AT HOME IN LONG TERM CARE:  
A PHENOMENOLOGICAL EXPLORATION OF THE MEANING OF HOME  
FOR RESIDENTS OF AN INTERMEDIATE CARE FACILITY  

by  

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ABSTRACT

Six residents of Whytebridge Villa, an intermediate care facility, three male and three female, aged between 75 and 85 years of age, were asked questions about homes they had lived in before moving into Whytebridge Villa and about their experience of Whytebridge Villa as their home. Four of the six participants stated they considered Whytebridge Villa to be their home. They identified their private rooms as their home and stated having their personal possessions in their room and having congenial relationships with staff as being important considerations in accepting an intermediate care facility as their home.
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INTRODUCTION

Home. A small word which invokes powerful feelings and images, few English words have such emotional meaning. These meanings are so much a part of our day to day lives we have evolved a variety of aphorisms to express them: "Home is where the heart is." "A man's home is his castle." "Home, Sweet, Home." "There's no place like home." Love, autonomy, comfort, safety - all summed up in one word: home.

In many ways, who we are as a people and our homes are so interconnected that it is impossible to know where one starts and the other stops. Csikszentmihalyi and Rochbert-Halton (1981) suggest that homes are more than just a shelter, they are material environments that represent what the dweller perceives to be the most important. The home "becomes the most powerful sign of the self of the inhabitant who dwells within" (p. 123).

Heidegger and Liiceanu (Korosec-Serfaty, 1985) note that in Old German and Greek the verbs "to dwell" and "to be" could be used interchangeably, showing, according to these authors, the interconnectedness between dwelling and the essence of being human. The image of house-as-body is found in secular and sacred speech as well as in popular art (Korosec-Serfaty, 1985).

An example of the interconnectedness between dwelling and being and the idea of house-as-body familiar to many can be
seen in the last line of the Twenty-third Psalm of the Hebrew Bible, "and I shall dwell in the house of the Lord forever" (Psalms 23:6, Revised Standard Version). A metaphor is created of a dwelling place which includes an everlasting existence on a spiritual level and as part of a spiritual entity.

Ancient Greeks too connected the spiritual realm with the home in the form of Hestia, the Goddess of the Hearth. For the ancient Greeks, it was Hestia's presence that sanctified both home and temple. She made places holy by her presence (Bolen, 1984). Whether it was a new couple marrying and setting up a household or a colony setting out to create a new city-state, Hestia accompanied the sojourners in the form of a sacred fire, "linking old home with new, perhaps symbolizing continuity and relatedness, shared consciousness and common identity" (Bolen, 1984, p. 108).

The Romans worshipped Hestia as the goddess Vesta, believing that her sacred fire, tended by "vestal virgins", united the citizens of Rome into one family (Bolen, 1984).

Cross-culturally, the home is both the object of ritual and the location of ritual. Ground breaking, topping out and house warming; birthdays, weddings, and funerals; home festivals, family rituals and domestic routines all serve to reinforce meaningful ties between individuals, families and groups and their dwelling places (Saile, 1985).

We have created laws to protect our homes and ourselves in our homes from others; even the police must have strong
grounds, and often the court's permission, to enter a home without the resident's consent. As a Victim Services volunteer with the Vancouver Police, I often heard people who had been robbed equate having their homes broken into with having themselves been physically violated. When Korosec-Serfaty (1985) interviewed people whose homes had been burglarized about their reactions, they characterized the experience as one of defilement.

People feel strongly about their homes and have a clear sense of what is home and what is not home. When asked to describe what home means, however, a wide range of meanings are offered. Despres (1991) has identified ten general categories of meaning as described by home dwellers. They are: home as security and control; home as reflection of one's ideas and values; home as acting upon and modifying one's dwelling; home as permanence and continuity; home as relationships with family and friends; home as centre of activities; home as a refuge from the outside world; home as indicator of personal status; home as material structure and home as a place to own.

A question arises then about people who reside in dwellings that may not meet these commonly-held meanings of home - prisons, military barracks, boarding schools and nursing homes, to name a few. These institutions neither share nor allow many of the qualities we value about our
homes. Does this mean that people living in these environments are "homeless"?

This question comes from my experience as a summer student, working in an intermediate care facility. In my first days working there I saw over one hundred people living under one roof, eating their meals in a cafeteria at preset times from a preset menu, sharing bedrooms and bathrooms with people with whom they had no prior personal relationship who had been selected by management to live together, and having most aspects of their intimate daily routines supervised by staff. Although it was euphemistically referred to as a "home" it did not resemble any image of "home" with which I was familiar. And yet, as I got to know the residents, I came to realize that many of them did consider the facility to be their home. Obviously, something was happening that I did not understand.

As a researcher it is very easy to ask a multitude of questions. The hard part is determining which questions are meaningful to the people about whom the questions are being asked. I have found very few answers to the question I started with, my research question, "What is the meaning of home for residents of an intermediate care facility?". What I hope I have found, however, are a few of the questions that are important and meaningful to the people who live in intermediate care facilities.
Phenomenology has been used both to inform the research method and as a theoretical approach to understanding the concept of home. Dovey (1985) notes that while "house is a discrete variable, home is not an empirical variable whose meaning we might define in advance of careful measurement and explanation" (p. 34); it is rather an "intrinsically intangible phenomenon" (Dovey, 1985, p. 34).

In observational astronomy, a technique known as averted vision is used to observe faintly-seen stars. When an observer concentrates on a star without directly looking at it, details, invisible by direct observation, will often become distinct (Dickinson, 1983). While engaged in this project I have often felt that clarity and understanding about an "intrinsically intangible phenomena" such as the meaning of home has come via "averted vision"; that is, fleetingly and indirectly, disappearing when I tried to look directly upon it.
There are two separate groups of theories which need to be examined in order to begin to understand how people living in an institution make sense of that place as their home - theories about homes and theories about institutions. In this section, I will discuss these two very different sets of theories as well as review several pieces of research which, while not directly exploring the meaning of home for institutionalized people, do inform this inquiry.

THEORIES OF HOME

Within the theories which attempt to explain the meaning of "home", there are two different but related groups - home as a transactional unity and home as a phenomena. Each of these groups of theories informs the other and so they must both be explored.

Home as a transactional unity

In this view, homes are seen as being created by the confluence of three aspects: environmental properties, temporal qualities, and people and psychological processes (Werner, Altman and Oxley, 1985). It is the transaction amongst these three variables which generates an individual's home.
Home is not something which is a given in the environment but is something which is created through an interaction or transaction between the individual and his/her environment (Sixsmith and Sixsmith, 1991). People and their environments are seen as part of a unified whole; that is, although it is possible to change an individual's environment, it is impossible to separate an individual from his or her environment. It is impossible for a human being (at this level of existence, anyway) not to have an environment.

A transactional perspective also assumes that the element of time is intrinsic to the relationship between people and their environment (Werner et al., 1985). One does not generally immediately accept a new environment as one's home. Developing and becoming familiar with new everyday routines and activities associated with the home, as well as experiencing seasonal and cyclical events (Christmas, birthdays, etc.), all happen over time and all contribute to the experience of being at home (Sixsmith and Sixsmith, 1991).

The process of becoming "at home" must be seen to be occurring "over and in time" (Werner et al., 1985, p. 5). As well, this process is bound in time; the "meaning, nature, and probability of enactment (of this process) can change with the resident's own changing life stage" (Werner et al., 1985, p. 5). Each person's definition of home is dynamic and ever changing during the course of his or her life cycle.
Three general psychological/sociological processes link people to their homes. These are: social rules and social relationships, affordances, and appropriation practices (Werner et al., 1985).

Social rules and social relationships include a wide range of interpersonal processes which take place in the home: social and cultural norms and rules, affective, emotional and evaluative bonds, and cultural rituals and practices (Werner et al., 1985).

Affordance refers to the way in which objects and environments are perceived in terms of their meanings, actions and the behaviours they imply, rather than solely by their physical characteristics. Thus a dwelling place is seen not just as a collection of wood and concrete and wire, or even of walls and ceilings, but as a place where humans carry out activities that lend psychological meanings to the objects and places that make up the house thereby transforming it into a home (Werner et al., 1985).

Appropriation practices refer to three processes by which humans invest places with meaning and significance and the behaviour that follows. These processes are appropriation, attachment and identity (Werner et al., 1985).

Appropriation refers to a dialectic process wherein we take our world into our being and in turn are transformed by this process (Dovey, 1985). Some of the ways humans appropriate space include taking control over,
familiarization, caring for, and investing with meaning (Werner et al., 1985).

Attachment and identity refer to a process in which people become attached to or identify with an environment or with the objects in that environment.

The transactional approach gives quite a comprehensive explanation of how humans create a "home" out of a dwelling place. It also acknowledges that the meanings that arise from this process of creating a home are important in understanding our relationships with our dwelling places. However, it gives no insight into how meaning is made. This theory holds that human meaning is a central issue in the creation of "home" and yet it offers no explanations about how humans make meaning. Without this explanation, the transactional theories are limited to describing behaviour, not explaining it.

Phenomenology offers an explanation of how humans make meaning in their lives. I would like to briefly outline some of the important elements of the philosophy of phenomenology and then look at a synthesis of the ideas presented in the transactional model of home and the ideas presented by phenomenology.

**Home as a phenomenon**

**Philosophical Roots of Phenomenology**

Much of the way people from Western cultures understand the world they live in is based on Rene Descartes' belief that
knowing precedes being. That is, Descartes thought if one could understand how a person knew something (epistemology) then one could understand how a person existed (ontology). He summed up his solution in one sentence, "I think, therefore I am" (Benner and Wrubel, 1989).

This reductionistic approach concerned Edmund Husserl, a 19th Century German mathematician and the founder of phenomenology (Craib, 1984; Pallikkathayil and Morgan, 1991). He argued that the belief that one can reduce a phenomena to an objective reality separates the phenomena from the "everyday experiences and activities in which it is rooted" (Craib, 1984, p. 83). Thus he developed a method of looking at the world which included subjective experience (Pallikkathayil and Morgan, 1991). In this approach he suggested that objects have meaning only through our consciousness of them (Craib, 1984) and that rather than looking at just the objective meaning or the subjective meaning, one should look at the "point of contact where being and consciousness meet" (Pallikkathayil and Morgan, 1991). Phenomenology has thus been characterized as the science of "experience" (Pallikkathayil and Morgan, 1991, p. 195).

Martin Heidegger, in 1962, proposed a phenomenological view of a human being in which the ontological question (Who am I?) takes precedence over the epistemological question (How do I know?), suggesting that the answers to the second question arise from the answers to the first question (Benner 10
and Wrubel, 1989). Heidegger suggested that a person is "a self-interpreting being" (Benner and Wrubel, 1989, p. 41) who is not born predefined but who becomes defined by living in a meaningful context and who has an "effortless and nonreflective understanding of the self in the world" (Benner and Wrubel, 1989, p. 41).

In the Cartesian model, the type of understanding that is acknowledged and valued is reflective understanding; that is, the ability to stand outside of a situation and consider that situation through deliberate and abstract thoughts and concepts. Heidegger proposed that there is another way of knowing, that of nonreflective understanding or knowledge. Nonreflective understanding refers to an individual's direct grasp of the meaning of a situation while the individual is engaged or involved in that situation (Benner and Wrubel, 1989). Heidegger uses the concepts of embodied intelligence and context to help describe some of the aspects of this "self-interpreting being", who can understand her or his contexts through reflective and nonreflective understanding (Benner and Wrubel, 1989).

