodies were managed was through waiting. Residents became aware through staff comments that staff had a high caseload of residents, and that they were not the only ones with care needs. This message was often conveyed through waiting for care.

*So I have to be patient and wait. And that's an aggravation, but it's a realism.
[Brian, Interview Three]*

Rachel, in particular, discussed many incidents that happened to her in which she had to wait for care. Rachel needed more assistance from staff for body care than did Edward and Brian, which is probably why she had so many examples of having to wait for care.

I came up to the third floor. Rachel was coming down the hallway in the wheelchair holding the left arm with her right hand. I said hi. She saw a nurse and told her that she had to go to the bathroom. "I've been ringing. Did nobody hear me?" she said. The nurse replied, "I don't see the call bell going off. It must not be working." I followed Rachel down to the bedroom and we chatted. The nurses still weren't coming so I asked if she wanted me to go down the hall to find someone. I went and found two nurses who said they would come. They came in. Rachel said, "Oh, you're finally here." The first nurse said, "We had lots of other people before you. We were making our way down the hallway." Rachel stated, "I thought my call bell wasn't working." The second nurse said, "Oh, it's working. Do you hear it ringing? That means it's working." The nurses left and I came back in to visit with Rachel. [Field Notes, February 15, 2006]

Waiting for care often impacted other activities Rachel wished to participate in.

I went to [Rachel's] room. She was watching TV. She said hi. She said she was waiting for a nurse to come and take her to the bathroom so she could go to the music program. She had called twice already. They said both times someone was coming, but never did...She pulled the call bell again. It rang for at least five minutes with no one answering. I asked her if she'd like me to see if I could find a nurse. She said yes, that they were awfully slow today. I walked out, but couldn't

find a nurse anywhere... As I was walking back, two nurses came and took her to bathroom. I told them I would wait until they were finished, and I would take her to the music program [which started at 2:00 p.m.]. When finished, Rachel asked for her left foot pedal (the stroke side), and the nurse put it on. By this time, it was 2:20 p.m. I brought Rachel into the auditorium, late for the program. [Field Notes, October 11, 2005]

In some cases, residents waited for care that never came.

Rachel On the floor generally it's nice and quiet. The only complaint I do have is you phone in the night for a bed pan, and they tell you off.

Elaine Now, did they do that again last night? I know you told me the other night they did that.

Rachel Yeah they did. They said they'd be here in a few minutes and they never come at all. So then when the nurse come in this morning, I told her that I had called. She said how did you hold it that long? I said it wasn't easy. Your stomach gets awful sore.

Elaine Oh, Rachel, that's terrible.

Rachel Your stomach gets so sore.

Elaine So how many times did you ring?

Rachel Twice. And every time they'd tell me the same thing. We'll be there in a minute. It's just that night nurse. The other girls come.

Elaine They're pretty good?

Rachel Well yesterday they were. I waited what, an hour?

Elaine Half an hour, yeah. Yesterday, well I think it was about a half an hour. It was long yesterday that they made you wait. Yeah.

Rachel I don't know why they do that because they don't want me to go to the bathroom by myself. I can't get out of the chair by myself, and they know that. [Interview One]

Rather than waiting for care, the nurses told Rachel to go to the bathroom in her brief.

Rachel I called for a nurse last night to use the bedpan. She told me just to go in my diaper. I didn't like that! I know when I need to go and I don't want to lose that.

Elaine So what did you do? Say?

Rachel I held it 'til morning. I told the nurse in the morning and she said that should never happen, that they should take you right away.

Elaine Yeah of course. And today, they were so slow. It took them half an hour to get to you.

Rachel Good thing I didn't have to go really bad. Can you imagine waiting if you had to go really bad?

Elaine No, that would be horrible.[Field Notes, October 11, 2005]

Julie also described Rachel's frustration with waiting. Staff had to reconcile waiting as a normal part of life in long-term care.

There was something now, I can't remember what it was though. She did have an issue with somebody I'm pretty sure but I don't think it's been all that bad or anything. She sometimes gets a little frustrated waiting to lie down and stuff eh. But that's a typical complaint and it's just also loss of independence, learning that you have to wait for stuff sometimes. [Julie, Recreation]

...a typical routine is to wait for somebody to get up. Wait for somebody to bring you to breakfast. Wait for someone to take you out of the dining room. Wait for somebody to bring you back for lunch. Wait for somebody to take you out. And then maybe you have a nap and then you're in bed waiting until you can get up for supper or waiting for help. Hopefully they're at programs but that's a small amount of the day. Really that's only, if there's an evening program, let's say they were at an exercise group for half an hour in the morning, at an afternoon program for an hour, and at an evening program for an hour, that's two and a half hours. And the rest of the day they're, they're sitting. [Joyce, Recreation, Initial Interview]

Staff also discussed the perceptions of residents and families and their expectations of immediate care. Many people were not aware of staffing levels and the difficulties of staff to balance the needs of all residents, thus resulting in a perceived notion that staff simply didn't care about residents' body needs.

That's a difficult transition for everyone who comes here, whether they had a home or, yeah, it is. I think that people are often under the illusion that that will happen here. That everything will be done immediately and right away, and that's one of the main points of family. You know, Mom and Dad want to go to bed, and why aren't they in bed? Right now? And you have to wait because there's other people to get to, and we're on our way and we'll get there. Or maybe today we can't and I think that is hard. For staff of course. But for families and residents, that's a hard one. They think they're paying for something. You think you're paying for something that you should be able to get it right away. But they seem to work through that. Some do and some don't. [Sarah, Management]

Staff described waiting that often happened around the need to go to the bathroom. Staff viewed waiting as a normal part of long-term care.

Waiting. Bathroom. Being told they have to go to bed early. Being told what time to get up. And being told what time they have to eat. Giving up what little control they have left in their life. And ah, being told what they have to wear. It's everything. But I would think number one bathroom. Even if, nobody wants to soil themselves, and no one wants to admit they need more help there. But sometimes the ones who could still be toileted end up not being toileted. And they get stuck in

depends, and I think that's gotta be really degrading. And you'll see some of them that will just sit and cry. I have a lady that will sit and cry because she is a little bit heavier now to put on the toilet, so they tell her to go in her pants. I hate that. That is totally neglect. But she needs two staff to help her on the toilet, and they're not able to, I guess, have two people do it at certain times. I don't know. So that's really gotta be the hardest thing. [Joyce, Recreation, Initial Interview]

Waiting, then, reinforced the place of residents' bodies and how they were managed within the institution. Waiting informed residents of two things: that they were one of many residents, and that there were not enough staff to take care of all of these residents. Waiting was also used as a consequence to residents not conforming to staff requests.

I learn that if I cause trouble, it may be a deterrent for how my needs are met. And people learn that. And I really would like to say that that doesn't happen, but I know it does. I know that it does. Because I know that those individuals who may be deemed difficult or not conforming their care as in a sense of hands-on care may not be lowered, but in how it's done. As in, oh, it's so and so. I'm just going to make them wait for ten minutes. And I'm not going to respond. And the people that live here know it. Because I've had many residents say to me, I said can you talk to the nurse about that? I can be with you. No. no. Because they're afraid. Now to me, you can be afraid of something because you don't know what to expect, and that's a reality. But we can also be afraid of something because we know and we're afraid of those consequences. Because we're aware of them happening. [Karen, Recreation, Initial Interview]

As such, waiting was an institutional process that served its purpose—making residents aware of the place of their bodies and discouraging possible “trouble” by residents through encouraging compliance.

8.5.4.3 Managing Through Risk Management

Risk management in long-term care facilities is a common approach that limits residents' autonomy (Lidz, Fischer, & Arnold, 1992). At Ridgemount, the body was managed to avoid any possible risk in which the body might be injured. Edward and

Maybelle, in particular, felt the implications of a risk management culture. Edward did not like always visiting Maybelle on the locked unit, so he took her upstairs to his room one day. He fell asleep in his chair, and Maybelle wandered down the hall. Staff were concerned that Maybelle might wander out the front door. Edward was told that unless he was able to supervise Maybelle, she should not come upstairs to visit him. While some staff doubted that Maybelle would wander out the front door, the message conveyed to Edward was very clear that she needed to be supervised all the time.

Another way that risk was managed for Edward was the use of his walker. Edward wanted to walk with only his cane by his 100th birthday, and would practice in the hallways without his walker. When staff saw him, they usually requested that he go back to his room to use his walker if he wanted to walk in the hallway. Because Edward had a few falls, they were concerned about the risks to his body. Edward described his perceptions of the situation.

Edward had to go through a row of walkers and wheelchairs to sit beside Maybelle for karaoke, so I suggested that he leave his walker and I would give him an arm. He said, "I got hell." I said, "You did? Why?" He replied, "I walked without my walker." [Field Notes, October 4, 2005]

Staff described how they needed to ensure that Edward did not attempt to walk on his own and ensure that he used his walker.

He did try a couple of times to get up on his own. And we would tell him, you make sure you ring and we will come and help you. But he adjusted fine to that afterwards. I think he realized that he couldn't do it on his own. [Monica, Nurse]

Edward did have a lot of frustrations because there was things that he was told he couldn't do, he still wanted to do. Like he would, unsafe things really. He would wanna leave his walker and take a little walk down the hallway. The nurses would say "What are you doing." I mean out of safety and he would be very frustrated because he'd just want to walk without his walker so that one day he would maybe not need it. So things like that, I don't think there was really anything else and that was more, it wasn't something somebody put in control or

him not conforming, it he's just, I mean you lose, you do that you taking his hope away. Because he thinks maybe one day, it felt good for him I'm 99 to think he that maybe he wouldn't need his walker one day. But he also could've fallen and broken a hip so, then at 99 should you be that protective? I don't know. Really. He's lived this long doing what he wants to do so. [Joyce, Recreation]

When Edward was in a wheelchair, he commented, “*Put your seatbelt on. That’s what they tell me all the time.*” [Field notes, October 4, 2005] Edward also described how although he was trying to be independent, the staff kept warning him to be careful.

Elaine *It must be hard now having the staff help you with things.*
Edward *Well, I try to do things for myself as much as I can. I tell them that’s what I want. They say, just be careful. Don’t do something that might hurt you. [Field Notes, January 30, 2006]*

Rachel wanted to use the commode in the bathroom rather than in her bedroom, as described earlier (see Section 8.5.1 Placing the Body). She requested that a bar be put in her bathroom so she could transfer onto the commode in there, but by the end of data collection, this had never occurred. Deborah, her granddaughter, figured the situation was due to staff reluctance to transfer her and risk possible injury. Staff injury was prevented at the expense of Rachel’s control over her space and her body.

Brian wanted to sleep in his chair so he could get up to go to the bathroom at night by himself, but staff did not want him to.

Now I just, I can’t get up to go to the bathroom. And you can’t go to the bathroom in your bare feet. Because the floor is slippery and they don’t want you to fall because they’re not, you don’t have an attendant with you all night. For me, I can’t bend down to get my shoes off, so I go to bed with my shoes on. [Brian, Interview Three]

Staff described the management of Brian’s body because of the potential risk of him falling, and as such, he was not assisted to the bathroom at night.

And ah, I know in the beginning too when he came, there was a lot of problems with nursing as far as him going to the washroom at night, they didn’t want to take him because they said he was too big, he was too rigid, he might fall, and I

tried to approach them and try to get them to make suggestions themselves, because it always works better when people make their own suggestions, and it wouldn't be followed through. And I thought oh my God. [Sarah, Management]

Brian, however, described how he attempted to work around the staff's attempts to manage him going to the bathroom at night.

To give you an idea, the older you get, the more often you have to go to relieve yourself in the bathroom. They don't allow you to walk on the floor in bare feet or socks because you're liable to slip. You don't realize what's going on. I couldn't get out of that bed. My legs were getting so weak that things that I took for granted were coming to the fore now. I just have to get out of bed and go to the bathroom. But then I do that on the sneak because if they found out about it, they'd put you on their method of relieving yourself in bed. And you realize then that it's coming and you fight it. You don't want it. The more you don't want to do it, the more you have to do it. And they have to adjust to you as much as you're adjusting to them. [Brian, Feedback Interview]

Brian also wanted to get an air conditioner window unit for his room in the summer because he was always hot.

I asked him again if he knew anything about getting an air conditioner. He said they were concerned about Legionnaire's disease, but they were going to find out for him if he could have one. [Field Notes, July 3, 2006]

In the end, Brian was not allowed to have an air conditioner unit in his room. I am not sure what the rationale was for this, or if Brian even received an explanation. He simply informed me that he was not allowed to have an air conditioner in his room.

Risk management was not always focussed on the individual body, but was also focussed on the collective body. In February, 2006, during the data collection period, Ridgemount was quarantined due to a respiratory infection outbreak. The day before the facility was closed, I visited with my son, Gabriel, who was four months old at the time.

Monica came in to see Gabriel. She said I shouldn't have him on the floor because five residents were sick with chest infections. She didn't think Gabriel should catch it, but didn't want him to. Another nurse pulled me aside a few minutes later and told me the same thing. [Field notes, February 17, 2006]

The facility was closed for three weeks, although according to some staff, only eight residents (out of 150) were sick. No family members, visitors, or any other outside people were allowed into the facility, no residents were allowed out, and no group recreation programs were allowed to be scheduled.

Joyce said that it was ridiculous that the facility was closed. There were only about eight people that were sick (as opposed to fifteen quoted on the radio). Two ladies on the first floor had a little bit of a sniffle, and were confined to their rooms for eight days. Joyce said it was very extreme how they reacted. Now they are only allowed to have unit programs and are not allowed to have programs in the auditorium or off the unit. During the quarantine, Martha and Joyce weren't allowed in the rec. office because they might bring the virus from their floors to the second and third floors. [Field notes, March 7, 2006]

The residents did not like the quarantine, and expressed their discontent.

Rachel Two weeks is a really long time to be without anything. No family. No activities.

Elaine We would have been in earlier, but we weren't allowed in.

Rachel It's horrible that they wouldn't let anyone in. [Field notes, March 7, 2006]

Rachel also said, "It's so nice to be out of jail." When I asked her what she meant, she said she had been confined to her room for two weeks. "It was horrible. I couldn't go out at all." I replied, "That must have been so lonely. I know how much you like to socialize." "It was," she said. [Field Notes, March 7, 2006]

Staff described numerous ways in which risk was managed within the facility.

Some of them had difficulty balancing their beliefs in residents' rights to autonomy with attempting to protect the residents from harm.

Joyce Well, there's a good example. And how do you keep that pride and dignity and keep the rules? You know, health and safety. We don't want them, they're at risk for falls. Okay, well, they could fall anywhere... we get to a point too where we're trying to be too cautious. Set these are the rules. Well we don't want them to fall. Well you know what? And then you could get into, we don't want you walking down the hall anymore because you could fall and break a hip. Well then they get in the chair and then they're depressed and they get worse cognitively, and then they sometimes, ah, I mean there's probably no proof, but I find when they have to give that up,

they go downhill very quick. Whereas if they were walking around, they'd be happy. I don't, put me in a chair, I may just walk and break a hip. Then good. Maybe I'll die in a hospital and not come back. [laughter]

Elaine Exactly.

Joyce That's what it's supposed to be.

Elaine And you gotta wonder what's worse?

Joyce Being tied up in a chair with a tight belt around you. Your back and around your stomach and you're sitting in this sweaty diaper. [Joyce, Recreation, Initial Interview]

Risk management, then, was a common institutional process that was used in the socialization process to manage the body. By managing risk, residents were taught that their bodies were frail and old, and needed to be protected at all costs. As such, desires to maintain independence and personal care were disregarded as staff set limits as to what residents were “allowed” and “not allowed” to do with their bodies. As Darlene stated: “*I like to say we're a philosophy of care and independence, but independence all around issues of safety and risk*” [Darlene, Management, Initial Interview]. Risk management as an ideology structured residents' day-to-day lives and experiences.

Managing the body through routines, risk management, and waiting yielded an end result of residents losing independence and control. Creating dependence also entailed a process for the residents of losing control. While most staff did not say that control was taken away from the residents or that control was taken by a specific person, they did say that most residents experienced a loss of control.

[E]verything, everything is taken away from the, they've got no control. One of the big things I find is loss of control. You have to get up now, no. Why do I have to get up, I don't wanna get up. You have to eat now and you have to get dressed and I have to wash and dress you. So loss of control. Loss of, you take everything away from them like I said, their home, their clothes, you lock that cupboard. And they just, they don't know how to accept this. Like I can't even get into my cupboard at my own clothes. OK so I find loss of, loss of control. So I think that's gotta be about the biggest thing, loss of control, loss of being able to say when, what, who, why, how. [Leslie, Nursing, Initial Interview]

Just losing that autonomy, losing that ability or that autonomy to make those decisions, you know, “I don’t wanna do that now.” “Well you really should do that now”, or “We really need you to do that now.” [Marlene, Management, Initial Interview]

Although residents learned that the body was the focus of the institution and of interactions with staff, particularly nursing staff, the body was also managed to accommodate to the routines and structures of the institution. Management of the body occurred through routines, through waiting for care, and through managing risk.

8.5.5 Relating to the Body

This theme of relating to the body incorporated relationships and their contexts, and how the institution and the body structured and defined the boundaries of relationships. The institution defined the boundaries of relationships. This was evident in residents’ relationships with others—first with family and friends, and then with staff themselves.

8.5.5.1 Defining Resident Relationship Boundaries

The boundaries of relationships were defined by the facility and its very nature, as well as by its rules, regulations, and policies. This was particularly evident in the relationships between spouses. While this was not an issue for Rachel since her husband had passed away many years before, it was an issue for Brian and Edward. When Brian was admitted to Ridgemount, his wife entered the hospital and then palliative care. He was not able to see her as often as he would have liked.

I asked Brian how things were going so far. “As good as can be expected,” he said. His wife is in the hospital. I said, “That must be difficult for you.” Brian said, “Yeah. I can’t even call her because my phone’s not hooked up yet. I can’t

call her so I don't know how she's doing. I went to see her last Friday though. My niece picked me up and took me." [Field notes, February 6, 2006]

Because of his inability to get around, he had to rely on others to take him to visit his wife.

I went in to see Brian. He was standing by his clothes cupboard. I said hi and asked how he was doing. He said fine. His wife is doing better. Her heart stopped and they revived her on Monday night. She was on ICU, but is out now. I said, "It must be hard for you to be here."

Brian I can't even see her.

Elaine That must be so hard for you.

Brian It is. But everybody's got to deal with something.

Elaine Well yeah. But not to see her. Are you going to be able to see her?

Brian Some friends are coming tonight. They're going to take me to see her. They work, so it won't be until later this afternoon. [Field notes, March 15, 2006]

While they were still able to speak on the phone, when his wife became weaker, they were no longer able to use the phone to communicate. Shortly thereafter, she passed away. For Brian, the lack of accessibility to visit his wife could be attributed to his body but also to place and the lack of opportunity and support to leave the facility to see her.

The boundaries of the relationship were also defined between Edward and Maybelle. As described earlier, since Maybelle had some form of dementia, she was living on the first floor locked unit while Edward was living on the second floor extended care unit. When they first came into the facility, Valerie (Edward's daughter) was not aware that they could be in the same room. When she was approached about the possibility a couple of months after Edward and Maybelle moved in, Valerie refused. She felt a tension between respecting his wishes and promoting his well-being.

My Dad was very upset that my mom was going to be living somewhere else. I said you know, you can go there anytime, all the time. The phone rang on me Thursday or the Friday, and it was Ridgemount saying that because your dad was now on the priority list because one spouse is here, we have a bed available. And it was like, oh my God. So I said well I have to talk to my dad. This isn't, you

know. So he decided that because mom was coming, he didn't want to be separated from her. I think he still kind of thought they were going to be in the same room. And to me, that just wasn't going to happen. That just wasn't going to work. Because I understand now that could happen if we worked on it. But I think that would be detrimental to my dad. The nurses, I've talked to them a couple of times and they agree it's just not a good idea. One of the people that worked on the floor actually suggested it to my dad one time. And that was kind of ugly.
[Valerie]

The separation was very difficult on Edward and Maybelle. Numerous conversations with Edward centred around the difficulty of being separated from his wife of 68 years.

I don't like it that Maybelle and I can't be together. I go to sleep up there and Maybelle goes to sleep down there in her room. It used to be when we were living together that we would crawl into bed together and cuddle together. Mind you, we'd behave ourselves, but we'd cuddle together. And now we can't do that.
[Interview Two]

Even at the third interview, Edward still could not get used to being separated from Maybelle.

Edward I'll tell you right now, I don't like it.
Elaine What don't you like about it?
Edward What I don't like about it, I don't see why a man and wife who are happily married can't have rooms in a place like this. I think that's one of the, that's something I have against this place and always will. There's, mother and I have been married I don't know how many years.
Elaine A lot of years.
Edward And we never had trouble at all in all that time. And I don't think we'd get in any trouble if we were together now. And I know her heart is broken. And when she goes, mine will be broken. And that's the way I feel about it. When they bury me, if I get a chance to say something, it'll be against this place. And I hope it's loud enough that people hear me and take it to heart. But I don't like it here. It's a good place for a single man, but why can't they have couples here? You would hate to have to go into a place and leave your husband.
Elaine Absolutely I would. You're totally right, Edward. And I understand why you would feel that way.
Edward Well I, it's bad that I feel that way. I don't like it because I have nothing against anybody that I know of. But I have against

whoever started that. And I haven't been able to find out just who was the instigator of it. But I can't do anything about it.
Elaine *But I guess it's not the same just to go visit Maybelle downstairs.*
Edward *No. We, well she won't talk anymore. In the day before, you know, we could talk. Lie in bed and talk things out. If there was something I did she didn't like, then she would tell me and I would have my say again. And we always parted in good company. No hard feelings anywhere. I can't say that anymore. And ah, I've lived a life where I had everything above board. Now I haven't.*
Elaine *So is she upset with you that you can't be together or just upset that you can't be together?*
Edward *She's upset that we can't be together.*
Elaine *Oh, okay.*
Edward *She has nothing against me. I have nothing against her.*
Elaine *So she doesn't think it's your fault?*
Edward *Oh no. The only thing is sometimes when I'm kissing her goodnight, she'll say, when are you coming to take me?*
Elaine *Oh, that must be so hard.*
Edward *That bothers me for, all the time. So, they'll never have me saying a good word about this place.*
Elaine *Well, I can't blame you.*
Edward *It's a good place for a single man.*
Elaine *I've only been married to my husband for a year and a half, but I know if I had to live apart from him, I'd be pretty upset too.*
Edward *Yeah. That's the way I feel about it here. And, I'm not going to change my thoughts about it unless they change. I don't know think they'll change in my lifetime. [Interview Three]*

Being separated also had a significant impact on Edward's wife, Maybelle. Since Maybelle had limited short-term memory, she felt that Edward had neglected her or left her, and was often upset with him at the beginning for not coming to see her. Edward visited every day, often more than once a day, but in Maybelle's reality, Edward was rarely with her.

When I came in, I asked how he was doing. He said fine. "I haven't seen my wife for four days." I said, "You haven't?" He said, "Well, my wife was just up here and she's upset because she said that I hadn't seen her for four days, but I have." I said, "Yeah, you were just there yesterday." He said, "Yeah, I go down to see her everyday." Later he said, "Her mind's not working properly, so she's wondering why I don't come down to see her all the time." [Field notes, September 28, 2005]

In addition to not having a room to share together, there were other issues surrounding the dining room. When Edward and Maybelle first moved in, Edward went down to the locked unit every day to have dinner with Maybelle. Maybelle, however, did not come upstairs to have dinner with Edward, nor was it ever offered to the couple. Whether this was intentional by the staff or not, the atmosphere was not welcoming for Maybelle to come upstairs and have dinner with Edward.

Elaine *So ideally, it would be nice if the two of you could have a room together.*
Edward *Well yes. But it's impossible here.*
Elaine *It's so too bad.*
Edward *Yeah, well, we can be together every day. I have meals at her ah, her abode. She, I don't think she's ever been here for a meal.*
Elaine *No, I don't think she has, has she?*
Edward *No. and ah, there'd be no place at our table for her. They'd have to make one.*
Elaine *Yeah, an extra place.*
Edward *...and there's five of us sits at one table now... [Interview One]*

At the second interview with Edward, the situation still hadn't changed.

I had dinner with Maybelle last night. And ah, I'll possibly go down and have dinner with her tomorrow. Now that's another thing you see. I go down there and I have dinner. And I just tell if they're there, I'll be here for dinner. But I've never had Maybelle here for dinner. See that's different. And I don't like it. [Edward, Interview Two]

Another way the boundaries of their relationship was defined was the issue of Maybelle coming upstairs to visit with Edward in his room. Staff were concerned about the potential issue of Maybelle wandering, and discouraged Edward from having Maybelle upstairs to visit.

I think he feels that she is good there. When she's come up and sort of stayed in his room and, I don't think he really, when she gets up to go, he's not really concerned about her going, but we are. You know? We are concerned. [Jennifer, Nursing]

Edward's daughter also talked about her concerns regarding this situation and understanding where staff were coming from.

I said to him, dad, really, you're in the same building. You can go down there anytime you want. He, I don't think that he realizes that he has as much freedom as he has. You know, I think that he thinks that he's kind of under rules too. I know that he brought Mom upstairs one time and he kind of nodded off, which he does, and she got up and started, she started down the hall. So I know the nurses were understandably upset, and they just said to him, you know, you're not going to be able to bring her up here if this is going to happen. And I think he just kind of took that as if a privilege was taken away from him. I said no it isn't, but they have to worry. What if mom had gone outside? You know, what if she would have, you know, there's too many what ifs. [Valerie, Daughter]

Edward and Maybelle's relationship, then, was defined by the institution and boundaries were established in their relationship that had not existed before.

Another method of defining relationship boundaries was in facilitating relationships. Staff had the ability to facilitate relationships they felt were important because they were often in positions of greater power to do this. While this was not necessarily negative, it certainly demonstrated the limitations of residents to facilitate their own relationships, yet again drawing boundaries on relationships.

Some staff facilitated Edward and Maybelle's relationship by helping Edward downstairs to visit Maybelle, particularly in the beginning when he wasn't able to find his way around. Relationships are played out in the public, and are no longer private, as illustrated here.

He had one incident one night where they had a little argument. And apparently that was the first argument they had in all the years they were married. And I guess she kind of said something to him, and it upset him. And he came upstairs. And it was so sad. He wouldn't eat. He went to his room. So I brought him coffee and sandwiches in his room. But he had me almost in tears. Because it was so sad. He was telling me, "Sixty years and we never had an argument." Well he paced the unit so much that evening, so I finally said, Edward, I will take you downstairs. Because she does have Alzheimer's. so I explained to him that. He said, I know. Her sister apparently had it. And he said, but you know, it's

different. It's Maybelle now. So I took him back downstairs. When I brought him down there, she was in her night-gown, and I said you know what? You go back down there. You're never going to sleep. Because he was so upset. So I said, let's go down. So I took him down. She was standing in her bedroom in her night-gown with her hands on her hips, and I brought him in and I said, well, I said, Maybelle I brought Edward to say goodnight to you. And she said, well he should. But she was in a really bad mood that day apparently. But I left them for a while and came back, and he was saying, well Mom, you know, we've made it 60 years. This is not going to be the end. Well I had to leave, because I thought I'm going to start to cry here. But when I went and got him, he told me, he gave me a big hug after and he said to me, I will never forget you for doing this. I was like oh my goodness. He says, I'm so happy you took me back down there. But oh it was cute. [laughter] [[Monica, Nursing]

The recreation staff in particular made an effort to bring Edward and Maybelle to the same programs and sit them together so they could enjoy each other's company.

[Edward] said he sees Maybelle pretty much every day. "I go down there to see her or she comes up here. This afternoon there's a concert going on and they're going to bring her up here. It's nice that they do that so I can see her." [Field notes, November 16, 2005]

Staff also determined who might be appropriate to sit together in the dining room in an attempt to encourage residents to make friends with each other. In some instances, this succeeded. Edward, for instance, became friends with the men sitting at his table. In other instances this did not succeed, such as Rachel who disliked one woman at her table so much that she asked to switch tables.

But yeah, staff do go out of their way to try and make the person feel comfortable. you try. I know that one of the things they do is try to seat them at the table where they feel, you know, somebody they might be interested in communicating with. Because some people don't communicate or they don't speak English so you try to keep those kind of people together so they don't feel uncomfortable because somebody keeps asking them something and they don't know what they're talking about. So there's little things like that. [Sarah, Management]

The boundaries of relationships, then, were defined by the institution and by staff. Staff either encouraged relationships, or significantly limited relationships, such as when they moved Rachel from her table to another table in the dining room. Even though Rachel

wanted this move, it was the staff who had the authority to make the move, not Rachel herself. The policies of the institution clearly delineated the boundaries of relationships, so much so that Edward and Maybelle, who had been happily married for 68 years, were no longer able to share a bed. The boundaries on these relationships further contributed to the dismantling of the self, as described earlier.

8.5.5.2 *Defining Staff Relationship Boundaries*

Staff also very clearly defined the boundaries of their relationships with the residents. While there were staff who were nice and friendly, tension existed continuously between a caring attitude and task orientation. Residents were very clearly aware that staff were extremely busy and did not have time to spend with them except to complete required tasks.

The people working here are very busy at that time [morning] [Brian, Interview One]

Elaine *Now what about the staff here? Do you talk to them a lot or is it just that they come in and help you with what you need and that's it?*

Edward *Most of the staff here I like. They're good. They help you in a lot of ways. And I find they're very helpful. In a lot of ways.*

Elaine *But are they often too busy to talk too, or do you get a chance to talk to them?*

Edward *Oh, I get a chance to talk to them. Not as much as I'd like to sometimes, but then they're busy. They've got a job. Their job is to look after us. As I understand it. Although oh, it's good for us in that way. You know? They take time and maybe sometimes it's part of their time. [Interview Three]*

Nurses' abrupt interactions also reinforced the notion that they were extremely busy all the time.

As we were talking, Brenda (RPN) came in with a spoonful of applesauce with meds in it. "See, they're spoon-feeding me," Brian said. Brenda put the spoon in his mouth and walked out without a word. "Thank you," he called after her.

“You’re welcome,” she called back walking down the hall. [Field notes, April 27, 2006]

Toward the end of our visit, another nurse came in, stood in front of his walker. “Come on Brian. Lunchtime.” She walked out before he could respond. [Field notes, May 12, 2006]

The boundaries of the relationship between residents and staff were drawn beyond which lay the personal. That is, many staff were not personally acquainted with the residents, but the relationship instead focussed on the task. This is not to say that some nurses were not friendly or nice, but the relationship still was extremely task-oriented and impersonal. Edward recognized that staff were available to be a care-provider to him, and did not have time to be more than that. Earlier in the interview, he stated that he was friends with some people, but he had no one with whom he could talk about anything private, discuss his past life, or discuss his opinions about certain things such as politics.

Yeah. I think there’s, either one of the two here that I think are friends ‘cause we can sit and talk about different things, but never anything private. It’s always just something about the weather or something like that. [Edward, Interview Three]

Elaine *So if you were to say, do you feel like the staff, that they know who you are or that they just kind of know your name and that’s it, the people here?*

Edward *Well, I know that they know who I am. And maybe there’s a little bit they know about my past, but very little. Because I haven’t been talking to people about it, my past. And not that I’m ashamed of anything in my past, because I had a lot of good friends that I worked with. And I had a lot of good times.*

Elaine *But is it just that the relationship you have with people here is not, like acquaintances and nothing else?*

Edward *It’s not exactly the same as you can’t say well I did such and such and got away with it. No, you don’t see that anymore. But they take good care of me here, I’ll say that. [Interview Three]*

One of the reasons for these impersonal relationships was the limited time that staff had. Other staff, such as the housekeepers, recognized that nursing staff had little time to spend with residents, and they tried to compensate for this.

Because for one thing, nursing only has so much time. they can only get in there and get out. And they haven't got time to listen to each one's story. And we shouldn't either, but we do. [Brenda, Environmental Services]

During Brian's feedback interview, he described his relationship with staff: "And you get to, there again, unconsciously accept that as your family." Brian was likening his relationship with staff to his relationships with his mother and wife, when he had women taking care of him and how he took orders from them. The nature of staff relationships, while having a type of physical intimacy because of care of the body, was an authoritative type of relationship with Brian perceiving his conformity to the staff "orders". The relationship, in his mind, was defined as hierarchical and the boundaries were implicit. In essence, it was a custodial type of relationship.

...That they have a way to make you think that you're your own boss. When you're not...if you let yourself go, to accept these things, here I'm going to use the word unconscious, it's subconsciously accepting the name as part of your family, part of your how you used to live and take orders from your parents and whatnot, you know? [Brian, Feedback Interview]

Brian then stated, "You can't fight it, Elaine...but they're trained not to listen to you too much. And the more you fight that, the more frustrated you get." Brian also discussed how the staff adapted to some of his body needs, and in this way, there was a body familiarity with Brian that was similar to a family relationship. Brian stated how "there's a couple of women, or more than a couple of women, a whole bunch of them, that have me figured out, and I know it." This relationship is similar to what Twigg (2000a) defined as bounded intimacy between care providers and care recipients. The nature of the care relationship had an air of intimacy because of nakedness and body touch, yet staff distanced themselves from this intimacy. Brian described the body familiarity that staff had of him—they had him figured out—yet staff gave him orders and did not listen to him too much.

When I further discussed with Brian the focus on the body in staff relationships and the lack of personal and emotional connection, he raised a number of interesting points. First, Brian felt that he did not want staff “diagnosing” emotional problems. Simply by using these types of words and phrases, the pathological nature of the staff-resident relationship and the focus on “disease” had obviously been recognized by him. Staff were not there to help him with the emotional adjustment he was going through, but were simply there to take care of his body.

Elaine *I wanted to ask you too, part of my findings here is that there’s very much a focus on the physical body, on what you need in terms of care, whether you need medication, whether you need a bath, whether you need that type of thing, but that emotionally and stuff, how people are doing. I mean, it’s a hard adjustment to come here. I can’t even imagine what it must be like. But that the emotional adjustment for people seems to be something that isn’t talked about it.*

Brian *Now I don’t think, or should say I think that the staff is never trained for that. Simply because a little knowledge may be a bad thing. And if they get to thinking that they can help you with your mindset, they’re going to change you in a way that you’re going to think that you can handle them. Because they’re going to try to do things to you, try to diagnose your problem. And I think that’s discouraged. To a certain extent, I think it’s discouraged. That they are, the staff is quite well adapted to changing their style of helping you to your style of accepting help. But I haven’t talked to any one of them, and I’ve talked to quite a few of them in a different way. I haven’t noticed that they have the ability or the willingness to try to find out what your mental problem is. You are unconsciously adapting to a whole new way of life. It’s like quitting smoking day by day. You need that patch on your arm to quit smoking. You need the patch on your arm to help you adapt here. But you don’t get that. [Feedback Interview]*

Brian also mentioned how staff did not ask him how he was doing after his wife passed away, after giving up his house, and after putting his dog down.

