

Becoming a Nursing Home Resident

An Anthropological Analysis of Danish Elderly People in Transition



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| | |
|--|-----------|
| Contents | 2 |
| Acknowledgements | 4 |
| 1. Introduction | 6 |
| The Nursing Homes | 10 |
| The Research | 13 |
| Theoretical Approach | 14 |
| The Analytic Methodology | 19 |
| Ethics | 27 |
| Understanding the Elderly Peoples` Transition and Thesis Structure | 29 |
| <u>Phase One</u> | |
| 2. Waiting to go into a Danish Nursing Home | 33 |
| Introduction | 33 |
| Ageing as Disability | 35 |
| Identity | 39 |
| Home Care Assistance in Denmark | 42 |
| Ritta`s Physical impairment | 45 |
| Control of Home | 54 |
| Conclusion | 62 |
| <u>Phase Two</u> | |
| 3. The Illusion of Home | 65 |
| Introduction | 65 |
| The Meaning of Home | 68 |
| Cherished Possessions | 75 |
| Home for the Elderly People | 77 |
| Settling in | 84 |
| Conclusion | 93 |
| <u>Phase Three</u> | |
| 4. Becoming “a Good Nursing Home Resident” | 98 |

| | |
|--|------------|
| Introduction | 98 |
| The Institutional Context | 100 |
| Nursing Homes as Total Institutions | 102 |
| The Move to the Nursing Home: the Residents' Perspective | 107 |
| Expectations of Residents: the Staff's Perspective | 122 |
| Conclusion | 131 |
| | |
| 5. The Nursing Home Meal | 134 |
| Introduction | 134 |
| Eating Together as Establishing a Sense of Community | 137 |
| The Ideal Nursing Home Meal | 139 |
| Daily Eating Practice | 145 |
| What Were the Obstacles? | 155 |
| Conclusion | 163 |
| | |
| 6. Quality of Life at the Nursing Home | 166 |
| Introduction | 166 |
| Quality of Life | 171 |
| Quality of Life for the Elderly People | 175 |
| Longing to Appropriate Space Again | 186 |
| Åse's Hope | 191 |
| Conclusion | 194 |
| | |
| 7. Conclusion | 197 |
| The Results | 198 |
| Major Findings | 204 |
| The Welfare State: Considerations | 205 |
| The Welfare State: Recommendations | 207 |
| | |
| Literature | 210 |
| | |
| Appendix | 225 |
| | |
| Summary | 253 |

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1. Introduction

A representative from a Danish municipality assessed Oline¹ for nursing care at the age of 91, as she was unable to manage on her own at home and her relatives were worried about her situation. It was difficult for Oline to keep her balance, but she was reluctant to accept this aspect of her physical impairment. She still insisted on trying to carry out her ordinary daily activities at home even though she was unable to, mainly due to increasing bodily impairments. Her daughter mentioned what she called the “bacon episode” to illustrate her concerns. One day Oline fell as she was frying bacon. Smoke developed rapidly in the kitchen, and she was unable to get to her feet again and turn off the stove. Luckily, the home care assistant turned up just before the frying pan and bacon burst into flames. It was this that finally enabled her to convince her mother to go into a home.² Oline was assessed for nursing care in December 2004, just after the “bacon episode”, and by early January 2005 she had entered the nursing home.

It is the transition from home, sheltered accommodation or hospital to a nursing home which is the topic of the study presented in this thesis. I focus on sixteen elderly people in the period of their lives when they enrolled in nursing care, waited for a permanent flat in a nursing home and experienced their first six months in the home.

In the following, I use the term “transition” to define a period of time in the elderly people’s lives within which they experience a change of residence and status. By exchanging their home, a hospital bed or a temporary flat in sheltered accommodation for a permanent flat in the nursing home, their status changed from being autonomous citizens to being nursing home residents. This change also included having to adapt to a new physical and social environment and accept new aspects of their identity.

¹ All proper names have been changed to protect the anonymity of informants.

² Generally, relatives were unable to tolerate stressful situations of constant worries regarding whether their elderly relatives had left the kettle on unattended, or whether they were lying on the floor with their alarm out of reach, for instance. In other European countries researchers have studied decisions to enrol in nursing care with similar evidence that relatives play a significant part in the decision-making (see, for example, Allen et al. 1992, Steverink 2001, Dwyer 2005).

Transition theory has a long history in anthropology, reflecting particularly the works of van Gennep on rituals (Kralik et al. 2006). However, the rituals he discusses end with some participants having obtained a new status after periods of liminality and incorporation. By contrast, no formal rituals marked the transitions into nursing care. As I shall argue in Chapter 2, prospective residents were already experiencing pre-institutionalised conditions in their homes before the transition. When they entered the nursing home, they became residents from the very first day, as they were faced with a new physical and social environment and the staff's expectations of them.

Analytically I have chosen to define the transition as beginning with the assessment for nursing care and then being divided further into three phases. The assessments by the municipalities initiated the transition as a way for these authorities to manage the elderly people's disability by providing care facilities for them. The first phase concerns the time spent waiting at home for nursing care upon assessment, the second the dissolution of the home, and the third their experience as nursing home residents. I have decided to cease treating the period as transitional when they have been residents for six months. This broad and pragmatic definition allows me to adopt a processual approach by focusing on the experiences leading to the move into nursing care and on the elderly people's adaptations to their new physical and social environments.

For Oline and the other elderly people involved in this study, the years leading up to the assessment were a process of increasing bodily impairment, with loss of ability to perform certain activities, and characterized also by illness (cf. Cook 2007). A consequence of losing their physical abilities was that the elderly people experienced a need for assistance provided by the home care assistants and nursing home staff. Their bodily impairments increasingly prevented them from accessing their physical surroundings and taking part in the social activities. One reason for this was their reduced motor abilities and limited senses, such as impaired movement, hearing, vision and at times speech. Typically, their impaired movement was reflected in their very unsteady feet and a constant fear of falling. This impairment provoked a need for facilities like hearing aids, magnifying glasses and lamps, wheelchairs or zimmer frames. Added to this was the need for assistance from home care and nursing staff.