**Embodied Intelligence**

The idea of "embodied intelligence" reintegrates the mind-body split as conceptualized by Descartes. Embodied intelligence relates to the "various rapid, nonexplicit, and nonconscious ways of grasping the significance of a situation
for the self" (Benner and Wrubel, 1989, p. 43). It includes such activities as "recognizing familiar faces and objects, integrated recollection of our past experiences, to maintaining posture and moving our bodies without conscious attending" (Benner and Wrubel, 1989, p. 43), and skills such as playing the piano, driving a car or typing a thesis.

We are using our culturally-mediated embodied intelligence when we stand at precise intervals from each other in a line up, on a bus or at a party. When our cultural conventions regarding space are violated, we move to re-establish them immediately without being conscious of what we are doing. If we are unable to re-establish our space, we become uncomfortable, though we may not be able to articulate the reason for our discomfort.

We take our embodied intelligence so for granted that it is often invisible to reflective understanding and often becoming aware of our embodied intelligence causes it to work less well - I make more mistakes when I think about typing than when I just type. This taken-for-granted nature of embodied intelligence makes it difficult to hold up for reflective study.

**Contexts**

An important element of phenomenology is that the individual cannot be separated from his or her context. Context takes into account all the ways in which a person is
connected to the world. Heidegger has conceptualized the different elements of context as background meaning, concern, situation and temporality (Benner and Wrubel, 1989).

**Background meaning** is provided by the culture, subculture and family to which an individual belongs. It becomes the foundation from which the individual makes sense of his or her world, through which the individual distinguishes what information is important, what is not, and what to do with it. However, it is not an entity in itself. The analogy has been made that background meaning is like a light: "One does not see the light but what it illuminates. Without the light, one can see nothing because there is no basic, 'objective' world, only the interpreted one" (Benner and Wrubel, 1989, p. 114).

**Concern** is the term Heidegger used to describe how people are involved with things that matter to them. Embodied intelligence and background meaning provide information about how an individual is in the world; concern addresses the issue of why - why we make the choices and decisions we do, why we are motivated to behave the way we do.

Concern is a two-way connection to our contexts. As we develop concern about a particular item or issue, things that we were formerly unaware of take on new relevance and we in turn can be transformed by our awareness. An example of the two-way connection of concern can be seen by looking at stress through a phenomenological lens. Stress can be defined as "the inevitable result of living in a world in which things
matter to one" (Benner and Wrubel, 1989, p. 61). If there is no concern, there is no stress. When we become aware of our concern, we become stressed. What is important is not whether the stress is positive or negative, but how we are transformed by our awareness of our concern.

The situation is, simply, the circumstances of our lives; the real world with which we must contend. It is the stage upon which our embodied intelligence, background meanings and concern are played out. As our situation changes, so does our understanding of those circumstances. Thus, the situation becomes the ever-shifting sands against which we try to make meaning of our lives (Benner and Wrubel, 1989).

Situation is an important element in the phenomenological understanding of the person in that it shows how we both constitute and are constituted by our context; how we must adapt and change and find new meanings throughout our entire lives.

Temporality refers to the element of time. It is essential to the way we understand ourselves; our identity and continuity are linked to our sense of time. This sense of time, however, differs from the common understanding of time as linear, in that it allows that the past can be revisited in light of new self-understanding and new knowledge and can, as a result, be reinterpreted. Time is understood to be relational and directional and it is not experienced in the abstract. "It is specific and formed by what has gone on
before and by what is anticipated" (Benner and Wrubel, 1989, p. 67).

I would like to end this section with a quotation from Benner and Wrubel offering a summary of how a human being is viewed from a Heideggerian phenomenological approach, and explaining why reductionistic, positivistic research approaches are fated to see only part of the whole of a person's life:

This approach proposes that the person is not a mind-body duality, but a self-interpreting being, that is, a being who is an embodied intelligence brought up in a world of meaning, who has concern, all of which provide embeddedness (connection) in a situation grasped in terms of its meanings for the self. Such a being cannot be studied objectively, because such an objective, de-situated, ahistorical study will always miss the essential aspect - the self-interpretation, the lived meaning (Benner and Wrubel, 1989, p. 112).

**Phenomenological Insights about "Home"**

A phenomenological model of "home" does not contradict the processes described by the transactional model. It simply adds to the understanding of how we shape and are shaped by our environment.

From the perspective of embodied intelligence, home would be related to familiar routines - washing dishes, making beds - that had become second nature and almost automatic. It would also be found in our deep familiarity with the physical environment; noticing a new crack in the ceiling, holding the
poorly functioning TV remote control at just the right angle to change channels without being conscious of doing so.

Background meaning would be expressed in the ways we ornament our dwelling places with family heirlooms and other meaningful objects; in carrying out tasks in the same ways as our parents and grandparents - my mother's method of canning peaches, my father's system of cutting the lawn. That part of our background meaning shaped by our culture would determine who lived with us and how we lived together.

Our concern regarding our homes would vary. We could be concerned about any one of the elements that form the transactional unity that is a home - environmental properties, temporal qualities, and people and psychological processes. Our concern would change as the object of our concern changed and as we, ourselves, changed in response.

The situation, too, would vary depending on the events in our personal lives and in the world around us.

Perla Korosec-Serfaty (1985) has written extensively about a phenomenological understanding of "home". Her perspective is based in hermeneutics, a branch of phenomenology, which she describes as being "based on the idea that phenomena and human experiences are not immediately accessible and therefore call for an interpretive reading...a kind of phenomenology of words" (Korosec-Serfaty, 1985, p. 69). Through this lens, she looks at the concepts of boundaries and appropriation.
Boundaries refer to the "differentiation and qualification of space" (Korosec-Serfaty, 1985, p. 72) and are constituted by "insideness and outsideness" and the "hidden and visible" nature of home.

Insideness/outsideness refers to the phenomenon by which "space" becomes "place" (Korosec-Serfaty, 1985, p. 72) with the home being a place that is an "inside" as opposed to being an "outside". A boundary is the entity that both separates and links the inside and the outside.

The hidden and the visible reflect, according to Korosec-Serfaty, that any dwelling is closed and open, it conceals me and shows me; it designates me as a unique individual and as a member of a community. It obviously conceals me more or less, depending on my character and personal history, depending on my degree of acceptance of a cultural pattern" (Korosec-Serfaty, 1985, p. 73).

Appropriation as defined by Korosec-Serfaty is much the same as the concept of appropriation used in the transactional approach. However, she expands on the processes by which space is appropriated. She states that appropriation occurs in its own way in places where voluntary actions have taken place, and it is these voluntary actions that form the basis of appropriation. One need not own the space that has been appropriated or even have any kind of recognized claim to the space that has been appropriated, but one must have voluntarily invested in the space one's work or one's physical presence. She gives two examples of this. The first relates
to the ornamentation, maintenance and housework performed in a new house, which most likely was not built by the dweller, but which serve to make the dweller's imprint on the space. The second example relates to space that one is unable to physically work on;

...the city that I cannot transform may be strolled in and appropriated through the fatigue of having walked through it or through the familiarity of routinely walking the same streets (Korosec-Serfaty, 1985, p. 75).

As a result of this, what is appropriated is not the physical space, it is the meaning and the relationships that the dweller establishes with the space that is appropriated. Appropriation, therefore, does not only occur through voluntary physical actions in the "home environment", it also occurs in the effects the actions have on the dweller. Thus the dweller constitutes and is constituted by his or her environment.

Korosec-Serfaty makes an important distinction between the roles of voluntary and involuntary work in the appropriation of space. She notes that appropriation will only occur when the action or work is voluntary. If the work is not willingly accepted, it will not lead to appropriation.

In this section I have looked at a transaction theory of home which describes the processes through which we make space into our home. I have also looked at a phenomenological model in an attempt to begin to understand how human beings make
meaning. I have then looked at home from a phenomenological perspective using Benner and Wrubel's model, and Korosec-Serfaty's model. This material is important to this work as it states that the concept of home must be viewed from both a "reflective" or thoughtful lens as well as a "phenomenological" or felt lens, given the nature of home as a place that we inhabit on a felt level as well as a reflective level.

In the next section, I will look at theories of institutionalization.

THEORIES OF INSTITUTIONS

Total Institutions

In his book, Asylums, Erving Goffman (1961) describes the concept of a total institution. In the basic social arrangement of Western culture, an "individual tends to sleep, play and work in different places with different co-participants, and under different authorities and without an over-all rational plan" (Goffman, 1961, p. 5). In a total institution the barriers that normally separate these spheres of life are broken down (Lidz, Fischer & Arnold, 1992); that is, most facets of life are carried out within one environment and under the same authority, which is not usually held by the residents or inmates of the institution.
Goffman classifies total institutions into five "rough groupings" (Goffman, 1961, p. 4):

1. Institutions established to care for persons felt to be both incapable and harmless - homes for the blind, the aged, the orphaned, and the indigent.
2. Places established to care for persons felt to be both incapable of looking after themselves and an unintended threat to the community - TB sanatoria, mental hospitals and leprosaria.
3. Institutions organized to protect the community against perceived intentional dangers to it, with the welfare of the persons thus sequestered not the immediate issue - jails, penitentiaries, P.O.W. camps and concentration camps.
4. Institutions established to pursue some instrumental task - army barracks, ships, boarding schools, work camps, colonial compounds and large mansions from the point of view of those who live in the servants' quarters.
5. Establishments designed as retreats from the world often serving also as training facilities for the religious - abbeys, monasteries, convents and other cloisters (Goffman, 1961, p. 5).

This paper will deal with the type of total institution described in the first classification; institutions created for the care of those felt to be "incapable and harmless".
In 1992, Lidz, Arnold and Fischer, using a participant observational research technique to gather data, examined the relationships between staff and residents of an non-profit geriatric facility in the U.S. Although the authors were primarily interested in looking at issues of autonomy, they looked at Goffman's theory of total institutions in the context of their own data because of the nature of the relationship between autonomy and the social structures of total institutions. They noted that while the nursing home they studied did not meet every characteristic of a total institution, it did approximate Goffman's conception of a total institution (Lidz et al., 1992). Fifteen attributes of total institutions, and their applicability to care facilities, as noted in the work of Lidz et al. (1992) include the following:

1. Entry rituals, including stripping of an individual's private identity and categorizing and processing an individual's life, such as history-taking, are common.

The authors found that when an individual is admitted to a care facility, that person goes from being a unique individual with a complex psychosocial history to being a patient who is largely known by his or her medical history. As well, residents are able to bring only a few of their possessions with them and those items are often subject to approval by facility administration.
2. Locational dedifferentiation: all aspects of life are conducted in the same place.

Many residents eat, sleep and spend their waking hours within the same building, rarely leaving the facility.

3. Dedifferentiation of authority: in "total institutions" there is a single, unspecialized authority hierarchy.

People within a care facility belong, for the most part, to one of two groups - staff or resident. The authors note that in the majority of cases, staff have the final authority to make decisions and when there is a disagreement between patients and staff about what should be done, staff's viewpoint tends to dominate.