Brian *I think, Elaine, that they don’t talk to you about it. They didn’t talk to me about my wife. They didn’t offer any sympathy at all, because I think they figured that emotionally you don’t want to be*

reminded too much of what part of life you're going through. With my wife, they all knew that she was sick and she was going to die and everything. And not one of them ever said, you know, are you lonesome? They never talked to me in that fashion about the wife. None of them ever asked me how is your wife? They know that they're reminding you it's happening.

Elaine

So there's a reason why they do that?

Brian

Yes. I try to think of it in a way of have they been trained to do it or not? And I think they have. Because with putting the dog down, I knew that I was going to have to come in here without my dog. And they never said anything about that either. They just let that slip by and let you get on with your life. [Feedback Interview]

Brian did, however, mention that he didn't want sympathy from staff, and although staff were not sympathetic and he felt often that they didn't care, they did listen to him when he talked.

Elaine

What would you have preferred? Would you have wanted someone to occasionally say to you how are you doing, Brian? I know this must be a really rough time for you. Or was that something you felt you really didn't need from the staff?

Brian

It's something that you don't refuse to talk to them. But it's something that you probably don't want to hear. And I'm that way. If something's happening, I don't want sympathy. And that's the only thing they can offer you. The day I had my dog put down, they ah, nobody said anything about it, and that's the way I wanted it. They knew I was sad about it because I was sad to talking about it... a minimum of talk, a minimum of conversation with them about it. So I think that's, when I thought of it after, you get to thinking, gee, they don't care. But they listen to every word you said. because a woman bought a dog, and she came to me about training the dog and everything. And you realize they're listening, they're just not saying.

Elaine

So there's different ways that they express things?

Brian

Yes, you find that if you open a conversation, but if you wait for them, you're withdrawing into yourself. I think it's best this way. Because they don't remind you of what's going on. They accept that you know what's going on...sometimes you think, well, they don't care. Then you realize that yes, they do care. [Feedback Interview]

In retrospect, Brian could see that the staff cared in different ways, but in the middle of the difficult situation, Brian felt like staff didn't care. Brian may have found a way to

cope with a difficult situation by defining the situation in a positive light when reflecting on it.

Another way in which boundaries were defined is the difference between individual staff and their approaches to residents. Some staff were very friendly, while others weren't. Residents learned very quickly that they could not expect that all staff would be friendly and caring.

...and you have to get somebody that can talk in your style. Now there's one girl here, I haven't seen her for a couple of days. She's sort of a brusque girl. And when you first meet her, you figure she's a domineering old biddy. But when you realize what she's doing, you realize she knows what she's doing, and she does it in a fashion that's good for you. [Brian, Feedback Interview]

The nurses have been very nice to me. Just the odd one that, but you have that every place. [Rachel, Interview One]

While the interpersonal skills of some staff were difficult for some residents to get used to at first, the physical care was good, and Brian, in this case, realized that she was doing what was good for him physically.

Comments about young staff being "bossy" and older staff being friendly were also very common.

Elaine So the staff here, Brian? How are the staff?
Brian I would think that on a scale of one to a hundred, they're 99, 99.
Elaine So they're pretty good.
Brian Some of the younger ones, try to get bossy.
Elaine You're not the only person that's said that.
Brian But I know human nature says that everyone doesn't have the same amount of patience and if the nature's a bossy nature, it's harder for them to control it...
Elaine Younger people usually are, well they just haven't had life experiences to see things the same way as other people. [Interview Two]

And I find too, a lot of the nurses if they're older, they're more compassionate. That should be a restriction for homes, really. [Deborah, Rachel's Granddaughter]

Even some staff commented on how some of the younger nurses showed little compassion and consideration for the residents during care.

...some of the young ones, they're just like charge in and do it and you know, have the conversation over the person's head. Which you know, especially if the person could understand, can kinda go, you know you don't need to discuss what you're doing this weekend and what you did last night. And so sometimes I, like you know, especially if I'm with them and they start doing that, I'll always just turn to the resident and just, you know, involve them in the conversation. So if they don't feel like, "What am I, a piece of meat?" [Sasha, Nursing]

In addition, the nature of the relationship between staff and residents seemed to depend on the residents' willingness to get along with staff and be amiable. Residents were aware of this and attempted to get along with staff. They generally understood that if they were good to staff, staff would generally be good to them.

That's why I say, you be good to people and they'll be good to you. You be ugly with them, and they'll be ugly with you. One of the nurses told me, it's nice to see somebody smile. They want to start smiling. Forget about their troubles. That's all it is. It's all in their head. [Rachel, Interview One]

Elaine How have you adjusted since being here?

Rachel I adjust fairly well because I get along good with everybody.

Elaine It seems like the adjustment's gone fairly smoothly for you. The transition.

Rachel Yeah. Because I talk to everybody and I get along good.

Elaine Yeah. And I guess it must be a bit easier for you than for some other people because you were at McIntyre and at St. Mary's too. So, like, I know for some people that are coming straight from home, it's a bit more difficult for them because everything's kind of new here.

Rachel Yeah.

Elaine I guess you've had a little more experience kind of, eh?

Rachel And if you can't talk to people, well it must be an awful adjustment.

Elaine Yeah, for sure.

Rachel But that's really your own fault. [Interview Two]

I try to be as jovial as I can. For my own benefit as well as for theirs. I try to, like one girl told me, you've always got a smile on your face. Well, I remember an old saying when I was very young, and every time I'd get a little sour, my mother

would say, smile and the world smiles with you. Frown and you frown alone. [Brian, Feedback Interview]

One of the staff members also discussed how she was aware of the conditional relationships between staff and residents. In particular, residents learned that if they created “trouble”, there would be repercussions.

And I believe that residents learn that very quickly. That if I do this and next week I need something, that staff may say within themselves, well they haven't been that much of a problem lately. They've been really good to me. And they've been nice. And you know what? I'm going to do that for you. So I really believe that lots of the work relationships with residents is all about um, when you give to something but you're expecting something. Conditions. It's conditional. And I really believe a lot of that happens. It's conditional. And I believe residents learn that. [Karen, Recreation, Initial Interview]

The staff also discussed the Residents' Code of Conduct. (Interestingly, fewer staff discussed the Residents' Bill of Rights). They placed high emphasis on this code of conduct and the requirements for residents to “behave” accordingly.

There is the (telephone is ringing) of course the Residents' Bill of Rights which is their rights but along with those rights there are responsibilities as well. Absolutely and they're provided with those right at the first day. Certainly we recognize individual rights as residents residing in a home but along with that there's many response, not a lot but there are responsibilities. I mean aggression is huge both verbal and physical, this just can't be tolerated, it just can't be. Probably that's the biggest one because everything else flexibility could be built in there. Routine yes I mean flexibility again but that's the one thing we can't, we can't accept, just can't... That would be the main responsibility. I mean just to be courteous and respectful of other individuals and if you don't like someone to try and keep those thoughts to yourself because that's verbal aggression too and that's just abusive. [Colleen, Management, Initial Interview]

And that's just part, yeah the rules and regulations but they also have responsibility for themselves and for the people they live with. [Darlene, Management, Initial Interview]

Some staff had an inability to understand residents' needs and their embodied experiences, which was evident in their interactions with the residents. Therefore, the boundaries were drawn between residents and staff, and empathy was not part of the care

relationship for some staff. While staff may have felt that they were caring and empathetic, their body gestures and communication, particularly during care, indicated a focus on completing tasks.

Brian *You see, if you're a person standing here that's 20 years old, start their job and they talk about retirement. When I retire, I'm going to do this and that and the other thing. What they're trying to do is to put a 20 year old mind in a 60 year old body. that's another thing that just don't work. And you know, people here go to Community College. Can I have a Kleenex? And they learn something at Community College, but they never realize that Community College is only an interim thing. It's for people who haven't made it here and aren't going to make it there, so they've got to settle someplace. So they settle in the middle. And when they graduate, they think they've got it made and they look at an old person and think what's that old turkey doing? And it's hard to go to them and say, realize that one day you're going to be there unless you take the alternative. And to take the alternative, you ain't gonna be hurt at all. You hurt someone else, but your hurting is all done. But you can't tell them that.*

Elaine *The foolishness of youth.*

Brian *Yes.*

Elaine *So, I know you and I have had quite a few conversations and stuff, but do you find that the staff are very respectful of you and you're able to have conversations with them and stuff?*

Brian *Well, yes. And the things they say they don't really mean. It's just there and they say it.*

Elaine *The younger ones or all of them?*

Brian *Well, some older ones. But mostly just the young.*

Elaine *So they don't think before they speak?*

Brian *Yeah, it just rolls out and their movements are fast. Like I see them feeding old people, and I can remember back, when my mother spent six years in Grande Prairie Lodge, in Highmount Hospital. And they, I used to tell that girl they feed you like they're feeding a French goose. They stuff food in a French goose until the liver softens. Then when they kill them they get liver pate. That's what my mother said...But the other people with their fast movements never realize when they put the food in the person's mouth, I say woman's mouth because at the next table to me it's all women they're feeding. And when they put it in they pull the spoon out you know. I always make the comparison when you're coming, you're born, you're going to go, your baby now is on a spoon. He's being spoon fed. When he gets to his second childhood, he's going to be spoonfed in the other direction. This is spoonfed coming in and this*

is spoonfed going out. And I tease them here, like they come in here to give me a pill and they've worked it out for pretty much everybody. They put the pills in a spoonful of applesauce and they swallow easily. I tease them that they're spoonfeeding me you know. I tease them, say my mother used to do that, you know? But then the young people they scoop up another scoop, spoonful of food... She's too slow to eat on her own. She's too slow to swallow fast. It's not that they don't realize it. They don't think of it.

Elaine So not considering

Brian No, it's more in the scope of thought. To think of those things, you've gotta be in that direction.

Elaine Well you kind of have to put yourself in someone else's shoes to think about how you might feel if you were in that situation.

Brian It's easier said than done though. It's not like quitting smoking or anything, but you're ah, you're habit is a hard thing to break. And you're unconsciously in a habit when you're feeding yourself. You watch some people and they're very slow eaters. [Interview Two]

Brian saw the care staff gave to other residents, and how other residents were treated. While he did not explicitly state this, he may have seen himself in the future if he were to get sicker and require more assistance. Brian had to become accustomed to different approaches from different staff. In this way, it became easier to get along with staff.

Now there's a nurse on night shift downstairs, she's downstairs on night shift. She's a single woman. She works all her life on nights. I ring the bell three or four times a night. If I go to bed too early, they like you to go to bed by seven or eight o'clock. I don't go to bed 'til midnight. And if I had to go to the bathroom, I'd give her a call. You can't go up to go to the bathroom on your own. And she'd come in and she wouldn't fuss with me. Like if you're not comfortable in bed, move over and get your own comfort. Can't expect them to do it for me, and I had to catch on to that. Once I caught on to it, her and I are the best of friends. From my part anyway. I don't know about hers. [Brian, Interview Three]

Relationships, then, existed within boundaries defined by the institution and by extension, the staff. If we do indeed know ourselves within relationships and create and solidify a sense of self and identity, these relationships with very specific boundaries create and solidify, to some extent, a sense of simply being a body. Residents have limited

opportunities for interactional others (Paterniti, 2000). This is particularly true in the relationships with nursing staff, since residents primarily have interaction and contact with nursing staff. Residents did not discuss the nature of relationships with staff other than nursing staff. Thus, the boundaries that were defined were with nursing staff. Relationships, then, within boundaries, are simply ways of relating to the body.

The institutional processes of placing the body, defining the body, focussing on the body, managing the body, and relating to the body were all ways in which residents were socialized into the long-term care facility. These institutional processes were centred on the body, and on assumptions of the body as frail, dysfunctional, and in need of assistance. Through these institutional processes, residents learned that their bodies were important, but that they were also subject to the structure of the institution.

8.6 The (Inter)Personal Processes

In addition to the institutional processes that made residents into bodies, there were also a number of (inter)personal processes that occurred to make residents into bodies. These processes consisted of *internalizing the body*, *accommodating the body*, *accepting-resisting the body*, and *re-creating the body*. These findings indicate that while in some ways residents internalized and accepted the identity of being a body, they also found ways of resisting this identity and re-creating alternative identities. These processes, while being internal to the residents' experiences, were formed in interpersonal environments and relationships, hence the naming of these processes *(inter)personal processes*. These internal processes often occurred as a result of interpersonal relationships, particularly with staff. There were also internal processes,

such as re-creating the body, that were visible in interpersonal environments and the success in which they were able to re-create the body was dependent on this interpersonal environment. Thus, these processes are referred to as (inter)personal, recognizing that the personal occurs as a result of and exists within interpersonal contexts. These four (inter)personal processes will be described in detail next.

8.6.1 *Internalizing the Body*

As one might expect, residents internalized the notion of simply becoming a body. This was evident in the ways residents viewed themselves—*being a number*, and *being a burden*. Residents did not simply exist in their bodies, nor did they exist in relationships focussed on the body, but they also internalized the body. The inability of staff to understand and empathize with their visceral embodied experiences and the focus of the institution on bodies and body care contributed significantly to an internalizing of the body.

8.6.1.1 *Being a Number*

As mentioned earlier, residents were very aware that staff were very busy. Through various management techniques of the body, such as waiting for care as described earlier, residents came to feel like a number. Being a number meant recognizing that staff had other residents to care for, and residents' body needs could not necessarily be addressed immediately when they requested. While residents may not have defined themselves fully as a number, they recognized in their interactions with staff that they were a number. Once residents internalized this, they stopped demanding that their

body care needs be met immediately. Each of the participants in this study reached that point.

- Elaine* *So do you have any staff that you've developed a fairly close relationship with at all? Or is it mostly just kind of strictly business?*
- Brian* *No, some of the, I was going to say older girls, but they're all younger than I am. [chuckles]*
- Elaine* *But I know what you mean.*
- Brian* *Some of them are very good. Most of them are. Some of them, most of the guys, there's males here too. Most of them are pretty good.*
- Elaine* *So you could have a conversation with them like you're having with me.*
- Brian* *Oh yeah. The only thing is that when you meet them, they're on a job. And if you try to get into a conversation with them, you're doing something contradictory to their work. And if their boss sees they're not going they're talking to me. I think they'll have certain times that they're busy. Right after a mealtime. Before bedtime at night they're busy. And I remain a little independent. [Interview Two]*

Being a number meant that staff did not have time to engage in conversation with residents, particularly during care. Thus, Brian did not attempt to have conversations with staff. Being a number also meant that residents had to learn to wait their turn. There were numerous examples of situations in which residents learned that they were a number (see also Section 8.5.4.2 Managing the Body Through Waiting).

- [Rachel] then called the nurses to go to the bathroom.*
- Nurse* *Hello.*
- Rachel* *I need someone to help me to the toilet.*
- Nurse* *Okay Rachel. You'll have to wait. The nurses are busy right now.*
- Rachel* *Okay. [Field notes, March 30, 2006]*

Valerie, Edward's daughter, noticed that Edward had some difficulty waiting for care, and she tried to help him realize that he was a number.

And in that sense he's really lost a lot of, he was never a "right now" type of person. Whereas I've noticed especially when he came in here, things are supposed to happen now. Like if he calls the nurse, she should be there. You're not the only person on the floor... Yeah. I think it's still an adjustment. You know,

it's like, well, we're all a number anymore. You go to the grocery store, you wait in line. You go to the doctor's office, you wait. So it's all the same type of thing. But I guess in your home you don't expect that. [Valerie, daughter of Edward and Maybelle]

Staff described how Brian, after he was first admitted, had to learn that he was a number, and was frustrated with waiting in line.

But then in the morning, [Brian would] ring that bell right away and he wanted to be the first one up immediately. So they had other issues. So they had to explain to him, well, we have some 20 other residents here that need their needs met too. And we're going to do our best to help people. We can't be here right away. And so the following day he was sitting up in the chair again. Well you're not putting me into bed again. Because you're not getting me up in the morning on time. [James, Nursing]

Staff felt it was important that residents understand that they were a number.

I think [Brian's] wife used to cater to him, and it's one-on-one for him at home. And he doesn't understand that you've got over 30 residents here, and if it's on night-time, you've only got two health care aides, one RPN and one health care aide there to meet his needs. And he didn't understand that they have all these other people that have to be taken care of too. [James, Nursing]

Staff very much recognized that residents became a number when they came into Ridgemount. While they did not like that this happened, they also described the limitations on their work of needing to care for all the residents. Thus, they had to treat residents as a number in order to accomplish all of their tasks.

And um, what I find difficult is the routine when it comes to getting washed right away or getting dressed right away. Or they want to get up in the chair if they can't do it right away, so there's, they want that all to happen right away, and we just can't get there when they need us, and that's the frustrating part, even for nursing, because they would like to be able to jolly on the spot be able to get everybody up and do everything at once, but we've got 38 people, and it's just ah, it's impossible. So look at your priorities and kind of well, just base them on that. Not even on a seniority thing. [Glenda, Nursing, Initial Interview]

But I think it would be difficult for a resident 'cause when you're, depending on where you come from, if you're coming right from home you know, there's a big difference, you know, you're by yourself in a home, maybe your spouse and

*others, you're living with 37 other people. It's a big adjustment. Very hard.
[Eleanor, Nursing, Initial Interview]*

8.6.1.2 *Being a Burden*

Residents also very much felt like a burden to the staff. Feeling like a burden seemed to be attributed to two things in particular—a failing body, and treatment by staff. Inevitably, a failing body led residents to depend on others for body care. Specific treatment by the staff also led the residents to believe they were a burden. Rachel described how difficult it was to ask for help now since she was so accustomed to being independent before her stroke.

Elaine *So what's it like to have people help you? In the morning and at night and that type of thing? Is it hard?*
Rachel *It's hard to have to ask people to help you. Because you're so used to being independent.*
Elaine *Yeah. You've done it for so many years yourself.*
Rachel *But you just gotta face it. If you can't do it, you can't do it.
[Rachel, Interview Two]*

Because of her lack of independence and her dependence on staff, some staff treated her as an inconvenience, while other staff made her feel like it was their job to help her.

Elaine *So does it get easier to have the staff help you with what you need?*
Rachel *Yeah. You'd like to have your own independence but you know you can't so...*
Elaine *Yeah. And I guess it must make a big difference if, like the staff who don't make you feel like you're a bother.*
Rachel *The older nurses are like that. They make you feel as if it's my job to do this. You know? It's the younger ones that...*
Elaine *That make you feel like you're being a bit of a bother?*
Rachel *Yeah. Not that Karen.*
Elaine *She seems nice.*
Rachel *She never makes you feel as if...*
Elaine *As if you're being a bother?*
Rachel *No.*
Elaine *You're not the only one that's said that. I've heard other people say that too, that some of the younger nurses just don't have the same way with people.*

Rachel *No. The younger ones, you'll go to the bathroom. They'll just pull up your clothes. The older ones will wash you and make sure you're nice and clean [Interview Three].*

Inevitably, a loss of independence made residents aware that they had to depend on staff for their bodily needs. Brian described fighting the process of accepting help, and eventually, had to stop fighting and accept help.

Elaine *So...now in terms of the staff helping you, you're fairly independent with everything, aren't you? Or do the staff come in here to help you?*

Brian *Well you think you're independent but you're not. I can't bend down to take my shoes off. I can take them off, but I can't get them back on. And there's things that you don't like to believe you've got to accept. And if you try to fight them, you only frustrate yourself. You've got to give in.*

Elaine *And accept the help?*

Brian *Yeah.*

Elaine *Has that been a hard process for you?*

Brian *To accept that?*

Elaine *Yeah.*

Brian *Not really. If you've got an ounce of intelligence, which most of us have, you just realize it comes with age. When you first come into a building like this, a home like this, into a life like this, and they serve you supper. It's a slice of meat or something, and they come and cut it for you. Or if your hands are tight and they come and feed it to you, at first you're embarrassed. Then you look around, and everybody that's in there, except the young people that are working for you, everyone in there's in the same kind of boat.*

Elaine *Except the help. [Brian, Interview One]*

The loss of independence and resulting dependence on staff, particularly in an environment where residents were a number, led Brian to perceive that he was a burden on staff.

And that's an aggravation, but it's a realism. Knowing you're limiting someone else's life. [Brian, Interview Three]

There's a lot of people here think they're a burden. They more than likely suffer with pain rather than call the nurse. I was like that at first. I wouldn't let anybody know that I had a problem. That's when you get to realize it's no embarrassment to get sick because everybody in here is sick to a certain extent. Some of them are

sick of living and some of them are sick of dying. The staff realizes very shortly, because they've been through it all before, and they realize very shortly that this one is bucking the trend. Don't ask for help. I was like that for a while, and I knew what I was doing and I knew what was wrong. [Brian, Feedback Interview]

One of the nursing staff described his perceptions of Brian's struggle to accept his dependence on staff.

I think he [Brian] didn't feel, initially I don't think he felt like he was worth very much. He couldn't help himself, he couldn't help others. So what use was he? Just totally useless. But I think now he's much more accepting that this is the stage that he's at. And he is of use to us. He can talk, he can joke around with us. He can contribute that way. [James, Nursing]

For Rachel, not having a bedpan at night was a way in which she felt like a burden, since staff would not give her the bedpan at night.

Elaine So is there anything about being here that you don't like?
Rachel No! no, I can't say there is. Only that I... to not getting the bed pan at night. Because I'm not used to going in my brief.
Elaine I think that's terrible.
Rachel Yeah. I can't go in the brief. So I hold it 'til morning and then I'm in agony.
Elaine I don't know, I wouldn't be very happy, I can tell you that.
Rachel I'm going to tell Deborah and maybe Deborah can go talk to them.
Elaine I think if that was me, I'd just keep pressing my call button until someone came. Cause ah, that's terrible.
Rachel Just use your diaper, your brief. You can't. I don't want to get into that habit either.
Elaine And you shouldn't have to, Rachel.
Rachel Well, I want to be able to go visit my family and have control of myself.
Elaine Absolutely. Yeah. You shouldn't have to. You shouldn't have to.
Rachel I think it's just a lazy nurse.
Elaine That's terrible.
Rachel It's easy just to take the brief off.
Elaine But still, it's not that hard to just give someone the bedpan either. It's not. It's not at all.
Rachel She gets up and goes to the bathroom [pointing to her roommate].
Elaine On her own?
Rachel Yeah. I wish I could. I wouldn't bother them at all. [Interview One]

Again, Rachel commented on how younger staff made her feel like a problem or a nuisance, while older staff were not like that.

- Rachel* *They make you feel as if you're not a nuisance. Some of the young ones, they make you feel as if you're a problem, you know? Why don't you just lay there and shut up? But not the older ones. I like the older nurses.*
- Elaine* *And usually in the daytime there's quite a few of them that have been here for 20, 25 years. A long time. Yeah. [Interview Two]*

Rachel was made to feel like a burden and an inconvenience if she asked for the bedpan at night and was not able to go, or if she needed to use the bedpan twice.

- Elaine* *So you were talking about the staff helping you and how it was difficult for you sometimes because of your independence.*
- Rachel* *Yeah. Like last night I called for the bedpan, and he brought it and then I just had to go pee. And the nurse come and took it away and then a little while I had to do more, so I called her, called for the bed pan and he says, not again. I says never mind not again. I asked you for the bed pan and I want it. So he brought it. And then Nancy come to me. I said it wasn't you that answered that call, was it? No, she said, it wasn't.*
- Elaine* *So there's been some staff that you've had a little bit of a conflict with then.*
- Rachel* *Just him.*
- Elaine* *Just that one night nurse? I know you had said before that he had said you better do something when you asked for the bedpan?*
- Rachel* *Yeah. [interruption of nurse] [Interview Three]*

Staff also described some residents and their feelings of being a nuisance.

That's a hard one but what stands out in my mind is the odd person that thinks they're such a nuisance now. I'm sorry to ask to for help, I'm such a nuisance, I can't do it by myself, and if you don't mind. Lots of times I'll say don't be silly that's what we're paid for, you got to ask us and we'll help. That's the only one that stands out in my mind anyway that type of person...They feel guilty that they're having to depend on somebody. [Mary, Nursing]

The body was internalized by residents, and they came to view themselves as a number and as a burden in their interactions within the institution. The interactions with others around them, particularly staff, helped to create these feelings and perceptions.

Being a number and being a burden occurred mostly in interactions with nursing staff. In this way, these feelings were sometimes defined by others and imposed on them, but residents also accepted these realities and this part of their identities in certain contexts.

8.6.2 Accommodating the Body

As a reaction to the institutional processes of placing the body, defining the body, managing the body, focussing on the body, and relating to the body, residents learned to accommodate the body to the structures of the institution and the making of the body through conformity, compliance, and cooperation. There were deliberate things that staff did to attempt to influence residents to comply with the structures and routines of the institution. In many ways, staff would pay the repercussions of residents not complying, as illustrated earlier (see Section 8.3 The Structure of the Institution). As an example, if a resident wasn't in the dining room for mealtimes, staff would have to supervise him or her in the bedroom while eating, meaning that staff would be taken away from other tasks. Because staff had many tasks to be completed, forcing the residents to comply with their wishes essentially made their jobs easier, with fewer repercussions from management and others for uncompleted tasks.

But they very soon adapt to your way of thinking and when they're adapted to your way of thinking, they're unknowingly to you, they're forcing you to live the life that they have prescribed for you. [Brian, Feedback Interview]

When residents didn't necessarily co-operate or when residents' body needs became an inconvenience to staff, staff were quick to let residents know their displeasure.

Joyce and I brought Maybelle up to karaoke with two other residents. We had to wait for the nurse to give her meds. The nurse got her up out of bed and put her shoes on. She rolled her eyes as she walked out of Maybelle's room. [Field notes, October 4, 2006]

In fact, in Rachel's case, as mentioned before, they stopped giving her the bedpan at night by telling her to go in her briefs. She finally stopped asking them for the bedpan and would go to the bathroom in her briefs during the night. She conformed to staff requests of not using the bedpan at night.

Elaine *And what about at night with the bedpan?*
Rachel *I don't have it at night.*
Elaine *You don't at all ask for it anymore?*
Rachel *No. they told me just use my briefs, so I do. I don't like it, but I do.*
Elaine *I know you were really upset about it at first.*
Rachel *Seems to take all your, everything away from you when you have to use them. But ah, doesn't wake me up either in the night. Lucky I don't have to wake up. I hate those bedpans.*
Elaine *But it takes away a lot of dignity, doesn't it?*
Rachel *Yeah. Cuts right into your back.*
Elaine *So if you would have still had a choice, you probably would still used the bedpan, right?*
Rachel *Yes, I would have still used the bedpan. But I didn't have a choice. Because every time I'd ask for it, they'd say just use your briefs. So I just quit asking for it.*
Elaine *Awful. [Interview Two]*

By the third interview with Rachel, the staff had started bringing her the bedpan at night again. I am not sure whether Deborah, her granddaughter talked to staff or whether Rachel herself commented to someone about the situation, but she was given the bedpan at night again. However, some staff expressed their displeasure at doing this, according to Rachel. Deborah, Rachel's granddaughter, was concerned about possible repercussions if she were to mention some of the issues she had with staff and with Ridgemount.

... And then do you make a stink about it? And then risk her getting neglected?... So, I let that one pass, and Grandma's doing better.

There were also instances where staff were accustomed to things being done a certain way, and if residents threatened their routines, staff were unsure what to do. In the example of Brian, they could not accept that he would sleep in his chair or go to bed later

than others. That was not the typical routine of a resident, and so they attempted to make him conform to their wishes.

Like they ran into a solid wall. That's why they came to me and said, what's going on here? We can't do anything to him. He's resistant to care. He's not co-operating with us... And then what happened is, when I was on evenings, I would go in there and talk to him, and I would assist him to the bed. Say okay, now it's time for you to lay down. I'm going to help you in bed, and this is what we're going to do. And he was okay with that... He doesn't argue about his physical care. He seems to have accepted that this is the way it is here. These are the routines. Yes you do have to go to bed and lay down and go to sleep. Or you can stay up later or sleep in a little later if that's what you choose. But you have to acknowledge that when you ring, we can't be there within two minutes to meet your needs. [James, Nursing]

James I guess we had to do a lot of education here that this is the stage that he's at right now. And we had to go ahead and respond to his needs, decrease his anger, make him feel comfortable, and to be able to allow him to settle. And some of the staff seemed to take it real personal. Like this is our routine. Why is he breaking our routine? He's not allowed to do that. It's like, well, what was he hurting anyway? He's just hurting himself. Like I said, we just have to look at where he's coming from now, and slowly work toward what we want to accomplish. And then get everybody on the same page and realize it's not about them and their routine, it's about him.

Elaine So it was from your part, education of the staff?

James The staff, and education for the resident for different routines and expectations. [James, Nursing]

In Brian's last interview (feedback interview), he mentioned how staff forced residents to conform to their way of doing things.

They amaze me in the hidden intelligence of the people here. They don't force you to do anything knowingly, but they're forcing you to change to their way of doing it, whether you like it or not. And they're pretty darn good at it. I tell them they're sneaky Petes. Some people are not, they're not winning, but they're losing in another way. Like life is only as pleasant as you make it. And if you're not a total dud, you learn to accept their ways that they're forcing on you.

There were specific repercussions for residents if they did not conform to the structures of the institution and staff requests.

I learn that if I cause trouble, it may be a deterrent for how my care is met. And people learn that. And I really would like to say that that doesn't happen, but I know it does. I know that it does. Because I know that those individuals who may be deemed difficult or not conforming their care as in a sense of hands-on care may not be lowered, but in how it's done. As in, oh, it's so and so. I'm just going to make them wait for 10 minutes. And I'm not going to respond. And the people that live here know it. Because I've had many residents say to me, I said can you talk to the nurse about that? I can be with you. No. no. Because they're afraid. Now to me, you can be afraid of something because you don't know what to expect, and that's a reality. But we can also be afraid of something because we know and we're afraid of those consequences. Because we're aware of them happening. [Karen, Recreation, Initial Interview]

The repercussions of not conforming to staff requests meant a conflictual relationship with staff. While some residents may have thrived on this conflict, the participants in this study, particularly Rachel and Brian, learned to give in to staff to keep the peace. Rachel talked in detail about co-operating with the nurses. While she didn't necessarily wish to go to bed so early in the evening, she knew the nurses had limited time. She also knew that if she refused care at the time when the nurses offered it to her, she may not receive assistance when she wished it. As such, she often went to bed early in the evening when the staff had time to get her ready.

Elaine Does that make the evenings long?
Rachel You don't have too much going on in the evenings. No, I come back to my room and I go to bed early. I go to bed around 7:00 every night.
Elaine Do you? Now last time you said that's because the nursing staff gets you ready and puts you in bed at that time. Is that still?
Rachel They come in and ask me if you want to go to bed. I usually get ready for bed because I feel too that if you say no, I don't want to go yet, you're putting them out.
Elaine And then you might end up getting to bed later too, right?
Rachel You've learned to co-operate with people.
Elaine So that's the name of the game, eh?
Rachel That's the name of the game. Co-operation.
Elaine Yeah. So to adjusting to living here too, is that co-operating with staff? So kind of going at their schedule? Is that?
Rachel Like they don't put me to bed, tell me I have to go to bed. They ask me if I want to go to bed. And usually if I don't sleep in the

afternoon, I'm ready for bed. But I usually get at least an hour's sleep in the afternoon.

Elaine And are they usually pretty good about coming to put you to bed in the afternoon and then getting ya'

Rachel Taking me to the bathroom and then putting me to bed. I have no complaints about the nurses here. They're all good... Yeah, you gotta co-operate with them. Let them do things while they have the time. Because by putting you to bed, for one thing, they have time, and then if you say no, I want to stay up for another hour or so, then they don't have the time to put you to bed.

Elaine And that's not intentional?

Rachel No, it's not intentional. It just doesn't work out that way. So when they come here after supper and say are you ready for bed? I say yes. Because I can lay there and watch TV as well as I can sit in here.

Elaine Yeah, that's true. And you said you go to bed pretty early some days just if you haven't had a chance to have a nap in the afternoon, right?

Rachel Yeah. [Interview Three]

Brian also learned that he had to co-operate and get along with the staff. At the beginning, he recognized that he would exasperate the staff unintentionally.

There are always some people in there that can't get along with themselves. But you learn through the years that nobody's perfect, not even yourself. You don't think you're doing anything that will exasperate somebody, but you are doing something. So you learn to take it, and just go with the flow. [Interview One]

Brian's conflict with the staff over sleeping in his chair only lasted a couple of weeks, according to one of the nursing staff, until he adjusted and complied with staff's requests. However, there were still issues with some of the staff regarding the dining room and mealtimes, although Brian described getting along better with the staff now than at the beginning when he was first admitted.

Elaine So have your feelings toward this place changed since you've come? Over the past five months?

Brian No. I think it's a good place. And you have to get along with people in order to accept it. You can't, if you fight it, if you don't like it, you're fighting it. If you're fighting it, you don't like it, you're not going to like it. 'Cause nothing's going to happen your way. For every person that you are, there's 10 out here that's gotta

work for ya'. You've got to accept each and every one of them as they are. And I find I'm getting along better with them now than I used to.

Elaine

Are you?

Brian

When I fought with them before, it was always in my mind. A mental thing. And I find I'm getting along better with them now than I did before. [Interview Three]

One of the staff described how much Brian tried to compromise with the staff and his routines and wishes.

And you know with certain residents they just hit the roof and there's family involved. There was nothing. He was just oh, they don't want to take me. I'll just do the best I can. He tried, he really knows what compromise is, and maybe it's his background and the way he worked his way up through his life, but he knows that you kind of gotta meet halfway. And he realized that when he came here. He didn't have to learn that. And that's one of the biggest rules of adjustment that I think the residents learn here, is that okay, you're right and so is the staff right. So now okay we're not getting anywhere even though both of yours is right, so we have to compromise, and we have to come to something that's going to be good for both of us. [Sarah, Recreation]

Brian gradually came to accommodate the staff's wishes.

And if they want to do something to me, like give me a bath or something, I don't fight it. When I came in first, I didn't want to change my habits. Which is normal. It's like quitting smoking. It's not something you do with pleasure. And I would say to them, can you, they would come and say to me, it's bath time. I'd say, can you wait half an hour? I'm watching a horse race. You realize that they're changing their schedule so much that it's such an inconvenience that if they allow you to do it, they suggest in a odd manner, that maybe you should get up and come with, you know? So now I do it. They know darn well what time I like my bath and what time my horse races go on. But you adapt to their way of life as much as they adapt to yours. [Feedback Interview]

Residents learned, then, to cooperate and comply with staff in order to get along with staff and to avoid being an inconvenience. In this way, residents accommodated the body—they cooperated and complied until they became bodies. They conformed to staff requests and conformed to the structures of the institution, the “unwritten” rules and regulations of the facility.