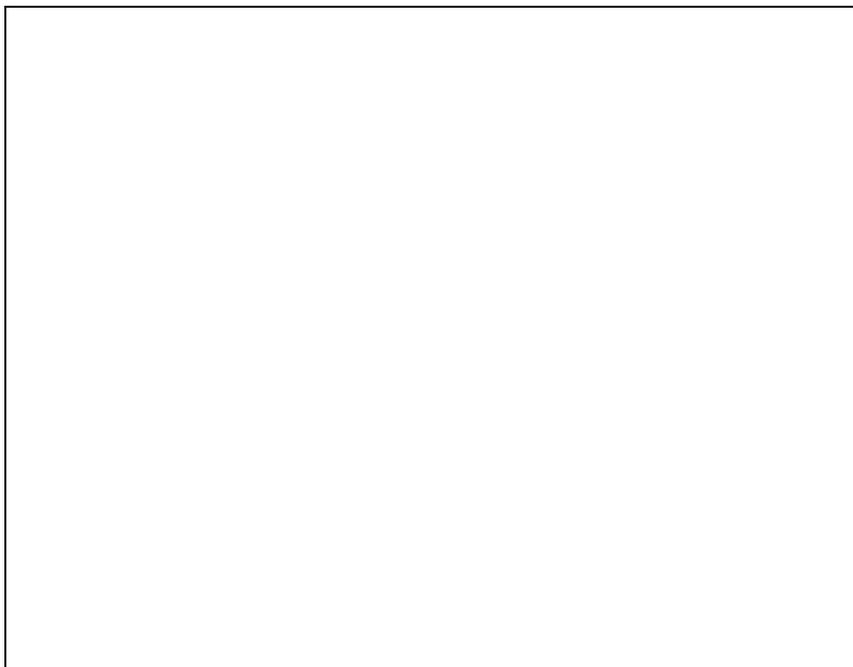
To illustrate some of these progressive limitations, I quote extracts from two interviews with Oline below. Oline was unable to speak, and she answered my interview questions in writing and with gesticulations. By the time of the last interview, she had nearly lost this last possibility to communicate.

Fik du alle dine ting med, som du satte mest pris på, da du flyttede?

Mon ikke du er klar over, hvor far jeg
& sidde her og tænke, ~~for~~ skyldes jo min
elendighed, og jeg jo netop på at det af -

Ola Beate

~~Min~~ Mine børn bliver jo alle så meget fra
mere hjertet gerne mig meget efterhånden (~~og~~)
(Isen ~~er~~ ^{de} var half svær ved at forstå mig!) gode vil
ikke koncentrere sig om min tale!) - Børn har været
væsentlig bedre!



The first extract above shows her able to write as a new nursing home resident in early January 2005. The second conveys the loss of this ability, as the written words turned into something like strings.³ She wrote the latter the day before she died, on April 6th 2005. What cannot be seen from the scanned documents above are the stains from the coffee or juice she tried to drink while we communicated. These fluids were constantly dripping from her mouth down upon the papers we exchanged during the interviews, which began in her home in December 2004.

Until her death I interviewed and observed Oline on the nursing home ward on several occasions. To provide the reader with an impression of the nursing home context, I briefly quote from my observations of my first visit to Oline's ward.

Upon entering the ward, I walked towards the sitting room. Two residents sat watching the few ongoing activities at the dining table (see Chapter 5 for further details of the layout of the ward). I asked them whether they could please assist me in finding their new resident Oline. None of them answered, and they just kept looking curiously at me. I asked again in a louder voice, but still I received no answer. Presumably, they were suffering from defective hearing, dementia or an inability to speak. I paused for a second and I began looking around for a member of staff. However, the two of them on duty were trying to convince a female resident, presumably suffering from dementia, that the particular flat on this ward was actually her home. Nevertheless, she insisted repeatedly that she intended to go home and that she needed to get tea ready for her husband and children. One of the members of staff caught sight of me and set off to ask what I wanted. But she was again interrupted by the female resident asking whether the member of staff would be so kind as to inform her where she was and the direction of her home. This time the member of staff ignored the question, greeted me and showed me Oline's apartment. Oline had closed

³ The first extract reads: Were all your cherished possessions allocated for in your [nursing home] flat? Don't you understand why I am here? It is because of my wretchedness, from which I expect to die.

Ole and Bente

At present, I do not hear much from my kids, which is bothering me seriously. (Ole in particular has difficulties understanding me. He will not accept my situation. Bente has been much better at this.

The second extract reads: R... I...would. Will. I would please like a, a glass, gl.. Teat glass, plat.. Teat glass.

her door to prevent the other female resident from entering her flat in her search for her home and family.

The aim of this study is to investigate how Oline and other elderly people experienced the transition into nursing care and their first six months in these institutions. Using a phenomenological perspective, I intend to see their ageing bodies as experiencers (cf. Leder 1992) of the transition. They repeatedly referred to their impaired bodies when they explained how they managed their everyday lives. I thus take their bodily experiences as the starting point in approaching an answer to this question. These experiences were investigated mainly through interviews and observations carried out during fieldwork which lasted from June 2004 until December 2005. Finally, I intend to use the answers as a basis for some recommendations which might improve aspects of future transitions for elderly people.

The Nursing Homes

Present and predicted demographic changes indicate that the answer to the above question is of considerable importance. These changes predict a substantial increase in the number of elderly people within the next forty years in Denmark and other industrialised Western societies (Harper 2004, Teknologirådet 2002). Researchers and policy-makers predict that this increase will intensify the demand for nursing care, and consequently a larger number of elderly people will be in transition from home to nursing care. Based on these predictions, it is the political intention to double the number of nursing care flats in Denmark by 2030 from a present level of 48,700 to 96,000 (Møller and Knudstrup 2008). It is therefore important to identify the essential elements of what constitutes a positive beginning for a nursing home resident.

Oline and the other fifteen elderly people in this study were just some of approximately 26,000⁴ elderly people who each year became nursing home residents in Denmark in 2004 and 2005, and who lived for an average of two and a half years in the homes. The average age of the sixteen people was 89 when they entered this study. Only 10% of elderly people in Denmark above the age of 65 live in this type of care facility for the elderly, and of these the majority (67%) are over eighty.⁵

In this study, I focus on two types of nursing home to enable me to compare the Staying and Living Environments (“*Leve- og bomiljøer*”) (SLE) and the so-called traditional nursing homes. Oline and nine other elderly people became residents at SLEs, and another six at traditional nursing homes (see further details in the Appendix). The expectations regarding the residents are somewhat different at these two types of institutions, as discussed further below.

SLEs have gradually been replacing the traditional nursing homes since the early 1990s in an attempt to improve the physical surroundings for both residents and staff (Høeg and Nielsen 2005). One overall intention was to establish more homely settings, with more room for the individual layout of the flat for the elderly in the SLE, as compared to the institutional layout of traditional nursing homes (Andersen 1998, Wagner 1998). In this study, I chose two nursing homes of each type. The two SLEs were Grønnehaven in Elsinore and Lillevang in Farum. The traditional nursing homes were Sølund in Copenhagen and Bakkegården in Gladsaxe.⁶ These institutions are described with the aid of further ethnographic details throughout the thesis.

There are conspicuous architectural differences between the two types of nursing

⁴ Although these elderly people are often described as a group, the inclusion criteria is only defined as physical and/or mental impairment, as well as by the fact that they are assessed as being incapable of living alone.

⁵ These figures are based on data from Danmarks Statistik (www.Danmarks Statistik) and the Ministry of Social Affairs Homepage (www.Socialministeriet.dk /Figures and Facts/ Social Care in Numbers/Care for the Elderly).