4. Each phase of the patients' daily activity is carried on in the immediate company of a large group of others, all of whom are treated alike.

Residents of a care facility are seldom able to choose either their fellow residents or the staff who care for them. As a result they spend most of their time in the company of people with whom they had no prior personal ties and who were selected by others. As well, residents' days seem to be structured more around organization procedures rather than around residents' needs. It was also noted that staff restrictions seemed to be focussed primarily on safeguarding patient health and institutional efficiency rather than on individual resident requests or needs.

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5. Daily activities are scheduled by staff with little individual variation permitted.

It was observed that the daily routine of residents - when they get up, meal times, recreational activities and bedtimes - were all structured by the staff with very little patient-directed activity or organization of time.

6. Violations of privacy are common.

It was noted that there was very little privacy in the nursing home. Rooms were shared and almost anyone could obtain unrestricted access to patients' space. The authors also found that privacy of information, of possessions and of the body were routinely violated in the nursing home.

7. There is a small group of staff members whose primary role is to ensure enforcement of the rules.

Line staff were noted not so much to enforce rules as to maintain a routine. It appeared that staff's primary role was to physically assure compliance with the organizational routine.

8. Restrictions on patient contact with the outside world, particularly at entry.

Although there were no formal restrictions on communication with the outside, access to telephones in the facility Lidz et al. studied was difficult. Many patients could not afford a personal telephone and the only public telephones were in the staff lounges. To use these phones, the residents were required to ask for permission. The
authors noted that over time, residents had greater difficulty maintaining significant relationships with people outside the facility and leaving the facility became an uncommon event that acquired a special significance.

9. Line staff function to control patient communication to higher staff.

Lidz et al. noted that communication between patients and their physicians was almost always mediated through the nursing staff. However, they did not note any other attempts to limit patient communication with other higher staff such as administration.

10. Patients and staff view each other through narrow, hostile stereotypes.

Staff were noted to view patients as "demented, unrealistic and demanding" (Lidz et al., 1992, p. 171). Patients tended to view all staff as alike and were found to make few distinctions among them. Upper staff, who did not have to tend to day-to-day details of body care, were found to have a considerable fondness for some patients.

11. Patients were excluded from making plans about themselves.

Patients were not included in care conferences or discharge planning meetings. Rather, they were informed when the discharge or transfers were planned.

12. Rituals characterized by patient deference toward staff develop in total institutions.
Lidz et al. did not note any such behaviours or rituals in their study.

13. Patients must request staff permission for routine activities and tools.

Patient interaction with staff was noted to consist almost entirely of requests for assistance in accomplishing most tasks, particularly for residents with a physical disability. As mentioned earlier, residents were obligated to request permission to use the public telephone from staff.

14. Discrediting reports about patients commonly spread through staff ranks.

Lidz et al. noted that they saw many instances of this activity, most commonly by staff spreading hearsay obtained from other staff. The authors also note that the medical record became a repository for this sort of information.

15. All activities are brought together into a single rational plan designed to fulfill the official aims of the institutions.

The official aims of this organization were noted to be organized around the value of health. The normative expectations of patients and staff were found to be defined by a medical model. "Elderly individuals living in the nursing home were seen as 'sick' patients. Their job was, therefore, to comply with the staff's orders in an attempt to 'get better'." (Lidz et al., 1992, p. 172).
Adaptation

Goffman (1961) offers four typologies of inmate reaction and adaptation to a total institution: situational withdrawal, intransigence, colonization and conversion. Bowker (1982) adds two more types of adaptation specific to a geriatric setting: severe, long-term depression and nonreaction.

In situational withdrawal, the resident withdraws from institutional life and focuses his or her attention only on those events which occur in his or her immediate vicinity. Situational withdrawal is often expressed by extreme territoriality such as jealously guarding a favourite chair or area in the hallway or lounge.

Intransigence is displayed when residents openly refuse to cooperate with staff. This may be manifested in verbal abuse of staff, by insisting that they do not belong in an institution or in physically striking out at staff.

Colonization occurs when the resident expects to be in the institution until they die and they want to make the best of their remaining time. Colonizers make themselves at home and act as model residents as long as staff will treat them as humans beings and not as patients.

Conversion is said to occur when the resident adapts to his or her circumstances by taking on the image staff have of them as patients. They do their best to become good patients
to the point that they become increasingly passive over time and eventually are unable to participate in their own care.

Severe, long-term depression is found when the stress of relocating to a facility is combined with any number of other stressors and losses, such as the loss of a spouse or other loved ones, a home or financial security. Residents may withdraw completely from life or they may engage in overly compliant behaviour.

Nonreaction occurs when the resident no longer has an organized personality system upon admission to the facility. Bowker (1982) describes these people as "the residents who are awaiting a physical death but who have already suffered a social death" (p. 37).

REVIEW OF LITERATURE ON LONG TERM CARE ENVIRONMENTS

Much has been written about people who live in nursing homes. The literature tends to fall into two distinct groups - those written by researchers, measuring the behaviour and responses of nursing home residents (Lipman and Slater, 1976; Diamond, 1992; Lidz, Fischer and Arnold, 1992), and those written by concerned people from academia and the media, describing and otherwise exposing conditions in nursing homes (Manard, Kart and van Gils, 1975; Tulloch, 1975; Krause, 1982; Baggett, 1989). The majority of this literature tends to be written from the authors' perspective, answering research questions the researcher is interested in, describing daily
life in a nursing home, the procedures and the details from the point of view of the person doing the writing. This is a problem because, in the words of one senior, "I know what it means to be old. You can only speculate [which is] a hell of a lot different from my reality of things" (Burnside, 1988).

Literature expressing the point of view of the resident of a nursing home, his or her thoughts and experiences and what they mean, is harder to come by. There are two pieces of work which, although they do not directly address the meaning of home for residents of an intermediate care facility, do attempt to understand the meaning and experiences of nursing home residents in general, and to look at the meaning of home for the elderly. I would like to briefly discuss the work of Jaber Gubrium (1975) who, in *Living and Dying at Murray Manor*, undertook a participant observation study of a nursing home; and of Andrew Sixsmith (1990) who explored the meaning of home through a phenomenological, qualitative study entitled the "Meaning and Experience of 'Home' in Later Life".

**Living and Dying at Murray Manor**

Although this work is 20 years old, it endures as one of the most important pieces written about life in a nursing home. Jaber Gubrium, a gerontologist, spent several months at Murray Manor (a pseudonym for an Eastern American nursing home) as a participant observer. He took on a variety of roles ranging from "toileting" residents to acting as
consultant gerontologist at staff meetings. As well he interviewed staff and residents about both the meaning of place and the way care is accomplished by the people who participate in the everyday life of the facility.

Of particular relevance to this study are his findings about residents' reactions to Murray Manor as their home. Gubrium finds that most residents, "once they are established at the Manor, ...guard their remaining home ties vigilantly" (Gubrium, 1975, p. 84) by maintaining contact with the outside world. He notes that "making peace with hopelessness" (p.84) is one of the primary tasks encountered by residents of Murray Manor. By moving into the Manor, people were faced with a "near total" loss of their way of life - loss of people, loss of possessions, loss of the "familiar trivia of everyday life... (that is) often the hallmark of solid ties... (and which) assures one that...all is basically 'as usual' in one's life" (p. 87).

Gubrium does not report any resident who has accepted Murray Manor as his or her home. Many residents are eloquent in their praise of the care they receive, the kindness of the staff, the cleanliness of the environment; however, as one resident reported "if I could help myself to be on my own, I wouldn't be in here five minutes" (p. 88), a sentiment held seemingly by all residents.
"The Meaning and Experience of 'Home' in Later Life"

Using a phenomenological, qualitative approach, Sixsmith (1990) conducted in-depth interviews with sixty people who resided in their own homes in Newcastle-upon-Tyne, England, and who were over age 65. Participants were asked to talk about what home meant to them. They were encouraged to expand on their views as much as possible and to talk freely about their feelings and experiences. Data were reduced to basic meaning categories through content analysis. These categories were then compared to two groups comprised of employed and unemployed people under age 65.

The analysis showed three concerns that are related to the meaning of home for older people. First, older people were noted to be more oriented towards their homes than were the younger people in the comparison groups. Sixsmith suggests that this is possibly because the home becomes increasingly important as other social roles are replaced.

Secondly, the older people were noted to be more concerned with the instrumental aspects of home. This was thought to be related to the impact the environment has on an increasingly frail elder's desire to remain living in his or her own home and to maintain their independence.

The third concern shown by older people related to the issue of memories, that is past associations having an effect on the present experience of the home.
In this section I have discussed the concept of a total institution, that is, a place where the normal boundaries separating work, play and sleep do not exist, and I have discussed some ideas regarding the ways in which residents of total institutions adjust to living in an institution. I have also discussed two pieces of literature relevant to this study.

I have included this material as some of the dynamics individuals residing in an institution have to face are different from the dynamics dealt with by individuals living in a private residence and it is important to have a theoretical basis to explore the meaning of living in an institution.
CHAPTER 2
METHODOLOGY

Description of Design

Given the nature of the questions being addressed in this project, a qualitative perspective was chosen rather than a quantitative approach. The research question is intended to explore the meaning of an experience rather than to measure or otherwise quantify that experience. A phenomenological approach was chosen as it was considered to be the philosophical/theoretical framework most honouring of the experiences of the participants. Honouring the experiences of participants is an important element as often, when research is being carried out by younger people on issues related to older people, assumptions are made by the researcher which can bias the findings. It is difficult for younger people to understand the experience of being old and the experiences of older people. A phenomenological approach allowed for an open-ended and unstructured research tool (the interview guide) and for consultation with the participant regarding the meaning of the results generated by the researcher.

Validity and Reliability of Qualitative/Phenomenological Method

One of the challenges of research is to have a sense of whether the data gathered and the analysis presented represent what the participants were actually saying to the researcher.
Phenomenology was chosen as a research method because it is qualitative in nature, asking participants to say in their own words what is important to them about a subject of interest to the researcher. Allowing participants to choose what is significant to them and to communicate that to the researcher helps to increase the validity of the research conclusions.

Due to the quantity of data, the sample size is very small - in this study it was 6; therefore, any conclusions drawn from this work can only be applied to the six participants and not to the entire population of elders living in an intermediate care facility.

**Sample Selection and Criteria**

As the goal of this research was to explore experiences and meanings, rather than to measure and quantify, I decided to use a smaller rather than larger sample size. As well, on a practical level, the large amount of data generated supported a small sample size. It was decided to interview a maximum of eight residents of an intermediate care facility. The sample was limited to residents in an intermediate care facility for several reasons. This was the setting in which I started to ask many of the questions relating to "home" and so it was a natural place to look for answers. I felt that it would be difficult to find extended care residents who would be willing and able to participate in the research.
In order to be considered for inclusion in this study, residents had to be over 70 years of age; cognitively intact; willing to engage in reflection and discussion about their meanings and experiences of home; able to participate in three to four interviews of one hour duration spread out over several weeks; and have lived in the facility over one year.

A minimum age was included as I wanted to explore the meaning of home for older people in an institution. On occasion younger people, who are unable to care for themselves due to a variety of factors, reside in long term care facilities. My sense was their experiences of living in a facility may be very different from those of an older person. While their experiences and meanings are important and should also be explored, it was outside the scope of this research to do so.