The unwritten stuff that people very quickly in their transition here learn to conform to. And it must be pretty strong because people do conform to it. [Karen, Recreation, Initial Interview]

8.6.3 *Accepting-Resisting the Body*

There was a constant tension between accepting and resisting the body on the part of residents. Residents at times accepted their bodies, the assigned identity, the altered life within the institution, and their body limitations. Yet, they also fought it and resisted these things. The body reflected the limitations of the body, the institution as a place for the body, and the assigned identity of simply being a body. Thus, accepting-resisting was to all of these issues tied together. While this tension was not completely resolved by the end of the data collection period (i.e., six months after residents' admission), the residents did become more accepting of becoming a body, of the altered life within the institution, and of their body limitations.

Edward had difficulty adjusting to life in the facility, most particularly his separation from his wife Maybelle. By the end of the data collection period, he seemed to have accepted these changes, and although he still didn't like being separated from Maybelle, he seemed to be more accepting of it.

*Elaine So this has been a big adjustment then. A big change.
Edward Yup. A big change for me. But I'm getting used to it. You never get
used to it. [Interview Three]*

His statements of "getting used to it" and "never getting used to it" reflect the accepting-resisting of the altered life in the institution and the tensions between these two things.

Rachel became adjusted to the facility by the end of the data collection period. She had much time to become adjusted with her body after her stroke since she had been

in health facilities for over a year before coming to Ridgemount, but Ridgemount was also an adjustment to her. For Rachel, the process of accepting was of “getting used” to life in Ridgemount Facility.

*I'm getting used to everything now. Getting used to the people that work here.
[Rachel, Interview Two]*

Elaine So the last time I asked you what it's like to have staff help you with your care in the morning. I don't even remember what you said. I know you said sometimes it was really difficult because you feel like you've lost your independence. Is that--

Rachel No. not lately.

Elaine It's different now?

Rachel I've got used to them I guess, eh? [Interview Two]

Rachel described, however, that life was sometimes difficult and that she sometimes became discouraged. Even though she was accustomed to this life, she was still discouraged and depressed at times with her present circumstances.

Elaine So has there been anything that's helped you adjust to being here? I know you said you adjusted fairly well.

Rachel My family helped me a lot.

Elaine And they seem like they're really involved and come often to visit you.

Rachel And if I get down in the dumps and discouraged, they give me a little pep talk. You get discouraged and down. You can't help it. Because it's not like the life you're used to...

Elaine So you do have days when you get discouraged and down?

Rachel Yeah. And you just want to sleep all day.

Elaine Yeah. So what do you usually do then? Do you usually call your family or...

Rachel Or work on my puzzles or write letters.

Elaine So you have things to do to make you feel better.

Rachel Yeah, or I call Deborah and talk to her.

Elaine Does it help having friends here so you don't feel so down and discouraged?

Rachel Yeah. You can't do nothing like this for yourself [referring to her manicure] and you did it all the time before? [Interview Two]

Rachel had accepted life in the facility by the end of the data collection period. For

Rachel, acceptance was helped along by being involved in activities and therapy.

Elaine So over the past five and a half months, how do you think you've adjusted to living here?

Rachel Good. Well I just come to make myself believe that this is where I gotta stay, so I just gotta adjust.

Elaine So it's not so much a matter of, it's putting your mind to adjusting.

Rachel Finding things to do, and...

Elaine So what do you find to do?

Rachel I go to the Bingos and I go to the exercises. I'm keeping up my therapy.

Elaine You're always at exercises every day.

Rachel Yup. [Interview Three]

Edward had a hard time accepting his aging body and his waning independence.

His daughter talked about this when I spoke to her.

Even the 100th birthday. If that's what your focus wants to be, you have to have something. I really try to make sure I keep reminding him about stuff like that, you know. Just take a look around you dad. You're a lot older and you're in a lot better shape than a lot of these people. So quit feeling sorry for yourself. And I guess that's easy to say. Well I can't do what I used to. Well neither can I! [laughter] But no, I guess it's a whole time has no meaning thing. Age, well, I can't do the stuff I used to do 20 years ago. Well hello! You're 20 years older. I can't do the stuff I did 20 years ago. [Valerie, Daughter]

It was Brian, however, with his self-reflective and introspective nature, that described in great detail the tension between accepting and resisting the body. I have included numerous quotes from him to illustrate this point and give an in-depth description of this theme. Brian's acceptance was based on two inter-related things—acceptance of his aging and unpredictable body, and acceptance of life in an institution.

Brian was still coming to terms with his diagnosis of Parkinson's disease, particularly because the manifestations of his disease did not look like Parkinson's should. He described it as an “atypical Parkinson's”.

Course it's something [Parkinson's] that grows on you, you know. It's not as though you've got a pain in your tummy. It's something with your nerves. And it grows on you, so you get used to it. You tend to think you accept it, but you don't really accept it... you know you have it and you accept it, you don't really accept

it. You accept it in a service. Deep down in you resent it a little bit. [Interview One]

Brian *It was fun. Lots of good times. Then, age put a curb on it. Slows you down. If your brain is active, you don't really accept it because, you don't resent it, if you've got a spark of intelligence, you know it's going to come. And you don't really resent it, but you don't really accept it either. You stay in the middle ground, and sort of, you tend to let things go and ah, just live with it, rather than trying to change it. But in your mind, you're always cautious. You're always trying to fight it. You think maybe there's a miracle around the...*

Elaine *Around the corner.*

Brian *When you know darn well there's not. [Interview One]*

At the second interview, Brian still tried to resist the aging body and life in the institution by reserving some independence.

Elaine *So you said you haven't adjusted to being here yet.*

Brian *No., I haven't yet.*

Elaine *Do you think you ever will?*

Brian *No, I don't think so. I don't think so. I'll come close, but I'll always reserve a bit of independence.*

Elaine *Well good for you. As you should. That's what keeps you going.*

Brian *Yeah. [Interview Two]*

By the third interview, Brian was starting to come to terms with his life and the changes that had occurred. Once he accepted that his body was aging and that he needed help, he was able to accept life at Ridgemount, although he described it as “making the best out of a bad situation.”

Elaine *Um, somebody said to me once that some people cope with being here, but they don't necessarily adjust to being here.*

Brian *Some people which?*

Elaine *They cope with being here, but they don't necessarily adjust to living here.*

Brian *No, those kind of people are not what I call a fluid person. They won't go with the flow. They're really, what they're doing, they're deliberately keeping their mind from accepting what's happening. You can't stop it. You can't stop aging. We're older than we were when you came in here. You can't stop aging, so you might as well accept it and do what you can. [Interview Three]*

Accepting an altered life meant accepting an altered and aging body, and the dependence that came along with an aging body.

You're in here because your body is wearing out. I now have to wear a pad at night. Where I used to get up and go to the bathroom, now I'll wear a pad. And I know that because well I guess my bladder's going weak. But everybody in here wears them. Everybody that's old enough to wear 'em. And you've got to accept those things. And you've got to try, if that hurts you, then you're not going to accept the life you're living. You're going to try to fight it and you can't fight it. [Interview Three]

At the third interview, Brian was more accepting of his diagnosis and trying to make the best of things.

Brian *And the doctor was in Sunday afternoon, and sat here for five minutes. He told me I could have any Tylenol 3 I wanted, except there had to be four hours difference. So that tells me that what he's telling me before there's no, at my age, there's no cure. It's all maintenance. And I believe him now. So I'm starting to make the best of what I can.*

Elaine *So making the best of*

Brian *Making the best of a bad situation. [Interview Three]*

Brian also talked about his struggle to accept living in a facility and what that entailed:

And the experience in here has been great. Although it never leaves your mind that you'd like to go home and stay home again. If I did that, I may not get back in here. [Interview One]

The institutional life was not necessarily accepted by Brian, but he stated that he put up with it. Leaving the facility to visit home was a stark reminder of how life had changed, as Brian described through his reflections on his experiences with his mother. According to Brian's perceptions, putting up with and learning to live with his circumstances was different than accepting institutional life.

Elaine *What about your routines during the day? Have they changed since you've been at home and moved here? Like how your day's structured, what you do during the day?*

Brian Not a great deal. I can remember my mother, she lived in a place called Pinemount, an old aged home. That's 30 years ago. And I remember going picking her up, taking her out. She got to telling me that after a while, don't take me out. Come to visit me, but don't take me out. She said, you know you gotta go back. And it's just not pleasant. It's the same here. When you get out of the car, you go back in, you know where you're going. And you say you accept it, but you never truly do. You more put up with it than accept it. [Interview One]

Brian's acceptance of his life in the facility was difficult for him, particularly at the beginning.

How long can this go on? The doctor tells me, you've got another ten years to live. And I told him, geez no. I don't want to live in a room like this for ten years. [Interview One]

By the second interview, Brian realized that coming into the facility and accepting this life was also accepting immanent death.

Elaine So how come you think you're coming out of it? Is that getting more, I don't want to say adjusted or getting used to being here, or are you just making up your mind that this is what you need to do?

Brian Making up my mind... my mother used to say you make your match. Someplace in the world there's your match. I think I met it right here. The only thing is that you have to realize you never accept you're here until you die. [Interview Two]

Brian had a difficult time accepting institutional life since he had not anticipated coming into Ridgemount so soon, and he felt that he and his wife were managing well at home together. By the second interview, he was starting to accept that institutionalization was necessary because of the needs of his body, but he was not necessarily ready to accept institutional life.

Brian ...and here I haven't given it a chance. People that I know are very friendly. The ones I've got to know. And you have to accept that. 'Cause you ain't going no place else. The only thing I think I've been feeling sorry for myself because I couldn't see my wife. I guess, she's in poor health too. And I accepted that because I knew it for a long time. I accepted it, but I couldn't accept the fact that it

would all happen at once... To me, I wasn't quite ready. Although if I look back and see the care my wife was given me, I should have been outta her hair. But I didn't expect to have to come in here. Because coming in here is so final... But I'm getting to a point now where I haven't accepted it yet. If someone said let's go for a drive this afternoon, I'd be gone. My legs are such that if I get in the car, I can't get out.

Elaine Oh, because you can't move around.

Brian Can't move. And you don't want to accept that. If you're sick and your mind is as sick as your body, you accept that. My body's sick. My mind's not. I say it's not. It might be.

Elaine I don't think it is, but...

Brian Yeah. I haven't accepted yet the fact that I'm here.

Elaine And like you said, it's very final. Being here.

Brian Oh it is. It is final.

Elaine And that's something that you have to wrestle through and come to terms with. And ah, and if you weren't ready to come in here, and of course with your dog and your wife and not being home anymore. It's a lot of changes in a short time.

Brian If you were home waiting to come in. I wasn't... So once you're in here... it's finalization. [Interview Two]

The accepting-resisting was also about the finality of life and the reality of death.

Brian You're very independent, but when you go to do something like put on a shirt with your arms over your head, the arms won't go. Then you, the old brain will say hey wait a minute. If you know that the place is here, not to prolong your life. Nobody can do that. But they can prolong the attitude that you have about the place, they try to make you accept that without telling you. They don't come out and say you're going to be here until you die. They come and interview you and put it in your mind that you ain't going no place. You is here for the rest of your life.

Elaine Without actually telling you.

Brian Right. They let you realize it by yourself. And if you do that, you're okay. If you try to fight it, you'll fight a losing battle. And no one else can lose, you can lose the battle and still win the war. But who wants to lose that battle? And nobody can tell you that you're winning or losing, you've got to realize it for yourself. [Interview Two]

The awareness that life was slipping away, regardless of how he tried to fight and resist, was part of accepting the body and institutional life.

They [new residents] fall into the routine. If they're not fighting it, they fall into the routine. Which is a good thing. You can't fight so go along. If you fight it and you lose, it'll only break your heart. You have to give in to aging and if you give in. Some people say you're giving up on life, but your life is giving up on you. [Interview Three]

Brian I think, Elaine, I've accepted change enough to know, that all I'm fighting, if I want to fight, all I'm fighting is the obvious. It's the not so obvious, the things that sneak up on you. Such as age. You don't know when you go out here today, that you're a day older than yesterday. Because it hasn't come to you. And to anybody your age, it's a different life because you move into it. And after being in a building like this for a period of time, let's just say three or four months, unknown to you, you have changed. And you accept that changed...unconsciously, subconsciously, in your thoughts that you don't use all the time, there's a change happening.

Elaine So for you, the whole coming to terms with everything, and accepting everything isn't just about coming here, it's about accepting—

Brian Life in itself. [Feedback Interview]

Accepting the body was a process that occurred for residents after coming to Ridgemount. Not only did residents have to accept becoming bodies in Ridgemount Facility, they had to accept aging and unpredictable bodies along with an altered way of life that bore little resemblance to their former lives. While residents tried to accept this, they were also fighting this at the same time. The tension between acceptance and resisting or fighting was not completely resolved, although residents seemed to be able to live with this tension, rather than completely accepting the body. They understood at some level that it was better to give in and accept institutional life than it was to fight the changes. There was just no use in fighting anymore.

8.6.4 Re-Creating The Body

There were ways in which residents re-created their body identity in order to resist the assigned identity of being a body, which is the outcome of these institutional and (inter)personal processes of socialization. Residents re-created and redefined the body through alternative identities. These identities were not necessarily salient in every circumstance, particularly in interactions with staff, but they were shown to various people in certain circumstances. These alternative identities, or ways of re-creating the body, were varied for each individual, but of utmost importance.

When Edward became sick and had to depend on staff for help, he became very depressed and wanted to die. Being dependent on staff for all his body care needs was too difficult for him to cope with.

Elaine *How was that for him [when he was sick]? Because he was so independent before?*

Jennifer *I know, and it was traumatic for him. But we kept instilling in him that it's just because you're sick, and you're going to get better, and you won't need this. It's just because, you know, you can't get up, you're too weak, you can't get up to go to the bathroom all the time. and he himself was saying I'm having accidents and he didn't like that. That's why he wanted to die. Many times he would say, you know, this isn't good. And he wanted to die.*

Elaine *Like after he'd had an accident?*

Jennifer *Yeah, well, you know, just because he needed help. And he wants to be independent.*

Elaine *Good for him. What's his goal? To walk with the cane before his birthday?*

Jennifer *Yeah, exactly. What a man. [Jennifer, Nursing]*

Edward re-created his body by reclaiming the aging body. Since he was almost 100, he reclaimed his aging body as something that was not completely negative, but was something to be proud of. He wanted to reach his 100th birthday and walk with a cane. In this way, he was reclaiming his aging body identity as positive, rather than accepting the

negative connotations that are associated with age. He was also resisting having to succumb to only using a walker.

- Edward* *I don't figure I got too many more years to live. I'll be hitting 100 before the end of this year and I hope before the end of the year that I can walk around here with a cane. I've said I'll walk around with a cane.*
- Elaine* *Good for you.*
- Edward* *I may not be able to do it, but...*
- Elaine* *You're going to try.*
- Edward* *I'm going to try. And I won't fall down doing it. [Interview Three]*

Rachel refused to accept the relationship boundaries that were defined by staff and that contributed to becoming a body, and viewed her relationships with most of the staff as being very close and friendly. She claimed an identity as being different than other residents, and it was because of this difference that staff were friends with her. She did not accept the boundaries of staff relationships which defined her as a resident, as a body, and as similar to other residents. The focus on the body in the staff-resident relationship was expanded to a more personal relationship, thus allowing her to recreate an identity beyond being just a body.

- Rachel* *Yeah, and I've got to know a lot more people. The nurses, I like all the nurses. They're good to me.*
- Elaine* *Yeah. They all seem really nice.*
- Rachel* *They spend a lot of time talking to me because they said I'm the only one they can talk to.*
- Elaine* *Yeah, there's not very many they can have a good conversation with.*
- Rachel* *That's what they said. [Interview Two]*

Rachel's relationship with staff included the nurses taking extra time to paint her nails, which was not done for every resident.

- Rachel* *I'll have to see if my nurse comes back tonight. She should be in tonight. Her and my son sat here and laughed and talked, 'cause my son knows her dad. They used to party together in Longhill.*
- Elaine* *Oh wow.*

Rachel *And they were sitting here laughing and talking, and then she put me in the corner. And I laughed and said good for you. She's good to me.*

Elaine *That's Victoria?*

Rachel *Yeah. She comes and does my nails. She done them after she was done work at night.*

Elaine *Oh, isn't that nice?*

Rachel *And the old ladies, that bothered me at that other table, says I don't know how you get your nails done all the time. I've been here for three years and I've never had mine done. Maybe if you were nice to people they'd do it.*

Elaine *I was going to say, it probably helps...[Interview Two]*

Elaine *So how do you think Rachel your relationship with the staff is?*

Rachel *Good. I get along good with the staff.*

Elaine *And how do you think they think? I know you said they liked you before because they could have a conversation with you.*

Rachel *Yeah.*

Elaine *So do you feel like they know you?*

Rachel *They often come in here and talk with me.*

Elaine *Do they? Rather than come in and just help you and give you care?*

Rachel *In the evenings they'll drop around and sit on my bed and talk to me.*

Elaine *That's nice. So it's more than just them helping you with stuff.*

Rachel *Yeah. [Interview Three]*

While Rachel said she had a very close relationship with the staff, I am not sure to what degree this happened since I was not able to witness care interactions. One staff, Martha, stated that she didn't think Rachel had any particularly close relationships with nursing staff.

I've never seen anybody take a special, real liking to her. And I don't know if that's the right word, but I don't know. But maybe because she is so independent and knows what she wants and can say it. That she was not one they really maybe worried about, right? So, I don't think anyone's necessarily gone out of their way that I've seen. [Martha, Recreation]

The nursing staff that I interviewed stated that Rachel had adjusted well to the facility and that she was co-operative and pleasant to staff, but did not discuss any close relationships that were formed between her and staff. Since I was not on the unit all the

time and did not have a chance to observe care interactions, I am unaware of the status of her relationship with staff. However, Rachel felt that she was very close with the staff and this was an important part of her identity. Being close to the staff was a different identity than other residents could claim, and it also created an alternative identity than simply being a body as assigned by staff and the structures of the institution. Rachel's relationship with staff went beyond the body, allowing her to create an alternative identity to the body in this interactional context.

Rachel also re-created the body by focussing on her appearance, and continuing many of the beauty routines that she had previously maintained. While she required some assistance now, she was still able to maintain things about her appearance that contributed to a sense of well-being. She always liked to have her hair done and make-up on, as well as her nails painted. In this way, her body was not one simply in need of care, but was also a body that could look its best, despite being old and disabled.

She said she always used to take care of her nails, and put nail polish on them about twice a week. She said, "It's important to look good. Some of them don't care at all about the way they look." I replied, "It makes you feel much better about yourself, doesn't it?" "Yes", she agreed. [Field notes, December 3, 2005]

After I finished her nails, she looked at them and said, "Oh, that feels so much better. I can go out now." Later she said, "Oh, that feels so much better. I feel more like myself now." [Field notes, March 13, 2006]

Staff mentioned the importance of appearance, particularly for female residents.

And they don't, like I shouldn't say they don't care, staff doesn't care, but it's not the same as their own appearance. They just think they're not going out anywhere, so if their hair isn't brushed properly, or their oral health care...Because it's about personal care. It's about appearance. It's about looking well and feeling good. [Karen, Recreation, Initial Interview]

Because if you look up, and they see themselves at 25. How do you see yourself now? And we even do that. We look at a picture and say, wow, were you ever beautiful. And I've said that. So does that mean I'm saying you're no longer

beautiful? Or beauty is in youth? We get caught up in that. And isn't that our society anyways? I mean, everything is for the young, and you're only beautiful until you're 30, and then, so, and I think we're guilty of that as staff too. That we see that. That we see the beauty and now they're just here. [Karen, Recreation, Initial Interview]

Brian found his alternative identity in focusing on his mind as the primary body identity. Since his memory was good, this was the counter-narrative to his body. In this way, Brian also defined himself as different from other residents. In defining difference from other residents, these participants were also able to re-define themselves as different than the bodies they were made into. Brian defined his body-identity as his mind. Other residents were confused and not able to carry on conversations, and as such, were very different from him.

Brian *But that's typical of the people. There's no way to carry on a conversation. Mostly women around here. Some men. No way you can get close to them to talk to them.*
Elaine *Which must be hard for you if you don't have anyone to talk to.*
Brian *You try to talk. You say hello. They smile back. It's not much of a conversation. [Interview One]*

He then went on to describe the accuracy of his memory, which differentiated him from others.

Brian *Because you're, like, my memory is crackerjack. It's A-I.*
Elaine *It's amazing, yeah.*
Brian *They test it every now and then, you know. [Interview One]*

When he described other residents, he described them quite differently than himself, and stated that he could not have a conversation with them.

I asked her her name and she just looked at me blank. She is pretty well typical of the patients on this floor. ... But that's typical of the people. There's no way to carry on a conversation. Mostly women around here. Some men. No way you can get close to them to talk to them ... You try to talk. You say hello. They smile back. It's not much of a conversation. [Interview One]

He then described in the second interview how his body was sick but his mind wasn't, which differentiated him from others who could not even carry on a conversation.

Can't move. And you don't want to accept that. If you're sick and your mind is as sick as your body, you accept that. My body's sick. My mind's not. I say it's not. It might be. [Interview Two]

Brian I came in here with the idea that I'm better than the person over there. That's not the case.

Elaine Well, you certainly are different than a lot of the people here.

Brian Yeah, when you get down to the basics of it, it's almost the same.

Elaine Well, that you need a little bit of help. But in terms of your mind, your mind is still very active compared to a lot of people here.

Brian Yeah. I've been ah, my memory's A-1. [Interview Two]

By this second interview, Brian seemed to view his body as the same as others, yet his mind was very different from other residents. As he stated above, "...when you get down to the basics of it, it's almost the same." In some ways, he accepted the identity imposed on him of being a body, as other residents were bodies, yet re-created the body by claiming an alternative identity in which his mind was prioritized. "I've adapted my life to this way of living. And the only thing I haven't changed is my thoughts" [Feedback interview].

Brian also talked a lot about memories and the role that memories played in the maintenance of his identity. Because Brian's re-creation of the body was a focus on the mind, memories played a significant part in this re-creation in that he spent much of his time in his memories.

Brian The memories are sharp as long as you have the thing that caused the memory close to you. I find that if, as in the case of my wife, I never miss her when she died as much as I missed the dog going down. Now that might sound strange, missing your dog more than your wife. But the wife was remote to me in the last six, last couple of years. I couldn't get to visit her and she didn't want me to come and visit her because she knew how hard it was. So I only saw her once a month or twice a month. And the memories are fading at

that time. Even though memories are being built, they're fading at the same time. Now I miss her, but I'm starting to live another life. Like you say a small room. And I'm not the only person. But ah, you have to think about a thing before you get the memories.

Elaine *So the process of everything changing and missing your wife happened long before she was gone.*

Brian *Yes. Yeah. See a year ago last month I was in Sunview Home, and that started the whole thing. It's been a year and a half we've been totally apart. Sure, the memories now are shorter. They're greater but they're not as often. My niece brought in a little Labrador dog the other day. Looked just like Shadow. The memories came back then. And I remember her too because we had to put her down. Right in the final part of her life. So I remember the good things about her. [Interview Three]*

Brian did not like having personal pictures in his room. He felt that memories as an active part of his life were better served without pictures, since pictures only served as a snapshot, while his own reminiscing allowed him essentially to relive the memory again.

I remember my sister saying, she didn't particularly care for a camera. Why not? Well, a camera is a fake piece of your mind. You look at those pictures to remember something. Because a picture's a past. You look at it and you remember something. She said if you can't have a picture in your mind of what you saw, then you're losing something. I'm the same way. I don't like it. [Interview Two]

Brian *Memories are something that you make, or memories are something that can fade. You never lose them unless you've got a disease to make you lose them. But you realize you can only take them so far. All the pictures I had, like Doris and I had, they're all gone. There's no point in*

Elaine *You didn't keep them?*

Brian *No. I never believed in the camera. I, memories are in your brain, your mind... I never believed in pictures. Pictures only remind you of one time. they don't remind you of your full past. Memories are in your past, they're not in your future. And if you have an active mind, your memories are better than pictures. Pictures are something that if you were to rehash, something to bring back a memory. You'll notice I don't have a picture of my wife here.*

Elaine *I noticed that.*

Brian *She had a picture of me. On the dresser. But I didn't have a picture of her. There was a picture of our wedding picture, that's all. I never really, like, we shot a deer one time. A young fellow and I shot a deer one time and we thought, it was a huge animal, and I*

believe now it was almost a champion. We never took a picture. But I still got the memory of that in my mind. I can go through the whole thing from stem to stern. We get in the deer and clean him, how big he was. How big the horns were and everything. Never had a picture. Can you put my legs up here? Memories you can only take so far. My sister used to say, you can only take them to the grave with you. You can't take them in the grave. She's right you know. [Interview Three]

As evidenced in this following quote, Brian's memories were so alive in his mind that he could envision himself in another place. He was not only remembering, but reliving his memories in place.

Brian Yes. I still, it's May June July. April May June July. Pretty near four months since we put her down. I'll still see a shadow on the floor and think it's Shadow. I'll read something in the paper and think gees, I'll go and tell Doris. And I haven't been able to do that for a year and a half. Time drifts by and you realize you can't stop the clock. You realize time goes by. Like my wife died June the fourth. Today is July 10th?

Elaine 11th.

Brian Nine, ten eleven. It's a month and a week. And it's still in my mind that she's in the next room. Or like my young lad came in yesterday, my niece's son. Brought me a ... pile of shorts. And ah, he said I gotta cut the grass. I can envision him cutting the grass around here, I still think this is home. I still think in my mind this is the house. [Interview Three]

Brian described how he treated his past as an active life, and by doing this, he was able to go with the flow and change with the times.

Well, I try not to dwell on them, but you can't help thinking about them. And I'm the kind of a person that, I've got a good memory. But again, I don't dwell on the memory. I treat my past as an active life. And I have always tried to live unconsciously, tried to live every day as if it were my last. I didn't think of it that way, but I was very active. That's probably one of the reasons why I don't get too lonesome because I kept changing with the times. I cannot say consciously. It wasn't as though I was trying to. I just went with the flow. My memory served me well. [Interview Three]

There were many ways that residents re-created the body to redefine an alternative identity to being a body. In many ways, focussing on the mind as a manifestation of self

Edward *Oh, I tried it for a while, but...the lady was in this morning wanting me to go, and I said no. And I hated to, I like that exercising. It's good for ya'. Of course, that's all different from the work.*

Elaine *Because you go for walks during the day a lot for your exercise?*

Edward *Oh yeah....*

Elaine *So what about the other activities here? I know you've got your calendar up here. Do you go to a lot of the programs they offer here or just here and there?*

Edward *Just here and there. I look out over as soon as they put a new calendar up. There's so much on that you can't remember and you just put a little mark on whether you're interested in or not. That's it.*

Elaine *So what do you usually go to? Music events?*

Edward *Well, today I went to the sing-song. Well that was only for 20 minutes. You might go and walk or something. I do quite a bit of walking. I used to do a lot, but the last three or four days, I haven't walked near as much as I should. But it's just that I got lazy. I've had me but I find I can't walk as much as I used to. I've got to give up a lot of it. [Interview Three]*

While Edward's walking did slow down somewhat due to his unpredictable body, he still walked three to four times a day around the unit. The programs that he attended were often the big events in which Maybelle would be attending too, so they could participate together. In this way, he also reinforced the identity of being a spouse and being Maybelle's husband. Whether this identity was intentionally reinforced or not, the outcome was that everyone, including many residents, knew that Edward and Maybelle were married.

Joyce brought Maybelle up to yoga. It was probably about quarter after two, 2:30 by the time Joyce brought her up. When I asked Joyce about it later, she had stated that Maybelle had gotten up out of bed and was asking where Edward was. So Joyce, although she had a music program, took her right up to see Edward. We made room for Maybelle beside Edward so they could sit together. She smiled when she saw him and said hello. [Field notes, September 22, 2005]

Rachel attended most of the recreation programs that were offered in the facility.

Recreation played a number of roles for her. One role was helping her to adjust to the

facility. As she stated earlier, participating in recreation programs helped her to adjust to the facility by getting to know people.

However, participating in programs also offered her opportunities to become close to the recreation staff, thereby claiming an identity of having a close relationship with the staff. Recreation programs allowed her to get to know many people, both residents and staff, in order to develop those relationships.

You meet a lot of people when you go to therapy and exercises and, I go to everything. [Interview Two]

Elaine *Yeah. So um, in terms of the other residents here, have you gotten to know some of them and made some friends?*

Rachel *Oh yeah. Yeah. I know a lot of the women.*

Elaine *From where? From going to programs? From the dining room?*

Rachel *Bingos and that. And the dining room.*

Elaine *Do you have anyone that you meet outside of programs, or is it that you just kind of see them in programs or in the dining room?*

Rachel *Yeah. [Interview Three]*

Rachel especially had a close relationship with Johnny, one of the part-time recreation staff. She described how he makes an effort to ensure that she attended programs.

I go to all the entertainment. I go to Bingo. I take in pretty well everything. Johnny makes me. He's a big guy. And when he comes here and says come on, we're going, we go. [Interview Two]

Brian refused to attend recreation programs. Since his alternative identity was based on his sharp memory and his bright mind, and he viewed himself as being so different from other residents, coming to recreation programs would have reinforced the identity assigned to him by the institution and may have defined him as similar to other residents.

Brian *It's not a routine, but it's a, strictly a one man routine. They come and invite me to go down and play Bingo, and that doesn't excite me...*

Elaine So you don't go to any of the programs, well, obviously not Bingo which I can understand.

Brian They have a sing-song, but I'd rather not. [Interview One]

Elaine You're not much into the activities, are you?

Brian No, I'm not a bingo player. See, my mind hasn't slowed down.

Elaine I know. And they're geared towards a certain type of people that you don't fit.

Brian Yes. You can't, they couldn't be geared to me or to a person with a fast thought. Instead they're geared to a person with a slow thought. They have to find a happy medium and sometimes that's not there. [Interview Two]

Brian, however, did pursue his own activities that helped to sharpen his mind and connect him with the outside world, such as reading the paper, watching the news, watching sports, reading magazines and books, and thinking.

Brian Oh yeah, I'm accepting it. It's tough though. As long as you keep your mind active and you don't have to go on no job to get your mind active. You can keep your mind active just by reading and thinking.

Elaine Keeping up with the news and everything, which you do, right?

Brian Yes, as long as you keep your mind active. You'll find it's not so boring. [Interview Three]

Recreation, then, as planned and structured by the facility, played a part in socializing residents into the long-term care environment, thus contributing to the process of being made into bodies. Recreation also played a part in re-creating the body for some residents. Thus, the recreation programs that were provided for residents were consistent with some residents' identities while other residents refused to participate because they were not consistent with an identity they had of themselves. Brian, for example, did not participate in structured programs because they were geared toward people with a slow thought, which he was not. Leisure opportunities, as initiated and chosen by the residents in structured and unstructured formats, provided opportunities for residents to reinforce alternative identities and maintain desired identities.

8.7 Helping to Adjust to an Altered Life

Staff talked about the different ways in which they helped residents to adjust to living in the facility. These included encouraging involvement, making home, maintaining independence, and choice within structure.

8.7.1 Encouraging Involvement

Staff encouraged residents to get involved in various activities in the facility. One way of getting involved was socializing with other residents in the dining room.

But I find most people that are independent want to get up and be in the dining room and socialize. The whole aspect of socializing with other residents. [Glenda, Nursing, Initial Interview]

Staff attempted to sit residents together who had similar functioning levels or who they felt would get along.

And they try to be very careful who they sit them with in the dining room too. You know they kind of try to judge their character. If they're gonna be messy um not messy that's not the word I wanted to say. If they're a feeder, if you have to feed them then they try and sit them at an appropriate table. If they're gonna talk lots and converse then they'll try and sit them with somebody they can have a conversation with. [Mary, Nursing, Initial Interview]

Well, again, including them at programs. And the really big thing is at meal times, trying to get them social. Sitting them with people that you think they may enjoy, and assessing that and maybe changing it. They spend three times a day, that's over an hour a day with these people for how many years? If they're here that long. That, this is their home this is where they're going to be. Mealtimes, it's like your own dining room, so you would think that starting there is going to definitely get them included and the whole feeling of being at home and interacting with everyone. [Joyce, Recreation, Initial Interview]

Staff also encouraged residents to get involved in recreation programs as they viewed them as being important to the adjustment process. Many of the staff, including nursing

staff, talked about the importance of recreation programs, particularly as a place to get to know others.

...then they would typically go seeking out activities because action, there's been action since probably five or six in the morning. So it's like a good part of their day is done you know so they, I really do enjoy the um group um, I don't like the name, I don't like Morning Group, I think we gotta come up with another name for that because it's more news and views keeping them in tune with the community, what's going on in their local environment and the world like New Orleans, those kinda things you know. So, and they do simple range and motion exercises, but the important part of that activity is the um camaraderie and the communication and the link to current events...the majority of people want to attend some kind of activity in the afternoon because it's social. [Colleen, Management, Initial Interview]

Other ways of getting involved included helping residents make friends and having familiar faces around the facility.

It's nice to see, it's really nice to try and buddy them up with somebody for the off times so they recognize them and then they have like a friend. Everyone needs people, then they have somebody. Say they're having a bad time and they see that person in the living or dining room. They say oh, that's right I'm supposed to be here and that's my friend. Or maybe not. [Joyce, Recreation, Initial Interview]

...try and buddy them up. If you can buddy them up with somebody, that really helps. [Mary, Nursing, Initial Interview]

8.7.2 Making Home

Making home consisted of staff and families bringing in possessions from home and trying to make residents' rooms look "homey".

We try to remember some of the furnishings that are gonna honour their memories, things that they, they had in their kitchen for example, those kinda things so, so um you'll see examples of that on Plaza 1, we've just started there where we're kinda getting we've put the corner cabinet in there, those little things. [Colleen, Management, Initial Interview]

I think easiest for them to adjust to is probably their room. So that I, I encourage them to have their own pictures, their own furniture, having some familiar things. Like have lots of pictures. Have as many pictures as you want. Have the whole place covered in pictures. Have music that you like. Have your own TV. Have

things that are familiar to you. Like if you liked to play chess or games, make sure that you bring those with you. So things that are familiar to them and that make them really feel good. Like one of the residents had a computer. Bring it in. Bring the computer in. Or you got a favourite lounge chair. Bring that in... Yeah, because that makes it familiar, and it makes it a safe place for them because it's something that they can recognize and making sure that their name is on the outside of their door, and if they can't read it, then we've made sure that their name is bigger on the door if they're not able to see . so yeah, I think that's probably one of the most important things. [Glenda, Nursing, Initial Interview]

There was, however, a perceived tension between making home as consistent with the meanings of their past home and the rules and regulations of the facility.