⁶ The names of the nursing homes involved have some significance for Danish-speakers, namely Bakkegården, Lillevang, Grønnehaven and Sølund, all of which connote something small, peaceful, a place to relax, perhaps with family and friends, in comfortable and scenic surroundings.

home. The SLEs were designed in new buildings from 1998 and 2005, the traditional nursing homes in buildings from the early 1970s. These provide the residents with small one-room flats situated along a corridor hosting approximately thirty residents. According to Hjorth-Hansen and Nielsen (2002), it is the privacy of the residents that guides the layout of the latter. They further argue that it is the rationality of hospitals in which a focus on illness, hygiene, care and rehabilitation activities guide layout and daily activities. The SLEs accommodate residents in small groups of approximately ten residents, and each resident lives in a two-room flat. Their individual flats lead on to the communal kitchen. Contrary to the traditional nursing homes, it is a basic requirement for new residents at the SLE to remain actively involved with other residents and if possible take an active part in preparing the ward meals or other communal activities (Hjorth-Hansen and Nielsen 2002). According to Hjorth-Hansen and Nielsen (2002), the daily activities, with their focus on food preparation and social life, are the core elements of everyday activities, and other activities should derive from the different needs of the residents.⁷ I have compared the two types of nursing homes in the discussion of the meals in Chapter 5, which also describes how both staff and residents appropriated these settings.

Preceding these institutions were respectively 'poor peoples homes' (*fattiggårde*), built from the early 1900s, and 'homes for the elderly' (*alderdomshjem*), built from the 1930s (Andersen 1998, Wagner 1998). The term 'traditional nursing home' (*plejehjem*) applied here refers to nursing homes built from the early 1950s, and these are now being replaced by the SLEs (Høeg and Nielsen 2005).

Local municipalities in Denmark organize care for the aged and the construction of nursing homes (Møller and Knudstrup 2008). Compared to, for instance, the UK and the US, where the majority of the care facilities are privately administered, the municipalities run by far the vast majority of care facilities in Denmark. This implies among other things that individual financial resources are not decisive in one's ability

⁷ The underlying tendency to see residents as actively taking part in and being responsible for their own rehabilitation also reflects a more general tendency in the Danish welfare society. It reflects a neo-liberal influence where impairments and other deviations from the normal are seen as problems for the individual and not just a political problem (cf. Jöhncke 2007). The change in the aims of nursing care has shifted from a focus on a patient being treated to a user actively trying to improve his or her own situation by being active in rehabilitation activities, for instance.

to become a resident in a nursing home. Residents pay all the expenses themselves, which for Oline at Lillevang accounts for approximately 730 Euros. However, if a resident only has a retirement pension, then the municipalities cover most of the expenses and leave the resident with a surplus of a little more than 100 Euros a month when rent, heating, electricity, full board, medication and cleaning are all paid for. A flat for a single resident usually has one or two rooms with a bathroom and toilet en suite, depending on the type of nursing home. The smallest flats were of 32 m² and the largest were of 64 m². Married couples like Hans and Anna (see illustrations in Chapter 4) had a larger two-room flat. However, these figures in square metres also cover a part of the hallway and dining room. The actual flats are somewhat smaller. For instance, a flat at Sølund is 22 m² and at Grønnehaven 32 m².

The municipal authorities implement political aims in respect of the policy of care of the aged. Through their provisions of care facilities and the allocation of assistance, the municipal authorities thus define essential elements in the quality of life for the elderly people (Henriksen 1992, cf. Phillips 2006). At a more general level, these aspects indicate how the Danish welfare system manages these impaired bodies.⁸

The Research

The present study had its genesis in the poor nutritional status of 60% of the nursing home residents in Denmark (Ingerslev et al. 2002).⁹ My personal interest in food, combined with my professional work with nursing home residents and nutrition-related issues, defined this issue as a point of departure. This also accounts for my use of the Minimum Data Set (MDS), as among other things this enabled me to follow the changes in the Body Mass Index (BMI) levels of the elderly. However, during

⁸ The quality of nursing care is controlled by two institutions in Denmark. One aspect of the quality documentation is inspections once a year by the Danish Medical Officer of Health (*Embedslægen*), who mainly documents how staff handle residents' medication. The municipal authorities document general care quality by mounting regular unannounced inspections twice a year. Despite these inspections, the quality of care for the elderly in nursing homes and home care is a theme repeatedly debated in Denmark (Andersen and Nielsen 2006). Media coverage has often focused on incidents of neglect ("*omsorgssvigt*") (Ældre Forum 2003). Despite increased documentation of quality, media coverage is still overall negative (Konge Nielsen 2006).

⁹ This problem is also seen in many other Western countries (Morley and Silver 1995).

fieldwork other issues became more prominent than food, as the physical impairment of my informants called into question a number of other important intersubjective relations. I shall argue that the major changes concerned the relations the elderly people engaged in (cf. Jackson 1998), namely those with relatives, nursing-care staff and home care assistants. It also concerned relations with the elderly people's possessions, homes and institutional settings.

The transition entailed major changes in elderly people's lives, and it was indeed a difficult situation (Kraaij 1997), among other things because they were moving to the last residences in their lives (Lee et al. 2002), and because increasing dependence upon assistance, tools and facilities was an essential part of this. In Chapter 4, I cite Dorte describing a major consequence of the dependence she experienced. She was unable to move any part of her body but her right arm: "*This is not a life worth living*", she said, describing her situation. Nevertheless, Dorte still strove to influence her everyday life on the ward, and throughout this thesis, I will argue that the elderly people still strove to influence the relations and the presentation of themselves in these relationships. Alternatively, as Jackson puts it, "*though individuals speak, act, and work toward belonging to a world of others, they simultaneously strive to experience themselves as world makers*" (Jackson 1998: 8). The elderly people still tried, even though they were approaching the end of their lives and though their lives could seem without meaning due to the number of difficulties they faced.

Theoretical Approach

The phenomenological perspective is a major part of the theoretical inspiration for the analysis presented in this thesis. This perspective allows me to indicate the importance of the bodily impairments for the limitations on their agency¹⁰ and their subjective experience of the world in the transition.

¹⁰ Throughout the thesis I apply the term 'agency' to cover three aspects. I use it in a broad sense to refer to the ability to undertake activities, i.e. to move the body to places where they intended to go. Another aspect is their ability to establish beneficial relations towards home care assistants and staff at the nursing homes (cf. Jackson 1998: 12). This last aspect, also inspired by Jackson (2005), concerns the process of maintaining hope for the future through achieving improvements in their physical conditions.