Participants were required to be both cognitively intact and willing to engage in a process of reflection and discussion about their experiences. These criteria effectively excluded the majority of residents of most long term care facilities. It was necessary, however, as while there was is no way of assuring reliability of this type of data, reliability is increased by including participants who are willing and who are able to participate in a rather complex cognitive task.

Ability to participate in a number of interviews was included as I realized that people who were sufficiently
cognitively intact to participate would likely be living in a care facility because of a physical disability or illness. It became important therefore to identify to potential participants what would be required of them so they would be able to make an informed decision regarding participation as well as to lessen the chances that participants would drop out part way through as the demands would be too great for them.

Finally, participants were required to have lived in the facility for one year. The literature makes reference on many occasions to the element of time in the meaning of home. It was decided that participants should have had an opportunity to have lived in the facility for a while so they could meaningfully comment on their experiences. One year was chosen rather arbitrarily, as the literature gave no guidance as to the relationship between elapsed time and the experience of home. It was felt that a resident who has lived in a facility for a year will have experienced all four seasons, and all holidays, anniversaries, birthdays and other seasonal and personal markers, and will have had time to acclimatise themselves to their environment.
Participant Recruitment

Participants were recruited from Whytebridge Villa,\(^1\) an intermediate care facility in the City of Vancouver. Whytebridge Villa is a 130 bed facility providing Personal Care, Intermediate Care Levels 1, 2 and 3 (and, in special circumstances, Extended Care), as authorized by the Ministry of Health. It is a non-profit organization governed by a volunteer Board of Directors. Funding is primarily from the Ministry of Health and a monthly rent paid by residents. The residents' rent is based on income and is determined by the Ministry of Health.

The facility was built in the mid-1980's. It is a four storey building. On the first floor are the reception area, a large residents' lounge, the dining room, a craft and hobbies room, a greenhouse, the kitchen and administrative offices. There are two wings coming off the central section and there is a courtyard, accessible to the residents from the greenhouse, hobby room or dining room between the two wings.

The second, third and fourth floors contain residents' rooms. Residents are assigned to floors based on their ability to be independent in their activities of daily living. The most independent residents reside on the fourth floor. All rooms are private and have a private toilet and sink. While rooms vary somewhat in size, all rooms are large enough

\(^1\) The name of the facility has been changed.
to comfortably hold a single bed, an easy chair, a writing desk and chair, a dresser and a TV and TV table.

Whytebridge Villa was chosen as it met the criteria of being a non-profit organization, having a social worker on staff and being easily accessible to the researcher.

The social worker was initially contacted and the proposed research was discussed with her. She indicated that she would be willing ask the residents at the next Unit Meeting if they would be interested in participating in this research. (A Unit Meeting is a weekly gathering of residents and staff of a particular "unit" or floor to discuss issues and to communicate information.) The residents indicated they were interested and requested that I attend a Unit Meeting to provide more details and answer their questions.

I attended a Unit Meeting two weeks later and met with approximately 25 residents of the 4th Floor, which is the floor where the most independent and cognitively able residents live. I outlined my research question, described the research procedures and answered many thought-provoking questions. After all questions were answered, the social worker asked if people were interested in participating and several indicated their interest. After approximately six weeks, having received approval from the University Ethics Committee, I approached the social worker for the names and room numbers of the individuals who had indicated interest in participating. Seven names - four women and three men - were
provided. As I had decided that I could only reasonably conduct and transcribe six interviews, I chose the first three women who were in their rooms the first afternoon I was at the facility. (Had all four been in their rooms, I would have drawn three names at random from a hat or other suitable container; however, when I spoke to the nurse on duty, asking about residents' room numbers, I was advised only three were in that afternoon.) All three male volunteers were interviewed.

Data Collection Procedures

I approached each participant individually, five in their rooms and one in the dining room. I identified myself and reminded them of the presentation I had given at the Unit Meeting and that they had expressed interest in participating in the research. I asked if they were still interested in participating. All six indicated they would like to participate. I then described the project, stating that it was part of the requirement for my M.S.W. and that I would be asking them to answer some questions I had about the meaning of home, both in the past and in the present. I advised them that the interview would be taped and would last approximately 60 minutes. I also advised each participant that I would provide them with a transcript of the first interview and would want to set up another interview to discuss any issues arising out of the first interview. After this was discussed
and agreed to I explained the consent form and asked for the participant to sign and then set up an appointment for the interview. The amount of time between this meeting and the interview varied from a few hours to five days. One interview was cancelled due to illness on the part of the participant and had to be rescheduled.

All interviews were held in the residents' rooms. At the agreed upon time, I met the resident in his or her room. Each room was furnished with a hospital-type single bed and an easy chair. Four participants chose to be interviewed sitting on their bed; three reclining with their feet up and back supported by the head of the bed; the fourth sat on the side of the bed. Two participants sat in easy chairs; I was invited to sit on the side of their bed.

Once seating was established, I set up the recording equipment. The first interview, with a woman who reclined on the bed, was done using the microphone on the tape recorder. The quality of the tape was very poor, making transcription very difficult. For the five remaining interviews I used a lapel microphone. During the first interview with the lapel mike, I attached the mike to a cord to be placed around the participant's neck, necklace-style. This was done as the clip on the mike was stiff and I was concerned that participants may not have the finger strength to open and close it. While the quality of the tape was very good using the mike in this way, it seemed to be inconvenient for the participant (a woman
who sat reclining on her bed) to place the cord over her head and seemed to be a bit of a distraction. I decided after this interview that I would take the cord with me but that I would ask permission to clip the mike on to the resident's lapel, only using the cord if permission was not granted. The remaining 4 participants all agreed to have the mike clipped on to the collar or shirt front. Getting the lapel mike attached to participants' clothing served as an ice-breaker and was a bit of a distraction from the upcoming interview.

Once the mike was attached and a new tape unsealed and placed in the tape recorder a test was done to ensure that the machine was working and that the participant's voice was being recorded clearly.

I asked if the participant was ready to begin and all six indicated they were. I then proceeded to ask the questions on the interview guide and to explore information arising out of those questions.

Interviews ranged from 45 to 60 minutes in length with the average being 55 minutes. All participants were very cooperative. During two of the afternoon interviews with female participants a staff person with an afternoon snack and drink came into the room, after knocking and being given permission to enter. The aide brought in a cup of juice and a package of cookies. She also engaged the resident in some brief, cheerful conversation. Each resident made a positive comment about their interaction with this particular aide.
I ended the interview by explaining that I would be transcribing the interview and would drop off a copy of the transcripts to each participant. I advised that I would like the opportunity to discuss any issues arising from the interview or the transcript with the participant.

The transcripts were dropped off to each participant as they became available. I asked the participant to read the transcript through and then to call me to let me know when they had had a chance to look it over. This was done, as I wanted to follow-up with the participants at their convenience, rather than mine. One resident did contact me to advise me she had read the transcript. We set up a time for a second interview, however, she cancelled the appointment as she was not feeling well.

Unfortunately, life intervened and financial pressures made it necessary for me to find full-time employment. As part of the employment, I was required to be out of the city for a period of three months. Therefore, it was not possible to do the follow-up interviews with the participants.

**Data Analysis**

Tapes were transcribed by myself. This took approximately 4 to 6 hours per tape, depending on the length of the interview, clarity of the tape and the speed with which the participant spoke. Following Patton (1990), I read through all the transcribed material in one sitting to
familiarize myself with the content and to get an overall impression of what was contained in the material.

I read through the material again, this reading for sections that related to the "meaning of home". I identified two categories of "meaning of home", meaning of home before moving into the facility and the meaning of home while living in the facility. Using differently coloured highlighter pens, I "highlighted" sections of the material relating to these two categories.

On looking at the material again I noted that each person had provided information about how they came to be living at the facility. This was "highlighted" in a third colour.

The remaining material contained many anecdotes that were shared to provide explanations and examples of the issues we were discussing. I noted that these anecdotes related to information about life history and to living at the facility. They were "highlighted" in 2 different colours leaving me with five categories, highlighted in five different colours.

I then took scissors and went through the transcripts that had been highlighted, cutting and sorting the transcript into pieces based on the highlighted categories. When the entire transcript had been sorted this way I went through each category with scissors in hand and further separated the transcript into "complete ideas" (I had previously decided "complete ideas" would be the unit of analysis.) I have called these "complete ideas" elements. After identifying all
elements, I was then able to identify sub-elements, which are data that describe elements but which are not complete ideas in themselves.

Once all elements and their sub-elements had been identified, I began grouping elements into larger groups of similar meanings. I identified these as themes and sub-themes; themes being an overarching concept and sub-themes being more specific concepts that inform the theme.

Once all data in the transcripts had been identified and categorized, they were organized in a table (please see Appendix I).

Description of Participants

Confidentiality and anonymity were assured and therefore descriptors are general. Participants are referred to by Mr. or Mrs. and a letter of the alphabet (A to F) which was assigned at random.

Participants were between 75 and 85 years of age. All three men were born in the British Isles; two came to Canada as children, the other as a young adult. All three women were born in Canada; two were born in the Prairie provinces and one in Vancouver. All participants have lived in the Vancouver area since 1954. All are of European ancestry. Frequency of relocation of dwelling places varied with four of the participants (2 men and 2 women) having moved quite frequently and the other two participants (1 man and 1
woman) having moved only 4 or 5 times over the course of their lifetime.

All of the women and two of the men married. One male participant's spouse is living. The others have been without a spouse for at least five years.

All have lead rich and interesting lives. Although toward the ends of their lives they all live at Whytebridge Villa, the paths which have lead the participants here are as diverse as could possibly be imagined. One participant grew up in a village in Scotland; another was orphaned at a young age and grew up as a "homeboy" in Ontario. Yet another lived on various Indian Reservations in Alberta while her mother taught school. As adults, one had a career with a department store and moved all over western Canada while another moved into a home shortly after her marriage and lived there for 50 years, raising her own family and watching and helping her children as they raised their families.
CHAPTER 3
RESULTS

The data gathered during the research interviews clustered into one of five categories: Life Stories, Meaning of Home Before Moving Into Whytebridge, The Admission Story, At Home in Whytebridge Villa and Whytebridge Anecdotes. Below I will present the findings in each category.

LIFE STORIES

After reading through this information, I realized that these life stories had been provided as background to assist in telling me about the different homes participants had lived in or as a way of communicating how the participants saw themselves as people, where they have come from and how they have dealt with their lives. As these issues were not directly related to the research question, I did not feel it respectful or appropriate to subject participants' life stories to analysis. I felt these stories would only be diminished by reducing them to their component parts.

Therefore, these stories were treated as context, to describe, in the methodology section, who the participants are.
MEANING OF HOME BEFORE MOVING INTO WHYTEBRIDGE VILLA

Information about the meaning of home before moving into Whytebridge Villa evolved into three themes that were somewhat overlapping: reflective home; felt home and the phenomenological home. "Reflective home" identifies some of the components participants identified as necessary in order to understand a dwelling place as one's home. "Felt home" relates to the subjective and affective experiences of home. The "phenomenological home" is about the home as experienced at the point where being and consciousness meet.