If I sat in a resident's room, what would be their perception of you know "My home was like this and this is like this" I'm not too sure how they would feel about that, certainly different for them. Um you know that we let them know to bring in articles from home, pictures, you know a favourite chair, what is it gonna be, everything that they would like to have here no, no. So that might be just a little difficult, so they love the facility, they think it's great. Is it what they would think they would have their home look like, probably not... Kinda like when you can't have your favourite rug here or you know you can't have "Boy, if they saw my house on a Friday" just sheer chaos and you know you can't have that because you know housekeeping needs to get in to clean and you know we don't want anyone falling or tripping or again we're kinda the rules and, and um things come into play but, but certainly encouraging some of their lifestyle in the past to be in the home with them. [Darlene, Management, Initial Interview]

8.7.3 Maintaining Independence

Maintaining independence was another way staff tried to help residents adjust to the facility.

I'm in a wheelchair but, you know you can get yourself from point A to point B or you know let's keep your arms strong or your legs strong or you know standing to go to the washroom or just, trying to focus on maintaining the abilities rather than the disabilities. And again there's frustration in that but I think that staff are, again very sensitive to let's promote or encourage what they can do. And it's all around that whole independence issue. You know like you might not be able to do this but you can brush your hair or just small little things that can have value in the resident maintaining that identity... I still believe in that. Do we do it every day? I'm not too sure. I still believe in it you know. [Darlene, Management, Initial Interview]

I think it's to try and maintain as much independence as you can. I know it takes longer to get the resident to brush their teeth by prompting but you know it's something that they can still do for themselves. [Eleanor, Nursing, Initial Interview]

While staff described maintaining independence, the lack of time in which to complete tasks may have interfered with this since maintaining independence typically requires an investment of time. Residents did not mention maintaining independence; in fact, Brian described how staff just did tasks for him. Staff may perhaps believe in the importance of maintaining independence, but may not be able to practice this because of time constraints.

8.7.4 Providing Choice Within Structure

Some staff attempted to give residents as much choice as they could possibly allow while still maintaining the structure and routines of the facility.

So anyway they may go to bed earlier than what they want or we do have um particularly Floor Three we have a large number of residents who like to stay up later. So in all fairness we've had to almost develop a rotational system where everybody gets that opportunity at some point because otherwise what do you do. Pick names literally because we just don't have the nurses available. We have two nurses available after 10:00 o'clock for the most part. Some floors are three but that's not a lot and then you've got breaks there. Yeah so they go to bed earlier than what they want. [Colleen, Management, Initial Interview]

And I think in explaining that too for volunteers and staff we try and meet the individual needs of each resident. Within some general schedules that just kind of have to fit...I think it might not be the way they want things, but I still think they have choice within the routines...So I don't think it meets the needs of 150 residents that live here into the way that they probably lived their lives, but I think they adjust within those schedules. [Darlene, Management, Initial Interview]

Providing a flexible routine and trying to meet individualized needs were ways that some staff attempted to provide some choice within the structure of the facility and

help residents adjust to the long-term care environment and accommodate residents as best as they could.

You know we try to provide a similar routine, you know if they were allowed, if they didn't get up until 11:00 we just try to maintain that same thing, you know try to individualize as much as possible their care, you know provide, try to give them some sort of a preference or some sort of. [Eleanor, Nursing]

So when you do that, you're not so, we don't have to be in control. This isn't about us being in control. This is about kind of going with what they want. I mean there's rules and policies and procedures here, but what it really comes down to is them. It really is their needs that need to get met. And we need to go with that. And their independence. That's what I find. [Glenda, Nursing]

Despite staff's discussions of the many things they did to provide flexible routines and choice, residents still felt that they had to conform to a rigid routine, as described earlier.

While it may appear that the routine was somewhat more relaxed at the beginning after admission for residents, Brian's experience suggests that this was not the case, as staff expected him to sleep in his bed instead of his chair and expected his attendance in the dining room for meals.

...they're pretty easy going with not following a strict routine in the beginning. Like OK, we'll let you sleep in and then you let us know when you want your breakfast. [Mary, Nursing, Initial Interview]

While staff discussed these numerous methods that they used to assist residents in adjusting to the facility, residents did not discuss any of these methods for helping them adjust. In fact, they did not discuss the role of staff in helping them to adjust to the facility at all. The role of staff, from the residents' perspectives, was to help them with their body care and to help them conform to the routines and the regulations of the institution. Thus, there seemed to be a significant disjuncture between staff's ideas of assisting residents to adjust to the facility and residents' descriptions of their lived experiences.

8.8 Making Institutional Bodies

Making institutional bodies was the ultimate outcome of the socialization processes that were earlier described. *Making institutional bodies* implies a number of things, simply by the words used in this phrase. *Making* implies that bodies are made in interactions and discursive environments, rather than created in isolated settings. As evidenced through these socialization processes, the making of institutional bodies occurred in interactional contexts. Bodies are not simply made through spoken language, but through body language as well. The care encounter was a significant site in which residents were made into institutional bodies, both through interactions, body language, and discursive environments. *Bodies*, of course, captures what residents become and the disregard of the psychosocial aspects of residents with the sole emphasis on the physical body as an object. The body is not seen as an experiencing subject, but rather as a receiving object—receiving of physical care and medical treatment.

I think that whole, part of that to me would even be how people start to feel that they're just a body. Where I hear residents are saying staff are rough. And they may not realize they're being rough. But it's that whole sense of just seeing people as bodies. And rolling people over and moving people and to bathe them or to do whatever it is that they're doing. [Karen, Recreation, Initial Interview]

Thus, residents are *made* into *institutional bodies*. In essence, the theme *making institutional bodies* captures what residents become once they are socialized into the long-term care environment. Bodies conform to the institutional environment. It does not, however, necessarily capture how residents view themselves. Residents seemed to be aware that staff viewed them as bodies, and indeed, staff even described this. However, as evidenced by residents' ways in recreating the body, being a body is not a fluid, stable,

and predominant identity at the exclusion of the self. The self is still very much present, alive in history and memories, situated within a biographical context (Gubrium, 1993).

The institution, however, does not recognize this self, and the focus on functioning expediently and instrumental rationality creates bodies.

I think sometimes because nursing is an entity in itself, I think that the mindset is that I do nursing care. I don't need to know all of this other stuff. All I need to know is this. I think when you're working with a human being, it cannot be just one thing. Because they're not one thing. I'm not one thing. I'm not just a physical body. [Karen, Recreation, Initial Interview]

So you're right. In a sense they have lost, we have forced them to lose their humanness when they come into long-term care. [Karen, Recreation, Initial Interview]

In summary, then, institutional processes and (inter)personal processes made residents into institutional bodies. While these processes manifested themselves in different ways for different residents, there were processes that occurred due to the structure of the institution that seemed to be common across these three residents. Dismantling of the self and the context of the move were factors that affected the socialization process prior to admission. Institutional processes included placing the body, defining the body, focussing on the body, managing the body, and relating to the body. (Inter)personal processes included internalizing the body, accommodating the body, accepting-resisting the body, and re-creating the body. These processes came together to make residents into bodies, although residents found ways to resist the body and re-create the body. While residents were living within structures of power, there were also instances where residents were able to resist these structures and find ways to define alternative identities. The socialization process, then, into long-term care is complex and intricate, involving many different people, different places and spaces, different bodies,

and different selves. The socialization process takes place on different levels, including an institutional level, an interpersonal level, and a personal level. Brian summarized the socialization process with this quote:

*You know, you live 79 years of your life free. I have come to think in some way, in quiet time, I have come to think of how, I hear on the television that someone was tortured. And it makes me wonder how long does it take to break a person? Now they're not torturing me here. And it's not part of their subconscious. But very silently, very quietly, very sneakily, I'm being trained to live in a solitary confinement way... You get a chance to adapt if you play the game right. And allow the adaption through, to work itself out. You'll be better off for it.
[Feedback Interview]*

CHAPTER NINE: DISCUSSION AND CONCLUSIONS

The findings of this research expand our understanding of the body, self and identity, and place within the context of the long-term care institution. In this chapter, I use recent literature and research to situate the findings of this research and provide context. I then expand the findings into a theoretical discussion. The findings provide a greater understanding of life within an institution and of socialization into the institutional culture. I first discuss adjustment and socialization, and then discuss the locational context of socialization, the interpersonal context of socialization, and the corporeal context of socialization, before further theorizing on these contexts together. I then discuss recreation and leisure as well as gender issues in the institution. Practical implications, future research considerations, and limitations of this research follow.

9.1 Adjustment and Socialization

As described earlier, this research study was focussed on the socialization process as the process by which we learn to become members of a society by performing social roles and internalizing the norms and values of the society (Marshall, 1998). Adjustment, as the adaptation to a particular environment or set of relations, was a part of examining this process of socialization (Colman, 2001). The process of admission to long-term care facilities has been examined in the past specifically focussing on the adjustment and adaptation process. Many of the factors that impacted adjustment, such as past experience with institutions (Porter & Clinton, 1992), internalizing the admission (Wilson, 1997), and the perceived need of admission (Porter & Clinton, 1992) were evident in the present study. Residents' adaptation at Ridgemount was also impacted by past institutional

experiences and the perceived need of admission. This perceived need of admission, however, did not necessarily appear prior to or just after admission, but instead was a process of reflection, particularly in Brian's case. Kahn (1999) found that residents "made the best of it" and that residents felt ambivalent toward their situation in long-term care. Rachel, Edward, and Brian all spoke of positive aspects of Ridgemount, but did not necessarily feel ambivalent toward the facility. Indeed, their feelings seemed almost paradoxical at times, such as describing the facility as a nice place, yet describing many negative aspects of the facility and of life in the facility. Thus, the participants in this study did not adjust through ambivalence, but instead created and accepted paradoxical meanings of the facility simultaneously. Whether residents simply adapted to life in the facility or actually adjusted could perhaps be argued. Adjustment, defined as getting used to another way of life, was not necessarily a term that I would use to associate with the residents' experiences. Edward, for example, became more upset as time went on over his separation from his wife, although he had learned to live with it. Brian discussed relinquishing his past life as a door that has closed and will never open again, but yet discussed his past often and discussed both his acceptance as well as his resistance to life in the institution. Thus, adjustment may not necessarily be a term that describes the full experiences of the residents. Adjustment to institutional life has a complexity about it that is not fully described in the literature.

Adjustment is often seen as a process that becomes complete and finalized, a process with a number of stages that residents progress through (Wilson, 1997). Indeed, any specific phases of the process were not evident in these participants' experiences. Adjustment was also not a complete and finalized process, and by the end of the data

collection (six months post-admission), the adjustment process was not complete. Brian stated that he hadn't adjusted yet by the second interview, and that he never would. "I'll come close, but I'll always reserve a bit of independence" (Interview Two). By the third interview, he stated, "*You can't stop aging, so you might as well accept it and do what you can.*" Brian had come to accept that this was the way life had to be, though he had not necessarily completely adjusted to his new and more limited life in the facility.

Adjustment also wasn't necessarily voluntary, but as Rachel stated, "*I just come to make myself believe that this is where I gotta stay, so I just gotta adjust*" (Interview Three).

Residents had adapted to day-to-day life, but had not necessarily adjusted psychologically to the immense changes in their lives. Coming into the facility and adjusting to it also meant adjusting to the finality of life, as described in Section 8.6.3 Accepting-Resisting the Body. Brian described it as "fighting a losing battle." He also stated, "*If you fight it and you lose, it'll only break your heart*" (Interview Three). Thus, adjustment as a complete process does not necessarily apply to the residents' experiences in long-term care, but adjustment as a term of complexity and paradox, as accepting and fighting, as clinging to life and yet seeing life slipping away, is perhaps more reflective of residents' experiences. Adjustment may never be finalized.

The socialization process, on the other hand, occurred in different contexts and was a much more complex and diverse process than adjustment. An embodied approach to understanding institutionalization, the experience of living in an institution, and the socialization process into the institution has furthered our understandings of these experiences and processes. Taking a phenomenological approach to understanding institutionalization and socialization into the institution has provided greater

understanding of experiencing bodies, experiencing bodies in place, and experiencing bodies in relationships. In this study, institutional bodies were created within different processes. Conceptualizations of the body within institutionalization were then internalized and resisted. In the following discussions, I theorize about the places in and through which bodies are created and the types of bodies that are created. Each of these sections will also include relevant discussions and critiques from the literature.

9.2 The Locational Context of Socialization: The Institution

The institution was the locational context for the socialization process. This location was not only a physical environment, but also a social environment, and these environments had certain values attributed to them. The locational context will be discussed after a literature review on the organizational context of long-term care.

9.2.1 The Nursing Home from an Organizational Perspective

The nursing home as an organization is guided by sets of rules, regulations, and policies that here in Ontario, are put into place by the Ministry of Health of Ontario. Previous ethnographic studies have discussed the regulations imposed by government bodies. Diamond (1992) discussed how state officials were rarely present in the setting, but “exercised a documentary power of presence” (192). That is, documentation and records made the events of everyday life countable, and as such, the facility was reimbursed based on these records. What Diamond did not discuss in detail was how the policies and regulations structured the documentation and records. He discussed the role of documentation and records as tools within the institution that structured everyday life,

but not *how* the regulations structured the documentation. In essence, it was not the documentation and records that structured the events of everyday life, but it was the regulations and policies implemented by bureaucratic hierarchies and government bodies that structured the events of everyday life. While the residents themselves were not aware that these regulations and policies were implemented by the MOH, staff members most certainly discussed in detail how these policies and regulations imposed a set of rules upon them which they had to follow in their day-to-day encounters with residents. Indeed, much of the socialization that the residents described were the government policies structuring staff responsibilities and interactions with the residents, although residents weren't necessarily aware of where exactly these policies were coming from. As Diamond (1992) states, "control by absent authorities permeated everyday life" (pp. 192-193). Gass (2004) wrote an interesting memoir on his experiences working as a nurses' aide in his book, *Nobody's home: Candid reflections of a nursing home aide*. While this was not scholarly research, his reflections on his experiences working in long-term care resonate with my own experiences in long-term care. He stated that most nurses' time has to do with protecting the institution against litigation, rather than focussing on residents' health or nurturing. "I surmise that the threat of malpractice is by far more central to our operation than the residents' control over their own lives and property." (p. 151). Indeed, nurses' time was structured by the demands and regulations of the Ministry and the facility which was focussed on risk management, rather than on residents' needs. The control of the institution by the government and regulating bodies structured every aspect of day-to-day life from what residents were given to eat for meals, to eating meals in the dining room, to the care provided by staff.

Paterniti (2000; 2003) in her ethnographic study of a nursing home, described in-depth the culture of the nursing home and how it impacted residents. She found that residents were perceived by staff as “bed and body” work. Residents were categorized according to their level of care and functioning, and related to based upon these categories. In the present study, staff constructed residents as bodies. Upon entering the facility, the process of becoming a body was started. Numerous assessments needed to be conducted in order to determine the residents’ functioning levels and “impairments”, in essence, what staff needed to do for the resident. Because of the time shortage, staff described doing for the residents what they could often do for themselves, despite supporting an ideology of maintaining residents’ independence. This created dependence in the residents, and residents learned to submit and accommodate their bodies to staff routines and schedules. While the routines as an important part of managing the body were described in Paterniti’s (2000; 2003) study, other strategies were not. Other strategies mentioned by the residents in this study involved managing the body and defining the body, which included risk management, waiting for care, and assessments. In essence, all of the structures of the institution from bounded relationships with staff to waiting for care were used to manage the body. This study furthers our understanding of the process whereby residents become bodies, and how they come to be defined as “bed and body” work.

Other ethnographic research has discussed the impact of the structure of the institution on staff. Diamond (1992) discussed how the emotional work of staff was discounted as their jobs were made into a series of tasks that were ticked off at the end of the day. Henderson (1995) found that a cult of time and task forced staff to focus on

physical tasks and routines, and the psychosocial care of the residents was ignored. Staff at Ridgemount also described having to comply with regulations and management wishes. Further, however, they described how they had to suppress their ideologies of what “good care” looked like in order to complete their tasks day to day. Some staff described not feeling good about their jobs because they were not able to be present emotionally for the residents in ways that were meaningful. While this aspect of the research was not fully explored and was not the focus of the research, it was a theme that emerged out of some staff interviews. Further research needs to examine how staff are able to cope with the expectations placed on them by government bodies and management to complete tasks, while feeling the burden of residents’ emotional voids and being unable to address this within their day-to-day jobs. As Gass (2004) states,

All the affection, all the consoling, all the filling of emotional holes and the tidying up of frayed feelings are invisible to the owners, to the administration, and to the official state regulators who monitor us so closely. The heart is impossible to legislate, measure, or chart, but that, as we discover, doesn’t make it any less vital or real. I have never known of any aide being rewarded or recognized for being kind. Yet I see it around me all the time. In general I will trust the heart of an aide over any other kind of worker. I know this is a very broad statement, but so many aides are selfless givers, which means they are easily used. (p. 114)

Gass (2004) in his reflections on being a nursing aide, describes his care encounters, and how they have been structured by the task-oriented nature of the institution:

Our residents have nothing to do but focus on their pain. At times our halls become a veritable sea of moaning, crying, begging, and whimpering. It is simply not possible to alleviate the waves of pain, anger, anxiety, boredom, despair, and loneliness. If I have learned anything from coping with this work, it is the need to say no. Before this job, I would not have thought myself capable of hearing a helpless old lady beg for my attention and keep right on walking without breaking my stride. But now I do. I do it every day. At first it’s bothersome, then it becomes routine. But someone else’s needs are always more pressing. I came into this work believing that I had a substantial capacity for compassion. Now, just

like everyone else, I've met the limits of my emotional reserves. Under enough stress, I get short. My reserves run low. Sometimes caregivers give and give until they give out. (p. 70)

Gass's honest description of the demands of nurses aides characterizes my observations. I often saw staff walk by residents asking for help. The task had overtaken, and the needs of the person, much more complex and time-consuming than the task, had to take a back seat to the task. Consistent with this, Twigg (2000a) discusses how careworkers need to establish boundaries with care recipients because of the task-oriented nature of time. Staff had to manage the overwhelming demands of the institution and of the residents, and in order to emotionally survive, had to establish boundaries.

9.2.2 Toward New Models of Care and Approaches in Long-Term Care

There have been many models of care proposed and adopted in long-term care over the past number of decades. Initially, a medical model of care approach was utilized in long-term care facilities. In fact, many facilities still continue to operate within a medical model approach, albeit somewhat more subtly than in the past (Henderson, 1995). According to Henderson (1995), the task-oriented work of nursing aides and those who provide direct care for the body is derived from the medical values of time conservation and physical care. Psychosocial care is ignored and undervalued. Within a medical model of care, residents are organized in terms of their needs for care (Paterniti, 2003). Residents are viewed as their body problems, and are treated accordingly. Recognition has been growing of the negative effects of a medical model approach to care (Jones, 1999; Thomas, 1996) and since then, alternative approaches have been posited.

Other models of care have focussed on improving the quality of care and quality of life of residents through various means. Some of these alternative models of care include Kitwood's (1997) personhood approach to care, the Eden Alternative (Thomas, 1996), and the Gentlecare approach (Jones, 1999). Adopting various approaches to care have been advocated to decrease the negative effects of institutionalization. Lopez (2006a; 2006b) conducted ethnographic studies in three different facilities. In one article (2006a), he describes the ethnographic findings of one facility in particular. This facility had adopted what he termed "culture change management". In other words, the facility had adopted the Eden Alternative as an approach to care to eliminate residents' loneliness, helplessness and boredom through enlivening the environment (Thomas, 1996). "Advocates of culture-change management suggest that the right sort of managerial philosophy can transform nursing homes from impersonal institutions to safe, caring homes and communities" (Lopez, 2006a, p. 56). What Lopez (2006a) found was that culture change management cannot address structural problems of inadequate staffing. Indeed, the staff at Ridgemount discussed the low ratio of staff to residents, generally inhibiting their abilities and time to develop meaningful relationships with residents. Lopez (2006a) suggests that culture-change management may actually become part of the problem that focuses attention away from structural problems and encourages managers to blame front-line staff instead. In Lopez's (2006a) study, the positive features of such a managerial approach could not address the problem of the lack of time staff had to complete the number of tasks in the proper way required.

In the eyes of management, the primary obstacle to the creation of a caring community was not understaffing, or low wages, or an authoritarian attendance policy. Perhaps because there was not much they could do about these issues, managers preferred not to see them. It was, perhaps understandably, easier to

believe that the main problem was the work culture of the aides...top staff preferred the idea that too many of the aides saw the work as “just a job”; top management was concerned...that a “core group” of aides with “bad attitudes” was “controlling” the other aides...Culture change, in this formulation, no longer meant that management should engage in self-criticism, but served as a convenient device for blaming aides for the structural problems of the nursing home system. (Lopez, 2006a, pp. 75-76).

Ridgemount Long-Term Care Facility had not adopted any type of culture-change management philosophy. It claimed no person-centred philosophy, Eden Alternative, GentleCare, or other type of alternative care philosophy. The essential problem was still the same, however—staff did not have enough time to complete the scheduled number of tasks, despite the higher staffing levels at Ridgemount than at other facilities. While I do think it is extremely important to attempt to implement culture-change management philosophies, it is also important to mobilize staff, families, and residents to act politically to demand more staffing in long-term care facilities. Ultimately, the front-line staff received the discipline from management if tasks were not completed, and as such, they did bear the blame and paid the consequences for issues related to the structural problems of inadequate staffing.

While each of the above theories has many benefits and to some extent, some similarities, there seems to be a focus on either the physical environment as central or as relationships as central to residents’ and patients’ experiences. While these are both important components of people’s experiences, an integration of both the physical environment, relationships, along with a recognition of the cultural and structural factors affecting long-term care need to be recognized. In addition, the role of the body and embodiment need to be considered. An approach to care on an embodied and

phenomenological level has not yet been articulated, particularly with reference to long-term care.

As evidenced from Lopez's (2006a) study, culture change within the institution can only successfully occur when changes happen at a structural (i.e., political) level as well as at an organizational level.

9.2.3 The Institution as a Container for Life

The institution of Ridgemount, as similar to other institutions, was a container for life. Socialization into life at Ridgemount was placed within a locational context. This container forced everything within to fit and mould to its structure. The container allowed for nothing to exist outside of it. Everything within this container was defined by the container itself. There were a number of ways in which the institution acted as a container for life: through making institutional bodies, defining temporal dimensions, and living in a spaceless place. The container of the institution greatly influenced all the lifeworld existentials (Van Manen, 1997), including corporeality, temporality, spatiality, and relationality. Relationality will be discussed in the next section as the interpersonal context for socialization, while corporeality, temporality, and spatiality will be discussed next.

9.2.3.1 Institutional Bodies

The relationship between places and bodies has been discussed by few authors (Nast & Pile, 1998). Nast and Pile (1998) suggested that the ways in which we live out place/body relationships is political, hence the phrase the politics of location. Spatial

practices define bodies within structures of power. As I suggested earlier in my theoretical framework, the body cannot experientially be separated from place, since our bodies exist in place. Therefore, older adults who live in institutions have their bodies defined by the spatial practices of the institution, thus becoming institutional bodies. The notion of becoming institutional bodies can be approached in two ways—from a phenomenological perspective and from a structural perspective. From a phenomenological perspective, residents became institutional bodies as they learned to be-in-the-world of the institution. Their bodies also became imprinted by the structure of the institution, thus becoming institutional bodies.

As new residents coming into a facility, participants had lost a sense of place. Homes that had been lived in for decades were sold and familiar environments were dismantled. The experience of coming into a long-term care facility was preceded by the loss of place. While the loss of place is most often considered psychological (Groger, 1995; Rowles, 1987), this loss of place is also the loss of body-place knowledge. This body-place knowledge is not just familiarity in the cognitive sense of the environment or attachment to the environment, but refers also to the unconscious being of the body in place. Body-place knowledge refers to the pre-reflective body perceptions people have of their worlds. A change in place or environment means a change in pre-reflective body perceptions as well. The change in place from home to institution also meant a change in body perceptions as residents' bodies experienced a new environment. This change of place is the loss of 'being-in-the-world' (Merleau-Ponty, 1962). The loss of this embodied place or of being-in-the-world left residents feeling unsettled, as evidenced in their comments regarding finding one's way around and getting used to the sites and

sounds of the facility. It was a loss of bodies knowing how to be in the world. Coming into the long-term care facility was not simply experienced on an emotional, cognitive, or reflective level, but was also experienced on a pre-reflective, embodied level. Coming into a long-term care facility, then, required a relearning of being in the world. This transition and new environment required becoming used to a different spatial arrangement, changing perceptions and bodily actions, and a changing 'intersensory unity of the world' (Merleau-Ponty, 1962). Thus, residents had to learn a new way of being in the world. Residents had to learn to 'be-in-the-world' of the institution.

Residents became institutional bodies in a phenomenological sense of learning to be in the institution. This new way of being in the world was not only about phenomenological perceptions as a result of a change in environment, but also incorporated bodily changes. Since the body is known through its functionality in place (Merleau-Ponty, 1962), residents' changing bodies also constituted a new way of 'being in the world.' Residents' aging and unpredictable bodies contributed significantly to this relearning process of being in the world. A new environment already meant that individuals had to relearn ways of being in the world without considering a change in body functionality. Residents, then, had changes both in place and the body, so relearning 'being in the world' was a struggle. Residents were relearning both the being (body) and the place (world) as well as the interaction between the two. This 'being in the world' also incorporated others (mainly staff) who forced residents to conform to a way of being in the world that was foreign to them. Routines, time, and body care were all ways of being in the world that had changed for residents. Thus, the spatial phenomenological changes that residents experienced from home or community into long-term care were

immeasurable since they incorporated both place and body. Residents' pre-reflective consciousness had to be altered because of this change both in body functionality and place. Descriptions of not sleeping the first few nights, being nervous, and getting used to strange sights and sounds were all described by residents. Thus, becoming an institutional body did not only occur on a cognitive level, but also at a subconscious or pre-reflective level. Residents had to learn new ways of being in an institutional world, which constituted a new place and a changing body. From a phenomenological pre-reflective level, then, residents became institutional bodies as they became part of the institutional environment and as they learned to be in the world of the institution.

Another way residents became institutional bodies was through the structures of the institution. The structures of the institution became imprinted upon the body, thereby making institutional bodies. Becoming institutional bodies by being imprinted by the institution occurred in a number of ways. The routines and risk management were elements of the institution that became imprinted on residents' bodies. In addition, because residents' bodies were public, their bodies became institutional property.

Becoming institutional bodies through institutional structures was particularly evident with the routines of the facility. Staff described residents as 'becoming part of the routine'. Rather than simply conforming to the routine, residents actually became the routine. The routines existed because of the residents and their care needs, while the structure of the routines existed because of the regulating bodies and the organization. Without residents conforming to the routine, the routine would not exist even though it was structured by outside forces. Thus, residents actually became the routine. At any given time particularly during body care routines, residents' bodies were in places

determined by the institution. At mealtimes, residents were in the dining room. During body care, residents were in their bedrooms or bathrooms. Thus, the routines determined where residents' bodies would be and what their bodies would be doing. Since choice was limited within this facility, both where bodies were placed at specific times throughout the day and what bodies were doing were structured and determined by institutional routines. Thus, bodies became institutional bodies by the routine. The routine structured institutional bodies.

Managing the body as part of managing risk is another way in which the structures of the institution were imprinted on the body. Ideologies surrounding paternalistic and custodial care underlie risk management issues, and the body was imprinted with these ideologies. The use of mobility devices, including walkers and wheelchairs, as well as the use of restraints illustrated the imprinting of these structures onto the body. What bodies were permitted and not permitted to do was determined by the risk management policies of the institution and those who enforced these policies. Managing bodies through risk was directly and visibly evident, marking residents' bodies as well as structuring embodied experiences.

Residents' bodies became institutional property. As evidenced by the management of risk, residents did not have a say over their own bodies. Their bodies became institutional property, both managed and defined by the institution and its gatekeepers, or the staff who worked there. Bodily functions and needs were met when staff had time in their routines. Assessments of the body, or defining the body, brought all the private embodied issues into institutional view. Documentation enabled residents' body limitations to be available for all staff to read about, as well as other people outside

the institution, such as doctors and government compliance officers. Therefore, those connected with the institution had access to residents' bodies, whether through documentation or care. Residents' bodies were written about, under surveillance, and in view for all in the institution to see. In all aspects, residents' bodies became institutional bodies, both in a phenomenological sense and in a constructed sense. Residents' bodies ceased to be private, and instead became institutional property, thus becoming institutional bodies.

9.2.3.2 Institutional Dimensions of Temporality

The temporal dimensions of institutions, while not a focus of this research initially as a guiding concept, emerged as a significant element structuring experience. When residents came into Ridgemount, they not only had to conform to the corporeal and spatial dimensions of the institution, but they also had to conform to the temporal dimensions of the institution. The institution structured all aspects of daily life, including the temporal dimensions, and conformity was required in all areas. There were three types of temporal dimensions evident in the facility—institutional time, body time, and life time. These three aspects of time were not all directly attributable to the institutional structure, although the institutional structure played a significant role in defining these temporal dimensions.

Institutional Time

Temporal dimensions were evident in a number of ways within the institution. In particular, institutional time was a significant temporal dimension structuring all aspects

of life. The institution was structured around routines, and routines were structured around hegemonic clock time (Twigg, 2000a). Both staff and residents described this process in great detail. The routines mainly consisted of body care, dining room and mealtimes, and activities. These routines were determined by staff, management, and government regulations, and were based on the number and type of tasks that had to be completed throughout the day. Similar to Twigg's (2000a) study of community care workers and recipients, days were structured around body care. Residents were required to go to the dining room for mealtimes which were set at certain times throughout the day. Although residents could resist going to the dining room for meals, strong pressure was put on them to come (see Section 8.5.4.1 Managing Through Routines). Henderson (1995) describes a 'cult of time and task' in long-term care. Staff had a certain number of tasks that had to be completed within a specified amount of time, and thus, routines were structured. This conformity of routines and the lack of emotional or psychosocial care provided were a result of the lack of time staff had to complete physical tasks and the pressure staff put on residents to conform to their routines. Thus, staff routines were structured by time and task, which forced residents' routines to conform to staff routines. The task-oriented nature of routines was one way in which time became institutional time. Rachel and Brian described conforming their routines to the staff routines with respect to body care and activities of daily living for which they required assistance. Routines lacked flexibility and individual consideration. Twigg (2000a) described this type of time as a new rhythm around care. This dimension of time, then, can be appropriately described as task-oriented institutional time.

Waiting for care was another way in which time was structured for residents, and was the site where temporality and corporeality met. Because staff had numerous tasks that had to be completed within the specified time and because of the limited number of staff, waiting for care was common. Rachel described waiting to go to the bathroom and waiting for the bedpan. This was a frequent occurrence, not only for her, but for many other residents as staff described. When residents did receive care, it was often hurried or rushed, as Rachel described at breakfast one morning (see Section 8.5.4.1 Managing Through Routines). Thus, time slowed or rushed, depending on the activity. Outside of care and recreation programs, residents described being bored and having nothing to do when they were not involved in routines, and time slowed then. Thus, institutional time existed based on the routines and availability of staff, part of the structure of the institution. This dimension of time, then, can be appropriately described as activity-related institutional time.

Both of these types of time were based on objective clock time. The amount of time that staff had in a day to complete their tasks was based on clock time. Mealtimes were based on clock time in that they occurred at specific clock times every day. Even when residents were waiting for care, they based their wait times on clock time (see Section 8.5.4.1 Managing Through Routines). These clock times were very much “felt” bodily by residents, such as when Rachel was waiting to be toileted and felt physical pain in waiting (see Section 8.5.4.2 Managing Through Waiting). Thus, time in an institution was based on objective clock time, and the lived rhythms of the body were ignored. Instead of suggesting this as clock time, however, I refer to it as institutional time. Clock

time, although existing far beyond the institution, was structured by the institution and determined the activities and routines therein.

Body Time

Time and temporal dimensions were also structured around the body and the physiological processes of the body. While time is normally structured around the body in daily life for the majority of people, body time took on a different dimension within the facility. For many people, body rhythms and time do not conflict or pose problems in day-to-day life. For the residents, though, who needed body care assistance, body rhythms and time often posed difficulty in day-to-day life. Because residents had to depend on others for care of the body, body time was often conflicting with institutional time. Twigg (2000a) suggests that lives become reordered around care. That is, residents' bodies had their own schedules and rhythms, which were not necessarily in sync with the rhythms of the institution. Thus, when Rachel's body needs demanded to be met, such as requiring the bedpan at night, the institutional time was not necessarily in sync with her body rhythms. As a result, she was not given the bedpan at night. Brian's body told him that he needed to go to the bathroom at night. He required assistance (or was told that he had to have assistance), and as such, staff did not always have the institutional time to assist him to the bathroom when he needed it. Institutional time defined interactions with staff, rather than body time (based on body needs), and as such, life was structured around institutional time, and body time had to be reordered around institutional time.

Life Time

Temporal dimensions were also structured around the life course and around residents' lived experiences over the course of their lifetime. These temporal dimensions were also at odds with institutional time. For residents, life at Ridgemount occupied a small portion of their lives. That is, in proportion to the objective time that was spent living in the community, time at Ridgemount was small. However, life at Ridgemount had such an impact on residents' lives that despite being a small portion of the overall lifetime, institutionalization was a significant portion of life-time. Life time was restructured upon coming into Ridgemount. Residents' histories and past were erased upon admission, although residents worked hard to maintain those pre-institution memories and identities. Life-time was dependent on others who shared this life outside of the institution, and with whom residents could reminisce and share—those who had common experiences. Since staff neither had the institutional time nor the shared experiences with residents, their past was erased. Indeed, staff described residents' past lives as ceasing to exist once they came into long-term care. Because of the dismantling of the self—loss of place and loss of relationships—residents had neither the locational context nor the relational context for life-time. Yet, residents still continued to reminisce and find small opportunities to discuss parts of their past, such as in their interactions with me. Thus, although life at Ridgemount occupied a small amount of time over the life course, it occupied a significant amount of time by redefining the temporal dimensions of residents' lives and erasing the past within the institutional context. This, of course, is not to suggest that residents' pasts were erased to them (indeed, if self resides in the body as well as the mind, the past can never be erased until our bodies cease to exist), but within

the context or 'container' of the institution, life-time, to a very large degree, ceased to exist.