Following the phenomenologist Leder (1990), who has also analysed bodily impairments, the bodies of the elderly could be seen as absent and “*a transparency through which we engage in the world*” (Leder 1990: 82) before this impairment began. Through impairment, their bodies increasingly became the focus of their lives, as they prevented the elderly from undertaking daily activities and thus reduced their agency. Merleau-Ponty (1994), who analysed bodily perception as a phenomenologist in very profound ways, explains this aspect further. He argues that although a person may have a paralysed arm, the world still invites him to reach out for it. The paralysed arm becomes prominent, as the world invites one to reach out to it with an arm which one is unable to control. In this perspective, the physical impairment constantly reminded the elderly people of their bodily conditions whenever they wanted to reach out for the world. In this vein, their bodies increasingly became a prison for them in a process of increasing impairment, as they were unable to reach out for the world. Leder defines this situation as bodily “*dys-apperance*” (Leder 1990: 86).

For the elderly people themselves, it was mainly their unsteady feet which had prominence in this respect, but also senses like hearing and seeing were being reduced. Merleau-Ponty (1994) argues that it is through bodily movements that the body perceives and engages with persons and things in the surrounding world. Moving the body means directing it towards things and through these movements responding to the world, which invites one to reach out to it (Merleau-Ponty 1994: 49) using one or more of the five bodily senses (cf. Csordas 1994).

Through the impairment of their bodies, tools and facilities became important. Merleau-Ponty (1994) argues that our presence in the world is extendable by the use of tools. One of his examples is the blind man and his stick. His ability to perceive the world extends and increases to the end of his stick, once he has become intimate with it or has appropriated it and is able to use it as a natural part of his everyday walking. The stick extends the range of his tactile senses, and in this case the stick becomes an extension of his bodily perception of the world (Merleau-Ponty (1994: 98).

Oline`s fall illustrates the phenomenological perspective further. Lying on the floor, her body was only able to perceive the floor. At the same time, her body had lost its

upright presence in the kitchen, where the bacon pan indeed invited her body to turn off the stove. When falling, “*our existence actually suffers, it is torn from its position in the world...*” (Binswanger 1963: 223, in Jackson 1996). Oline needed to move, but as she was unable to do so, an insurmountable distance arose between her and the stove. In this way, distance became a question of the body’s ability to reach out, not of physical distance (cf. Merleau-Ponty 1994, Zahavi 2003). Lying on the floor, she was unable to influence the world around her and needed the aid of the home care assistant to prevent the bacon from bursting into flames.

For the elderly people in this study, facilities and tools also played a significant role in their everyday lives. However, although the elderly needed several facilities and tools, they also needed to change these on a regular basis. New tools and facilities only extended their presence in the world temporarily. With different tools, they presumably extended their perceptions of the world, as Merleau-Ponty argues, but when the tools had ceased to function any more, this intimacy tended to be replaced by an awareness of the tools, as of the paralysed arm (cf. Zahavi 2003). The regular replacements and readjustments of tools and facilities reflected a period of increased limitations regarding bodily perceptions. By the time of our last interview Inge had nearly turned blind, and tools and facilities could not assist her senses any more. Oline’s fall further exemplifies this aspect. At the beginning of the transition, there were no tools or facilities which could have enabled Oline to get back on her feet again. She had to leave the invitation of the world unanswered, as major parts of her contact with the world were broken (cf. Merleau-Ponty 1994: 56).

Inge’s increasingly defective ability to see underlines another important consequence of this increasing bodily impairment. Merleau-Ponty (1994: 66) argues that impaired sight gives the body an uncertain ground for its reach towards the world. Applied to the elderly people, both their sight and hearing were most often impaired, and this made the ground for their moves and participation in conversation uncertain. In addition they were all, except one, unsteady on their feet, another factor making their movements and motor abilities in reaching out for the world more uncertain. The impaired bodies of the elderly had wider consequences than just the increased distance from their immediate physical surroundings and extensive need of tools and facilities. Their perceptions of the world were reduced too.

Seen in this perspective, the nursing home was important in the transition, as the physical layout of these institutions enabled the new residents to appropriate these surroundings to a greater extent. In the nursing home, the process of increasing limitations upon their presence in the world ceased for a moment. While they were waiting at home, they were increasingly unable to appropriate their homes by virtue of their own movements (cf. Casey 1996, 2003).

Intersubjectivity

The impairment of individual elderly bodies did not only concern the individual persons, as Jackson (1998) argues. Influenced by the phenomenological perspective, Jackson pays attention to changes in relationships and individuals' goals of influencing these in very different contexts. As such, "*it is never solely individuals whose identity is at stake but relationships between persons as well as relationships between persons and the things that have ultimate value for them*" (Jackson 1998: 17). In other words, a person engages in several relationships. We recall that in the opening description of "the bacon episode", Oline fell and was unable to get to her feet again. Her impaired body and reduced agency influenced her relatives, as they became worried about her ability to live alone. Her daughter often paid her visits, and she and her brother eventually convinced her that she ought to enrol in nursing care. In this way impairment was also a matter of relationships, as humans are social beings before anything else (Jackson 1998: 12). Subjectivity, Jackson argues, is in effect a matter of intersubjectivity and an experience of interexperience (Jackson 1998).

In the following analysis, I have applied Jackson's (1998) intersubjective perspective to assist my understanding of the transition. His broad definition of the concept is the main reason why I am applying it, as it allows me to encompass the changes and negotiations of many different relationships: "*The field of intersubjectivity includes persons, ancestors, spirits, collective representations and material things*" (Jackson 1998: 9). The argument is that "*our thoughts, like our actions, have meaning only in relation to the practical and social life in which we engage*" (Jackson 1996: 4). In other words, meaning lies in our relationships as they are lived. Intersubjectivity then

defines a way of being-in-the-world or having a presence in the world, with a focus on the relationships that the elderly people engage in throughout the transition.

An important aspect of intersubjectivity is how the individual try to influence the relationships he or she becomes a part of, i.e. how the elderly in this study used these aspects of their agency. Through loss and impairment, there is “*always a reaction, on the part of the affected organism or individual to restore, to replace, to compensate for and to preserve its identity*” (Sacks 1986, in Jackson 1998: 17). To describe these activities, Jackson uses the concept of balance: “*Balance is a matter of control, and it is the struggle for this control that is the driving force of intersubjective life*” (Jackson 1998: 18). Balance, it should be emphasised, is not a matter of re-balancing a relationship and reaching a previous equilibrium, but of the ability of the individual to have some influence or even control of some of the relationships he or she engaged in throughout the transition.

The municipalities assessed the elderly in respect of their mental and physical abilities, based in a biomedical neutralisation of the body (cf. Mogensen and Whyte 2007: 47). It was an indication of the assessments that the elderly people had mostly lost their capacity to take proper care of themselves. This, and being treated as bodies in need, was another essential part of the subjective experience in the transition. Reflecting Goffman`s term “stigma”, they felt being at times “*reduced in our minds from a whole and usual person to a tainted, discounted one*” (Goffman 1963: 3). The elderly people resisted this way of being treated by engaging in rehabilitation activities and trying to establish relationships with home care assistants and nursing staff to negotiate the stigma of being a disabled elderly body. The elderly had lost abilities they once possessed. The rehabilitation facilities they were able to attend basically set out from the assumption that every condition can be treated and adjusted, though not all can be cured (Whyte 1995: 270). However, as I will show, the elderly in this study were unable to improve their bodily conditions, partly because of limited rehabilitation facilities.