Reflective home

The themes that were identified as being important in knowing an environment as one's home can be further grouped into two distinct sub-themes - those sub-themes dealing with people and our relationships with them and those dealing with the physical environment.

Included with the sub-themes dealing with people and relationships are the need to "know and be known",

Oh, I think, I knew it was my home because, because it was a village, a country district, I knew everybody and they knew me...(Mr. E.)

and to understand one's role or status in the community where one is known,

...and they knew me as my father had some kind of status and as (his) son and so I had to watch my P's and Q's a bit, you know, because of my mother and father...(Mr. E.).
Relationships with people in the environment were also noted as being an important feature of being home. Having friends and relatives visit in a place and "knowing it" (Mrs. D.) and having the dwelling place itself trigger memories of the people who had been there and the things they had done were identified as significant,

everything about the place had some of his [participant's husband] handiwork in it or what we had done or who had stayed with us or where we had put them all (Mrs. D.).

Living with "friendly people" (Mr. F.) and "good neighbours" (Mrs. D.) were also noted as being important features of one's home.

Physical amenities were noted as being an important feature of what constitutes "home". A "nice garden" (Mrs. B.) and a variety of "comforts" which included a "self-cleaning oven", a "washer", a "dishwasher", "enough room", a "TV", a "comfortable bed", "pleasant colours/decor", a "radio" and "one's own bathtub".

The final physical amenity mentioned was location. For several participants a "convenient location" was an important factor as was living in a "nice part of town". The importance of location was demonstrated by Mr. F. who, although he had lived at Whytebridge for a number of years, still experienced a sense of loss when thinking about the facility he had been required to leave when it closed down,

...the Manor, it's (was) close to Granville...and every night after supper I used to go around to
Benny's...and I'd have potato chips and a cola...(now) it's too far away (Mr. F.).

**Felt home**

Feelings about home elicited two types of feeling responses from the participants - happy feelings about home and sad feelings about home.

Mr. E. characterized his days at home as "really my happiest days". Mrs. B. noted that her first home after she married was a place where she felt "settled for the first time in her life".

Mrs. A, who had a career she loved, noted that,

I was always very, very happy to go to work and very happy to go home when I finished...it was the combination of the two...

For Mr. C. recalling memories was not pleasant. He identified home as "a place where one worked very hard", where, growing up as an orphan, he often felt "abandoned",

Because you have no one to turn to, you see, even these people who have their headquarters in Ottawa, the Catholic Immigration Association or Society or whatever they (were) call(ed), well you might as well talk to the wall, they have no time for you. Once you're out, off their premises, it's good-bye...or whatever. Yup. But they do, they send a couple of nuns around every couple of years and say hello to you and that's about it.

Interviewer: You were truly on your own.
Mr. C.: Oh, yeah. Half of the time, most of the time, sure.

Mrs. B., who moved frequently as a youngster, identified that she "never had deep roots" until she married and moved into a home with her husband.
Phenomenological Home

There seemed to be some intangible factors relating to the meaning of home that were difficult to express but which, at the same time, were important elements in constituting how participants understood a place to be their home.

When one participant was asked how she knew a place was her home, she replied, "Well, it is a home, it was our home." (Mrs. D.). She seemed to have a very clear vision of what "home" was but could only provide information about that vision through examples, she was unable to define what she meant.

For Mrs. D. in recent years, home was a place where she could "still recall everything",

After my husband died I mean, and the kids said, "Well, you should sell it and move into an apartment". I said, "No, there's too many memories here." I said, "I couldn't go yet".

For her, the memories were, for the most part, pleasant ones.

...it was where I lived for so many years, my husband had lived there.. and I'd look at things and know that he'd done this or done something else, and just, you know, it was comfortable (Mrs. D.).

Mr. E., when asked about how he knew a place was his home, indicated that

home was still where I was brought up...that I would have to say, it's something I would automatically think of it, I might not say it was my home, but that's what I would think of.

Finally, Mrs. A. who has a sense that, "wherever I am, it's my home". How she knows a place is home seems to be
related to something she takes with her and that is as much about who she is as are her personality and temperament.

THE ADMISSION STORY

Participants recounted in varying details the circumstances which led to their admission to Whytebridge Villa. All of the participants sought intermediate care due to failing health and increasing difficulties caring for themselves. Several lived in other intermediate care facilities prior to moving into Whytebridge Villa; others visited various facilities, decided on Whytebridge and remained on the waiting list until they came to the top.

...so when I come to visit, they had visiting hours for people to come and take a tour, on Mondays, I think it is, so my daughter and I come and she was sort of being my attendant, you know, when I was going anywhere, pushing my chair. So I was quite impressed with it and so I asked my social worker to put my name down, and she did. She said there'd be quite a wait but I said, "I know but that's where I want to go", and later she said, "If you put your name on other lists, you might get in the place faster". I said, "It makes no difference, this is where I want to go." (Mrs. D.)

Three participants, one man and two women, were matter of fact in recounting the events that lead to their admission; the others were still clearly affected by the events surrounding their admission to the facility.

So I said, "OK, I'll come Thursday, Friday", I said, "Friday? OK." She [the Whytebridge social worker] phoned me the next day and said, "Oh, we've had an emergency and we'll have to ask you to go on the second floor temporarily", and I didn't realize exactly that the second floor was all Alzheimer's,
so there were two of us who weren't Alzheimer's on the whole floor (Mrs. B.).

Participants related that the decision to seek intermediate care and being admitted to a facility were stressful events that happened in a time of crisis - the loss of a spouse, or sickness, or financial constraints - in their lives.

...I got a little bit sick and I was in the hospital for, really I can't remember how long, but it must have been four or five months anyway, and then I went to...(another) care facility...and it was terribly expensive, so my brother was looking after my affairs and he and his wife decided that they'd try to find me another place that was a little more affordable. So that's what they did....about $2400 a month, so that drains your resources quite substantially (Mrs. A.).

AT HOME IN WHYTEBRIDGE VILLA

Data in this section were grouped into five main themes with many sub-themes and sub groupings. The major themes are: Reflective Home, Relationships, Perceptions of Whytebridge as Home, Reactions to Whytebridge as Home, and Adjustment.

Reflective Home

Participants were asked to identify elements that constituted home for them as they experienced it, living in Whytebridge. These elements were: being cared for by "nurses, the aides, the kitchen staff, even the cooks"; having one's "own hairdresser" on site, as well as a "foot doctor",

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an "eye doctor" and a "dentist" who "...come, so we have everybody that comes here and if you want to see them, you just let the nurse know you want to see them and you have an appointment" (Mrs. A.); the food - "(it) isn't all that bad, it isn't all that good, but it's not, you know, repulsive or anything"; a comfortable room surrounded by one's possessions

"...because it has my own things in it, this stuff is all mine [gestures to room] and it has my own things in it and I'm comfortable, and you know, it's a type of a room I like, it's small enough and big enough for me and I've got my TV and things I need or want" (Mrs. A.)

and having access to "a bit of green space in the big city" (Mrs. B.).

**Relationships**

There seemed to be very different relationships with staff and with other residents.

Relationships with staff were characterized as positive, with several of the participants identifying a special relationship with one or two staff members, "one or two of the nurses I'm quite friendly with and the aides, you know. I like them all really. They're a nice bunch." (Mrs. B.).

As well, several participants noted the impact staff have on participant's lives,

The people [staff] are very important. Some of them are very dedicated, you know, they like their work...[referring to a care aide who had just been in the room] like that one lady that just come in. She says she just can't wait to get to work. When she's off for a few days, we miss her (Mrs. D.).
Relationships with other residents were not, for the most part, positive. Several participants identified that they did not consider themselves to be friends with any other resident. Mr. E. noted that, "...I can't think of anybody [resident] just at the moment, however, who I would look on as a personal friend." It was noted by participants that other residents "did not want to talk" or would "completely isolate themselves".

One of the impediments to forming relationships with other residents which was identified by the participants was dementia.

...you can't have a real good conversation with too many, you know, they're all in different forms of dementia. (Mrs. A.)

...then you can leave your door and you get a little bit of a through draught, but then you don't know what else you're going to get. You know, somebody may wander in if your door's open... (Mrs. B.).

**Perceptions of Whytebridge as Home**

Many participants perceived Whytebridge to be their home on both a psychological/emotional/intellectual basis and on a physical basis.

All participants were asked if they considered Whytebridge their home and how they did or did not know this. Of the six participants interviewed, four accepted Whytebridge as their home, one did not and one was working through a
process to determine whether he would be able to feel at home at Whytebridge.

The four who did accept Whytebridge as their home identified a variety of reasons regarding how they knew this. Mrs. D., when asked "How do you know?", replied "Because when I go out I'm always looking forward to coming back home again." Mrs. B. stated that "...other than the part that I'm paying rent [laughs] ...well, I feel comfortable and I'm well looked after" in response to the same question. Mr. C. identified that it was a feeling of "contentment" that made him know that he was "home".

The one participant who did not accept Whytebridge as his home identified another facility, one that had closed down, as being his home.

And finally, one participant was still in the process of determining if Whytebridge could be his home. When asked if he considered Whytebridge his home he replied,

Oh, yes. Well, yes. I have to consider it my home. But not home as a home, if you follow me. It's where I'm going to stay. Yes. I wouldn't change (Mr. E.).

Participants perceived Whytebridge as their home on a physical basis as well as a psychological one. At the physical level, most participants identified their rooms as their primary "home",

...I feel that this (gestures to room) is my home. When I come in here and shut that door, then I'm home free. I mean, I mix with people and I'm quite a good mixer and that, but, um, after a while you
get, you know, so you want to get by yourself. (Mrs. B.)

Other areas of Whytebridge that were identified as being important to the participants' sense of home were the lounge, the hobby room and greenhouse, and the courtyard in the summertime.

**Adjustment to Whytebridge as Home**

By far, the thematic area with the greatest amount of data is that of "Adjustment". Participants identified a number of issues to which they have had to adjust since moving into Whytebridge Villa. These are: institutional rules and structures; separation from family; congregate living; and living with dementia in others. In addition to outlining the challenges of adjustment they face in making Whytebridge Villa their home they also outline some of the strategies they have used to make their adjustments.

Adjusting to institutional rules and structures seems to be one of the biggest tasks facing a resident of Whytebridge Villa. This adjustment seems to be highly personal. In the interviews conducted for this paper I was told that Whytebridge Villa was "not regimented in any way" by one participant and that "...the regimentation is the main drawback", by another participant. Most of the participants fall somewhere in between these two viewpoints, identifying a number of adjustments that had to be made to institutional living. Some of the circumstances requiring adjustment
included communication problems, "the main thing that bugs me is that messages don't get through" (Mrs. B.); and getting around outside of Whytebridge Villa,

...(if) I think "I'll go (to the store) for a little while today", you know, you're kind of stuck. You've got transportation to figure out and if you can't really walk too well on your own or manage on your own, you've got to get them to get somebody to go with you (Mrs. A.).

The lack of choice around meal planning, "...here, I think, well, I'm going to get what they put on my plate and that's it" and the frequency of bathing, "we can only have one bath a week, which I find very aggravating" were adjustments that Mrs. B. had to make. She also stated that,

...it took me a while, I've been just over a year, in March I was here a year so it takes...getting used to...a big upheaval from having your own place to coming in and then having to be a certain time for meals, certain time you're there, there, meals at, certain you gotta be there. So, whereas at home you just putter around and eat when you feel like it, and different things like that. You have to get used to (it).