Brown (1998) discussed the notion of time in prison. While this is not to suggest that the institution was a prison (although some residents have referred to it as such—see Wiersma, 2003), Ridgemount was a total institution (Goffman, 1961), similar to prison. Time reflecting on the past, according to Brown (1998), could be used up, and reliving memories too many times resulted in a shift to the future for some. Time passing, however, was meaningless and there was an extended sense of the present in prison. Life time once in the facility changed. Time, however, seemed to exist in a liminal state. The residents, too, had an extended sense of the present when discussing boredom and time slowing. The present was extended. Although the past was a salient part of residents' lives, as evidenced by the numerous times residents reminisced and told me stories of the past, the past was erased by the institution. The future, however, loomed in front of residents, not a future of possibility necessarily, but a future of certainty. The certainty and immanence of death bounded residents' lives and structured dimensions of life-time. The facility was the last stop and life was slipping away. Residents lived in the past (although erased by the institution) and the present (although structured by the institution), and although they acknowledged the future, the future was not discussed within the institution. In a sense, the future was erased as a topic of conversation or as a consideration, particularly with staff. Thus, the temporal dimensions of life-time were reordered to reflect an extended present, a salient yet erased past and a certain yet limited future. Institutional time then structured life time in that the present was recognized as a

temporal dimension, but the past and future were beyond the realms of institutional consideration.

As discussed, the institution as a container for life structured all temporal dimensions. Institutional time, based on clock time, was the hegemonic temporal dimension and body time and life time were both structured and determined by the institution and institutional time. Now or the present existed, with no past and no future. Thus, residents lived in a liminal temporal dimension. Time was embedded in the structure of the institution, rather than the body (Brough, 2001). Now or the present was not just an absolute point of reference (Brough, 2001), but it was the only dimension that existed within the institution.

9.2.3.3 Living in a Spaceless Place

Space, as described earlier in the Literature Review, is defined as intangible, something that cannot be directly described or analyzed (Relph, 1976). The concept of space is used as an abstraction here, rather than something concrete or the physical aspects of the environment. Space is organized around the body and is a symbol of openness and freedom (Tuan, 1977). The institution, in this light then, is considered a place with no space. It is a place because of its physical location and concreteness (Gieryn, 2000), but does not have space.

The institution as a place with no space is visible in the lack of a sense of freedom. Since space is defined as a symbol of openness and freedom (Tuan, 1977), Ridgmount had no space. The participants discussed the lack of freedom and the life of confinement. Previous research has also indicated that long-term care residents felt the

institution was a prison and a restrictive environment (Wiersma, 2003). The rigid routines, locked doors (locked units for residents with dementia as well as locked front doors), lack of privacy, and general inability to leave the facility regularly contributed to this restrictive sense of place. The facility as a place was a restrictive environment with limited freedom, thus eliminating a sense of place. Space as freedom can also refer to the control over space and the ability to have a say in what occurs within that space.

Twigg (2000a) described how home care workers perceive rules of behaviour in clients' homes because the space is not viewed as their own. In the institutional setting, however, she suggests that "[w]orkers regard care home as their territory, and residents are under their control and management" (Twigg, 2000a, p. 134). Thus, staff viewed the institution as their own space, in the sense of viewing space as control and freedom to determine activities. Residents were aware of these boundaries. Residents had little control over their rooms and what activities occurred therein. As Brian stated, privacy becomes redefined. The space, then, was not their own but belonged to staff.

There were also places within the institution that were out of bounds for residents (Twigg, 2000a). The lounges and auditorium were rarely used except upon staff permission or accommodation. Residents rarely used the living rooms, and the activity rooms were used for planned activity programs or to watch television (often for residents who were not mobile or not verbally communicative). The participants in this study rarely used these areas unless planned recreation programs were occurring. Staff offices were out of bounds. Other areas directly related to body care, such as the kitchen, soiled and clean utility rooms, and linen rooms were locked and out of bounds. Staff bathrooms and other staff areas were inaccessible to residents, either because of locked doors or

location (in the basement away from residents' living areas). Even the cafeteria was not often used by residents unless families or visitors brought them there. A fireplace and lounge area on the balcony and the lounge in the main lobby by the children's daycare was only frequented by a few residents, typically those who were more independent and ambulatory. The space of the facility was bounded, with many areas off limits to residents, either explicitly (locked doors) or implicitly. The spatial ordering of the facility hid frail, aging, and unpredictable bodies away from view. The very nature of long-term care homes as total institutions apart from the community serve to "hide" aging from the rest of the community (Hazan, 2002). Bodies were welcomed in the dining room and bedrooms, but other areas were not accessible to many residents, particularly those with no mobility. Simply by the placing of residents in the dining room, activity room, or bedrooms, these residents were hid from view. While this may not have been purposefully done by the facility, the spatial design of the facility designated specific areas for residents that were typically out of public view or away from common areas that the public frequented. Even in the spatial ordering of the facility, a place meant to care for the body, bodies were hidden, and thus defined and made into rejected bodies (Wendell, 1996).

Thus, the institution as a place cannot be described as having space. Indeed, the only personal space that the residents had was their bedrooms, and even their bedrooms were sites of accommodation and resistance because of the activities that occurred there, such as body care. Bathrooms at home are considered semi-private (since they are only used upon permission of the person living in the home) and bedrooms are considered private, only for the use of those who live here (Twigg, 2000a). In the facility, however,

residents' bathrooms and bedrooms were the most public rooms, since these rooms were the site of care (Twigg, 2000a). Although residents used possessions from home to make the bedroom feel more like "home", and though residents occasionally closed their bedroom doors to decrease surveillance and obtain a semblance of privacy, their bedrooms were still public places. As evidenced by my observations, nursing staff often walked into bedrooms or knocked and walked in, simply announcing their presence and not asking permission to enter. The bedroom, typically the most private place of home, was public space, leaving no place of privacy and control for residents, no place that was free from outside interference. Bodies in this space, then, were not free because they were public property, on display, and under surveillance.

The lack of privacy also defined the lack of space. As described in the findings, residents had to reconceptualize their notions of privacy in order to function and adjust to the institution. The control over their rooms and their space was eliminated, as was their control over their bodies. Thus, lack of privacy in the traditional definition of the word—that of control over space and body—did not exist at Ridgemount. The simple act of receiving care puts bodies on display and under surveillance (Twigg, 2000a). At home, worlds are private and individuals have control over their space and their body in this dimension (Twigg, 2000a). Although the long-term care facility was called a "home", this notion of privacy was non-existent. Indeed, even staff recognized that the facility was not home particularly because of the rules and regulations, and discussed this in detail.

In sum, while the facility may be seen as private from the outside world because of the closed nature of the institution (Dupuis, Smale & Wiersma, 2005), there were many aspects of the facility that crossed the boundaries into the public domain. First, the

facility was operated by the municipality and received public funding at a provincial and municipal level. Thus, its very status was defined as a “public” institution. Second, as described above, the place was regarded as staff’s territory. Thus, the private domains of home, even within the site of the bedroom, were not private at all, but were public. Third, the private domains of home allow a control over the body (although some feminists might dispute this, particularly in cases of domestic abuse—see Manzo, 2003 for a further discussion of “home”). The residents, however, did not have body privacy, thus rendering their bodies as public property within the institution, under the purview and surveillance of staff. Space as freedom was not existent in Ridgemount for these participants. In this way, the place had no space.

The lack of space was also evident in interpersonal relationships, and this lack of space also refers to narrative space. Golander (1995), as described earlier in Chapter Two: Nursing Home Life, discussed the deselfing process that happened with long-term care residents. Social and personal identity became one. Gubrium (1993), however, discussed the use of narratives by residents in long-term care and how these narratives provided opportunity for residents to portray images of self. Indeed, Paterniti (2000; 2003) also discussed the use of reminiscing and narratives to resist institutional identities and establish an alternative definition. The use of narratives to reveal images of self in this present study is not unlike other studies (Paterniti, 2000; 2003). What became most interesting was the space in which these narratives were provided by the residents. The participants discussed how busy staff were, and how the staff did not know much about them personally. While the relationships between the participants and staff, once established and negotiated, were not particularly conflictual, they were certainly task-

oriented and bounded. Therefore, although residents used narratives to portray images of self alternative to institutional definitions, the space in which those narratives were heard (or not heard) was narrow or did not exist. This spatial analytical perspective has not been suggested in past work on narratives and identity, and has only been examined from the ways residents present themselves rather than the ways in which staff receive these narratives. As Twigg (2000a) suggested, time and space are interconnected, and time defines interactions. The socialization process taught residents that staff did not have time to hear their narratives of self, and so while residents maintained certain aspects of the self, they had little or no space within their relationships with staff in which to express this. Thus, narrative space as an abstract concept carries with it dimensions of temporality as well as spatiality. While personal narratives were used by the residents in different situations, they were also aware that there was little space for these personal narratives. Since I, as a researcher, had the time to visit and chat with these residents, I learned much more about their lives than did many of the staff, even the recreation staff. What became clear was that the space to reveal personal identities and the intersubjective space in which these identities were heard and listened to were not free and open in the facility. These spaces were narrow and restricted. Space, then, as confinement/freedom, privacy, and narrative space, was not a part of the place of the institution. Space was restricted, narrow, with little sense of freedom.

The notion of home often implies an embodied identity (Rowles, 1987; Twigg, 2000a) as well as a place that is shared with others with common histories and experiences. Thus, home and the private sphere represent spaces for revealing identities and selves, essentially free and open narrative spaces. The institution as a public space

implies a narrow, restricted sense of narrative space. Thus, the physical place structures the interactional context and the narrative space. Place, then, as a physical location, is directly tied into narrative spaces and interactional contexts, and indeed, even structures these dimensions (Wiersma, 2003). Thus, the experience of place becomes more about how place and space are experienced and structured. The meanings of place, or sense of place, and how place and space were experienced, was a place of conformity to rules and regulations and interactional boundaries, with little narrative space.

9.3 The Interpersonal Context of Socialization: Relationships and the Care Encounter

While I have been discussing much of the organizational structure and the limitations that this structure places on staff in terms of their jobs, the nature of staff-resident relationships and the care encounter also play a significant part in the socialization process and the residents being made into bodies. There have been numerous studies in the last number of years that have examined the nature of staff relationships with patients and residents in health care and institutional settings (Twigg, 2000a; 2000b). Before I can discuss the care encounter as the site for the production of bodies, much more needs to be discussed and understood about the nature of staff-resident relationships in the long-term care context. As evident in the findings of this study, the relationships between staff and residents were bounded and often focussed on the body. Despite this, however, some residents described having a close relationship with staff and described staff as nice and good. Relationships were complex and multidimensional, and served many purposes and played many roles.

9.3.1 Nature of Staff-Resident Relationships

Henderson (1995) conducted an ethnographic study in a nursing home, as mentioned previously. He found that the nature of nurses' aides' work was task-oriented in nature and care was focussed on physical tasks. He reported that staff generally seemed to be unaware of the residents' real experiences of nursing home life. What is particularly interesting in the present study is that staff, in their interviews, seemed to be extremely attuned to residents' experiences of daily life in a facility and what the

adjustment process was like for them. Indeed, many of the findings of the initial staff interviews were similar to the processes residents described in becoming adjusted and socialized to the institutional environment. In theory, at least, staff were quite aware of residents' experiences. This could be due to the fact that many of the staff who were recommended to me to participate in the research at least initially were labelled as "good staff", those staff who genuinely seemed to care for the residents. In particular, though, those staff whose role it was to focus on more psychosocial aspects of life (i.e., recreation, social work) seemed to have a greater understanding of residents' experiences in the institution. However, the nursing staff that I interviewed were also surprisingly aware of residents' experiences and described feeling compassion and empathy for what they described as a difficult time during the transition into the facility.

What was also particularly interesting about this study, however, was that the staff knowledge about residents' daily experiences did not seem to translate to the residents' experiences. The staff described in great detail the difficulties residents experience coming into long-term care, yet the residents themselves did not state that any of the staff were particularly understanding or empathetic toward them, particularly during those first few weeks when their lives had been, for the most part, completely changed. Staff described a number of techniques in which they attempted to help the residents adjust to life in the facility, but residents did not describe any of these techniques. They did not even seem to be aware that staff were attempting to help them adjust. Staff described giving residents choice within the structure of the institution, yet residents described having to conform to the routines and structure of the institution, with little opportunity for choice being afforded them. It may be that staff were aware of residents' experiences

in theory, yet in the day-to-day reality of the institution, where a series of tasks were expected to be performed and regulations were expected to be followed, staff lacked the time to demonstrate this awareness in any empathetic form. Learning limits and setting boundaries are important aspects of care work (Twigg, 2000a), and indeed, staff may have had to set boundaries to accomplish their tasks and conform to regulations.

Foner's (1995) ethnographic study from nurses' aides' perspectives described the tension between defining staff as "saints" or "monsters". Staff were not all good or all bad. In many ways, staff reacted as much to the structure of the institution as they did to the difficulties of coping with the continuous demands of residents and families, not to mention other staff and management.

One response to patients' demands and abuse is the kind of insensitive and cruel treatment so often chronicled in the nursing home literature. Another response is understanding and compassionate care. In fact, most Crescent aides fall somewhere in between: they are neither saints nor monsters. Only a very small minority are consistently cruel or consistently warm and supportive. Most aides are generally kind and helpful to residents, although at times they lose their tempers and behave in ways that come across as mean. And many establish relations with residents that they and the patients find gratifying. (Foner, 1995, p. 38)

The complexity of staff experiences working in long-term care are often unacknowledged, and common assumptions are to view staff as monsters or saints, rather than viewing relationships between staff and residents as complex, multidimensional, and situational. What was evident at Ridgemount was that while there were some staff who were consistently insensitive and even occasionally abusive to residents, there were also very many staff who were good to residents. However, working in an environment that can often place unreasonable demands upon its staff takes its toll as well on them.

Ridgemount had many staff who had worked for the city for numerous years (some staff

who I interviewed had been with the city for 25 years), and it is quite possible that the toll of working in this type of environment for numerous years can accumulate. Interestingly, however, the residents stated that the older staff were more compassionate and understanding than the younger staff. As Twigg (2000a) found, older careworkers identified more directly with the aging process and its bodily impact. Further research should examine how various factors such as the length of time working in general in long-term care and more specifically, the length of time working in a specific facility and at a specific facility impact caring behaviours among nursing staff within the nursing home context. Interestingly, most of the staff I interviewed were older staff, who were described by the residents as more compassionate.

9.3.2 Negotiated Relationships

The relationships between staff and residents were not easily defined and spoke of a nature of complexity and negotiation. As illustrated, boundaries marked these relationships. Relationships were centred around the body, which spoke to the negotiated nature of relationships. Relationships with staff were established for the sole purpose of caring for the body and meeting bodily needs. Within the certainty of the purpose of the relationship, however, was also a degree of negotiation. Relationships around the body were negotiated because of differing goals, discomfort around body intimacy, and differing temporal dimensions.

Staff and residents had different goals in the relationship (Paterniti, 2003). Staff needed to accomplish specific tasks with and for residents' bodies. Residents, on the other hand, wanted their bodily needs met in a timely fashion and their pains and

discomfort alleviated. Thus, relationships around the body were negotiated. As Twigg (2000b) suggests, intimacy is present in the dynamics of the care exchange, although not necessarily sought or welcomed. The recipient of care is often required to enter a relationship of physical and personal exposure that is often unwelcome. As such, there is a desire, both on the part of staff and the person receiving care, to put limits on the physical intimacy of the work. Twigg (2000a) terms this “bounded intimacy”. Carework is dirty work, as it deals with dirt and disgust over bodily fluids, as well as negotiating nakedness (Twigg, 2000a). Intimacy is present in the physical exchange, although managed through different techniques, such as the use of gloves. As evidenced by some of Brian’s and Rachel’s comments regarding care, humour was often used to gloss over the discomfort of physical intimacy without an appropriate emotionally intimate relationship. (This was also found in Twigg’s 2000a & 2000b research). Yet at Ridgemount, intimacy was most often present in the physical exchange as an unwelcome but necessary part of the staff-resident relationship. The staff-resident relationship in every other aspect was bounded, as described in the boundaries of the staff-resident relationships. Emotional intimacy was not necessarily welcomed from all residents. As Brian stated, he did not want staff diagnosing him, pitying him, or sympathizing with him. However, residents expressed that they would like more time to talk with staff, indicating that they would like some degree of emotional intimacy or connection, although perhaps control over the degree of intimacy with staff was most important to residents. Part of the socialization process for residents, then, was to learn the place of intimacy. Intimacy was always bounded, in the context of care and physical intimacy.

Intimacy was bound by the task-oriented nature of the institution, by the rules and regulations, and by the choice of staff.

Through various methods, particularly the focus on the tasks at hand, residents became aware of these boundaries. The task-oriented nature left little room for narrative space. Yet, Rachel described being close to the staff and Brian described them as his family (albeit in a paternal sense). Relationships were very carefully negotiated, particularly by residents who attempted to make life easier for staff, and consequently, themselves, through kindness and niceties as well as being respectful of staff's time.

Twigg (2000a) described community care staff and how they needed to learn limits and say no to clients, otherwise they might be overwhelmed by clients' needs. Twigg (2000a) described the dangers of staff becoming too attached to clients and having difficulty bearing the unhappiness of their clients. The bounded nature of staff-resident relationships may reflect this. Other research (Dupuis & Wiersma, 2006) suggests that some staff develop particularly close relationships with residents, describing them as family. Whether the residents themselves might describe these types of relationships with staff has been less frequently explored in the literature. Thus, relationships with staff are carefully negotiated by residents in order to obtain the best possible care for their bodies.

9.3.3 Staff as Institutional Brokers

Part of the negotiation of staff-resident relationships lay in staff's conflicting directives to meet the needs of residents as well as to follow the rules and regulations of the institution and of the Ministry of Health. These two directives were more often than not directly at odds with each other, leaving staff in a difficult position. As a result, staff

acted as institutional brokers. Broker refers to a middle person. Staff were the middle people between the regulations of the MOH, the demands of management, and the culture of the institution on the one hand, and the residents and their needs on the other hand. As evidenced from staff quotes and from my own knowledge of long-term care and the MOH regulations, consequences were inevitable if the regulations were not fulfilled. In addition, compliance officers had liberties in interpreting these regulations, and could impose their own regulations if they so wished. Management then played a role in ensuring that the institution was structured to accommodate these rules and regulations. Management also partially created and impacted the culture of the institution, which directly impacted the ways in which staff carry out their day-to-day work. Staff, however, were responsible for following the rules, regulations, and requirements of the government and of management. In an increasingly regulated culture, staff often found themselves with more and changing regulations impacting their jobs and residents' care (Dupuis & Wiersma, 2006). Because of these regulations, staff's interactions with residents became rigidly structured. Many of the processes that residents described were results of the enforcement of regulations. Residents often interpreted these regulations as staff shortcomings since they did not have an understanding of the MOH requirements. While some staff described their discomfort with the rules and regulations imposed on them, their descriptions of other staff in the facility led me to believe that some staff may indeed internalize these rules and regulations as simply the way things are done. Comments from staff about "unwritten rules and regulations" indicated that a culture of compliance was internalized. Thus, being an institutional broker was internalized as well as resisted by different staff, but was a role within the institution that they must comply

with. Residents often did not recognize this pressure on staff because of their lack of understanding of the rules and regulations imposed by the MOH. Staff had a difficult role of enforcing rules and regulations, paid the consequences when regulations were not complied with, and often received negative feedback from management as well as residents and families (Dupuis & Wiersma, 2006). While some staff may not recognize their position as institutional brokers (or perhaps not care), other staff who cared about the residents and their needs found this position difficult. The ramifications, however, of not following rules and regulations were immediately evident and strong enough that staff generally acted within their roles as institutional brokers. Staff held a tenuous position as institutional brokers, although this position was often at odds with staff's own care ideologies, at least for many.

9.3.4 The Care Encounter as the Site for the Production of Bodies

Before I discuss the production of bodies, I need to define the care encounter. The care encounter is a phrase used by Twigg (2000b) to describe bodywork and carework in the context of homecare. By 'care encounter' in the long-term care facility, I mean to refer to any interaction between staff and resident for the purpose of accomplishing a goal of the institution. This is similar to Twigg's (2000b) use of the term, although within a different care context. The care encounter, of course, is not always easily defined and can be contested, but in general, the care encounter can refer to body care, to mealtimes, to recreation programs, and to other encounters between staff and residents. This is not to deny that the care encounter is not beneficial to residents; indeed, often the goal of the institution and the resident can be the same. However, care encounter refers to all staff-

resident interactions in accomplishing the institution's goals, whether in line with residents' own goals or not.

The care encounter brought the lifeworld existentials (Van Manen, 1997) together in this one experience. The care encounter was structured by place. The encounter not only physically occurred within place, but was also structured by the nature of the facility. The care encounter was also defined by the temporal dimension of institutional time, since staff were often rushed in providing care. Most importantly, however, the care encounter was where corporeality and relationality came together—the lived body and the lived other. Thus, the care encounter was the intersection where these spheres came together, but most importantly, was where the body came to be defined as an object by the other—the staff.

The importance of the care encounter was emphasized in this research. The making of residents as institutional bodies, although implemented from government policies and regulations, as well as management policies, was produced in the care encounter between staff and resident. As Twigg (2000a) stated, “It is in the dynamics of the care encounter that the nature of what is produced is defined; production and consumption collapse into one another” (p. 1). It was in the nature of the care encounter between staff and resident that institutional bodies were produced. Routines were enforced during the care encounter. Risk was managed. The care encounter occurred upon staff schedules, forcing residents to wait for even the most basic of bodily needs. The care encounter was not simply periods of time in the morning or evening when staff helped the residents out of bed or into bed, washed, dressed, and toileted them. The care encounter was every minute encounter that occurred in which some task of the body was

the focus. Abrupt interactions, as illustrated in Brian's encounter with one of the nursing staff giving him pills (see Section 8.5.5.2 Defining Staff Relationship Boundaries) characterized a care encounter when residents recognized they were a task and a body without emotions and feelings. The care encounter not only managed the body, but also defined the boundaries of relationships with staff.

Much of the research on long-term care facilities and their characteristics has been from a social constructionist perspective, examining the role of discourse in creating an institutional environment (Gubrium, 1993; Gubrium & Holstein, 1999). While this approach has provided us with important understandings in how illness and disability become constructed and how the nursing home acts as a discursive anchor to talk about the body (Gubrium & Holstein, 1999), it has left a limited understanding of other embodied dimensions, focussing on the discursive at the risk of the experience itself. Williams (2006) describes how a strong social constructionist perspective, one that views reality as text and discourse, has erased the body as experiencing, and has only focused on how the body is discursively constructed in culture. Much the same has happened in aging research, where the focus has been on the discourse around the phenomenon, rather than the phenomenon itself (Turner, 1995). The limits of social constructionism present the body as discursively produced, denying any basis in physiology (Twigg, 2004). As such, the body as experienced by long-term care residents has been erased.

Gubrium and Holstein (2001) suggest that the self is becoming increasingly social in a post-modern world, and that the self is always crafted in light of social conditions. The self is conceived as a social structure.

In a world understood in *post-modern* terms, however, the relationship between the personal self and society dramatically changes. The social self moves to the

foreground as the personal self is decentered from itself and recentered into myriad going concerns” (Gubrium & Holstein, 2001, p. 10).

Gubrium and Holstein (2001) suggest that the notion of institutional identities are resources for structuring selves, and individuals make connections between the personal self and an institutional identity. This connection involves interpretive activity, identity work, and biographical work. The post-modern world provides numerous discursive environments for identity work, the nursing home being one of those environments (Gubrium & Holstein, 1999). Much of the discussion in the aging literature on identities within long-term care has also focussed on the narrative as a primary marker of identity (Gubrium, 1993; Paterniti, 2000, 2003) and as a way of resisting “bed and body” identities.

Kontos’ (2003; 2004) work on the location of the self in the body as well as the mind challenges and expands some of the social constructionist perspectives of identity creation and production. If the self is located in the social world among institutions that provide options for our identity, then the body as self is also located within these institutions and provides an interactional site for the production of self. If we take the notion that the body is the site of the self, or indeed is the self, and that the self is located within discursive environments which are inherently social, then institutional identities are not only produced through discursive language, but also through body interaction and communication. What is perhaps as significant as spoken language and narrative in the creation of identity is body language and body interactions. In the institutional setting where body care is the primary focus, the sites for the production of body-self are not only discursive, but embodied. Thus, the institutional identity of being a body is not simply produced through discursive anchors, but is also produced through the bodily

interaction staff have with residents. Becoming a body is not simply a discursive identity, but is also an embodied identity.

The care encounter, as described above, made residents into institutional bodies. This care encounter, however, was not simply about verbal communication or discourse. The care encounter was where staff and residents interacted with and around the body. While the discursive was a large part of the care encounter, body language and body touch were where residents also learned that they were simply physical bodies. What has been illustrated through the socialization processes was that communication from the staff was more in what is not said than what was said. Various incidents pointed to the messages relayed to residents through body language, not through spoken language. The incident with Brian and the staff member regarding attendance at the dining room for lunch (Section 8.5.4.1 Managing Through Routines) illustrated how the message was conveyed to Brian that he was an inconvenience without using any spoken words. While I did not think much of that interaction at the time, Brian's comments after she left the room about her being "*one of the most ornery people I've ever met*" indicated that not only did they have a history of conflict, but that her body language spoke volumes to Brian. Brian's descriptions of young people feeding residents illustrates very clearly how body touch conveys strong messages to residents (see Section 8.5.5.2 Defining Staff Relationship Boundaries). The staff who wouldn't fuss with Brian and help him get comfortable illustrated that he was a body, whose comfort was unimportant (see Section 8.5.5.2 Defining Staff Relationship Boundaries). Rachel's descriptions of how older staff take time with her and "keep her clean" when she went to the bathroom again illustrated that body touch in the care encounter was the primary vehicle by which communication

occurred (see Section 8.5.5.2 Defining Staff Relationship Boundaries). Abrupt interactions, again more related to what staff didn't say than what they did, reinforced the nature of the task-oriented relationship. Waiting for care also sent residents a number of unspoken messages—that of being a burden and of being a number. Narrative structures and discursive environments do not provide us with the only options of who we can be, but we also create identities and selves through the body and through body interaction.

Gass (2004) described the importance of the care encounter and of body language:

Normally it is the aides who are left to touch and nurture the residents, if the residents are to get touched at all. Aides form the front line of defense for an entire population in emotional peril. Intimacy is built into the aide's work, and loss of intimacy tears the most aching void in our residents' lives. It is up to us on the front lines to make our touch meaningful or cursory. More than anyone else in the diminished lives of residents, we can bring joy or misery. We are closer to them than anyone else on a daily basis. So our style of caring comes to represent all of humanity to them. (74)

The importance of touch and body language as a method of communication has not been addressed in much of the gerontological research. Touch as an embodied form of communication is at the heart of the care encounter, and the care encounter is the site of the production of institutional bodies.

9.4 The Corporeal Context of Socialization: Experiencing Bodies

In addition to institutional bodies, the socialization process produced different types of bodies that the residents internalized and described. As a result of the location and interpersonal contexts of socialization, different types of body-identities can be found. First, residents described disembodied bodies. The dualism between the mind and body was maintained as a technique of self-preservation. Bodies were also liminal—that is, they existed in between life and death. There was a dichotomy between the rejected body and the reclaimed body. Bodies can also be seen as repositories of memories, which invites a rethinking of the ways in which we view the old body, old age, and youth and age dichotomies.

9.4.1 Disembodied Bodies

Institutional bodies were disembodied bodies. Because the emotional was erased and because the focus was on the physical body as an object, the body as experiencing and as subject was not taken into consideration. As explicated earlier in the theoretical framework, this research took the assumption that the self exists not simply in cognition and in the mind, but also in the body (Kontos, 2003; 2004). From an institutional standpoint, however, residents were made into institutional bodies, as described in Chapter Eight: Findings. The dichotomy between the mind and body, from a medical perspective, is no surprise. In medical terms, the body is often treated as an object separate from the mind and at the exclusion of the self (Wendell, 1996). This treatment of the body, given the medically-oriented nature of long-term care, continues in this environment. The mind is typically treated in two ways. First, the mind is relegated to the

outer limits of the body. That is, residents' bodies are treated and cared for as objects, with little or no consideration for the cognitive, emotional, or social states of the residents. Indeed, one only has to examine where funding is allocated in long-term care to see evidence of this, since funding is primarily allocated to nursing staff. Nursing staff, who care for the physical body, comprise the majority of staff in long-term care, while other staff who focus on social and emotional aspects (i.e., recreation staff, social workers) are generally sparse, and thus have a much higher caseload than nursing staff do.

The second way in which the mind is treated in long-term care, however, is that it can be defined as the body—that is, since cognitive impairment is common in long-term care, the mind is medicalized and pathologized as a site for physiological and neurological dysfunction, resulting in altered behaviour states. The mind is treated as an extension, or a part of, the diseased and dysfunctional body. Cognitive impairment is almost expected in long-term care, since it is a common disease among residents. Emotions, however, as an expression of self, are strictly managed and are often interpreted through a pathological lens. Anger and frustration can be defined as an “inability to cope”. Sadness and grief can be diagnosed as depression. Concerns about death were “taboo” subjects and dismissed as inappropriate topics of conversation. The emotional was erased completely. In this way, residents became disembodied bodies. The emotional experiencing body was disregarded or worse, pathologized. The purpose of the long-term care facility is to treat the body not to treat the psychosocial aspects of the person (Henderson, 1995). Residents learned to become disembodied bodies as they learned to manage their emotions. They even came to see, as with Brian's case, how this

was necessary given the demands on the staff. Thus, any expression of the self was completely managed.

Becoming disembodied bodies meant being treated as objects by staff and by the policies of the institution. In this way, residents' experiences were disregarded and life became about objective markers of the body and of body care. As described above, the emotional and cognitive were disregarded with a sole focus on the physical. In many ways, as the body was managed, it was also erased as experiencing. That is, the body was managed to fit into the structures of the institution, as mentioned earlier, rather than as an expression and part of the self. Bodies were managed to conform to routines and to reduce risk, while body needs were sometimes ignored. As an example, a simple body need of going to the bathroom was often not met on time if the resident needed assistance. Body needs were sometimes not met or not met in a timely fashion. The body, then, was treated as an extension of the institution, as something to be conformed to the structures of the institution. The lived experiences of the body and body needs were neglected. The body itself was silenced.

While the approach of this research has been to view the self as located in body and mind (Kontos, 2003; 2004), the participants maintained the body-mind dichotomy, continuing to see the mind as an expression of the self. Rachel and Brian, in particular, used their cognitive functioning as a basis for which to create alternative identities, or recreate their body-identity. Since the body was silenced and forced to comply with the structures and routines of the institution (thereby becoming institutional bodies), the mind was the primary source for the location of the self and identity. Residents' cognitive abilities, particularly with Brian and Rachel, differentiated them from other residents.

Brian's memory differentiated him from other residents as he often described typical residents at Ridgemount as those who had lost their memory and who could not carry on a conversation. Rachel said that she was the only one with whom staff could have a conversation, which formed the basis of her recreated identity as the resident with a close relationship with staff. While the structure of the institution attempted to disregard the mind and emotions, these residents were still able to control their mind and emotions. Their bodies, however, were out of control. Morell (2003) found that the older women in her study had a need to distance the self from the diseased and disabled body to preserve a sense of the self as competent. A mind-body dichotomy played a role in maintaining a sense of identity and equilibrium for these residents at Ridgemount, and was necessary for maintaining definitions of self. Residents who have dementia may not wish or may not be able to maintain this dichotomy, but for the participants in this study, maintaining this dichotomy was important.

Thus, the ways in which residents accept, resist, and transform institutional identities of being a body seems to be very individual. Although I, as a researcher, can theorize about mind-body-self relationships and view self as body and mind, the residents felt the need to maintain the mind-body dualism, with the self situated in the mind, as evidenced through their conversations. The maintenance of this mind-body dualism preserved an identity of one who was more than just a physical body and as one who was not defined by the physical body. This is not to dismiss the mind-body-self connection because this view has great implications for practice, as will be discussed later, but understanding how residents resist and transform institutional identities provides us with ways in which to relate to residents. Thus, understanding lived experiences of the body

and place is key to understanding how residents view themselves within the context of the institution.

9.4.2 *Liminal Bodies*

Bodies were set in a liminal place, thus making bodies themselves liminal. Hazan (2002) discussed the nursing home as a cosmological void between life and death. The nursing home occupies a space of not life and not death. Both residents and staff were aware, for the most part, that Ridgemount was the “last stop” for residents. Residents were aware of the immanence of death and impending mortality. In a sense, admission into Ridgemount was one step closer from life to death. What is interesting is the avoidance of death as a subject of conversation and as a part of life (Komaromy, 2000). Staff avoided talking about death, and while residents talked about death to me, it was not a subject that was brought up in conversations with staff. The social workers in the facility recognized the avoidance of death, and felt that death was something that should be openly addressed with residents, but for the most part, death was avoided. Residents who passed away ceased to exist even in memory and conversation, and bodies were disposed of almost immediately after death. Death, however, is a part of the life cycle, and both residents and staff were aware of this. Residents lived in this paradox, that life was changing and death was immanent, and the institution existed between the two. The meaning of the institution, then, was far beyond a place that simply produced institutional bodies; it was also about a place that was the gateway to death.

Conceptions of temporality play a significant part in liminal bodies and places. Wyllie (2006) suggests that human beings are always aligned to the temporal dimensions

of past, present, and future. “The embodied subject experiences lived time as *shortages*: as a not-yet (future) and no-more (past); both not-yet and no-more are absences synthesized into the present” (p. 176). He suggests that human activity always tends toward the future, and that engagement in meaningful activity is necessarily forward and future-looking. The absence of looking toward the future can result in an impoverished present and past (Wyllie, 2006). The concepts of life and death provide an understanding of the orientation of temporal dimensions for residents. While those of us who are young(er) live for an orientation to the future, for the most part, either consciously or subconsciously, the participants were aware of the immanence of death. Thus, an orientation to the future meant an orientation toward death. Edward was aware that his body at 98 and 99 years old had lived beyond his anticipated lifespan. Death was brought to the forefront every time he was sick or ill. Brian stated how the future of living another ten years in a small room in the institution was troubling to him. Residents lived in a temporal dimension of the present, where institution attempted to erase the past, yet the future consisted of the immanence of death. The present was a life of restricted freedom and compliance to institutional structures. Living in the hyphen between past and future, life and death, is a place where not many live. It is no wonder, then, that temporality takes on different dimensions for residents. Bodies were liminal, existing between life and death, and the institution as a place for bodies was a liminal place.