The Analytic Methodology

Other research has investigated aspects of the transition I analyse. But generally the literature on the transition between home and nursing home is limited in all disciplines (Lee et al. 2002). Below I will indicate the most important literature for the present study.

In anthropology elderly people are often used as key informants, but until recently elderly people *as* elderly have hardly interested anthropologists (Hardon et al. 2001). A classic interest in anthropology has been in rituals marking transitions into new phases of life. One aspect of this is the analysis of the lifespan, which has often been analysed by anthropologists as a series of transitions between different social positions in society whereby the individuals concerned achieve a higher status. The elderly people in a society typically reach the highest position, as is reflected worldwide in gerontocratic features, in the sense that the elderly retain power by their control over material, social and religious affairs (Hardon et al. 2001: 110). This is in marked contrast to Denmark and most other industrialised societies (Dalsgaard and Gammeltoft 2007).

The study by Reed and Payton (1996a, b) is significant here, as the study design had major similarities to mine and provided me with the inspiration to focus on how the elderly managed parts of the transition differently. Reed and Payton followed 46 residents for up to six months after their move into two British nursing homes. However, compared to my study their methods were somewhat different, as they also used focus-group discussions with members of staff in the nursing homes. In their study, the authors indicated that by using different complex strategies, the elderly people worked to minimise the impact of the change and thus make a difficult situation in their lives manageable. The authors further underline how the elderly strived to build bridges between their past and present life experiences.

Nolan et al. (1996) takes this discussion further by defining the phases of a successful transition based on his own research and literature. He argues that a successful outcome of the transition to the nursing home must actively involve the elderly person, regarding both the exploration of alternative nursing homes, and providing him or her with clear, detailed information about these institutions. If one or more of

these phases is missing, the transition will be less successful, he argues (Nolan et al. 1996).¹¹

The works of Tobin and Leiberman (1976) have also contributed to my discussion of pre-institutionalised homes for the elderly (cf. Buus 2001). Their work indicated that awaiting care was often perceived as a stressful situation. I found this as well, although Tobin and Leiberman's focus was inspired more by a physiological perspective. They compared 84 elderly people who were on a waiting list for residential care with a group of institutionalised elderly people and a group of elderly people living in the community. They identified what they called the "*destructiveness of the institutions*" (Tobin and Leiberman 1976: 6), which affects, for instance, the elderly people's self-image and emotional responses. They found that "*effects are set into motion by the process of becoming institutionalized, prior to actually entering and living in the institution*" (Ibid.: 17). That is, the prospective residents begin to feel a sense of loss, and these feelings "*become inseparable from the fear or even dread of the impending institutionalization*" (Ibid.: 6) at the time they enrol in nursing care.

The literature on relationships among residents is substantial and inspired me to look for similar ones in my own fieldwork. The substantial literature focuses on the nursing homes and usual practice in these institutions, but there is only a limited focus on the actual process of arrival of new residents. In Chapter 4 I return to some of this literature¹². The importance of the role of the staff in the nursing homes is indicated in this literature. In addition, minor parts of the research on nutritional aspects of the elderly people's lives have investigated meals (see Mathey et al. 2001 for instance). The results of this research identified the importance of the role of the staff.

Getting into the Lives of the Elderly People

The fieldwork in this study was conducted in the elderly people's own homes, in respite care flats, by hospital beds and in nursing homes. I focused on sixteen

¹¹ In addition, a seminar series during 2006 arranged by City University, London, the University of Sheffield and Northumbria University in Newcastle focused further on the topic. I had the pleasant opportunity of participating in many of these seminars, from which I gained important inspiration.

¹² The literature is: Townsend 1964, Gubrium 1975, Ross 1977, Myerhoff 1979, Foner 1995 and Paterniti 2003.

prospective residents. Ten of these – like Oline - came directly from their homes, and six entered their nursing homes from a hospital or sheltered accommodation. An additional six decided to postpone enrolment or move to nursing homes not covered by this study. Therefore, in this thesis, I focus on the sixteen new residents, data concerning the other six being used to supplement the discussion in Chapter 4. In the appendix to the thesis, a brief case study can be found of the lives and experiences in the nursing homes of the sixteen elderly people. I mention their experiences throughout the chapters that follow, but if the reader prefers more details on particular elderly people and how he or she perceived the situation, this information is to be found in the Appendix.

I used interviews (life histories and semi-structured interviews) and observations to investigate lives in the prospective residents' homes. The life-history interviews provided me with an opportunity to learn about the elderly people's backgrounds, the major events in their lives and how they perceived these (cf. Brandon Wallace 1994; Steffen 1997), as well as their previous and present practices. In turn, this enabled me to understand better their bodily impairments and the different ways in which they preferred to influence their surroundings in the transition. Semi-structured interviews concerning food, physical impairments and their perceptions of a home followed the life-history interviews. I then introduced the nurse Lene Fenger, who conducted the MDS assessments, and the photographer, Torben Eskerod.¹³ The latter made portraits of five of the elderly people and took photographs of their homes, both before and after the move to nursing care. This provided me with an opportunity to document changes in their faces and the ways in which parts of their previous homes were relocated in the nursing home flat. In writing Chapters 2, 3 and 4, these photographs proved to be of particularly valuable help in assisting my memory, and I use them as illustrations throughout the thesis.

Inspired by the intersubjective perspective, I also conducted informal conversations and semi-structured interviews with other people in this transition who played a role in the elderly people's lives and had some sort of relationship with the elderly people. This enabled me to follow the relationships the elderly people became a part of during the transition and to identify how they negotiated their identities. Generally, the

¹³ Eskerod has also worked with the anthropologist Joao Biehl. See for instance Biehl 2005.

people who mostly influenced their lives were relatives, the staff in the nursing homes, and the other residents living in the nursing home wards in which they became new residents. By interviewing these people, I obtained the elderly person's view of everyday life at home and on the wards, and I was also able to contrast this with the perceptions of others and thereby increase the validity of my conclusions (cf. Hardon et al. 2001: 341). Further, by observing the situation in the elderly people's own homes and the nursing home, it was possible to contrast and discuss the perceptions they expressed in the interviews (cf. Hastrup 2003).