Only one of the six participants was married at the time of the interview. When he moved into Whytebridge Villa he had to adjust to separation from his wife. He stated,

Yeah, sure...I don't cry about it, you know, but yeah, you have ups and downs periods and, of course, it's, I suppose I'm more concerned about (my wife) than I am about myself...(It's) just that she's alone, that we're not together. You've been together quite a long time and...we've had a great marriage (Mr. E.).

Five of six participants had lived by themselves prior to moving into Whytebridge Villa. (The sixth lived with his
Therefore, sharing living space with 138 people required considerable adjustment,

Well, the only thing with a place like this is, sort of, you're sort of...you do everything on a collective basis...yes, you're regimented and that's the only think I don't like. I hate regimentation. I want to do it my way (Mrs. A.).

One of the most difficult and painful adjustments participants had to make was learning to live with others who were in varying stages of dementia. As Mr. E. poignantly notes,

You see the thing, the surroundings are a bit devastating sometimes because my heart goes out to so many people, who are just sitting, you know, just completely, they're put in a chair and they sit there all day. And to have to face this, this takes a bit of...I don't know the...how to say it, getting accustomed to it, you know. I feel so sorry for them, but there's nothing you can do and you've got to just not become oppressed by it all.

Each participant, at some time during the interview, made reference to the difficulty involved in adjusting to living with people with a dementia.

"I'm here and this is it."

At some point, most of the participants seemed to have adjusted to living in an institution,

You don't fully realize it 'til you've been here a while and then you look back and say, "Hey, hey!", you know. This is it, yes (Mr. C.).

I have to live here and so far, you know, if I don't lose any more brain matter, I'll be able to cope all right (Mr. E.).
Participants recognized the effort that was required to make the adjustment. "I think you have to work at it. I have to realize that I'm likely going to finish my days here..." (Mr. E.) and that "when you get older you don't adjust so quickly" (Mrs. B.).

**Adjustment Strategies**

Participants offered the following strategies to aid in adjusting to living in an institution:

- **Being assertive** with staff and other residents, "you have to stick up for yourself really" (Mrs. B).

- **Seeking solutions by seeing problems from a different angle - reframing.** One participant noted she saw Whytebridge Villa as a neighbourhood and used the skills she had used for 50 years in her old neighbourhood.

- **Using problem solving skills,** "I came with a different attitude, that it was going to be my home. Any little irritation, I would just have to work it out or go along with it. So that's what I've done and I like it here very much." (Mrs. D.).

- **Keeping busy,** "I work on things all the time, I'm always working on something." (Mrs. B.).

- **Maintaining one's sense of humour,** "You have to really laugh or else you'd feel bad all the time, if you couldn't see the funny side of it." (Mrs. B.).
Maintaining one's independence, "...but I still haven't
given up everything. I still look after my own bank account
and my bills and that kind of thing - most people here don't,
but I do" (Mrs. A.).

Accepting one's limitations and doing one's best, "I just
sort of felt that well, this is my life now, I just use what
there is available to me, that I can use and make myself
comfortable with." (Mrs. A.).

Persevering, "...but you gradually toughen up, besides
you've got to stick with it and make the best of it."
(Mrs. B.).

Maintaining a positive outlook, "...I have to force
myself not to get down-hearted and, I think [wife] expressed
it most clearly, you have to work at it, you know". (Mr. E.)

WHYTEBRIDGE ANECDOTES

I have placed in this final group, the stories that were
told during the interview to illustrate points and, as with
the Life Stories, to tell me about who the participants are
and what they do in their lives. As I read the stories, I
realized that through story-telling, the participants were in
many ways telling me about some of the basic themes of their
lives and some of the important issues they had to deal with.
Included in these issues and themes were: isolation;
recurring loss; aging and health; ability and lack of ability
to control one's environment; stigma of living in an "old folks home"; adjustment to a structured environment; dealing with complaints/dissatisfaction in a way that will get action/resolution; relationships with staff, other residents and with the outside; paternalism from staff; assertiveness; living around dementia; physical health and living with risk; dealing with different ethnic groups; and keeping busy.
I have often heard and read that people over age 65 are the most diverse group of people in the population. Knowing this, I am still struck by the diversity among the participants for this project. The range of life experiences and the different "home" environments from which participants have come, has yielded data rich in content and context.

Having said that, I must also note that this diverse group of people share some similarities which, I believe, have shaped the information they provided.

I experienced each participant to be an individual who was actively involved in successfully coping with and adapting to his or her living environment and who was empowered to give voice to his or her opinions in that regard; each participant was mentally alert and very aware of the issues of living in an intermediate care facility. Finally, this was a self-selected group. When recruiting participants, I asked people who would be interested in participating to come forward. I did not seek out individuals who had not expressed an interest. The information contained in this research comes from people who are successful, bright, empowered and self-selected.
Theory Revisited

I have presented in previous sections an overview of theory relating to home and to institutions, and the results of the data obtained through interviewing participants. I would now like to look at those results through the various lenses offered by theory. To make it easier for both the reader and the writer, rather than constantly repeating myself in discussing the meaning of home before moving into the facility and the meaning of home after moving into the facility, I will shorten this and refer to "home before" and "home after".

Home as a transactional unity

In this view home is seen as an interaction or transaction amongst environment, time, and people and psychological processes.

Participants mentioned the environment both when discussing "home before" and "home after". There is a difference in how environment was interpreted, however. The environment before moving into the facility is framed in terms of the physical environment - a nice garden, "comforts" such as a self-cleaning oven, a comfortable bed, enough space and pleasant decor; and location of the dwelling - convenient; good part of town. The environment of home, when discussing "home after", related more to the institution as environment. Comforts in this environment included the services of facility
staff and access to onsite health care and personal care professionals. Food was considered a part of the environment as was the ability to have one's own possessions in one's room. In terms of the possessions, it seemed the important part was not in the having of a picture or a chair, but in having a picture or chair that had belonged to the resident and not to the facility.

Time is the second factor which is part of home as a transactional unity. Included in temporal qualities are routines over time and events over time.

Time did not emerge as a distinct element or theme during the data analysis. I am not certain whether this is because it was not seen by participants as being important, or rather whether it is so fundamental to the meaning of home that it is beyond obvious and not commented upon.

It may also be that this was not captured as one of the selection criteria was that participants must have resided in the facility for a year. It is possible to imagine that the element of time is most noticeable during the first months of residence and after that becomes less of an issue.

I should note that the length of residence ranged from 10 months to 10 years. The resident who emphatically stated the facility was not his home was the resident who had lived in the facility for 10 years. The resident who was unsure whether the facility would become home had lived there for 10
months. The residents for whom the facility was home had lived there between 2 and 5 years.

The third property of home as a transactional unity is that of people and psychological processes. This includes social rules and relationships, affordances (the perception of objects in terms of their implied meaning, action, or behaviour) and appropriation practices (the processes through which we transform and are transformed by our environment, and are attached to and identify with our environment).

The wide range of interpersonal processes which make up social rules and relationships constitutes an important part of "home" for participants.

For most participants, "home before" was full of people and relationships and the feelings engendered by interactions with those people and relationships. Participants spoke poignantly about the importance of knowing others and being known by others in one's home; about feelings of deep contentment in one's home; and of feelings of loss and abandonment that prevented a place from becoming a home.

Social roles and relationships were not described with the same level of emotional intensity when discussing "home after". Relationships with people were described as more utilitarian than they had been when discussing "home before". What was discussed in some detail was the relationship with the institution itself and what the institution expected of and offered to residents. Issues raised by participants
included regimentation; ability to be involved in planning, and the tension between individual needs and preferences and the ability to meet those needs while living in a congregate setting.

Affordance is a psychological process in which objects and environments are perceived in terms of their meaning. This process was found when discussing both "home before" and "home after" - one participant who was not ready to leave the house she had lived in with her husband until she had processed all the memories that were inherent in her home and in the handiwork her husband had done; others who placed a special value on having their own possessions with them at the facility.

Appropriation practices are the processes by which we invest environments with meaning. These processes are appropriation, attachment and identity.

Appropriation itself is a dialectic process where we both transform and are transformed by our environment. There are a few examples of appropriation in the discussions regarding "home before", mostly in regard to the transformation impact of relationships on the formation of self, of knowing and being known, and of feeling and being settled for the first time in one's life.

As with appropriation, attachment and identity, the processes by which people become attached to or identify with an environment or objects in the environment, are seen in a
few places in "home before". One participant was attached to and identified with her dwelling through friends and relatives visiting and knowing her dwelling place.

When looking at the material relating to "home after", however, it seems that the majority of the energy around making the facility their home is tied up in appropriation practices - interactions between the individual resident and the institution in which each transforms and is transformed by the other. Examples of the struggle to appropriate space at the facility include issues around regimentation of day to day life; lack of participation in meal planning; problems communicating information and messages within the institution; being separated from one's spouse through necessity rather than desire; living communally; and living with residents who have dementia.

The literature describes four mechanisms by which people appropriate space: taking control over, familiarization, caring for and investing with meaning. All four of these mechanisms can be seen to be at play in residents' attempts to appropriate space within the facility. Residents described being able to shut the door to their room to take control over contact with other residents; being familiar with staff and with the rules of the institution; and caring for the green space and courtyard in the building.

The fourth mechanism, investing with meaning, may be the most important mechanism of all for appropriating space within
an institution. One of the striking features of the data during the analysis was the presentation of what I identified as adjustment strategies. On further reflection, I believe that these are not only adjustment strategies, but appropriation practices that enable residents to invest their space with meaning.

While all four mechanisms for appropriating space are described by participants, two of them - "taking control over" and "caring for" - are difficult for institutional residents. It is staff and administration who have control and provide care.

Residents become very familiar with their rooms, staff members and routines; however, they have little control over much of life in the institution and the act of familiarization becomes a passive activity - the resident learns the rules or participates in discussing possible new routines. Administration makes the rules and controls the information residents receive and use to inform themselves about the institution.

What is left entirely within the power of these mentally alert residents is the ability to make meaning and the way they make meaning is to draw on their experiences of "home before".

By having and using a variety of adjustment strategies, residents strive to maintain their sense of self and explore
and understand how that self fits into the complex institution in which they now reside.

It strikes me that the dialectical nature of appropriation occurring between an institution and an individual may be overbalanced in favour of the institution. Many of the adjustment strategies bolster the resident's sense of power, individuality and independence.

**Home as a Phenomenon**

I've suggested that phenomenology can provide some insights about how meaning is made - through embodied intelligence, contexts, boundaries and temporality.

Embodied intelligence shows itself in many places throughout the results - participants often responded to questions with great conviction but when asked about the meaning behind their conviction were unable to put into words why or what they meant. Despite this the conviction and sureness of their answers remained intact.

**Embodied intelligence** is found also in the adjustment strategies - residents did not sit down prior to admission and decide that they would use skills from their "lives before" to maintain their sense of self while engaging in a dialectic process with an institution to make meaning and thereby appropriate space as their home. The adjustment strategies were brought into use without conscious attending; the
adjustment strategies are a reflex action from years of living and successfully coping in their environments.