9.4.3 *Rejected-Reclaimed Bodies*

Morell (2003) wrote a fascinating article on her research with long-living women and the concept of empowerment. She states that an age-conscious definition of

empowerment must be an embodied definition. Age, despite our reluctance, brings about a body that is slowing down, becoming weak, and may be ill. "...I believe emphasizing strengths and de-emphasizing physical weakness and disability is ultimately disempowering" (Morell, 2003, p. 70). De-emphasizing or ignoring the physical aspects of age can pathologize or erase the experiences of those with an aging body. The community-dwelling women in her study attempted to decenter the rejected body and focus on the able self. These women did not define themselves by their disabilities and limitations, as society does, and instead focussed on what they were still able to do both physically and cognitively. While society emphasizes disabilities and limitations, scholars and health care professionals often emphasize a focus on strengths and abilities and capacities as a counter-narrative to medicalization, thereby attempting to balance the cultural focus on disabilities and limitations as a part of age.

My personal experience, my readings, and my interviews tell me that for social workers and others to emphasize abilities and de-emphasize disabilities is both incomplete and deeply problematic: such an approach reinforces everyone's flight from the rejected body. Positively valuing abilities reinforces disability as negative and extends the fear, ignorance, and hatred of aged bodies which fuels disempowerment in the first place. Individual fear and shame and silences follow. A social environment hostile to people's real needs remains unchallenged" (Morell, 2003, p. 79).

Aspects of aging that are disabling need to also be accepted as part of the aging process, while not negatively construing disability. "Frailty is an unalterable given in human existence" (Morell, 2003, p. 80). Thus, power and powerlessness from an embodied perspective do not necessarily exist in polar opposites, but can co-exist and interpenetrate (Morell, 2003). "While a medical model is clearly inappropriate because it targets embodiment to the exclusion of empowerment, empowerment models often focus on power to the exclusion of embodiment" (Morell, 2003, p. 82). Death and disability are

acceptable human experiences and natural parts of life. Ignoring death and disability as a part of aging also means ignoring fundamental embodied experiences of what growing old means.

The residents provided somewhat of a contradictory perspective in the ways in which they privileged their bodies. In many ways, they aimed to decenter the rejected body while focussing on an alternative identity. They de-emphasized their limitations while claiming aspects of a functioning mind and body. Residents focussed on their minds as fully functioning and as an alternative to the failing body. In this way, residents decentred the rejected body as described by Morell (2003). Residents found ways of doing this by focussing on the mind, although paradoxically also focussed on the body. Edward, in particular, reclaimed his rejected body by highlighting his age and his ability to still walk despite being almost 100. For Edward, this was quite a bodily feat, and one which he claimed as part of his identity. Residents, then, claimed an able self, both through the body and mind, as an alternative to the rejected body.

In Morell's (2003) study, the women disassociated from an aging and limited body because of the negative cultural stereotypes associated with this body. The culture of the long-term care facility, with its pathological focus on the diseased and disabled body was so dominant that despite residents claiming an able self-body, they also focussed on the aging and unpredictable body. Residents' bodies were treated as objects rather than as experiencing subjects, and their focus on the embodied nature of the aging and unpredictable body was perhaps a way of both accommodating and resisting the identity of being a body. Residents accommodated this identity by focussing on the rejected body. Yet they also recentred their embodied experiences of their rejected bodies

in certain contexts. Many of my conversations with all participants were focussed around the body, particularly an unpredictable body, and focussed my attention onto the rejected body. Although staff did not often recognize or privilege residents' embodied experiences, residents found ways and contexts in which they could privilege and recenter the body as subject and experiencing. In this way, residents not only decentred the rejected body, but also reclaimed the rejected body, and lived within this paradox.

9.4.4 Bodies as Repositories of Memories

The “mask of aging” (Featherstone & Hepworth, 1991; Biggs, 1997; 2004) has been a commonly accepted theory of aging. According to this theory, inner feelings, motives, attitudes, or beliefs are concealed or masked (Featherstone & Hepworth, 1991). Because post-modern society has many negative perceptions of age and stereotypes relating to aging, a limited vocabulary of aging exists, limiting the expression and scope of personal feelings by older people (Featherstone & Hepworth, 1991). Thus, the essential identity of a person remains underneath an aging exterior. Changes in outward physical appearance are seen to be separate from the self and there is a distinction between surface appearance and hidden depth (Biggs, 2004; Featherstone & Hepworth, 1991). Indeed, evidence of the ‘mask of aging’ can be viewed in advertisements, media, and other culture representations of age. By attempting to keep the body young and stave off age, a congruence is maintained between the inner self and the outer body. The cultural values associated with an aging body are seen to be negative. Since these values are hegemonic, the ways in which society views older people and older people view

themselves are limited. Thus, the inner self of older people remains separate from an aging exterior.

Research has attempted to confirm the ‘mask of ageing’ theory (Clarke, 2001). Clarke interviewed older women and their perceptions of their bodies, and reported that women viewed the inner self as continuous, stable, and unchanging. Women stated they did not feel their age, and some viewed their bodies as a prison when their bodies did not perform as they used to. Clarke (2001) concluded that chronological age and felt age are not synonymous; thus, the mask of aging theory must hold true, and self and body must be distinguishable and irreconcilable in old age.

The mask of aging theory, while perhaps applicable to the ‘young-old’ (chronologically defined as those under 75), and maybe perhaps even applicable to other older adults still living in the community, does not seem to be applicable to the participants in this research. There are many reasons why this theory is not applicable, particularly within the context of the long-term care institution. To deconstruct this theory, however, is to bring into discussion concepts and views of mind-body-self as well as temporal dimensions. In view of my understandings of Rachel, Brian, and Edward’s experiences of aging as well as the institutional context, the mask of aging hypothesis is incompatible.

Earlier, I discussed the view of the self as existing both in the mind and body. If we indeed take the perspective that the self, who we are, exists both in the mind and the body, then the theory of the mask of aging only reinforces the dualism between mind-body. Self exists in the body and the mind, and thus, an incongruence between the identity of the two is impossible. The mask of aging theory reinforces the Cartesian

dualism between mind and body, and suggests that the body only experiences age when confronted with negative cultural valuations of age or when the physical body does not perform as it should. Aging is compartmentalized, occurring in the physical body, and assumptions of age are imposed on the physical body by culture. The mind is separate and apart from this. My findings, however, suggest that we cannot perceive the body to be separate from our self and our mind. Indeed, Rachel, Edward, and Brian, although struggling with limiting bodies, all referred to themselves as old. There were no descriptions of a “young self” that existed within, yet separate from, the body and an old physical body. When I asked Brian if he felt his age, he stated:

See if I ask you to describe what it is like to feel 80, you can't. The things that you do that you take for granted. You don't take for granted any longer. Yeah, I feel older. You don't know what you're supposed to feel like when you're growing up. So you can't really say yeah, I feel 80. I don't know just what 80 means [Interview One].

If no one can know what being old feels like unless one is old, since age is an embodied experience, then our constructions of old age tell us more about societal values than about the actual embodied experience of age.

Rather than regarding the internal and external aspects of ourselves as inextricably bound together, part of an integrated whole which comprises our being, we compartmentalise them, imposing upon them a false dualism. We conceptualise the ageing process as one in which there is an increasing conflict between two camps: on one side, our corpus, which drags us inevitably into our dreaded old age, and on the other, our spirit, which remains forever young (Andrews, 1999, p. 301).

One of the assumptions behind the mask of aging theory is the ability of the mind to be reflective and treat the body as an object, essentially separating itself from the body. Our bodies live pre-reflectively in the world, as Merleau-Ponty (1962) suggests, and our minds live reflectively. It is our minds that have the capability to reflect on life, on

experiences, and on circumstances. Thus, the mind reflects on and analyzes bodily experiences as they are occurring and after they have occurred. Simply because the mind exists in the world in a different dimension than the body, one cannot make an assumption that the self does not exist in the body but in the mind. Thus, the Cartesian dualism of the mind-body dichotomy is continuously reinforced in the mask of aging theory. While the mind can be reflective, the body is still experienced and experiencing by individuals, and as such, to assume that this corporeal experience is not part of the self reflects a narrow conception of the self.

The notion of the ageless self (Kaufman, 1986) reinforces this Cartesian dualism and also perpetuates the notion of an inner ageless self that is separate from the aging body. This ageless self and the mask of aging not only reinforce the mind-body dualism, but also bring into question how time is constructed in the body. While these theories do not explicitly discuss time, it is inherent in these discussions. These theories presuppose a bodily time that is objective, that is a 'natural' part of aging, so to speak. The body ages, it gets old, it breaks down, and eventually it dies. Older people who describe an inner youthful self that is incongruent with an aging body are describing themselves in the context of objective bodily time. I suggest that time is written into our bodies (Turner, 1995). This does not simply mean that time determines our bodies or that our bodies age biologically as time passes. Time written into our bodies suggests that our bodies are repositories of memories and that time is constructed differently as we get older. The self through time exists in the body. The mask of aging hypothesis makes the assumption that memory exists in the mind and cannot exist in the pre-reflective body. Kontos' (2003; 2004; 2005) work suggests that intentionality and agency can and do exist in the body.

Her work with people with dementia suggests a bodily intentionality that is reflective of their past lifestyles. Thus, memories and past experiences exist not just cognitively in our minds but also in our bodies. And since memories and past experiences form who we are, the self exists in our bodies. Our bodies are infused with memories of youth and life. Perhaps, then, older people do not simply exist in the present or in objective bodily time as these theories suggest, but older people exist in the past, present, and future. The notion of existing in more than one temporal dimension has not been considered by aging theorists. Our bodies, as repositories of memories and possibilities of the future, exist in more than one temporal dimension. Time is bound up within ourselves. Thus, lived time does not exist necessarily in objective temporal dimensions (Wyllie, 2006).

Lived time is not simply an endless random series of “now” moments lacking unity or coherence. *Now* in lived time is a unity of the past, present, and future, and is more than simply a succession because the immediate “no-more,” “present,” and “yet-to-come” are ordinarily never sharply separate...the present has the past as its source, just as the future emerges from this present (Wyllie, 2006, p. 174)

Brian illustrated these dimensions of temporality. He stated: “*I treat my past as an active life*” (*Interview Three*). He described to me how when he closed his eyes and thought about home, he could envision that he was home (see Section 8.6.4 Re-Creating the Body). Brian still experienced the past viscerally in his body. His memories were not simply cognitive, but were embodied. Thus, his body and his mind were existing in more than one temporal dimension. He was present in the “now”, although living in the past. While this experience may not be true for every older adult (and indeed, the other participants did not describe this experience), some older people may experience institutionalization and old age in this way. Thus, aging may change dimensions of temporality for individuals. The ‘ageless self’ or inner self that is incongruent with the

body may simply be the past bound up in the body. The embodied experiences of an aging body require a change in learning how to be-in-the-world that is different from the capabilities that the body once had. Thus, the noted incongruences (if indeed, they are) between an aging body and inner self may be different constructions of temporality and corporeality, and invites a rethinking of views of the body and self, as well as time and temporality.

Andrews (1999), in her critique of the ageless self and the mask of aging, suggests that these theories erase and trivialize the past. She states:

Older people are in fact young people? Really? What happens to all the years they have lived, the things they have learned, the selves they have evolved from, and the selves they are becoming? Years are not empty containers: important things happen in that time. Why must these years be trivialized? They are the stuff of which people's lives are made (p. 309).

Age is about people's history and identities, and an ageless self or an inner self that is young erases this history and these identities. "Ironically, this denial of difference, this erasure of the years lived, further entrenches the barrier between us and them, as it strips the old of their history and leaves them with nothing to offer but a mimicry of their youth" (Andrews, 1999, p. 316). In an institution where the past is already erased simply by the purpose and structures of the institution, a double erasure of people's history and identities solidifies the making of institutional bodies. Thus, our conceptions of age as a 'mask of aging' require rethinking in order to ensure that residents' histories remain alive. Bodies as repositories of memories invites a rethinking of the aging body and self.

If we indeed view bodies as repositories of memories, then the ways in which we view institutions that contain bodies also changes. The long-term care institution, as I saw it, is alive with history and life. Past and present and future are bound up in life at

Ridgemount. The long-term care institution as an alive and vibrant place simply requires a different set of lens through which to view and a different set of ears to hear. As I got to know the participants, to hear their life stories, to hear their body stories, and to hear their stories of institutional life, I saw bodies-selves as living histories. To view residents through the eyes of the institution or through the eyes of social conceptions of age is to erase history and to erase a life. To view residents as simply bodies is to focus only on the negative aspects of age, without embracing the life that was lived, both with the positive and negative. To view residents as simply bodies is to erase the incredible strength and fortitude that many residents have to survive within the institution. If I had been focussing on cultural conceptions or institutional conceptions of residents throughout this research, rather than on the lived experiences of the participants, I would have missed out on the incredible opportunities to know more about others, to know more about life, and to know more about myself.

9.5 Reflections on Body-Self-Place Relationships in the Context of Long-Term Care

The theoretical framework of this study made the assumptions of the oneness of body, self, and place, which may be separated conceptually, but not experientially. This research sheds further light on these relationships. What is very clear from this research is that the institution structures individuals' experiences, even on a phenomenological level. While each of Van Manen's (1997) lifeworld existentials may exist interdependently for most individuals, total institutions structure each of these lifeworld existentials according to the mandate and purpose of the institution itself. Thus, at a phenomenological level,

the institution structures lived experiences. While past research has examined the negative effects of institutionalization and the impact of institutionalization on identity, the extent to which residents' lives are altered cannot be understood without examining the institutional experience on an embodied level.

As described earlier, place structures bodies both on an embodied and a structural level. Place also structures temporal dimensions through the hegemony of institutional time. In addition, place structures relational dimensions through determining interactional others (i.e., staff within the facility) and through the care encounter (where corporeality and relationality intersect). Thus, the institution as place structures each of these dimensions. In the case of a total institution such as a nursing home, the place itself, along with its structure, values, rules and regulations, and routines so completely shape every other dimension of the lifeworld existentials. The other lifeworld existentials are embedded in place. The structure of the institution is so pervasive that it pervades each lifeworld existential and structures lived experience. Each person might experience the world differently, but within the institution, common themes emerge because of the pervasiveness of the institution. Each lifeworld existential is subsumed by place.

As I argued earlier based on Kontos' (2003; 2004; 2005) work, self and body are inseparable. In the context of this research, residents described aging and unpredictable bodies. As their bodies aged, they too viewed themselves as old, contrary to a mask of aging theory. Identity was structured around the body, as residents began to accept an identity of being a body in their interactions within the institution and accepted an identity of being old. An inescapable part of their identities within the institution was that of being a body. Meaning was ascribed to them and identities ascribed to them based

upon their bodies. Residents also conformed their bodies to the identity of being an institutional body by conforming and complying to staff's demands regarding the body, while the body as experiencing was erased. Thus, even at an embodied level, residents accepted an identity of being a body. Yet, at times, residents defined identities and self apart from the institutional body. As I mentioned earlier, Brian and Rachel claimed an identity separate from an aging and unpredictable body—that of a highly functioning mind untainted by expectations of age and 'senility'. Residents tried to maintain independence through exercising their bodies and doing things for themselves that they were not 'supposed' to (i.e., Brian going to the bathroom at night on his own; Edward walking without his walker). Residents found ways of recreating the body and resisting these identities.

If self through time exists both in the mind and the body, then memories exist in bodily form as well as in cognitive form, as I described earlier. Memories, then, are embodied and can exist in the visceral depths of the body. Indeed, Kontos' (2003; 2004) work suggests that bodily habits and comportment are evident even in residents with dementia, suggesting that memories do exist in the body. Selfhood was also evident in Rachel, Edward, and Brian's bodies as I observed the ways in which they dressed and carried themselves. What is perhaps disturbing, however, is the erasure of residents' past by the institution and the narrow narrative space for the expression of alternative identities. If memories and the self also exist in corporeal form, then attempts to manage, objectify, and control the body is yet one more way in which residents' pasts are erased. While self exists in cognitive and corporeal form, both are managed or erased by the institution.

The body-place relationship has not been explicated in recent literature, particularly surrounding long-term care. There is perhaps no better example of the body-place relationship than the long-term care environment, and of the ways in which place can so completely structure body and body-identity. Power relations were evident in the ways that bodies were managed and controlled through regulations, routines, and even through the organization of space. Residents learned to make their bodies behave in certain ways as they were disciplined by the institution. On a phenomenological level, residents formed habits and relationships with place as their bodies learned to be-in-the-world of the institution. Residents became institutional bodies. The identities associated to place are directly tied into the body as experiencing and experienced. Rules and regulations were around the body and confinement was because of space and the aging body. The body-place relationship was one where the body was disciplined by place. Because the main purpose of the place was to care for the body, one can see directly how the body is implicated in the experiences of place and how place is implicated in the experiences of the body.

Place also structured selfhood. In particular, the social environment structured selfhood. The link between social relations and the body was very clear, as the body was produced within the care encounter. Total institutions typically have a lack of resources to maintain identities (McCorkel, 1998). The long-term care environment also has a lack of interactional others by which to maintain identities, as residents' main interactions are with staff who have little or no knowledge of residents' histories and past lives. Attempts to erase the past also on an embodied level, by forcing the body to forget old habits and learn new ones that conformed to the routines and the structure of the institution,

complete the process whereby residents become institutional bodies. Place structures bodies and in the process, structures selfhood.

What continues to amaze me, however, is that residents are still able to maintain the self and who they are, despite being implicated and deeply affected by the assignment of an institutional identity. A re-created body in resistance to an institutional body illustrates the ways in which residents attempt to maintain a semblance of the former self and create a new self in the institutional setting. Thus, even despite the structure of the institution and its power to assign residents identities, resistance is still possible.

Body, self-identity, and place, then, in the context of the long-term care facility are inseparable experientially, although conceptually can still be theorized apart from each other, to some degree. Any change in a lifeworld existential or dimension has a profound impact on the other lifeworld existentials, but in the context of long-term care, place and the body are predominant in their structuring of experience. Indeed, the ability of place to structure even the body would lead me to believe that place is the predominant dimension or context that has the ability to structure all experiences, at least in the context of a total institution. The body, then, experiences place and is also structured by place—it is both lived and acted upon. To discuss residents' experiences in long-term care without examining both the lived experience and the inscribed experience is to only partially understand what life is like living in a long-term care facility.

9.6 Reflections on Recreation and Leisure at Ridgemount Facility

While leisure was not the central focus of this investigation, the phenomenon as experienced by the residents still warrants a discussion. Residents did not discuss leisure

as a central part of their lives, and often our discussions about leisure and recreation activities occurred because of prompting from myself. However, residents had a lot of time in the facility with nothing scheduled. While the routines were rigid, time was also often free from care obligations, leaving residents with little to do. As Ice (2002) found, residents in long-term care often spend their days with little to do or doing nothing. Recreation and leisure, in the context of Ridgemount, played a couple of different roles. It was a part of the socialization process, it was a way to fill time, and it was a way to create an alternative identity to the institutional identity of being a body. Recreation and leisure occurred in two ways—through planned activities by the facility and through independent unstructured activities chosen and initiated by the residents themselves.

First, recreation as planned programs played a part in the socialization process. Staff described the expectations for residents to attend planned recreation programs, and often used strong encouragement to get residents to attend programs. The assumption on the part of staff was that residents would have a good time. Rachel attended most recreation programs, while Edward was choosy about what he participated in. Brian, however, did not participate in any planned programs. Staff also described recreation as a way for residents to get to know each other. Recreation was a part of the institutionalized routine in the facility. The recreation staff described how programs were scheduled into the routine of the facility. In the morning, residents were first engaged in body care activities. Programs were scheduled afterward in the morning, typically around 9:30 or 10:00 and 11:00. Lunch then occurred, and programs were scheduled for 2:00 after lunch. Programs occasionally occurred on evenings and weekends, but for the most part, occurred regularly in the morning and afternoon at specified times. Programs all occurred

within the facility, with the exception of the occasional outing. Thus, recreation programs were woven into the routine of the fabric of the institution. By attending recreation programs, residents became socialized into the institution. This is not to preclude the enjoyment and benefits residents might receive from these programs, but these planned programs occurred within the facility.

Residents themselves, however, often chose to participate in activities that were unstructured by the facility. Rachel spent time in her room watching TV, doing crossword puzzles, talking on the phone, and reading. Brian watched TV, read the newspaper and other magazines, and went for walks. Edward went to visit his wife, read the newspaper and other magazines, went for walks, and visited with other residents. These were ways for residents to fill their days with activities without depending on the institution. Both scheduled recreation programs and independent leisure activities helped fill time, as described by residents.

In both ways of participating in recreation activities, residents found ways to create and confirm alternative identities. Haggard and Williams (1992) found that participation in leisure activities affirms participants' identities. Leisure identity images are affirmed through participation in specific activities. Indeed, the residents here affirmed their recreated identities through their participation in specific activities. Brian refused to participate in recreation programs because they were geared toward people with cognitive impairment or limited mental functioning. Since he did not consider himself to be in this category, he refused to participate in formal recreation programs. He chose activities that continued to maintain his leisure identities that he cultivated throughout his life. His intense interest in hunting and fishing was evident in his books

and magazines that he had in his room. While he used to make his guns or work in his workshop, he described listening to talk shows on the radio, and he often continued to listen to these programs. The television programs that he watched also maintained his identity as cognitively able—news programs, sports programs, documentaries, and history programs. He rarely watched sitcoms or other programs on television, but focussed on those programs that had some intellectual content.

Edward, as well, continued to participate in activities that were an important part of his identity. Edward loved reading the daily newspaper. He could often be found reading his paper in the mornings after breakfast in his bedroom. Edward was very interested in politics, and when the federal election occurred, Edward described being disappointed in not having anyone to discuss politics with. He kept up with daily news by reading his newspaper. Edward also recreated his identity by reclaiming his body, and his leisure activities certainly reflected this identity. He participated in exercise programs scheduled by the facility, as well as spending much time walking around the unit to keep up his strength and abilities. His physical functioning was very important to him, and this was reflected in his choice of activities. Rachel recreated her identity through emphasizing a close relationship with staff and being involved in the facility. This identity, similar to Brian, also differentiated her from other residents since other residents did not have close relationships with staff. She was the vice-president of the residents' council, and attended all recreation programs. She thrived on knowing what was going on in the facility and with specific staff, and our conversations often focussed around stories of various staff, including the recreation staff, and what was going on in their lives.

Recreation, then, affirmed residents' identities that were recreated in contrast to the institutional identity of being a body.

9.6.1 Further Theoretical Conceptualizations of Leisure and Recreation

In order to further theorize about recreation and leisure in long-term care, I turn my attention now to leisure theory, and then to the provision and roles of recreation and leisure in long-term care. In order to further understand leisure within an institutional context, some of the assumptions underlying leisure as a concept needs to be deconstructed. I then suggest ways in which leisure can be reconceptualized to further understand its role and importance.

The role of recreation and leisure in long-term care is complex, and interestingly enough, does not seem to be a very important focus of the participants' lives that it deserved significant discussion by them. Indeed, issues of body care, body functioning, and relationships were the central focus of conversation, rather than leisure and recreation opportunities. Leisure and recreation mostly emerged in conversation through my specific and direct questions. This perhaps lends credence to Rojek's (2005) comments that the "notion of leisure as a segmented realm of human experience magically insulated from the rest of life and fated to become generalized in identity and lifestyle became common currency, almost without anyone noticing it" (p. 3). Rojek (2005) also states that "[c]ivil society engenders multiple and often discordant flows of information relating to medicine, genetics, environmental hazard, inequality, and human rights that has eliminated the possibility of theorizing leisure as a compartmentalized or segregated form of life" (p. 4). Sylvester (1991) suggests that "[l]eisure is not an independent object "out

there” in the world of nature (the fallacy of reification). It is invented in the interplay of thought, language, and cultural practices, including the practice of science” (p. 451).

Leisure has been viewed as an object, when in fact, it is subsumed by culture and cannot be interpreted apart from it.

As I described earlier, leisure defined as ‘perceived freedom’ can also be another form of social control. Using a subjective definition of freedom can be manipulated to change people’s perceptions of their realities, rather than changing social conditions and situations, which can provide powerful reinforcement for the status quo (Goodale, 1990). The focus on the individual has failed to address broad structural inequities. Goodale (1990) suggests that “[w]ith our relatively recent focus on perceived freedom we have abandoned freedom itself” (p. 299). Particularly in a restrictive environment such as a long-term care institution, leisure as freedom is both limiting, yet expanding possibilities.

9.6.1.1 Place and Leisure

Place has been a concept that has been little understood by leisure researchers. Indeed, much of the discussion of place within leisure has focussed on place attachment in wilderness areas (Bricker & Kerstetter, 2000), rather than on an in-depth understanding of leisure in place. As described by Wiersma (2003), leisure takes on the characteristics of place. In my previous research, the meanings of place as well as the meanings of leisure significantly changed when residents were exposed to a different environment. Residents with dementia living on a locked unit went on a trip to an accessible camp for four days, and experiences changed dramatically within these two environments. Leisure was restrictive within the facility, taking on the characteristics of that place. But at camp,

leisure was free. Residents chose what activities they wished to participate in and also initiated their own activities. The environment provided a sense of freedom and leisure activities reflected this, rather than leisure being free in and of itself. Thus, leisure can take on the characteristics of place. Understanding the role of place is critically important in understanding experiences of leisure.

Ridgemount was a rigid, routinized institution. While residents had activities that they participated in, overall they were still in a confined place that reduced them to being mere bodies. While leisure can potentially act as a buffer to the socialization process into the institutional culture, recreation programs themselves were also part of the socialization process. Leisure as re-creation of the body and creating alternative identities was directly in relation to the identities created by the institution. Thus, the institution also structured the meanings of everyday life in addition to the meanings of leisure experiences in this facility. Place, then, played a significant part in residents' perceptions of leisure experiences.

9.6.1.2 Embodied Leisure

While leisure has been considered as an object on its own rather than an interpretation of culture or situated within culture, leisure has not been considered as an embodied experience. The mind/body dualist way of thinking is glaringly evident in leisure theory. The theories and assumptions underlying leisure are social psychological in nature, and are premised on the assumption that humans are rational and cognitive beings. The body as a focus in leisure has been ignored. This exclusion, of course, is not any different than social theory prior to the explosion of discussions about the body and

embodiment in the last decade or so. Leisure theorists have a reluctance to embrace the body, if even considering the body at all. If the body has been embraced, such as in therapeutic recreation, it has been medicalized and pathologized, rather than understood as experiencing. The focus for the most part, however, has been on cognition and the mind as the site for self, and thus as a site for the leisure experience. The notion of perceived freedom and lack of constraints as the most central set of attributes associated with leisure (Mannell & Kleiber, 1997) indicates that cognition is privileged as the determining factor of leisure experiences. These theories privilege rationality and cognition. Therefore, leisure as an experience is determined by individuals' rational decisions and cognition. Indeed, much of the leisure research is premised on assumptions that individuals actively choose leisure, that individuals have specific motivations for participating in leisure activities, that individuals intentionally attempt to overcome constraints to leisure, and that the "true" experience of leisure as perceived freedom exists in one's cognitive evaluation of the experience. The literacy of embodied knowledge, however, is sorely lacking (Shapiro, 1999). The mind/body dualism is dichotomous thinking, where one becomes privileged and the other suppressed (Grosz, 1994). Leisure theory, then, has, whether consciously or unconsciously, suppressed the body and privileged the mind and rationality. Since the body is an inescapable part of life, it is surprising that the turn towards the body that is occurring in other disciplines is not happening within leisure studies.

An understanding of leisure as a phenomenon needs to be an embodied understanding. Leisure, in whatever form we choose to participate, is always an embodied event, as is any event in daily life. The body can play a significant part in

whether or not an experience is construed as leisure and whether or not one might actually participate in leisure. The residents in this study lived with unpredictable bodies. When bodies were unpredictable, they chose not to participate in leisure activities and recreation programs. Thus, their bodies as experienced played a significant role in determining their leisure pursuits from the outset. Recreation, then, can be disciplined by the body. The body can structure leisure experiences.

Leisure has also been investigated outside of a corporeal context. What needs to be more fully understood is how the body within leisure is in the world. A phenomenological understanding of embodied experiences within leisure must be more fully understood if we are to have a greater understanding of the role of leisure in individuals' lives. An embodied approach to understanding individuals' experiences must also be taken when understanding individuals' leisure experiences. While we know that body image plays a significant role in determining leisure pursuits (James, 2000), what this experience is like is not known. How people experience their bodies in leisure and experience their bodies in the world, and how these experiences are implicated in the leisure experience and satisfaction has not been examined in any systematic way. Body, if considered, has been relegated to a symbolic role as an inscription of culture, as an object rather than experiencing. Therapeutic recreation, in particular, has been complicit in relegating the body to the outer realms of life. By focussing on "fixing" people and providing "therapy", the reality of people's lived experiences of their bodies have all but been discarded. Indeed, to presuppose that the therapeutic recreation specialist (TRS) is "expert" is also to presuppose that this "expert" knows what is best for individuals' lives. By placing the TRS in control of the therapy process, tacit knowledge of clients' bodily

experiences in therapeutic recreation have been ignored. What is perhaps worse is that the proclivity of therapeutic recreation to lean towards a medical model means the body becomes pathologized through yet another “expert” gaze. Pathologizing the body reduces all bodily experiences to disease or dysfunction, rather than understanding lived embodied experiences, and as a result, further marginalizes individuals. It is absolutely vital, then, for therapeutic recreation, and leisure as a whole, to embrace embodied practice, and authentically engage in relationships with clients (Sullivan, Pedlar, & Miller, 2002).

9.7 Gender and the Research

Gender and old age has been a phenomenon that has been discussed and researched extensively in the last decade or so (Arber & Ginn, 1995; Calasanti, 2004; Gibson, 1996; Twigg, 2004) and feminist gerontology discussions have exploded (Calasanti, 2004; Gibson, 1996; Gibson & Allen, 1993; Ray, 1996; 1999; 2003). What has been strikingly evident, however, was that while older women as a distinct marginalized group were defined and studied (Gibson, 1996; Gibson & Allen, 1993), the gaze has not been turned to men in great numbers (Calasanti, 2004). Qualitative research studies are more likely to over-represent the voices of women (Russell, 2007). Indeed, as Russell (2007) states: “I would argue that, in significant ways, the gendering of old age as a social problem has shifted from a ‘masculinist’ to a ‘feminist’ bias within an overarching perspective of competitive suffering” (p. 177). Russell (2007) describes how authors have debated whether older men or older women “suffer” more in old age. While men have been included in gerontological research, they have not usually been examined

as men (Calasanti, 2004). Thus, how men and women do gender in older age has not been examined in-depth (Calasanti, 2004; Russell, 2007). Russell (2007) describes how studies, particularly in long-term care facilities, have referred to participants as “residents”, rather than as men or women, and have failed to examine the ways in which gender impacts the experiences of long-term care.

While the focus of the present study was not on gender as a phenomenon under investigation, gender cannot be discounted in the production of the findings of this research, both on an empirical and methodological level. As noted in Chapter Seven: Methods, there were three residents who participated in this research. One participant was a woman, while the other two were men. The findings of this research, then, are not simply about how “residents” become socialized into long-term care facilities, but about how men and women become socialized into the institution. To simply refer to participants as “residents” without recognizing gender as a part of this process is to erase salient parts of their identities that very much define who they are.

While some researchers have come to similar conclusions that residents use personal narratives as alternatives to institutional identities (Gubrium, 1993; Paterniti, 2000, 2003), the ways in which these alternative identities are gendered has not been discussed. While the focus of my research was not on gender and personal narratives, the findings suggest that the lived experience of long-term care may be different for men and women. In my informal observations and conversations, Rachel discussed her family, relationships, and appearance in conversation more so than Brian or Edward. Since Rachel took her grandchildren in when they were babies and raised them, her family was closer to her, and the role of “mother” or caregiver was one that she did not easily

relinquish, even upon admission to Ridgemount. Rachel's appearance was also a way in which she re-created the body. Charmaz (1995) found that women who are chronically ill manage their appearance to handle their feelings and bolster their confidence. Indeed, as Rachel commented after I had finished painting her nails: "I feel more like myself now" [Interview Two]. Edward and Brian discussed their own functioning as alternative identities—both body and mind—rather than their family connections, as did Rachel. Edward and Brian, in constructing their identity through narrative interaction with me, described work and leisure involvement over the course of their lives. Despite the fact that they had both been retired for many years (over 15 years), work discussions were an important part of their conversations. Many of the connections with people that they knew within the facility were work-related. Whether the differences in content of conversation were related to personality or to gender, or whether indeed these can even be separated, the nature of conversations with the participants was very different. Further research should explore the ways in which alternative identities are gendered in nature, and how this impacts gendered interactions with a female majority staff.

The nature of relationships between staff and residents was also gendered. For the most part, nursing staff were female. The interactions between female staff and residents as well as male staff and residents has not been examined in-depth in the literature. While the men in this study did not mention the sex of the nursing staff, Rachel did mention, particularly at the beginning of the research, how she was uncomfortable with care from the male staff. Her granddaughter, Deborah, also mentioned it during my conversations with her. Rachel had typically refused care from male staff, and preferred female staff. During my third interview with her, however, she described allowing a male student

nurse to give her a bath as part of his requirements of his practicum. When I questioned her about it, she stated that she had become used to care from male staff, and it was no longer an issue for her. In her comments about not getting the bedpan at night, she referred to a male nurse who was particularly impatient with her. She referred not only to his sex, but also to his race. Thus, the impact of gender and race, while perhaps not explicit in this study, structured care interactions and relationships between residents and staff. Indeed, other research has demonstrated how staff often have to take racist and sexist comments from residents (Foner, 1995). Little research has examined how gender is constructed and lived by long-term care residents, and further research needs to examine this along with gendered interactions with staff and between residents themselves.

9.8 Practical Implications

The practical implications of the research, as discussed below, are divided into two main considerations—that of an embodied approach to care and of critical space. An embodied approach to care focuses on considerations of the body in the care encounter and conceptualizations of care. Critical space reconsiders the notions of ‘spaceless places’ and privacy, and considers ways in which freedom and privacy can be facilitated and encouraged in long-term care.

9.8.1 Moving Toward a Sociocultural and Embodied Approach to Care

There are numerous practical implications to be considered from this research. The most important consideration, however, is the notion of care. This section draws on a

number of theories and studies from the nursing literature, where caring has been discussed in great detail. The nursing literature was also used since long-term care is situated within the health care system, as is nursing, thus concepts of care and caring are appropriate within this system.