Recruiting the Elderly People

The number of elderly prospective residents in this study was sixteen. The literature provides no ideal size of sample for this kind of study. Therefore I took guidance from Kvale (1996) regarding the number of residents that is necessary to cover the perceptions of a group of people using qualitative methods, and also looked to other recent ethnographic studies of institutionalised people (Jacobsen 2006, Biehl 2005). To cover the experiences of each of the elderly people, I scheduled approximately eighteen interviews. However, I stopped when information was repeated in the interviews (cf. Hardon et al. 2001). This means that some residents were interviewed more often than others.

I recruited people who had been assessed for nursing care while they were waiting at home for a permanent nursing home flat. They were over 65 years of age and included both men and women living at home. For me to be able to undertake interviews, the prospective residents had to be able to understand and respond to my questions. Based on my previous experience, this excluded people with dementia and Alzheimer's disease, as one consequence of dementia is a loss of ability to remember recent events. In other words, they had to be able to reflect upon recent events during the approximately ten months I intended to follow them.

Once they became nursing home residents, I conducted semi-structured interviews primarily to uncover their perceptions of everyday life in the nursing home, and secondly to discover whether changes had occurred in their perceptions (cf. Tjørnhøj-Thomsen 2003) and to uncover changes in their life situations (cf. Aggergaard Larsen

2003). I scheduled at least three interviews before the move to the nursing home, plus a further interview a few days afterwards to record first impressions and experiences. The next interviews were scheduled after approximately four weeks, and interviews continued after yet another four weeks, ending when the residents had been in a nursing home for approximately six months. The semi-structured interviews with staff and relatives focused on how they perceived the transition and whether staff perceived any changes on the ward when the new resident entered. One of the two members of staff I interviewed was their contact person, that is, the member of staff who assisted them with personal care and was thus in closest contact with the resident. The other member of staff on the ward was one who would occasionally take care of the resident. I also conducted semi-structured interviews with the other residents on the wards, focusing on their lives as residents and the possible changes they had experienced when new residents arrived.

Altogether interviews with five people covered the relationships the elderly person became a part of in the transition, and I also succeeded in interviewing their relatives, as it was the case for eight of the elderly people. These interviews were repeated twice.

I also had to use the interviews in the residents' homes as observation opportunities (cf. Rubow 2003) at times when the elderly people needed to pause, answer the telephone or discuss something with the home care assistant. In addition, I conducted observations in the nursing home from the time I arrived in the institutions until I left. I also conducted a series of observations of each resident concerning their practice on the ward during the day, with an intensive focus on their first days as residents. I observed meal events, different staff meetings and breaks, and I participated in many informal coffee breaks.

To supplement the ethnographic interviews and observations and to allow me to obtain some indications of how residents' bodily impairments and functional statuses developed during the transition, I applied the MDS part of the Resident Assessment Instrument (RAI), a quantitative tool developed for nursing home residents (see Chapter 5 for further discussion of this).

Methodological Challenges

The study design outlined above describes my fieldwork as I mainly succeeded in carrying it out. Based on the activities just mentioned, I gathered substantial ethnographic material supplemented by quantitative data. Nevertheless, I encountered a number of methodological challenges. This led to certain adaptations to the study design, which I will mention below.

From the outset, it was clear that relatively few elderly people matched the recruitment criteria in the small nursing homes. To counter this, I chose fairly large nursing homes with approximately a hundred residents to avoid having to wait a long time for prospective residents.¹⁴ As six months of fieldwork passed, I realised that prospective residents matching my criteria were rarer than I had previously anticipated, as I had only recruited three in this period. Municipal representatives told me that hospitalised elderly people who were unable to manage in their own homes and elderly people suffering from dementia had precedence whenever a flat became vacant in nursing homes.¹⁵ Furthermore the municipal representatives, whom I thought were committed to finding these prospective residents, had other priorities and seemed to forget all about my project. I realised that, although I had explained the purpose of the project to the best of my abilities, both oral and written, I needed to change tactics to be able to increase the number of residents in my study. In the event I could not change this number, but to make sure that the municipal representatives did not forget about my project, I started to call them every week. I also changed the recruitment criteria to include prospective residents who had been hospitalised and residents from respite care.

Consequently, I had to adjust my methods and schedules, this becoming a condition under which the fieldwork had to be carried out (cf. Hastrup 2003). As a consequence of this extensive waiting during the first part of the fieldwork, I had plenty of time for interviews with the first residents and thus time to identify the aspects of the transition

¹⁴ A nursing home with a hundred residents should receive approximately forty new residents each year, given that residents live for approximately two and a half years in the home.

¹⁵ I have been unable to find figures for the number of prospective residents in Danish nursing homes who are admitted from hospital and sheltered accommodation respectively. Of all Danish nursing home residents, approximately 60% suffer from dementia (Ingerslev et al. 2002). Similar figures are found in the UK (Matthews and Dening 2002).

that they themselves identified as important. This changed when, for instance, I achieved access to Hans and Anna only a fortnight before their move to the nursing home. Consequently, Hans and Anna were interviewed less intensively and had their introductory letter read aloud over the telephone. Moreover, new residents often fell ill, were taking strong medication or were unable to sleep at night. Thus due to fatigue, for example, they often wanted interviews postponed.

Due to the lack of new prospective residents during the early part of my fieldwork, I began a series of observations on different wards in the four nursing homes to gain an understanding of the daily lives and differences between the homes. The observations were made in the nursing homes from early morning to late in the evening, and sometimes overnight as well.

I had anticipated only observing wards just before the new residents entered them to be better able to follow possible changes caused by the new resident, but the size of the nursing homes made it impossible to predict which ward they would be accommodated on. Therefore I only managed to observe the wards of Dorte and Bo before they became residents of them.

Negotiating My Position

According to Hastrup (2004), the position of the fieldworker is a matter of negotiation. In a discussion of how to live our part in the field, she writes: “*This ‘part’ is very much a part allotted to us by the others*” (Hastrup 2004: 465). Below I will briefly illustrate my negotiation of opportunities in the field and how this influenced the ethnographic material I was able to gather.

Having plenty of time at my disposal turned out to be an important element in negotiating this position. I spent a substantial number of hours sitting in armchairs or on settees talking. Unlike the home care assistants and the nursing home staff with their heavy workloads, I could spend a whole day talking to one of the elderly people, whether at home or in the nursing home. The two groups of staff were busy with their contacts with the elderly people. They were most often observed on their way from one elderly person to the next, following a tight schedule. The hours of talking at home and in the nursing home also provided me with opportunities to observe the

relationship between the elderly person and the home care assistants and staff respectively. Both staff and home care assistants entered the elderly people's flats, for instance, to undertake cleaning, provide medicine or deliver laundry.

Contact with the new residents was limited due to the daily practice on the wards. Interviews were possible between breakfast and lunch, and then again as residents were woken up from their after-lunch nap until dinner. Then the staff started to help the residents into bed. Consequently what I was unable to observe had to be described from interviews with residents and members of staff. In the nursing home, it was possible to interview the elderly people in their flats. Interviews lasted from ten minutes up to several hours, as interviews and informal conversations were subject to interruption. Interviews with staff were also possible just outside the wards, in offices and meeting rooms, and these lasted one hour on average. Follow-up interviews were shorter, and most staff interviews were supplemented by occasional conversations in the corridor.