Embodied intelligence is also found in the familiarity residents had with their environment - not so much with familiar tasks, as discussed in the literature review, as with familiar routines and familiar staff. During two of the interviews a staff person brought drinks and snacks to participants. This was a regularly scheduled service performed for residents. Both participants commented positively about their interactions with this particular staff person.

Residents appeared to be selectively attentive to their physical environment; not all parts of the facility were considered home and different residents attached themselves to different areas of the residence. All attached themselves to their rooms. Participants identified their room as an important space where one could have some privacy and where cherished belongings were housed.

**Context**, which is defined as the way a person is connected to the world, is comprised of four elements: background meaning, concern, situation, and temporality.

The background meaning of each resident, formed over a lifetime of experiences and meaning, helps to inform some of the different reactions to congregate living observed in the participants, e.g., one participant saw the facility as much too regimented, another saw the facility as not regimented at
all. These differences in background meaning will inform the different adjustment strategies each resident brings into use.

Background meaning was also reflected in the attachment to possessions brought in from the resident's life before moving into Whytebridge Villa.

Concern addresses situations or objects with which we become aware or concerned. Phenomenological theory suggests that a situation or an object's meaning changes as we become concerned with it. Concern is a dialectic process.

By using a variety of adjustment strategies, residents of Whytebridge Villa identify situations or objects they are concerned with and thereby transform their environment and its meaning. For some participants their concern was around the lack of flexibility in the number of baths they could take in a week, another participant's object of concern was his inability to get to the favourite restaurant he had frequented when residing at another facility.

Situation is the reality in which we live our lives - the stage upon which we attempt to make meaning. The situation for residents of Whytebridge Villa is their rooms, interactions with staff, the challenges and frustrations of living in an institution. The situation can be changed and modified by the use of adjustment strategies to make meaning and in so doing change the dialectic.

Temporality in this context is not linear, it is a time that can be re-visited and re-interpreted. This revisiting
and redefining of time is an ongoing process for the participants of this study. The need and ability to understand the past and make meaning of the present through that understanding is a major element of the adjustment strategies. This non-linear nature of temporality was demonstrated in the way in which participants provided information. Although the interview guide was set up in a linear fashion—questions about ‘home before’ preceded questions about ‘home after’, participants frequently went back and forth in time to help explain the meaning of their comments to me.

Korosec-Serfaty suggests there is one additional concept of home, that of boundaries, and she expands on the definition of appropriation.

Boundaries refer to the ‘insideness’ and ‘outsideness’ of home. Although participants were not questioned directly about what part of the facility was considered inside and what was considered outside, the manner in which they identified which parts of the facility were home gives some insight to insideness and outsideness. When asked which part of the facility was their home the four participants who had identified the facility as their home first said their room. They then went on to list the lounge, the craft room and the garden, indicating less attachment to each area of home the further they went down in their list. Their room was ‘inside’ and the further they went from their room they were less ‘inside’ and more ‘outside’.

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Korosec-Serfaty expands the definition of appropriation by positing that appropriation also occurs in places where voluntary actions have taken place. Two examples she gives of this expanded definition of appropriation are decorating a house and maintaining it through housework; and by performing a voluntary routine task in a public space, such as taking the same route to and from home.

In these definitions, ornamentation emerges again as a method of making a space a home. During our interviews, participants referred again and again to the importance of having their belongings with them.

It is interesting to note that while all participants entered a long term care facility due to the level of care they needed, five of the six came to see their admission to Whytebridge Villa as having a voluntary aspect to it; that is, they did not choose to live in long term care but once in the system they did choose Whytebridge Villa.

The sixth participant resided in a long term care facility which closed down. He considered that facility his home and had come to Whytebridge Villa involuntarily. He had lived at Whytebridge Villa for ten years and was the only participant to state without doubt that Whytebridge Villa was not his home.

Much of life in a long term care facility is involuntary in nature, that is, residents live in rooms assigned to them, with people they do not choose, eating from a menu offering
little or no choice at meal times preselected by facility staff.

"Voluntariness" must be seen then as being on a continuum in which residents make choices from a finite rather than infinite set of possibilities.

Despite this limited set of possibilities, participants communicated a sense of voluntariness to their acceptance of Whytebridge Villa as their home. Just as you can "lead a horse to water but cannot make him drink", humans can be assigned to an environment but cannot be compelled to accept that environment as their home.

**Total Institutions**

Whytebridge Villa, in Goffman's classification system, would fit into the category of institutions which are established to care for persons felt to be both incapable and harmless.

I would like to look at the data I have gathered through the lens of the work by Lidz, Arnold and Fisher who in turn examined Goffman's theories in their own research into a long term care facility as an institution.

Fifteen attributes of a total institution and their applicability to this research as a follows:

1. Entry rituals; including stripping of an individual's private identity and categorizing and
processing an individual’s life, such as history taking, are common.

Participants did not identify or discuss ‘entry rituals’ as such. They did, however, give, with varying degrees of emotion, the narrative of their admission. I did not ask any questions about the admission process in the interview guide; however, every participant shared their story of coming to Whytebridge Villa with me.

Participants also commented on the importance of having their possessions with them. No one commented on what had to be done, if anything, to bring the possessions into the facility and no one commented on any admission procedures to the facility.

2. Locational dedifferentiation: all aspects of life are conducted in the same place.

For these participants most, but not all, aspects of life were conducted at Whytebridge Villa. Five of the six participants had regular and valued contact with people outside of the facility. For the sixth participant his move to Whytebridge Villa and away from a facility where he had easy access to a coffee shop to which he had an emotional attachment precluded the possibility of Whytebridge Villa ever becoming his home.
3. Dedifferentiation of authority: in total institutions there is a single, unspecialized authority hierarchy.

Participants clearly identified two groups within the facility - staff and residents, and clearly aligned themselves with staff. Whytebridge Villa has a process (unit meetings) to include residents in decision making and residents do have some power to make decisions. Participants did express some frustration over their powerlessness in having input to and making decisions about several of their activities of daily living, e.g., frequency of bathing and meal planning. Participants stated their understanding of the institutional need to make the decisions that had been made (such as staffing levels) however, this frustration seemed to inhibit some of the residents' ability to adjust to Whytebridge Villa as their home.

4. Each phase of the patients' daily activity is carried on in the immediate company of a large group of others, all of whom are treated alike.

As with the participants in the Lidz et al. study, Whytebridge Villa residents are not able to choose their fellow residents or the staff who care for them. Participants did express some distress about their relationships with other residents; however, they also stated they felt comfortable going to their rooms and closing the door when they needed privacy and to be in their own space.
5. Daily activities are scheduled by staff with little variation permitted.

Participants had mixed comments with respect to flexibility of activities - one resident citing regimentation as a major problem, another stating regimentation was not a problem at all.

6. Violations of privacy are common.

All residents of Whytebridge Villa have private rooms. Several participants stated their comfort with going to their room and closing the door. I noted during my visits to Whytebridge Villa that staff always knocked and waited for permission to enter a room before opening the door.

7. There is a small group of staff members whose primary role is to ensure the enforcement of the rules.

Participants did not comment on their perceptions of the role staff plays. A clear theme that emerged, however, was the importance residents placed on their relationship with staff. The reasons why these relationships were important was not explored in this study.

8. Restrictions on patient contact with the outside world, particularly at entry.

There were no institutionally-imposed restrictions to access with the outside world identified by participants. There were some systems problems - difficulties with messages
being communicated, difficulties arranging for transportation which were identified by participants.

9. Line staff function of control patient communication to higher staff.

One participant stated her satisfaction at being able to access her physician at the facility simply by telling a nurse she needed an appointment.

No comments regarding lack of access to administrators were voiced and I noted when I attended the unit meeting that residents were encouraged to discuss any concerns with management.

10. Patients and staff view each other through narrow, hostile stereotypes.

Staff were not interviewed and therefore I cannot comment on their view of residents. The residents I interviewed expressed a variety of positive and negative opinions about specific staff and staff in general. I did not question residents directly about their experiences with stereotyping, however, no information was provided which led me to believe this is a concern for residents of Whytebridge Villa.

11. Patients were excluded from making plans about themselves.

No participant commented on the institutional planning or case management process. Participants had contacts with people outside the facility and were able to plan their daily activities for themselves as they desired.
12. Rituals characterized by patient deference toward staff develop in total institutions.

No deference or any other type of ritualized behaviour to staff was identified.

13. Patients must request staff permission for routine activities and tools.

Participants talked about asking staff for assistance with activities and seemed to value this assistance as being 'cared-for'. No information was provided that staff permission was required, although at times staff cooperation was necessary.

14. Discrediting reports about patients commonly spread through staff ranks.

Staff were not interviewed for this paper. Participants expressed no concerns regarding staff negatively discussing residents.

15. All activities are brought together into a single rational plan designed to fulfill the official aims of the institution.

Participants did not comment on their perceptions of the official aims of the institution. Administration was not interviewed to determine institutional goals.
Adaptation to Institutional Living.

Goffman offers four types of adaptation to total institutions and Bowker offers two more types of adaptation specific to a geriatric setting.

**Situational withdrawal** occurs when the resident withdraws from institutional life and focuses on the events occurring in the resident's immediate vicinity.

While participants did talk about their ability to go to their rooms and close the door, there was no sense that this was a withdrawal from the institution but rather a desire for privacy and time alone.

**Intransigence** occurs when residents openly refuse to cooperate with staff. No participant talked about openly refusing to cooperate with staff. However, it may be that residents using intransigence to adapt to institutional living would not be willing to volunteer to participate in this, or any, type of research.

**Colonization** occurs when the resident expects to be in the institution until he or she dies and wants to make the best of his or her remaining time.

I wonder if it may be possible that the resident who was unsure if Whytebridge Villa was his home or not may be undergoing something akin to colonization. He clearly stated that Whytebridge Villa was where he had to live and that he was working hard to make the best of it.
It is difficult to know with other residents if their sense of “I’m here and this is it” represents colonization or if it represents successful adjustment to and acceptance of Whytebridge Villa as their home.

**Conversion** occurs when residents take on the image staff have of the resident as a patient. Residents who are adapting via conversion are noted to become increasingly passive in their own care.

None of the six participants showed any tendency to passivity in my interactions with them.

**Severe, long-term depression** occurs when the resident experiences multiple stressors and losses.

No participant showed any signs of severe, long-term depression.

**Non-reaction** occurs in residents who no longer have an “organized personality” when they move into the institution. This category is not applicable to participants of this research.

**Synthesis**

While not all fifteen attributes of a total institution apply to Whytebridge Villa, a few of the more significant characteristics do apply: there is an admission process that all residents go through; most aspects of life are conducted in the same location; ultimate authority to make decisions rests with staff; and residents live with a group of others.
who were not known to each other prior to sharing a residence.

These attributes, while few in number, are important ones. Goffman identified the basic social arrangement of Western culture as one where individuals sleep, play and work in different locations with different co-participants, under different authorities; and a total institution as a place where barriers separating these areas of life are broken down.

Residents of Whytebridge Villa have most of their activities conducted within the facility with the same group of people (other residents) who do not have final decision making power.