Theories such as Watson's (2005) theory of a caring science and Parse's theory of human becoming (Parse, 1998) have permeated the nursing literature, although there have also been critiques of these theories. Morse and her colleagues (1990) and McCance and colleagues (1997) conducted content analyses of the nursing literature on the concept of caring. McCance and colleagues (1997) found four attributes of caring that were common across much of the literature—serious attention, concern, providing for the patient, and getting to know the patient. Morse and colleagues' (1990) study, however, has been often cited, and described five ways that caring has been conceptualized in nursing literature—caring as a human trait, caring as a moral imperative or ideal, caring as affect, caring as the nurse-patient interpersonal relationship, and caring as therapeutic intervention (Morse et al., 1990). Caring as a human trait is seen as part of human nature and essential to human existence. Caring as a moral imperative or ideal refers to adherence to the commitment to maintaining an individual's dignity or integrity. Caring as affect refers to the emotional involvement with or empathetic feeling for a patient's experience. Caring as nurse-patient interpersonal relationships means that the interaction between the nurse and patient expresses and defines caring. And finally, caring as therapeutic interventions refers to the specific nursing interventions or work as caring. Thus, caring can have a range of meanings, from relational to emotional to behavioural.

Indeed, in my own review of the nursing literature, these conceptualizations of care seem to be common.

One of the issues, in my own perspective, of long-term care is that it operates within a theoretical void. Indeed, if long-term care does operate within a theoretical framework, it is typically a framework of instrumental rationality, economic efficiency, and medical culture (Estes, Harrington, & Pellow, 2001; Henderson, 1995; Paterniti, 2000, 2003). Theories of care and caring, and what caring might look like, do not seem to be prevalent. In addition, many of the nursing theories of care developed in the literature seem specific for acute care settings and professional nurses, rather than residential settings and nursing assistants. While approaches to care have been adopted for long-term care (i.e., the Eden Alternative), these approaches seem to be devoid of a theoretical understanding of care. Perhaps most troubling is the lack of research on care and on what, from residents' perspectives as well as staff perspectives, care really means, what it looks like in practice, and how it is operationalized. How do residents know that nursing staff really care for them? How do they feel cared for? What does care mean to them?

Thomas (1993) suggests seven dimensions that are common to all care concepts. These seven dimensions assist in providing a framework and context for care in different settings, and for the purposes of this discussion, in long-term care. These seven dimensions include: (i) the social identity of the carer; (ii) the social identity of care recipient; (iii) the inter-personal relationships between carer and care recipient; (iv) the nature of care (feeling state or activity state); (v) the social domain within which the caring relationship is located (public vs. private domains); (vi) the economic character of the care relationship; and (vii) the institutional setting in which care is delivered. Thus,

the sociocultural context as well as the nature of care must be taken into account when defining caring.

9.8.1.1 The Sociocultural Context of Care

Another issue with conceptualizations of care as discussed above is the notion of the ethic of care and feminist conceptualizations of care (Bowden, 2000). While conceptualizations of care are appropriate to discuss in long-term care, and indeed, must be further conceptualized, the sociopolitical context must also be taken into account. Caring and caring professions are typically seen as gendered professions (Twigg, 2000a, 2000b), caring being in the realm of women. Given that the majority of people who provide care both within the homecare sector (Twigg, 2000a) and within long-term care (Diamond, 1992) are female, gendered analyses of care must also be considered (Thomas, 1993). Bowden (2000) suggests that an ethic of care that incorporates institutional and political relationships when conceptualizing nursing care is important.

In long-term care, the burden of caring falls on health care aides (HCAs), personal support workers (PSWs), or certified nursing assistants (CNAs). Each of these titles refer to the same staff who typically carry out all the activities of daily living for the residents—feeding, washing, dressing, bathing, and everything else that residents need assistance with day to day. Typically, these staff have a low level of education (the PSW course is six months long), are often female (Diamond, 1992; Foner, 1995), come from a low socio-economic status (Diamond, 1992), are single mothers (Diamond, 1992; Foner, 1995), and often have to work at more than one job to meet their economic needs (Diamond, 1992). These are the staff who

have the most interaction with the residents on a daily basis. At Ridgemount, many of the staff who took on this role were actually registered practical nurses, although some were health care aides or personal support workers. The scope of their work, however, was not different from a typical health care aide. It is in this context—the day-to-day—that caring in long-term care occurs. These socio-cultural characteristics of staff play a significant part in care and caring (Tellis-Nayak & Tellis-Nayak, 1989).

In order to provide a caring environment for residents, a caring environment must also exist for staff. Some staff in this study described wanting to have opportunities to care for residents in ways that they felt were meaningful, but the cultural context of the institution did not allow them to. In other research (Dupuis & Wiersma, 2006), staff described the lack of organizational commitment to them, and described feeling undervalued and taken for granted. In addition, caregiver burnout must also be factored into the conceptualizations of care. Again, as evidenced in other research (Dupuis & Wiersma, 2006), many staff place a burden of perfection upon themselves to meet all the residents' needs, which may not always be humanly possible. Staff want to care for residents in meaningful ways, but the structures of the institution place severe restrictions on their time, energy, and abilities to care (Dupuis & Wiersma, 2006). To expect staff to care in all the ways described above without taking into account the structures of the institution and the politics surrounding long-term care would be neglectful both to staff and residents. Presently, the government of Ontario has increasingly regulated care due to the media spotlight on a number of situations of abuse in the last number of years, both physically and financially within the long-term care sector. Their solution has been to simply continue to regulate long-term care without addressing some of the systemic

issues underlying some of these problems. Indeed, the systemic issues of not enough staffing, not enough funding, lack of team effort and management support, and heavy workloads (Dupuis & Wiersma, 2006) continue to be issues that cannot be addressed through increasing regulation. Thus, a caring environment that recognizes the sociocultural context is important to consider when addressing issues of caring.

9.8.1.2 An Embodied Approach to Care

Another consideration to take into account when postulating about care and definitions of care is the embodied nature of care. Because care within the long-term care facility is focussed on the body, care is naturally embodied and involves both residents' and staff bodies. If we continue to maintain a view that self exists within the body as well as within the mind, the implications for practice are significant. Kontos (2005) suggests that in rethinking the mind-body-self relations, we must also consider the practical implications of this rethinking and how embodied selfhood can inform guiding premises and underlying assumptions of dementia. She suggests a new ethic of care with a focus on the awareness of non-verbal behaviour from residents with dementia. While this new ethic of care is important and needed, what is missing, however, in this conception is body relationality. Since the body is produced within the care encounter and particularly through body language as forms of communication, the ways in which practitioners "speak" through their bodies and through their touch of others' bodies becomes extremely significant. An embodied approach to caring is necessary if we are to provide person-centred care.

An embodied approach to caring requires a rethinking of our conceptions of care. Although the conceptualizations of care are relevant (McCance et al., 1997; Morse et al., 1990), what the research at Ridgemount illustrates is that residents are very aware of body language, and that much of the communication from staff to residents comes through body language. Thus, care is embodied as much as it is relational or cognitive. Indeed, care might be described as relational embodiment or embodied relationality. I described earlier how residents are made into institutional bodies through the care encounter and bodily relationality. The care encounter needs to be recognized as the site in which bodies are created, but is also the site in which staff have the opportunity to create meaningful embodied relationships with residents.

The depth of emotional intimacy, or bounded intimacy (Twigg, 2000a) that is lacking in much of long-term care can most certainly be attributed to structural issues such as a lack of staffing and a lack of time. However, intimacy can also be attributed to the fundamental philosophy under which most long-term care facilities operate—that of a medical model. Most facilities, particularly in Ontario, are forced to operate within a medical model because of the government regulations and other policy issues that dictate ways in which long-term care is provided. Government regulations emphasize care of the body through assessment and documentation (which is how facilities are evaluated and regulated), while care of the individual as a person is disregarded. To move toward an embodied approach to care, significant structural changes need to occur. Indeed, McCormack and McCance (2006) suggest that moving toward a person-centred care philosophy cannot occur without structural changes.

Emphasizing structural changes and de-emphasizing the responsibility on individual organizations and staff, however, is not conducive to changing conceptions of care. While recognizing that staff work within oppressive work regimes that limit emotional care work (Lopez, 2006a), there are also a multitude of opportunities throughout the workday in which staff can help build emotional intimacy. Indeed, emotional intimacy and an embodied approach to care are not necessarily unrealistic, but require a commitment to being with the person.

Parse's (1992; 1998) human becoming theory as an approach to care has important implications for an embodied approach to care. Truly being with the person in an attempt to understand his or her lived experience provides long-term care staff with a unique opportunity to create emotional intimacy that is appropriate with the level of physical intimacy that is required in the relationship. The relationship between residents and staff is no longer viewed as a subject-to-object relationship, but viewed as a subject-to-subject relationship, in which the staff can willingly enter and embrace the other's experience (Mitchell, 1991). It is about uncovering the meaning in what people say (Mitchell, 1990). The focus is not on diagnosing the individual, but listening to his or her perspective on what is occurring (Mitchell, 1990). This embodied approach to caring not only involves listening to his or her perspective, but attempting to elicit meanings on bodily care and the care encounter. What makes residents feel safe? What makes residents feel valued? What can staff do to affirm the individual and his or her experiences? How is this shown through body language and communication? As Rachel mentioned, a simple gesture of "making sure you're nice and clean" made her feel as if she wasn't a bother, as if it was staff's job to do this. Those staff who just pulled up her

clothes communicated to her that her body and comfort were unimportant and not part of their duties. This is one simple way in which care can be communicated. Thus, staff need to elicit understandings and meanings from residents about the physical care encounter and how embodied care might be shown.

Changing practice from a totality paradigm to an alternative approach is challenging (Mitchell, 1990). A totality paradigm focuses on life processes and phenomena and refers to them as problems to be labelled (Mitchell, 1990). This type of paradigm is indicative of a medical model of care. As Mitchell (1990) describes, however, "...changing practice approaches from one paradigm to another requires a transforming of values, beliefs, and ways of being" (p. 176). This is perhaps one of the most difficult elements of change. Changing from a bounded relationship of care to an emotionally intimate, embodied approach to care requires staff to engage in reflective practice and to know themselves, their values, and their beliefs (McCormack & McCance, 2006). Reflective practice is a vital component of an embodied approach to care. Staff need to examine their views of the human body, their views on bounded intimacy, and to interrogate whether they even wish to make the commitment to an embodied approach to care that involves being with the person. For many care workers, caring for older people brings workers face to face with the realities of aging and gives them a vision of their own future (Twigg, 2000a). This, too, needs to be reflected upon as part of an embodied approach to care. What does it mean to get old? How am I as a staff member different from, and similar to, the residents? How can I enter a subject-to-subject relationship rather than a subject-to-object relationship? The change to an embodied approach to care requires substantial emotional commitment on the part of staff and

management. Thus, an embodied approach to care requires both changes on a bodily relational level as well as a caring environment in which this change might occur.

Whether long-term care is ready for a change in approaches to care at this juncture in time remains to be seen. As McCormack and McCance (2006) state, moving to a person-centred nursing philosophy, and the implementation and practice changes required are beyond the scope of individual nurses and requires organizational and structural change. Moving toward an embodied approach to care would require the same type of changes. Thus, advocacy on a political level is a key to this process. While nurses are organized with their own unions and professional organizations, health care aides or nurses aides, who perform the majority of hands-on care for residents in long-term care facilities, have yet to become organized politically. As such, advocacy for change on a structural level is still in the hands of relatively few. The system, however, will not change itself, and every staff member and person connected with a long-term care facility who wishes to see changes made has a responsibility to become active politically to see these changes take place.

9.8.2 *The Role of Critical Space*

As described earlier, the institution as a place had no space. Thus, a sense of freedom was denied and privacy had to be redefined. The role of critical space, then, can be very important in guiding approaches to care in the long-term care facility. Critical space has been defined by McCorkel (1998) as space at the intersection of physical and conceptual spheres. In McCorkel's (1998) study of women in prison, critical spaces allowed the women to recover a sense of who they were that was distinct from the person that staff said they were. Critical space occurred in a room that physically was not fully under surveillance by staff (staff could only see partially in the room) and was a conceptual place for the recovery of self through a lack of surveillance and social interaction with others.

The notion of critical space is particularly applicable to long-term care facilities as well. The socialization into the institutional environment occurred so completely for residents that they began to internalize the identity of being a body. Residents had no place to go that was not under surveillance of staff. Even bedrooms, which typically are private, were spaces of accommodation to being a body. Bedrooms were the spaces in which the care encounter occurred to make them into bodies. As Brian described, privacy becomes redefined in long-term care. Thus, critical space, a physical and conceptual sphere for the re-creation of bodies and identity, was limited. The physical space was limited, as was the conceptual space, as described by the lack of narrative space for residents to re-create and maintain a sense of self apart from the institutional identity of being a body. As I found in my previous research (Wiersma, 2003), residents at camp found a space in which they were free to reveal themselves and engage in authentic

relationships than when they were in the locked unit of the institution. Alternative environments can provide the resources and opportunities for recreating the body and alternative identities, while total institutions lack the resources by which people can create alternative identities to institutional identities (McCorkel, 1998). Thus, critical space as a guiding concept of care in long-term care needs to be seriously considered.

The notion of critical space can be operationalized in various ways. First, critical space can be created through physical space. That is, staff need to understand issues of privacy and ensure that residents' bedrooms are respected as if they were their homes. In addition, bodily privacy needs to be respected, and residents should have control over their own bodies. Second, opportunities for critical space can be created by the provision of alternative environments. That is, on outings residents are outside of the surveillance of the institution and are provided with more resources by which to create and maintain the self. More open environments in long-term care would provide residents with opportunities for critical space. Third, critical space as a place in which residents can form relationships, potentially discuss issues related to the institution, and provide alternative frameworks for viewing the self apart from the institutional identity assigned to them is important. How this is provided remains to be seen, but the provision of physical space that is beyond staff surveillance is a step in this direction.

There are numerous practical implications from this research. I have mentioned two important concepts to consider here—that of a sociocultural and embodied approach to caring and the creation and facilitation of critical space. If we are to recognize the impacts of institutionalization on identity (both cognitive and embodied) and attempt to provide ways for residents to maintain their sense of self, different ways of 'doing

institutionalization' need to be considered. Simply changing culture within long-term care is not enough (Lopez, 2006a). Fundamental changes to policies, regulations, and the structure of the institution need to occur.

9.9 Future Research

This research leaves many questions unanswered and also raises more questions for further research. Further research needs to examine embodiment and being-in-the-world, and how these pre-reflective experiences influence sense of place, place attachment and place identity. Currently, these theories are cognitive and rational in nature, rather than embodied. Further examining how people are in the world can provide a fuller understanding of how a sense of place, place attachment, and place identity are created. The changing geographies of care mean that long-term care is increasingly being provided within the home environment (Williams, 2002). Thus, examining the socialization process of receiving care in the home and examining the changing meanings of home within the context of home care are also directions that future research should explore. In addition, the lack of long-term care services in rural communities and the relocation of rural elders to urban contexts for nursing home care (as in the case of Edward and Maybelle, and Rachel) should be examined, particularly the loss and disconnection to their communities.

There are further issues that need to be explored in the long-term care environment. While the socialization process has now been examined in the long-term care environment, further research should examine the socialization process into a total institution environment for other groups of people, particularly for residents with

dementia or other cognitive impairments. The locked or secured units for residents with dementia might form a completely different socialization process for residents. Further research should also consider whether this socialization process might transfer to other settings, such as group homes or residences for people with disabilities. In addition, gender and gender roles need to be further explored in long-term care (Russell, 2007), as currently much research assumes a 'degendering' process (Silver, 2003) or does not explicitly examine gender (Russell, 2007).

The concept of care and what care looks like in a long-term care environment is important to examine in order to enhance person-centred care and enhance staff-resident relationships. Care has been philosophized and theorized, but little research has examined care in a residential setting such as a long-term care facility, particularly the perceptions of staff and residents of this concept.

Long-term care staff's experiences also should be an area that is further explored. While little research has examined issues from a staff perspective (Dupuis & Wiersma, 2006), further understanding staff experiences working within a rigid and routinized environment as well as the expectations staff place on themselves for care of the residents, is needed. In addition, understanding how staff experiences impact relationships with residents, care, and staff burnout is vital. Further research also needs to explore the difference in perceptions of nursing staff and their techniques to help residents adjust and the residents' perceptions of these techniques, which were not apparent in this study. This research provides directions for future research in order to enhance our understanding of the long-term care environment and residents' and staff's

experiences in this environment, and how quality of life can be enhanced both for residents and staff.

9.10 Research Limitations

This research was not intended to provide a grand narrative of residents' experiences in long-term care. Instead, it was meant to provide insight through the eyes of three residents into the experiences of coming to live in a long-term care facility and the ways by which residents come to be socialized into the long-term care culture. By understanding these in-depth experiences, one can take this knowledge to provide insights into the experiences of other residents. Each of these participants experienced the facility and socialization process in different ways, and common elements as well as individual elements provide a more comprehensive understanding of these experiences. Similar threads run through each residents' experiences, which then provide a greater understanding of the socialization process of coming to live in a long-term care facility (Dyck, Kontos, Angus, & McKeever, 2005). In addition, the changes in my life throughout the research (i.e., having my first child), impacted the data collection, and although this provided many benefits in terms of rapport and relationship development, also limited the ways in which participant observation was able to be conducted. Thus, much of the data came from verbal interactions, interviews, and observations during my interactions with participants. Further research may wish to take a more removed observer stance to delve in-depth into the embodied phenomenological experience of living in a long-term care facility.

Finally, research by its very nature is biased and value laden because it is a human activity (Harding, 1991). I make no claims of objectivity or value neutrality; indeed, in many ways, my close relationships with the residents provided me with greater access to residents' thoughts and feelings. I have tried to make my values and biases explicit in Section 9.11 The Self in the Research and the Role of Knowledge, although my intense discomfort with the way we in North America provide long-term care, my dislike of medical approaches to care, and my concerns with a privatized, for-profit industry caring for vulnerable populations will always lean my interpretations toward a critical perspective. But no research is without its flaws or biases; I simply attempt to be explicit about these factors in my own research.

9.11 The Self in the Research and the Role of Knowledge

The notion of situated knowledges is derived from Haraway's work (1988). Knowledge is described as always being constructed from the perspective of social positions and locations. By being 'objective' and 'value-free', this situatedness is ignored and hidden, and knowledge is taken for 'truth' rather than perspective (Harding, 1991). In long-term care, knowledge is often derived from the expert perspective (Estes & Binney, 1991). As such, the knowledge from other perspectives, including from staff perspectives, from family perspectives, and especially from residents' perspectives, is either dismissed or ignored (Diamond, 1992). Therefore, to view knowledge as situated for my research is to not only include the perspectives of 'experts', but more importantly, to focus on those people actually experiencing institutionalization and experiencing the long-term care environment. These knowledges can deconstruct traditional knowledge

about aging, institutionalization, and care issues and challenge dominant ideologies (Collins, 1991).

Situatedness also involves understanding how I approach my research in relation to the participants. I am a 31-year old woman, relatively young in comparison to my participants who are all over the age of 78. While age is a socially constructed category, there are differences between the participants and myself. I represent their past, and they represent my future; we are inextricably entwined. I can potentially represent pain for them, since I represent what was and what was not. I have what many of them lost—a partner, a mother and a father, siblings, friends. I am experiencing the life stages they once did and have now lost—marriage, a family, a career. I am their memories. And yet, despite these differences in our current situations, there are also many similarities. Memories do not always bring pain, and as such, they can relive their lives as they are a part of me living my life. They teach me life lessons that can only be known from experience. Many times, I see myself as more similar than different from them. Yet in terms of current life circumstances, I am vastly different. They represent my fears. One day, will this be me? How will I live? Survive? Cope? I wonder what it must be like to lose the use of your body. Even more, what must it be like to lose control of your bodily functions? I am able to care for myself now. What must it be like to not be able to go the bathroom by yourself? To not be able to turn your body over in bed? To not be able to take a step without someone there beside you? I cannot pretend to understand this experience, and in this way, my research and my ‘knowledge’ is often situated outside of these experiences. This, of course, means that my research only presents a specific

perspective, since the bodily experience is a significant part of people's lives (Twigg, 2004).

Yet, these participants are much more than the sum of their functioning, than of their body. And, it is in this way that we become entwined. The values I hold dear—of family, spirituality, nature, work, responsibility—are ones that many of them may hold dear as well. The lessons and experiences of life, and the living history that they possess, teach me about another era. To a great degree, the knowledge I gained from the field both in past research and work experiences, and the things I learned was dependent on my relationships with the residents. To some degree, I wonder how much I took as opposed to how much I gave? Perhaps I was one of the few who did not just listen, but who saw the residents as not so different from myself. But regardless of how I view us as similar or different, it is inevitable that I present a view of the participants through my eyes—that of a white, first-generation Dutch, female, young perspective. To pretend any differently is to assume the authority of a non-present other, and to present my findings as truth. In reality (or in fiction), my research and my knowledge are situated.

If we begin from the world as we actually experience it, it is at least possible to see that we are indeed located and that what we know of the other is conditional upon that location. There are and must be different experiences of the world and different bases of experience. We must not do away with them by taking advantage of our privileged speaking to construct a sociological version that we then impose upon them as their reality. We may not rewrite the other's world or impose upon it a conceptual framework that extracts from it what fits with ours. Their reality, their varieties of experience, must be an unconditional datum. It is the place from which inquiry begins. (Smith, 1990, p. 25)

Embodiment and embodied subjectivity also means that I as a researcher must be aware of my own embodied subjectivity. Fieldwork as an embodied activity is interactive (Reich, 2003). Reich (2003) described her experiences collecting her data while she was

pregnant. Reich was observing social workers who investigated child abuse and neglect, as well as shadowing emergency response workers as they investigated abuse. In some cases, she was present while the social workers removed children from the parents' custody. Throughout her data collection, she states that "...my interactions with those I was observing were layered with the cultural meanings of pregnancy" (Reich, 2003, p. 356). She states that her pregnancy was an important source of data.

Pregnant bodies are public bodies (Reich, 2003). Reich states that her pregnant body allowed those she was studying to feel more comfortable and helped her gain earlier entrance into the group. Having a common identity as parents were important sources of shared knowledge and credibility. In my case, being pregnant allowed me to share a common identity with many of the participants and others in the long-term care setting, including the staff and the residents who are or have been parents themselves. This shared identity, as well as the excitement that children and babies often bring to the long-term care environment, inevitably altered my relationships with staff and residents. Many of our conversations were centred first around my pregnancy and later around my son, Gabriel. Because Gabriel was about eight months old when the data collection period was finished, the staff and residents were able to watch him grow and were a significant part of his life. Being aware of this altered relationship, I explored the ways in which my relationships developed with others, and how pregnancy (and later a baby) affected this.

For Reich (2003), the physicality of her pregnancy presented her with challenges during her fieldwork. Given that I had been experiencing nausea, vomiting, heartburn, fatigue, and headaches, in addition to making extra trips to the bathroom prior to beginning my data collection, I anticipated the many challenges that might be presented

to me during my data collection. By the time I started my data collection in July, 2005, I was six months pregnant. My nausea had mostly subsided by this time, but the fatigue, heartburn, and asthma were challenges, as was a chest infection. During the first week of data collection, I went to the facility every day. By the end of that week, my feet were so swollen I was having trouble walking and I was exhausted. I then decided to go three days a week, every other day, to give myself opportunities for a break and to allow my body to recuperate. Although data collection was not physically strenuous, I was on my feet for the most part, and water retention and swollen feet, particularly toward the end of my pregnancy, posed some physical challenges for me.

Due to pregnancy, there were also timing issues with relation to data collection. Data collection was ongoing for up to a year due to the birth of Gabriel and my ability (or lack thereof!) to be a mother and researcher at the same time. As I mentioned, I was able to resume data collection within ten days of giving birth, bringing Gabriel with me to the facility. This, as well, changed my relationships with the staff and residents. Babies create much excitement in long-term care facilities, and much of my communications with others revolved around Gabriel. I have included an excerpt from my journal to describe the ways in which my pregnancy and the birth of my son changed me, changed the research, and changed the relationships with the research participants.

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It's time for me to reflect on myself as a researcher, on my relationships with my participants. I find this very difficult to do. There is a mish-mash of emotions and to sort them all out requires an immense amount of emotional energy and self-reflection. Self-reflection causes me to see things that I would rather not see, and so it is much easier for me to eliminate this part of the research. Quite frankly, I am tired. The past three years have been intensely...well, pretty much any adjective would do here. (Is it an adjective or an adverb? I guess English classes never paid off...I digress, again trying to sidestep this process).

I can't do it. I can't ignore it. If I am to understand how I came to these findings, how I came to view this institution, how I came to be in relationships with these people, I need to dig deeper.

In order to understand the "Other", I need to reflect on myself. For the reader who might not know me, let me tell you what the last three years have entailed for me...a wedding, a move, a pregnancy, and a baby. These four life events, in themselves, leave much to be described. Between the lines, between the commas, is a lifetime of emotions.

I married Harvey on December 19, 2005. I was in my second year of my Ph.D., starting to think about my dissertation and work on my proposal. I moved from Waterloo, Ontario to Ridge Mountain, Ontario the end of December 2005. Ridge Mountain is a 16-hour drive from Waterloo. My family lives in Ancaster, about an hour outside of Waterloo. Ridge Mountain is a long way from home. January 2006 was a very cold month with temperatures of -40C. I didn't like Ridge Mountain. On February 25, I found out I was pregnant. On March 5, the morning sickness started. It didn't stop until June (I was five-months pregnant by this time). On March 5, the heartburn also started. It never stopped until October 17, the day my son was born. Infections, asthma, breathing problems, water retention, weight gain...whoever said pregnancy was wonderful? I missed my family terribly. I hated feeling sick all the time. I didn't like living in northern Ontario—a "redneck" culture. I was thinking about my dissertation and how was I going to finish with a baby? I started my data collection in August 2006. I planned on bringing my baby in with me and continuing my data collection. I determined I would be completed my Ph.D. in four years. It is three and a half years now, and I am finishing the final draft.

My son Gabriel was born on October 17. My life will never be the same again. This is said with extreme joy, happiness, frustration, sadness, and guilt. The guilt never goes away. But back to that later...

My mother had postpartum depression when my youngest sister was born. For me, the first few weeks were fine. I felt so much better without a huge belly. I wasn't sleeping much, but I didn't sleep much before he was born either. But there were indications that things were not so well either. I remember coming home after we were in the hospital for four days, and looking at our house like it was a different place. I wondered if I would be able to do this. I felt some nostalgia for the 'pre-baby' times, and that has never gone away. Does it ever? Or am I the only woman/mother to feel this way?

I love my son with all my heart. The fact that I need to say this shows that cultural and societal expectations of "mother" are deeply inscribed in my value system, despite my feminist leanings. The guilt over some of my emotions does not go away. And perhaps it never will.

I brought Gabriel into Ridgemount Facility with me when he was just ten days old. From then on, he came in with me two or three days a week so I could continue my research. In retrospect, this placed a lot of pressure on me and of course on him, but I think I would have gone mad to stay at home all day.

The birth of my son changed my identity in ways that I can't describe, and in ways that I do not fully even know. But one thing that has not changed was my

love for my work and research and my longing to have a purposeful career. These feelings were not even suspended for a short period of time after my son was born. So I continued my research. My husband Harvey had a job too. He loved his job and had a purposeful career. And so the tension started to build. He could not support me. I could not support him. We both became isolated.

It was shortly after my son was born that problems in my marriage became glaringly evident. Arguments, fights, tension, sharp words, dangerous tones...it was never-ending. Home was not a haven, but a place of conflict. I contemplated leaving my husband, something I said I would never do. I cried all the time. How much more could I take? Life was so complicated now with a baby in the picture. Where would I go? How could I take my son away from his father?

I don't know when things started to get better with us at home. Outside intervention helped. Buying a home and moving out of our small townhouse helped. Getting more sleep helped. Finishing my data collection helped. Getting adjusted to having a baby helped. (Although some days I feel that I am still not completely adjusted, and Gabriel is 15 months old now).

You may be wondering what this has to do with my research. I sometimes wonder the same thing. Yet I as the researcher am an integral part of the research process, and who I am, my life circumstances, significantly impact the research. My emotional upheaval impacted my research, possibly in ways that I may not even know. Becoming a mother caused me to see the world differently. I experienced a number of incidents in which I felt guilty for wanting a career and was made to feel guilty by others for wanting a career. But continuing with my Ph.D. was my sanity—I was still someone, not just a mother.

My relationships with the participants as well as the staff, indeed, with everyone in the facility, changed significantly. Most of the staff (the majority of whom were women) could identify with pregnancy and motherhood, and the basis of our conversations were almost always about Gabriel rather than about the research or my career. My conversations with the residents often centred on family and children. I'm sure I was viewed differently by the residents because of Gabriel. Connections with residents' families were made as well because of Gabriel. In short, he became my identity in the facility. Surprisingly, I think this made my research easier. There was rarely a lack of conversation. I'm sure I was probably less intimidating to staff, perhaps to residents too. Gabriel was the foundation on which relationships were built.

These ways in which I am different, and in which I am the same as the research participants, provide the necessity for my self-reflexivity throughout the process of this research, and for my awareness of the ways in which my relationships with the participants was structured based on these similarities and differences. As such, it was of

utmost importance that my self and my person were included in the research and in my reflections.

Research, especially ethnography, is an embodied experience. Few researchers have included or analyzed their embodied experiences when doing research (Rudberg, 1997). Understanding how the body is a significant part of the research experience is just as important as understanding the researcher's experiences. "Including the subjective and emotional reflections of the researcher adds context and layers to the story being told about participants" (Ellis, 2004, p. 62). Illuminating relationships and reflections between researcher and participants adds depth and understanding to the analysis of the research, and adds depth to the participants' stories.

March 6, 2007

I am recovering from a migraine yesterday. I have taken Advil today to take the edge off my migraine, and although I can feel remnants of yesterday's pain, I feel much better. Today, I am able to read. I have picked up Simon William's (2006) article, "Medical sociology and the biological body: where are we now and where do we go from here?" I confess, some of what he has to say is beyond my level of comprehension, having not been immersed in some of the sociological literature that he has been. However, the essential notion of his article is that medical sociology needs to take into account both biology and sociology, that social constructionism has superceded much of the biological discourse of the body. In social constructionism, the body and disease have become mere discursive matters. Phenomenology has afforded us a more fully embodied perspective on the body, but is still at an early stage in the emerging and evolving material-corporeal project.

I more than likely will not come up with an amazing theory that can answer all of these questions. There are numerous scholars, with a more in-depth understanding of these issues, that have attempted to already address these questions (Birke, 1999; Shilling, 2005; Williams, 2006). And I wonder how all this theorizing can help answer my question—how do I convey the residents' embodied experiences? First, how can I understand? And then, how can I convey? I was pondering this as I read the article. I do not know what it is like to live with a chronic illness or disability. The only thing I can liken it to is my struggles with migraines. The pulsing, throbbing pain. I dread having to pick up my son or move from where I am sitting to take care of him. The pain increases with the movement. My eye, usually just one, becomes swollen and bloodshot, tears often shrouding my vision. The pain is indescribable, but grasps one side of

my head. Yesterday, it was the right side. Pain behind my eye, distorted vision, black spots, flashes of light in my peripheral vision, throbbing at the base of my skull, and a grip of pain over my scalp. I cannot work, cannot read, can barely speak a coherent sentence. My poor son, just 16 months, gets the brunt of Mommy's anger and frustration. Somehow, he always seems to know when he can get away with all the things he normally is not allowed to do, and so he tests my patience. The pain does not go away. Medication does not help. Heat applied to the neck does not help. An ice pack on the forehead or over the eyes relieves a modest amount of the pain momentarily, but it comes back full force once the ice pack is removed. I want to continue my daily activities, but I cannot rely on my body. All my muscles in my body coil and tense, focussing on the pain in my head. I find myself clenching my teeth to cope with the pain. I feel my muscles in my neck and shoulders spasm and tighten. I know that when this is over, my body's muscles will ache with the exertion.

I think, then, what it must be like to live with pain permanently. I know, at least, that this pain in my head will go away in a day or two. Next month it will be back, but there will be relief. I survive, knowing that tomorrow, my body will be my own again. What does Brian feel every day with the pain in his knees? What does Rachel feel with the pain in her arm and leg on her affected side from her stroke? Are their bodies their own? The unpredictability and inability to depend on one's body must leave one feeling powerless. Again, I think of my migraines. I have no control over my body, over the pain. I worry about when I will be expected to perform at work, and what will happen on the days that I cannot depend on my body. What must it feel like to be unable to take care of your own bodily functions? Does your body feel alien? Or does one form and construct a new relationship with an unstable and unpredictable entity? What is the relationship between the mind/body/identity? My identity when I have a migraine becomes a migraine sufferer. My husband looks at me and can tell I have a migraine. All kinds of behaviour becomes excusable at this time. I have a reason. I have pain. I am no longer mother, wife, friend, sister. I have a migraine. I become my pain, and those around me relate to my pain. Of course, my son is too young to understand, and is the only person who does not. What happens if I am not given due consideration by those around me because of my migraine? If I am expected to continue my day-to-day activities? I certainly would harbour resentment towards those who have expectations of me. Perhaps this is how Brian, Rachel, Edward, and others feel. Is due consideration given to them if they are irritable because of pain? If they are frustrated because of bodies that will not follow their commands? Bodies that are unpredictable? Do we give them the same consideration?

The only way I know to understand others' embodied experiences is to put myself in their shoes. A rather inadequate method, fraught with subjectivities, privileged voices (my own), situational interpretations and representations...this is the only method I have to frame, contextualize, and interpret residents' embodied experiences. And so I situate myself. In some small way, perhaps this can address the limitations.

My relationships with the residents were rather complicated. As with any relationships, personality plays a significant part in personal connections between people. I had a difficult time connecting with Edward because he was always busy and did not often have time to talk. I visited with Rachel often, but still never felt as if I got to know her. My relationship with Brian was a much different story, and I felt a deep personal connection with him. I wonder, as I reflect on the research process and on my findings, how I can capture a life?

February 16, 2007

As I have completed my analysis, I read over the findings. I can see each of my participants in their quotes, but I wonder what someone reading these findings might think? These three residents—Edward, Rachel, Brian—they are real people. I have seen their smiles, but have also, maybe more importantly, seen their tears. Rachel crying when she talks about her family, her sacrifices raising her grandchildren. Her pride in her namesake—her great granddaughter. She was hard to reach and to connect with, and only a handful of times did I glimpse her vulnerability. I talked with Edward and his emotions on being separated from his wife. His pain when she did not remember his visits. His loneliness on no longer sharing a bed, sharing physical warmth and intimacy with Maybelle. But even more than these, my connection with Brian. I cannot explain it, and I feel guilty for feeling more connected with him. He reminds me of myself, of my father, of my husband. Brian talked to me of things that no one has before. He made me feel what it is like to be old, to have an aging and unpredictable body. He was a strong man, like my father, honest, hard-working. He was self-reflective, very introspective like my husband. There was something about him that kept drawing me back. He was more than an old man, as some might see him. He had a strength and depth of character that I have rarely seen in people. There was wisdom in his pale blue eyes that if you took a moment to look in his eyes, you would be transfixed. I admired him greatly and enjoyed spending time with him.