Situations in which staff assisted residents with their morning toilet turned out to be very delicate. Both residents and staff indicated strongly that these matters were considered too intimate for me to observe. If I missed the point – Bo's furious outburst when I entered his flat without knocking as he was on the toilet awaiting to be assisted into his wheelchair – made the point clear. This morning assistance was also a situation prized by both staff and residents, as this was when they developed a part of their mutual relationships, as discussed in Chapter 4. To uncover the meaning of these situations, I left room for this in the semi-structured interviews instead and added to them what I could observe from the dining room.

In interviewing residents suffering from dementia, I had to give up semi-structured interviews. Inspired by Okely (1994) and Van Dongen (2003), I used their family photographs and memories of childhood as points of departure. I tried to make them remember the members of their family and compare these memories with their present situation on the ward. However, their ability to understand this changed from one interview to the next. At one interview such residents might be in a quite good mental condition, which by the next interview had disappeared (cf. Swane 1998). Although this was by no means always successful, at least it enabled the conversation to take place and helped me create a rough picture of their perspectives of the social relationships on the ward.

Three of the elderly people in respite care thought of me as somehow affiliated with the municipal representative. They thought I might be able to shorten their waiting time for a permanent flat by promoting their case with the representative. Ole was explicit in this matter when he told me that I was “*One of them*”, meaning that I belonged to the category of municipal representatives like the home care assistant, the nurse and those calling him to inform him about his nursing home options. At the first interviews with these three prospective residents (Ib, Bo and Jørgen), they took a serious interest in my visits and postponed receiving care from home care assistants if I was scheduled to interview. When they became residents, they were very reluctant to agree to additional interview appointments, and as a consequence the quotations from the interviews with them are rare throughout the thesis.

Another aspect of my position in the nursing home was my close contact with staff on the wards. Residents tried to establish relationships containing mutual obligations towards these staff members. I believe that my close contact with the staff, with whom residents preferred to establish relationships, also influenced their attitudes towards me positively. Consequently I studied social relationships, which I myself influenced and became a part of (cf. Hastrup 2004).

Ethics

The elderly people received a brief written description of the project prior to the interviews and were asked for their informed consent when they had had time to discuss my description with their relatives or a home care assistant. Although they all seemed to understand this information, the reaction from the three who thought I was affiliated with the municipality indicated that in reality it was difficult for them to do so.

At times I attained the position of an ally with the elderly people against the municipal authorities. For instance, my availability provided an opportunity both to discuss the brief visits of home care assistants and assist the elderly people in reading letters from the municipality authorities, as well as discussing suitable answers to these letters. Further, my interest in them as individuals and the time I had to listen to them supported this position.

I also asked for the agreement of the heads of the nursing homes in advance, as well as the head of the department in the municipalities dealing with assessments of the elderly.

If one of the residents in my study had a very low BMI level and thus suffered from malnutrition, the staff were informed, and if I observed any case of serious neglect (“*omsorgssvigt*”), the head of the nursing home was likewise informed. It was important for me to inform the head of the nursing home and thus stress that my intentions were not to add to the negative exposure of staff in the media¹⁶.

As already mentioned, to ensure confidentiality, I have changed the proper names of the elderly people and staff members, though their portraits are traceable back to the individual elderly persona and eventually their relatives. My descriptions and quotes from the elderly people are not compromising in my view. Further, the different wards cannot be identified either. Therefore there was no need for further formal ethical approval of the study.

The exclusion of residents suffering from dementia was also based on ethical considerations, as statistically this excludes the voice of approximately 60% of the nursing home residents. However, I interviewed some ward residents who were suffering from dementia, especially on the small SLE wards at Lillevang, who were partly represented in the material in this way, although this was problematic, as indicated above.

In the interviews, I was also careful to not pass on information between residents and staff. Residents often asked how staff perceived them, but I declined to answer these questions.

Finally the project was registered with the Data Protection Commission (*Datatilsynet*).

¹⁶ See Ældre Forum 2003 for further details of the media coverage of care for the aged in Denmark.

Understanding the Elderly Peoples' Transition and Thesis Structure

I base the analysis in this thesis on a substantial body of material, consisting of tape-recorded interviews, of which I have transcribed a selected number. After every interview, I also wrote a summary based on the notes I took of conversations and added to the transcripts as a supplement. Observations were also transcribed and MDS assessments calculated and presented in tables. Quotes from the interviews and descriptions of observed situations were only edited for the sake of clarity and conciseness.

Like Oline, with whom I opened this introduction, I have used the cases of individuals as story lines in the succeeding chapters. This is justified by the prospect of giving the reader a feeling for some of the individuals and how they managed this situation differently. Inspired by Mitchell (1984), I also use them as exemplary ("*telling*") cases. The individuals I have selected do not represent all the other elderly people's experiences of the transition, but in accordance with Mitchell's suggestion (*ibid.*), I have chosen one story to give an impression of the importance of the theoretical and analytical aspects that I deal with in the different chapters. As already mentioned, I have provided an appendix, with more details of their life stories and their experiences of the transition.

The nutritional issue was the starting point of the present study, the process of eating and drinking indicating a very intimate relationship with one's immediate surroundings. But as already indicated, the elderly people repeatedly returned to their bodily conditions throughout the transition period. This rendered this latter perspective important if I wanted to understand their experiences throughout the transition period, that is, how the impairment influenced their experiences and their ability to influence the relationships they engaged in. Preparing food was, then, just one activity among others that they were unable to undertake any more. Their social isolation was another issue they often mentioned. Friends and many relatives from their generation had died. This loss, combined with a present inability to choose themselves whom they preferred to be in contact with, created a situation of mounting isolation. Their unsteady feet prevented them from leaving their homes, and if they

did so they required assistance. Trying to understand this part of the transition, Murphy's (1990) description of his gradual physical impairment and its consequences became an important inspiration with which to increase my understanding. His work underlined the importance of bodily impairment in terms of both engaging in one's surroundings and one's social isolation. Later in the analytical process, the works of Leder (1990), Good (1994) and Merleau-Ponty (1994) allowed me to deepen my understanding of the bodily impairments and their limited access to and limited influence upon those surroundings and relationships (Chapter 2).

What would eventually happen to their possessions was an issue that was often touched on. I anticipated that some idea of a home established with a late husband or wife would be prominent. But once they had been assessed for nursing care, the selection of which items were to be disposed of and which ones the nursing home and relatives could accommodate was an issue which preoccupied much of their waiting time. Margoux's (2001) studies of elderly people in a similar situation in Montreal, Canada, assisted my understanding of this part of the transition in respect of both their relationship with their possessions and the relationship between the concept of home and possessions. Analysing the material aspects of the transition further, Parkin's (1999) and Verrips' (1994) perspectives permitted an understanding how the prospective residents could dispose of the majority of their possessions (Chapter 3).