Mitigating this, however, is recognition by management of the problems inherent in a total institution and attempts by staff to help residents erect some boundaries to provide some separation of the different spheres of their lives. I observed staff respecting a closed door by knocking before entering and staff consulting with residents about their preferences regarding participation in this research during a unit meeting.

In terms of adaptation to a total institution, one participant made statements that could be considered consistent with a person experiencing feelings of colonization.

One of the limitations with Goffman’s work on adaptation to a total institution is that it seems to assume that
adjustment and acceptance to a total institution as home is not possible.

I don't think this assumption can be supported by the data collected in this study; four of six participants clearly feel Whytebridge Villa is their home. The one resident who stated Whytebridge Villa was not his home identified another long term facility he left involuntarily as his home.

The theories of home as a transactional unity and a phenomenon do not attach home to a space so much as they associate home with a process of thinking and feeling about a place.

Using these theoretical models, the data suggest participants both thought and felt of Whytebridge Villa (or another long term care facility) as their home.

The aspects of Whytebridge Villa that were identified as contributing to a sense of being at home at Whytebridge Villa included a private room which could contain possessions chosen by the resident, including furniture and ornaments brought with them from previous homes, and which had a door that could be closed; and familiar and congenial relationships with staff members which contributed to a sense of satisfaction in being 'cared-for'.

The transactional perspective describes 'home' as being created by three components coming together: environmental properties, temporal properties and people and psychological process.
Participants were able to easily identify important environmental properties: their own room, their own possessions in their room, and a door that closes.

Although time did not emerge as a thematic area, participants did state that adjusting to living at Whytebridge Villa "took a while". They also stated that they would realize that an adaptation had occurred when they looked back on their time living at Whytebridge Villa.

Further support for time as an element involved in adjustment to the facility as a home is the fact that the participant who had resided at Whytebridge Villa for the shortest period of time (ten months) was the only participant who had yet to reach a conclusion about Whytebridge Villa as his home.

The third aspect of home as a transaction is people and psychological processes. Participants described relationships with staff and the feelings of being 'cared-for' as important aspects of being at home.

Participants also described a number of adjustment strategies which, I believe, are a form of appropriation practice, specifically 'familiarization' and 'investing with meaning'.

These strategies, in addition to being a mechanism of appropriation, may also serve to create some of the boundaries which are broken down by a total institution.
These strategies make meaning and build boundaries by helping the resident to maintain their sense of self and promote their individuality and independence in a situation that is sometimes hostile to such qualities.

The finding that a majority of the participants viewed a long term care facility as their home runs contrary to that found by Gubrium in his study of 'Murray Manor'.

Participants interviewed for this study maintained outside ties but did not seem to have a need to "guard (them) vigilantly" as did the residents of Murray Manor. Participants spoke of acceptance and adjustment to congregate living rather than "making peace with hopelessness". Residents of Whytebridge Villa were faced with multiple losses by moving into the facility; and while adjusting to these losses was identified as something that needed to be dealt with, loss per se does not emerge as a theme.

Sixsmith found that older people are more oriented to their homes than younger people, possibly because home becomes more important as other social roles decrease; that older people are concerned with the instrumental aspects of home, possibly related to an elder's desire to remain living in their private residence; and that for older people past associations and memories of home effect the present experience of home.

Participants were quite concerned with adapting to the facility as their home and spent a fair bit of energy using
adjustment strategies to facilitate this. No participant linked residing in a facility and adjusting to it as their home to a decrease in other social roles - in fact, for some residents social contacts increased upon entering a facility. Two participants did comment on the need to maintain contact with people outside of the facility via telephone rather than in person. This, I believe, was related more to issues regarding transportation than it was to loss of social roles.

Participants were interested in the instrumental aspects of the facility. Participants all had health problems requiring the care of a professional nursing staff and all were concerned about a deterioration in their health that a fall or inadequate care could precipitate.

Past associations and memories did not seem to have an impact on participants' current experience of home. What did have an impact on the experience of Whytebridge Villa as a home was the skills and strategies for problem solving and coping with adversity that residents had accumulated over a lifetime.

I found it both interesting and curious that participants did not have significant relationships with other residents. Perhaps this is an artifact of total institutionality - residents with limited energy putting their resources into forming relationships with a powerful staff person rather than another resident.
I was struck by the poignancy and depth of feeling expressed by participants when they talked of adjusting to living with people who have a dementia. I think part of the strong reactions and feelings I saw were related to participants' own fears of developing a dementia and part were related to the frustration of sharing living space with people who could no longer have a relationship with their dwelling place or the other residents of that dwelling place and who had lost the capacity to have a home as home is understood by people without a dementia.

Implications For Social Work Practice

In this study participants have provided social workers and other staff with information about the conditions residents require to make a home, and strategies to both appropriate space and build boundaries within a total institution.

Residents require private space where they can have cherished possessions; positive relationships with staff; a sense of being 'cared for' and enough time to adapt and adjust.

Although participants of this study have identified a room of their own with a door that can be closed as being important, not all long term care facilities offer such a
luxury. In terms of practice issues for social workers in long term care settings, I think the concept of private space may be an important one. In facilities where residents are required to share a room with one or more other people, social workers can help each individual create a private space where they will not be interrupted without their permission and where prized possessions can be kept.

Staff can support residents in creating their own home by encouraging assertiveness, helping residents reframe situations, invoking residents' existing problem solving skills; helping residents keep busy; encouraging a sense of humour, helping maintain independence; encouraging residents to do their best while accepting their limitations, helping residents to persevere and encouraging and supporting residents to maintain a positive outlook.

The above is by no means an exhaustive list of strategies and social workers would do well to work with residents to explore strength and personal resources which can be engaged in this process.

Social workers also need to work with both management and residents to eliminate those aspects of a total institution which can be eliminated - such as stereotypical thinking and negative staff perceptions about residents; and to reduce the negative impact of those aspects which cannot be eliminated - such as locational dedifferentiation and dedifferentiation of authority.
Policy

This work has implications for policy development at several different levels.

On an institutional level, policies need to be examined to determine how each policy affects residents' abilities to adapt and adjust to the institution as their home. Those policies which reinforce the negative effects of total institutions need to be rethought and designed in a way to reduce or eliminate any negative effects.

At a systems level, governments need to examine their licensing standards and their long term objectives in caring for elders to ensure that these elements do not unintentionally create an environment that diminishes an elder's ability to enter into the system and access the tools and resources required to make a successful adjustment to living in the system.

Being able to feel that some part of the decision about living in long term care was a voluntary decision seems to have some relationship with the ability to adjust to a facility as one's home. Governments and health boards need to work to ensure that elders contemplating admission and those who are compelled by circumstance to be admitted to a facility are able to have some choice while making these important decisions.
When I started this work I had few expectations about what I would discover in the course of this study. I did, however, expect that I would more than likely end up with more questions than I had started out with; and I was right.

As I have been working with the data and the theories in this thesis, a number of questions have been circling about in my head.

All participants in this study resided in a private room. I have wondered how residents living two or four to a room would respond to these questions and what impact, if any, sharing a room would have on the meaning of home for residents in a shared room.

I’ve looked at these data through the theories of total institutions and home as a phenomenon and a transactional unity. Several times in this analysis I’ve wondered how the data would fit with theories of attachment. While it is outside the scope of this piece of work to explore the data from a third theoretical perspective, I think it is an important piece of work to be done as I anticipate it would yield more information that would be useful to all long term care workers in helping residents adjust to a facility as their home.

This study has attempted to learn what home means to residents of a long term care facility. I believe it would be interesting and useful to talk to staff and management about
their views of the meaning of home in long term care and to compare meanings of staff/management and residents. I think some interesting and disturbing but important differences would emerge.

One of the important factors of being at home for residents of this study was the sense of being 'cared-for'. Although I have used this concept several times in this work, I have not been able to define an exact meaning.

It may be helpful to pursue this concept further to discover specifically what being 'cared-for' means.

In the course of the interviews conducted for this study participants provided information about important issues they are dealing with, in addition to adjusting to living in an institution.

These issues are isolation, recurring losses - of home, people, social roles, health and physical ability; physical health and living with risk; living with a variety of ethnic groups and keeping busy.

All of these issues could be explored in greater depth as insight into each area will help improve the quality of life for long term care residents.

Another area of possible research interest that emerged from this study is around residents' admission stories.

Each of the participants told me in varying degrees of detail about the circumstances surrounding their decision to come into long term care and the story of their admission.
Questions about admission to the facility were not included in the interview guide, this information was completely unsolicited by me.

I am not sure what this information means; I wondered if these stores were told as a means of making a mental transition while discussing "home before" and "home after". I also wondered if there were some detail or aspect of these narratives that had a deeper significance for the residents. I examined the data closely and was not able to identify what that could be.

Had I been able to follow through with my research design, I may have been able to question participants about this in further detail.

I think the fact that this information was provided, unsolicited, by all participants suggests it is important to residents of a long term care facility and for that reason warrants further consideration.

The final question that has been circling in my head as I analyse these data comes from an article I read a year or so before starting this thesis. One of the conclusions contained in the article was that the physical and emotional health of seniors went into a decline when the senior made the decision to move into a long term care facility and the decline continued through admission to the facility. For some residents the decline continued and they died soon after
admission; for others a plateau was reached and improvements were seen in both emotional and physical health.

I worked in a long term care facility at the time I read this and was curious about the conclusion as I had noted that some residents did not do well after admission while others appeared to thrive and I had wondered why this was so.

As I have worked with these data I have wondered several times if there is any relationship between the plateauing and improvement in some resident's emotional and physical health and an ability to adjust to and accept a long term care facility as one's home. If so, the meaning of home for residents of a long term care facility may be related to quantity of life, as well as quality of life.
References


## APPENDIX I

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It has been explained to me that my participation is entirely voluntary and refusal to participate will in no way affect my care at . I understand that I may withdraw from the study at any time. I also understand that there is no monetary compensation for participating in this study. Further, I consent to the interview being AUDIOTAPED; and that the audiotape will be erased upon completion of this research project.

All information that I choose to provide will be held in confidence by the researcher, and all individual identifying information will be omitted in the final document. I will have access to the findings upon completion of this study.

My signature is acknowledgement of receipt of a copy of this interview consent form and to participate in this study.

Participant's signature                               Date

Interviewer's signature                               Date

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APPENDIX III
INTERVIEW GUIDE

1. To start out, could you tell me briefly about the different places you have lived?

2. Thinking about the places you have lived in before you moved in here, what is the place where you felt most at home.

Prompts:
A. Could you describe what it looked like?
B. Who else lived there?
C. How long did you live there? How old were you?
D. What were the things that happened there that made the place feel like your home? (If resident has difficulty answering, prompt with "Things like special events or occasions, rituals or routines or anything else you can think of.")

3. What is it like to live in Whytebridge Villa^2? 

Prompts:
a. Are there some parts of Whytebridge Villa that feel more like home than others? Could you describe them?
B. Can you think of some things that make these parts feel like home while other places, such as, (give examples from answer to above question) don't?
C. Are there any people who make this place feel like a home?

4. Overall, do you consider this place to be your home? How do you know it is or is not your home?

5. Reflecting on what we have just talked about, do you think your feelings about the meaning of home have changed over time? In what ways? Could you give me some examples?

^2Name of facility has been changed from original Interview Guide.

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