There was only one time I saw Brian near tears. I had finished an interview with him. I told him how much I appreciated him talking to me and how I had learned more from him than from all my previous years of practice and research. I thought I saw tears in his eyes as he told me that no one had been interested in what he had to say about these things—life, aging, death. We were silent for a moment before we moved on to safer topics of conversation. I don't know if he felt that moment, but I will never forget it.

I turn back again to my findings and wonder again, can you see them? Can you know them? Edward, Rachel, Brian—three extraordinary, unique individuals. No one like them. All my sociological analyses and theorizing seems

so inadequate. How can I capture the complexity of their lives? The depth of their emotions? the pain of their losses?

9.12 Conclusions

This research is situated within many paradoxical rhythms of life. As illustrated by the above conceptions of bodies, bodies are situated within paradoxes and cannot be simply described. As Parse (1992) states in her Human Becoming Theory, “[c]ocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing, enabling-limiting, while connecting-separating” (p. 37). Life and bodies are about paradoxes. The tensions of the paradoxes of life are never completely resolved, and as such, the “messiness” and complexity of human lives should be reflected in research (Ellis, 2004). There is no easy way to sum up this research, nor to theorize and yet continue to feel like I have been “true” to the participants’ experiences. Thus, I chose to conclude with a discussion of the paradoxical rhythms of life. This research illustrated numerous paradoxes of life in which bodies live—accepting-resisting bodies, life-death, public-private spaces, compliance-resistance. Thus, to theorize with grand narratives is counter-productive to the project of understanding older people’s lived experiences, particularly within the context of the institution. Bodies and lived experiences exist within the hyphens of the paradox. The participants of this research live within these hyphens, unsanitized, untheorized, in all the mess and dirt and wonder that is life. This research, too, lives within these hyphens, embracing the tensions of paradox, the complexity of life. To live anywhere else is to simplify the mysteries.

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APPENDIX A – INFORMATION LETTER FOR ADMINISTRATOR

August 2005

Dear Administrator,

You are invited to participate in a study that I am doing as part of my Ph.D. dissertation in the Department of Recreation and Leisure Studies at the University of Waterloo. I am doing this research to better understand how new residents become socialized into life in the long-term care facility. While research has examined how residents psychologically adjust to the long-term care facility, no research has examined how residents become a part of life in the facility. This research offers a unique opportunity to explore the ways in which facilities contribute to the socialization of new residents into the facility. Once we understand this process, facilities will be better able to provide supports to help residents throughout the transition process into the long-term care environment.

The purpose of this letter is to inform you of what participation in the study would entail, and to ask for your consent to conduct my study at Pioneer Ridge Home for the Aged. First, during the time of this study, I would like to conduct observations of between two and three new residents who have recently been admitted to the facility. Only those residents and their power of attorneys who provide consent will be included in the study. I will be observing the day-to-day life in the facility for these new residents, including their daily activities and interactions. I will not be observing any personal care activities. I hope to observe these new residents for approximately one or two days a week over the six months following their move to Pioneer Ridge Home for the Aged.

Second, I will be conducting a series of interviews to better understand resident and staff perceptions of life in the long-term care setting and how residents become socialized into the new environment. Those residents who provide consent to participate in the study will be interviewed by me four times over their first six months in the facility. I would also like to talk with some staff members, including yourself, the Director of Nursing, the Recreation Coordinator, as well as some nurses, health care aides and other front-line staff who are directly involved with the new residents. Again, only those staff members who consent to participating in an interview will be included in the study. Staff interviews, including the interview I hope to conduct with you, will last between 30 and 90 minutes and will focus on perceptions of the transition process into long-term care settings for new residents and information about the facility policies and procedures in general. Participants can decline to answer any particular questions if they wish, and can withdraw from the study at any time. I would like to audiotape my interviews with residents and staff so I can better understand experiences and have an accurate record of the conversations. All interviews will be conducted at a time and place convenient for individual residents and staff. All audiotapes will be destroyed once the study is completed (by the end of 2007), and transcripts of the interviews will be kept in a locked filing cabinet in the researcher's office until they have been thoroughly analyzed.

Finally, I would like to examine the medical charts of the residents who consent to participate in this study in order to understand ways in which staff members document daily life in the facility and how residents are portrayed in facility documents. This information could provide valuable information on the socialisation process for new residents.

Participation in this study is completely voluntary and you and others invited to participate in the study may choose not to participate. Residents and staff members, including yourself, may also choose to withdraw from this study at any time. All information gathered throughout this project, including my field notes from my observations, my notes from my document analysis, and the interview transcripts will be kept strictly confidential and accessed by only myself and my advisor, Dr. Sherry Dupuis. In order to protect the anonymity of the facility and all participants as best possible, pseudonyms for the facility and all participants involved in the study will be used in all notes taken throughout the project and in written and oral reports of the project. No identifying information will be attached to either descriptions of the facility, participants, or others who are observed during their interactions with the participants.

If you decide to give your consent for this study to be conducted in Pioneer Ridge Home for the Aged, I will be asking you to sign two separate consent forms. The first form will state your consent to allow Pioneer Ridge Home for the Aged to participate in the study, which includes my observations in the facility, permission to approach some of the staff to participate in an interview, and permission to examine the medical records of only those residents who agree to participate in the study and if necessary, whose power of attorney agrees to give consent for their participation in the study. The second form will state your consent to participate in an interview with me at a time and place convenient for you.

This study has been reviewed and received ethics clearance through the Office of Research Ethics at the University of Waterloo. This office is available for any concerns and comments pertaining to this study and can be reached by contacting Dr. Susan Sykes, Director of the Office of Research Ethics, at (519) 888-4567, ext. 6005. In addition, this study has been approved through the Senior Management Team of the City of Thunder Bay.

Should you have any questions about my study, please feel free to contact me at (807) 344-7055, or my advisor, Dr. Sherry Dupuis, at (519) 888-4567, ext. 6188.

Thank you for your interest and considering to participate in this project. I look forward to working with you.

Sincerely,

Elaine C. Wiersma

Ph.D. Candidate, University of Waterloo

APPENDIX B – DECLARATION OF INFORMED CONSENT FOR ADMINISTRATOR

I have read the information letter provided by Elaine Wiersma, graduate student in the Department of Recreation and Leisure Studies at the University of Waterloo, describing the purpose of her study. I understand that I will be asked to allow Elaine to conduct her research within this facility, which will involve:

1. interviewing and observing residents (two to three) who have consented to participate in the study throughout their day in the long-term care facility for one or two days a week over the first six months of living in the facility (for each resident).
2. approaching some staff members, including the Director of Nursing, the Recreation Coordinator and those staff members who have direct contact with the study participants (e.g., nursing staff, personal support workers, other staff) to participate in interviews regarding their perceptions of the transition process and how new residents are socialized into the long-term care environment. Only those staff members who give consent to participate in an interview will be included in the study.
3. allowing Elaine to examine the medical charts of the residents who have given consent to participate in the study and consent to access medical charts, or whose power of attorney has given consent for him or her to participate in the study and for Elaine to access medical charts, in order to examine ways in which staff talk about the residents through written documents.

My consent to the facility's participation in this research project is made under the following conditions:

1. Participation is completely voluntary and all data collected will be used solely for research purposes.
2. All information will be kept strictly confidential, accessed only by Elaine and her advisor, Dr. Sherry Dupuis. Pseudonyms for the facility and all participants involved will be used on all documents pertaining to the study and in all oral and written reports of the project.
3. Staff and residents involved in the study may withdraw from the study at any time by simply notifying Elaine or her advisor, and may refuse to answer any questions during their interviews.
4. I may request an executive summary of the findings upon completion of the study. These will be available through Elaine at the University of Waterloo after April 30, 2007.

This study has been reviewed through the Office of Research Ethics at the University of Waterloo and has received ethics clearance. Any comments or concerns can be addressed to Dr. Susan Sykes, Director of the Office of Research Ethics, at (519) 888-4567, ext. 6005.

I give my consent to the researcher, Elaine Wiersma, to conduct her doctoral research in Pioneer Ridge Home for the Aged.

Name of Administrator _____

Signature of Administrator _____

Date _____

I give my consent to Elaine Wiersma to access the participants' medical charts for the purposes of her doctoral research only.

Name of Administrator _____

Signature of Administrator _____

Date _____

Signature of Researcher _____

Date _____

APPENDIX C – INFORMATION LETTER FOR RESIDENTS

September 2005

Dear Resident,

The purpose of this letter is to ask you if you would like to work with me on a research project I am doing for my Ph.D. dissertation in the Department of Recreation and Leisure Studies at the University of Waterloo. I am hoping to better understand your experiences here at Pioneer Ridge Home for the Aged and how people like yourself become a part of life in this facility. I am doing this research to better understand how new residents become socialized into life in the long-term care facility. Once we understand this process, we can provide supports to better help residents throughout the transition process into a long-term care facility.

Your participation in this project would include talking with me at different times about your thoughts and experiences in the facility. I would like to talk with you within the first week or two of admission, and three more times over the first six months following the move. These interviews will take place at a time suitable for you, and the interview will be broken into smaller times if you get tired. I would like to audiotape my conversations with you so I can better understand your experiences and have an accurate record of our conversation. In order to better understand life in the facility for new residents, I will be spending a great deal of time at Pioneer Ridge Home for the Aged. I would like to spend time with you one or two days a week over the first six months after admission. I will be observing day-to-day life in the facility including daily activities and interactions with staff and other residents. I will not be observing any personal care activities, but will be present on the unit and participating in activities with residents.

I would also like to examine your medical charts to look at the ways in which the staff document about daily life in the facility and how staff portray residents in their written documentation. Finally, I will also be talking to the nursing staff and recreation therapists about their perceptions of the admission and socialization process in general. Again, I hope to audiotape these conversations to have an accurate record of my discussions with the staff.

All information collected in this project will be focused only on how new residents become socialized into the long-term care environment in order that we might better understand this process and find ways to better assist you and others throughout the transition. All information gathered throughout this study, including the audiotapes of the interviews, will be kept strictly confidential and will only be accessed by me and my advisor, Dr. Sherry Dupuis. All audiotapes will be destroyed once the study is completed (by the end of 2007), and transcripts of the interviews will be kept in a locked filing cabinet in my office until they have been thoroughly analyzed.

If you decide to take part in this study, I will be asking you to sign a letter formally stating your consent to participate. Your participation is completely voluntary and you

may choose not to participate. You can decline to answer any questions if you wish, and may also choose to withdraw from this study at any time. If you decide not to participate or to stop participating in the study once started, this will have no impact on your care and experiences at Pioneer Ridge Home for the Aged.

This study has been reviewed through and received ethics clearance through the Office of Research Ethics at the University of Waterloo. Any comments or concerns can be addressed to Dr. Susan Sykes, Director of the Office of Research Ethics, at (519) 888-4567, ext. 6005. In addition, this study has been approved through the Senior Management Team of the City of Thunder Bay.

Should you have any questions about my study, please feel free to contact me at (807) 344-7055, or my advisor, Professor Sherry Dupuis, at (519) 888-4567, ext. 6188. Cindy Jarvela, Administrator, Pioneer Ridge Home for the Aged would also be happy to answer any of your questions and can be reached at (807) 684-3917.

Thank you for your interest and considering to participate in this project. I look forward to working with you.

Sincerely,

Elaine C. Wiersma
Ph.D. Candidate, University of Waterloo

APPENDIX D – DECLARATION OF INFORMED CONSENT FOR RESIDENTS

I have read the information letter provided by Elaine Wiersma, graduate student in the Recreation and Leisure Studies Department at the University of Waterloo, describing the purpose of her study. I understand that Elaine will be asking me to participate in four interviews regarding my experiences in the long-term care facility. The interviews will last between fifteen and sixty minutes and will be tape recorded with my permission. I also understand that quotes from the audiotaped interviews may be included in the thesis and/or publications to come from this, with the understanding that pseudonyms will be used to identify the quotations. I understand that Elaine would like to spend time at the facility with me throughout the course of my day in the long-term care facility for approximately one or two days a week over the first six months following the move. I am also aware that Elaine will be analysing the notes in my medical charts to examine ways in which the staff document daily life in the facility and portray residents in facility documents.

My consent to my participation in this research project is made under the following conditions:

1. Participation is completely voluntary and all data collected will be used only for teaching and research purposes.
2. All information will be kept strictly confidential, accessed only by Elaine and her advisor, Professor Sherry Dupuis. Pseudonyms for the facility and all participants involved will be used on all documents pertaining to the study and in all oral and written reports of the project.
3. I may decline to answer any questions at any time.
4. I may withdraw from the study at any time, and any decision not to participate will have no impact on my care and experiences at Pioneer Ridge Home for the Aged.
5. I may request an executive summary of the findings upon completion of the study. These will be available through Elaine at the University of Waterloo after April 30, 2007.

This study has been reviewed through the Office of Research Ethics at the University of Waterloo and has received ethics clearance. Any comments or concerns can be addressed to Dr. Susan Sykes, Director of the Office of Research Ethics, at (519) 888-4567, ext. 6005. In addition, this study has been approved by the Senior Management Team of the City of Thunder Bay.

I consent to participating in Elaine Wiersma's research project, which involves interviews with Elaine Wiersma and observations of my activities at the facility.

Name of Participant _____

Signature of Participant _____

Date _____

I consent to having my interviews audiotaped.

Name of Participant _____

Signature of Participant _____

Date _____

I give my consent to the researcher, Elaine Wiersma, to access my medical charts for the purposes of her research project only.

Name of Participant _____

Signature of Participant _____

Date _____

Signature of Researcher _____

Date _____

APPENDIX E – INFORMATION LETTER FOR INITIAL INTERVIEWS WITH STAFF

August 2005

Dear Participant,

I want to invite you to participate in a study that I am doing as part of my Ph.D. dissertation in the Department of Recreation and Leisure Studies at the University of Waterloo. I am doing this research to better understand how new residents become socialized into the nursing home culture and environment with the hope of finding better ways to ease the transition process for residents.

Your participation in this research project would include participating in an interview that will last approximately 30 to 90 minutes. The interview will focus on your perceptions of the transition process into nursing homes for new residents and how residents become socialized into their long-term care environment. The interview will be conducted at a time and place to suit your preference and convenience. Ideally, I would like to audiotape our conversations so I can better understand experiences and have an accurate record of our conversation. All information gathered throughout this study, including the audiotapes of the interviews, will be kept strictly confidential and will only be accessed by me and my advisor, Professor Sherry Dupuis. All audiotapes will be destroyed once the study is completed (by the end of 2007), and transcripts of the interviews will be kept in a locked filing cabinet in the researcher's office until they have been thorough analyzed.

If you decide to take part in this study, I will be asking you to sign a letter formally stating your consent to participate. Your participation is completely voluntary and you may choose not to participate. During the interview, you may decline to answer particular questions if you wish. You may also choose to withdraw from this study at any time. Any decision not to participate will have no impact on your employment and experiences at Pioneer Ridge Home for the Aged.

This study has been reviewed and received ethics clearance through the Office of Research Ethics at the University of Waterloo. Any concerns and comments pertaining to this study can be directed to the Director of the Office of Research Ethics, Dr. Susan Sykes, at (519) 888-4567, ext. 6005. In addition, this study has been approved through the Senior Management Team of the City of Thunder Bay.

Should you have any questions about my study, please feel free to contact me at (807) 344-7055, or my advisor, Professor Sherry Dupuis, at (519) 888-4567, ext. 6188. Cindy Jarvela, Administrator, Pioneer Ridge Home for the Aged would also be happy to answer any of your questions and can be reached at (807) 684-3917.

Thank you for your interest and considering to participate in this project. I look forward to working with you.

Sincerely,

Elaine C. Wiersma
Ph.D. Candidate, University of Waterloo

APPENDIX F – DECLARATION OF INFORMED CONSENT FOR INITIAL STAFF INTERVIEWS

I have read the information letter provided by Elaine Wiersma, graduate student in the Department of Recreation and Leisure Studies at the University of Waterloo, describing the purpose of her study. I have been asked to participate in an audio-taped interview regarding my perceptions of the transition and socialization process of new residents into the long-term care facility. I understand that the interview will last between 30 and 90 minutes. I understand that the interview will be audiotaped and that excerpts from the audiotaped interview may be included in the thesis and/or publications to come from this, but that pseudonyms will be used to identify all quotations.

My consent to participation in this research project is made under the following conditions:

1. Participation is completely voluntary and all data collected will be used solely for research purposes.
2. All information will be kept strictly confidential, accessed only by Elaine and her advisor, Professor Sherry Dupuis. Pseudonyms for the facility and all participants involved will be used on all documents pertaining to the study and in all oral and written reports of the project.
3. I may decline to answer any questions at any time during the interview.
4. I may withdraw from the study at any time by simply notifying Elaine or her advisor, Professor Sherry Dupuis, and any decision not to participate will have no impact on my job here at Pioneer Ridge Home for the Aged.
5. I may request an executive summary of the findings upon completion of the study. These will be available through Elaine at the University of Waterloo after April 30, 2007.

This study has been reviewed by the Office of Research Ethics at the University of Waterloo and has received ethics clearance. Any comments or concerns can be addressed to Dr. Susan Sykes, Director of the Office of Research Ethics, at (519) 888-4567, ext. 6005. In addition, this study has been approved by the Senior Management Team of the City of Thunder Bay.

I consent to participating in Elaine Wiersma’s doctoral research, which involves an interview with Elaine Wiersma at a time and place convenient for me.

Name of Staff _____

Signature of Staff _____

Date _____

I consent to having my interview audiotaped.

Name of Staff _____

Signature of Staff _____

Date _____

Signature of Researcher _____

Date _____

APPENDIX G – INFORMATION LETTER FOR OTHER STAFF, FAMILIES, VOLUNTEERS
(SUBSEQUENT INTERVIEWS)

[Date]

Dear Participant,

I want to invite you to participate in a study that I am doing as part of my Ph.D. dissertation in the Department of Recreation and Leisure Studies at the University of Waterloo. I am doing this research to better understand how new residents become socialized into the nursing home culture and environment with the hope of finding better ways to ease the transition process for residents.

Your participation in this research project would include participating in an interview that will last approximately 30 to 90 minutes. The interview will focus on your perceptions of the transition process into nursing homes for new residents and how residents become socialized into their long-term care environment. The interview will be conducted at a time and place to suit your preference and convenience. Ideally, I would like to audiotape our conversations so I can better understand experiences and have an accurate record of our conversation. All information gathered throughout this study, including the audiotapes of the interviews, will be kept strictly confidential and will only be accessed by me and my advisor, Professor Sherry Dupuis. All audiotapes will be destroyed once the study is completed (by the end of 2007), and transcripts of the interviews will be kept in a locked filing cabinet in the researcher's office until they have been thoroughly analyzed.

If you decide to take part in this study, I will be asking you to sign a letter formally stating your consent to participate. Your participation is completely voluntary and you may choose not to participate. You may decline to answer particular questions throughout the interview if you wish. You may also choose to withdraw from this study at any time. Any decision not to participate will have no impact on [your employment and experiences at Pioneer Ridge Home for the Aged/your family member's care here at Pioneer Ridge Home for the Aged/your volunteer opportunities at Pioneer Ridge Home for the Aged].

This study has been reviewed and received ethics clearance through the Office of Research Ethics at the University of Waterloo. Any concerns and comments pertaining to this study can be directed to the Director of the Office of Research Ethics, Dr. Susan Sykes, at (519) 888-4567, ext. 6005. In addition, this study has been approved through the Senior Management Team of the City of Thunder Bay.

Should you have any questions about my study, please feel free to contact me at (807) 344-7055, or my advisor, Professor Sherry Dupuis, at (519) 888-4567, ext. 6188. Cindy Jarvela, Administrator of Pioneer Ridge Home for the Aged would also be happy to answer any of your questions and can be reached at (807) 684-3917.

Thank you for your interest and considering to participate in this project. I look forward to working with you.

Sincerely,

Elaine C. Wiersma
Ph.D. Candidate, University of Waterloo

**APPENDIX H – DECLARATION OF INFORMED CONSENT OTHER STAFF, FAMILIES,
VOLUNTEERS (SUBSEQUENT INTERVIEWS)**

I have read the information letter provided by Elaine Wiersma, graduate student in the Department of Recreation and Leisure Studies at the University of Waterloo, describing the purpose of her study. I have been asked to participate in an audio-taped interview regarding my perceptions of the transition and socialization process of new residents into the long-term care facility. I understand that the interview will last between 30 and 90 minutes. I understand that the interview will be audiotaped and that excerpts from the audiotaped interview may be included in the thesis and/or publications to come from this, but that pseudonyms will be used to identify all quotations.

My consent to participation in this research project is made under the following conditions:

1. Participation is completely voluntary and all data collected will be used solely for teaching and research purposes.
2. All information will be kept strictly confidential, accessed only by Elaine and her advisor, Professor Sherry Dupuis. Pseudonyms for the facility and all participants involved will be used on all documents pertaining to the study and in all oral and written reports of the project.
3. I may decline to answer any questions at any time during the interview.
4. I may withdraw from the study at any time by simply notifying Elaine or her advisor, Professor Sherry Dupuis, and any decision not to participate will have no impact on [my job here at Pioneer Ridge Home for the Aged/my family member's care here at Pioneer Ridge Home for the Aged/my volunteer opportunities here at Pioneer Ridge Home for the Aged].
5. I may request an executive summary of the findings upon completion of the study. These will be available through Elaine at the University of Waterloo after April 30, 2007.

This study has been reviewed through the Office of Research Ethics at the University of Waterloo and has received ethics clearance. Any comments or concerns can be addressed to Dr. Susan Sykes, Director of the Office of Research Ethics, at (519) 888-4567, ext. 6005. In addition, this study has been approved by the Senior Management Team of the City of Thunder Bay.

I consent to participating in Elaine Wiersma's doctoral research, which involves an interview with Elaine Wiersma at a time and place convenient for me.

Name of Staff _____

Signature of Staff _____

Date _____

I consent to having my interview audiotaped.

Name of Staff _____

Signature of Staff _____

Date _____

Signature of Researcher _____

Date _____

APPENDIX I – RESIDENT INTERVIEW GUIDES

Interview One—Getting to Know You

Preamble: Hi. I am Elaine Wiersma, a Ph.D. student at the University of Waterloo. We spoke earlier about the research project I am doing. I am trying to understand how people like yourselves like living here and how you are adjusting to life here. This means I am going to be hanging around here for a while and chatting with you if you are around. I also want to find out from the staff how they help people become adjusted to life here.

1. Tell me a little bit about who you are—where you come from, what you like to do...
2. What is important for others to know about you? How would you describe yourself?
3. Tell me about those people close to you.
4. What do you like most about yourself?

Place:

5. How did you come to be here?
6. How would you describe this place?
7. What do you think about this place? (i.e., environment, décor, etc.)
8. What is it like here? What is a typical day here like?
9. How are you finding it here so far? What is different for you? What do you like best about this place? Is there anything you don't like about this place?
10. What types of things do you do here?
11. What do you enjoy doing here?

Self:

12. Has anything changed since you moved here? If so, how do you think you have changed since moving here?
13. How do you think others here think of you?
14. What do you think of others here? How are you getting along with others here?
15. Have you met any new people here? Who do you like to chat with here?

Body:

16. What are the routines like here?
17. Have your daily routines changed since coming here? If so, how?
18. What is it like to be a resident here?
19. How do you feel about getting older?
20. How has your body changed as you have gotten older? How do you feel about your abilities?
21. What is it like to have the staff help you with different things here? How does this make you feel?
22. Is there anything about your experiences that is important, but that we haven't talked about yet?

Interview Two—The Transition and Adjustment

Place:

1. How would you describe this place?
2. What do you think about this place? (i.e., environment, décor, etc.)
3. What is it like here? What is a typical day like here? What did you think life would be like here?
4. How are you finding it here so far? What is different for you? What do you like best about this place? Is there anything you don't like about this place?
5. What types of things do you do here?
6. What do you enjoy doing here?
7. What do you do for fun, enjoyment, and relaxation here? How does this make you feel?
8. Are you getting involved in activities here? If so, what do you think of the activities?

Self:

9. Tell me a little bit about who you are—where you come from, what you like to do...
10. What do you like most about yourself?
11. Has anything changed since you moved here? If so, how do you think you have changed since moving here?
12. How do you think others here think of you?
13. What do you think of others here? How are you getting along with others here?
14. Have you had a chance to meet any new people here? Who do you like to chat with here?

Body:

15. What are the routines like here?
16. How have your daily routines changed since coming here?
17. What is it like to be a resident here?
18. How do you feel about getting older?
19. How has your body changed as you have gotten older? How do you feel about your abilities?
20. What is it like to have the staff help you with different things here? How does this make you feel?
21. Have you adjusted to life here? How have you adjusted? Has the adjustment been okay for you?
22. What has helped you adjust to living here? Is there anything that has made adjustment more difficult?
23. Has there been anything that the staff has done for you to help you adjust to life here?
24. What aspects of your life have changed in the last month?
25. Is there anything about your experiences that is important, but that we haven't talked about yet?

Interview Three—Socialization

Place:

1. How would you describe this place?
2. What do you think about this place? (i.e., environment, décor, etc.)
3. What is it like here? What is a typical day like here? What did you think life would be like here?
4. How are you finding it here so far? What is different for you? What do you like best about this place? Is there anything you don't like about this place?
5. What types of things do you do here?
6. What do you enjoy doing here?
7. What do you do for fun, enjoyment, and relaxation here? How does this make you feel?
8. Are you getting involved in activities here, and if so, what do you think of the activities?

Self:

9. Tell me a little bit about who you are—where you come from, what you like to do...
10. What do you like most about yourself?
11. Has anything changed since you moved here? If so, how do you think you have changed since moving here?
12. How do you think others here think of you?
13. What do you think of others here? How are you getting along with others here?
14. Have you met any new people here? Who do you like to chat with here?

Body:

15. What are the routines like here?
16. How have your daily routines changed since coming here?
17. What is it like to be a resident here?
18. How do you feel about getting older?
19. How has your body changed as you have gotten older? How do you feel about your abilities?
20. What is it like to have the staff help you with different things here? How does this make you feel?

21. Have you adjusted to life here? How have you adjusted? Has the adjustment been okay for you?
22. What has helped you adjust to living here? Is there anything that has made adjustment more difficult?
23. Has there been anything that the staff has done for you to help you adjust to life here?
24. What aspects of your life have changed in the last month?
25. Is there anything about your experiences that is important, but that we haven't talked about yet?

APPENDIX J – INTERVIEW GUIDE FOR MANAGEMENT INITIAL INTERVIEWS

General Interview [Beginning of Data Collection]

Policies and Procedures

1. Can you describe some of the history of the facility to me?
2. What is the mission or mandate of the facility? Do you have any guiding principles or values for your facility?
3. Can you describe the facility for me?
 - i. physical layout
 - ii. different units
 - iii. type of residents
 - iv. type of staff
4. How would you describe the life of residents? In other words, what do you think it is like for residents to live here? What is a typical routine for residents?
5. What do you think it is like for staff to work here? How would you describe the routines of staff?

Admission Process and the Transition

1. Can you describe the process of the move here for me?
2. What is your role or involvement in the move?
3. How would you describe the first few days of living here for the resident?
4. How would you describe the adjustment process for residents? What are the most difficult aspects for them? Easiest aspects for them?
5. What do you do to help the adjustment process? What do other staff do?
6. Are there any specific policies that the facility or department has that you have to follow of tasks to complete within the first month of a resident moving in?
7. What do you think residents' views of the facility are when they first move in? Does this change over time?
8. How do you think the new residents view themselves? Do you think residents' perceptions of themselves change after moving in?
9. How do you think other staff typically perceive the residents when they move in here?
10. The experience of needing physical help, whether with bathing, dressing, toileting or mobility, can be difficult for residents. How do you think residents experience their body limitations here? What about specific to you and your department/programs?
11. What does other staff do to help with this adjustment?
12. How do residents adjust to the routines in the facility? What techniques does staff use to help residents adjust to these routines?
13. Are there any regulations, written or unwritten, that residents have to follow?
14. How do residents become a part of life here when they move?
15. What role do you think leisure and recreation activities play in the socialization of residents or helping residents become a part of life here?

APPENDIX K – INTERVIEW GUIDE—INITIAL STAFF INTERVIEWS

General Interview [Beginning of Data Collection]

1. Can you describe the typical routine of an [RN, RPN, HCA, Recreation Staff] here?
2. How would you describe the typical routine of a resident?

The Move and Transition

3. Can you describe the process of the move here for me?
4. What is your role or involvement in the move?
5. How would you describe, from your own perspective, the first few days of living here for the resident?
6. How would you describe the adjustment process for residents? What are the most difficult aspects for them? Easiest aspects for them?
7. What do you do to help the adjustment process? What do other staff do?
8. Are there any specific policies that the facility or department has that you have to follow of tasks to complete within the first month of a resident moving in?
9. What do you think residents' views of the facility are when they first move in? Does this change over time?
10. How do you think the new residents view themselves? Do you think residents' perceptions of themselves change after moving in?
11. How do you think other staff typically perceive the residents when they move in here?
12. The experience of needing physical help, whether with bathing, dressing, toileting or mobility, can be difficult for residents. How do you think residents experience their body limitations here? What about specific to you and your department/programs?
13. What do other staff do to help with this adjustment?
14. How do residents adjust to the routines in the facility? What techniques does staff use to help residents adjust to these routines?
15. Are there any regulations, written or unwritten, that residents have to follow?
16. How do residents become a part of life here when they move?
17. What role do you think leisure and recreation activities play in the socialization of residents or helping residents become a part of life here?

**APPENDIX L – INTERVIEW GUIDE FOR SUBSEQUENT INTERVIEWS WITH STAFF AND
FAMILIES**

1. How did you get to know [participant]?
2. Can you describe the process of the move here for me for [resident]?
3. What was your role or involvement in the move?
4. How would you describe [resident]?
5. How would you describe the first few days of living here for [resident]?
6. How would you describe the adjustment process for [resident]? What were the most difficult aspects? Easiest aspects?
7. How has [resident] become a part of life here?
8. Have there been any significant incidents (positive or negative) since the move?
9. Have you seen any changes in [resident]? How has [resident] changed since the move?
10. What did you do to help the adjustment process? What did other staff do?
11. What do you think [resident]'s views of the facility are? Did this change since [resident] was admitted?
12. Do you think [resident]'s perceptions of him/herself changed after moving in?
13. How do you think other staff typically perceived [resident] when s/he moved in here?
14. How did [resident] adjust to the routines in the facility? What techniques did staff use to help residents adjust to these routines?
15. What role do you think leisure and recreation activities play in the socialization of residents or helping residents become a part of life here?

APPENDIX M – SENSITIZING FRAMEWORK FOR PARTICIPANT OBSERVATIONS

- Environmental location (i.e., time, location, other individuals in the vicinity)
- Social interactions (i.e., verbal exchanges with other residents, family, staff)
- Behaviours (i.e., wandering, anxiety, verbal or physical aggression, apathy)
- Affect (i.e., emotional expressions, facial expressions)
- Body language and gestures
- Physical appearances
- Involvement in activities (i.e., recreation opportunities, care, visiting with other residents, family, volunteers, or staff)
- Physical and social characteristics of facility

APPENDIX N – THANK YOU LETTER TO RESIDENTS

[Date]

Dear [Resident],

I would like to thank you for participating in my Ph.D. dissertation titled “Body, Self, and Place: The Process of Socialization into the Nursing Home Environment”. As you know, this study is examining the process of socialization of new residents into the nursing home culture and environment. Your perspective and insight has provided invaluable information to this study.

Again, I want to emphasize that all information shared during the duration of this study will remain completely confidential and will be used only for the purposes of this project. I will be sending out a newsletter summarizing the findings of the research for your interest once the study is completed.

If you have any questions, please do not hesitate to contact me at (807) 344-7055 or by email at ecwiersm@ahsmaail.uwaterloo.ca. I would also like to remind you that this study has been reviewed by the Office of Research Ethics at the University of Waterloo and has received ethics clearance. Any comments or concerns can be addressed to Dr. Susan Sykes, Director of the Office of Research Ethics, at (519) 888-4567, ext. 6005. Thank you again for your participation in the project.

Sincerely yours,

Elaine Wiersma
PhD Candidate
Department of Recreation and Leisure Studies
University of Waterloo

APPENDIX O – THANK YOU LETTER FOR INTERVIEWS (STAFF AND FAMILY)

[Date]

Dear [Participant],

I would like to thank you for participating in an interview for my Ph.D. dissertation titled “Body, Self, and Place: The Process of Socialization into the Nursing Home Environment”. As you know, this study is examining the process of socialization of new residents into the nursing home culture and environment. Your perspective and insight will provide invaluable information to this study.

Again, I want to emphasize that all information shared during the duration of this study will remain completely confidential and will be used only for the purposes of this project. I will be sending out a newsletter summarizing the findings of the research for your interest once the study is completed.

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Sincerely yours,

Elaine Wiersma
PhD Candidate
Department of Recreation and Leisure Studies
University of Waterloo

APPENDIX P – FEEDBACK LETTER

**APPENDIX C
FEEDBACK LETTER**

[Date]

Dear [Participant],

I would like to thank you for providing consent for participating in the research study titled “Body, Self, and Place: The Process of Socialization into the Nursing Home Environment” that was conducted in 2005 and 2006. This study examined the process of socialization of new residents into the nursing home culture and environment.

Again, I want to emphasize that all information shared during the duration of this study will (and has) remain(ed) completely confidential and will be (has been) used only for the purposes of this project. I have included a newsletter summarizing the findings of the research for your interest.

If you have any questions, please do not hesitate to contact me at (807) 344-7055 or by email at ecwiersm@ahsmail.uwaterloo.ca. I would also like to remind you that this study has been reviewed by the Office of Research Ethics at the University of Waterloo and has received ethics clearance. Any comments or concerns can be addressed to Dr. Susan Sykes, Director of the Office of Research Ethics, at (519) 888-4567, ext. 6005. Thank you again for your participation in the project.

Sincerely yours,

Elaine Wiersma
PhD Candidate
Department of Recreation and Leisure Studies
University of Waterloo