Once the elderly people became nursing home residents, the way the institutions changed their everyday lives became evident to me, and Goffman's (1961) seminal works on institutions assisted my understanding of these changes. This far in the transition, bodily decline had brought with it a series of losses of social relations, as well as a need to dispose of one's possessions. A question I often pondered on was whether they tried to compensate or restore these losses in any way? In this respect, relations with members of staff and especially their contact person provided major parts of the answer. Especially when the new residents experienced a change in contact person, this presumably strongly affected themselves, as well as the importance of the relationships and the different ways in which staff embodied¹⁷ the

¹⁷ When, throughout this thesis, I use the term "embody", I refer to how home care assistants and nursing staff individually represented the aims of care and of institutional modes of thought by their practice.

institutional aims rendered to me. At this stage I found the perspective of relatedness (inspired by Carsten 2000) fruitful in illustrating the character of these relationships. These relationships were a delicate matter, being fragile and temporary, and involving mutual expectations (Chapter 4). This perspective also sheds new light on relations with home care assistants (Chapter 2). It dawned on me in re-reading my field notes.

Increased dependence upon home-care assistance and members of staff in the nursing homes was one consequence of bodily deprivation, which the elderly people themselves intended to correct, as it was gradually changing their lives. The prospect of becoming a burden on staff¹⁸ and the staff's encouragement of them to take part in the rehabilitation activities added to the importance of the latter. It seems that the new residents thought of these as a way of compensating for the losses they were experiencing by halting the process of bodily deprivation.¹⁹ This prospect, and the idea of the effects of these activities, played a significant role for the new residents. A regaining of some of their impaired senses would, they thought, re-enable their bodies and widen their access to their physical and social surroundings. This prospect was further encouraged by the physical layout of the nursing homes, which, unlike their own homes, enabled them to extend their moving around in wheelchairs or with zimmer frames (Chapter 6).

The expectations regarding how residents should socialise in the nursing homes became evident at mealtimes. Nevertheless, on these occasions also their bodily impairments assumed prominence. The new residents were mostly reluctant to take part in the meals. Participation in these activities rendered the loss of major aspects of their senses palpable, and this added an uncertainty to their movements (cf. Merleau-Ponty 1994). On every ward, one or more residents were unable to manage to eat with knives and forks due to this uncertainty. In understanding these occasions, both works on Danish etiquette (Gad 2006 and Knudsen 1996) and Merleau-Ponty's (1994) and

¹⁸ See McPherson et al. 2007 for an extensive discussion of the burden aspect. Baunsbak-Jensen (2001) has described in a novel an elderly Danish man and his last three days in a nursing home before he dies. Among other things, he argues that today's generation of nursing home residents try not to become a burden, and the elderly man becomes embarrassed whenever he needs assistance.

¹⁹ For twelve of the elderly people, the bodily impairment happened gradually. Lis, Dorte, Åse and Ib all suffered a cerebrovascular event, meaning that the decline in their physical abilities happened from one day to the next.

Leder's (1990) discussions of oblivion and unlearned abilities informed the analysis in Chapter 5.

2. Waiting to go into a Danish Nursing Home²⁰

Introduction

Ritta, like Oline, was assessed for nursing care. At the age of 93, Ritta was waiting to go into Sølund, the traditional nursing home. Her impaired body restricted her movements in her home and her access to parts of it. She needed assistance from home care to manage most of her everyday activities, like getting out of bed in the morning, her morning toilet, breakfast preparation, etc. If she or the home care assistant forgot anything at the last visit of the day, she had to wait until the day after to recover it, like most of the elderly people in this study. For instance, if she dropped something on the floor, she hesitated to pick it up again for fear of losing her balance and waited until the home care assistant came back the day after to assist her.

This chapter deals with the first phase in the transition. It concerns the waiting time for elderly people who were about to move from their homes into a nursing home. The empirical context is the homes of the elderly people, where I use Ritta's example as illustration of the argument supplemented by the nine other prospective residents. The analytical focus will be the elderly people's disabled bodies, their increasing dependency, and how they intended "*to compensate for and to preserve... identity*" (Sacks 1986 in Jackson 1998: 17). The argument being pursued here is that the physical decline of elderly people's bodies leads to social isolation and the pre-institutionalisation (cf. Buus 2001) of their homes. This in turn confined part of their agency and ability to engage in social relations and to present personal identity. Although all the prospective residents strove to establish a mutual relationship towards "*my*" home care assistant in a way that enabled them to influence the care they received, only two of them (Ritta and Inge) successfully managed to do so. I apply a relatedness (Carsten 2000) perspective to illustrate that one way in which the elderly people compensated for their growing bodily weakness was to use the mutual relationship with the home care assistant as a way of restoring some sort of control in

²⁰ A draft version of this chapter has been published in *Generations Review*, *British Society of Gerontology*, Vol. 16, no. 2, pp. 22-7, 2006. A Danish version has appeared in *Jordens Folk*, Vol. 3, pp. 40-5, 2006.

their homes and thus aspects of their identity. In my analysis of the identity perspective, I primarily use Jenkins (1996) and Gullestad (1992). At issue in this chapter, then, is the aspect of intersubjectivity which concerns relations primarily with the home care assistants and their homes.

As I will argue in this and the next chapter, by their work in the homes the home care assistants increasingly changed the home into a place of work rather than of private residence (cf. Casey 1996, 2003). In the present chapter I will also pay attention to the way the elderly people experienced an insurmountable distance arising between themselves and parts of their homes (inspired by Merleau-Ponty 1994) and how tools and facilities became necessary but temporary extensions of their bodies.

Ritta was unable to leave her home unassisted to engage in social relationships outside the home, while the need for home-care assistance meant that she had to socialize with people she had not herself chosen. At the second interview in Rita's home, she was so pleased when her permanent home care assistant returned from holiday: "*You can't imagine what it means to me...talking to somebody I know*". She felt that the replacement for her permanent home care assistant had treated her "*just as if I was nothing but an old wreck*". And Ritta perceived this as being treated as a disabled body without any personal identity. Her permanent home care assistant assisted her in accordance with Ritta's personal preferences, making her bodily impairments less prominent to her. Her permanent home care assistant presumably found her person interesting and also took pleasure in talking to her. The replacement home care assistant presumably perceived Ritta as just another elderly body in decline and treated her by the book on basis of the assessments for home care assistance.

The home-care assistance with which Ritta and the other prospective residents were provided forms part of Danish community care for frail elderly people. Like the assessment for nursing care, the provision of home-care assistance depended on a bio-medically based assessment of elderly people's bodily and mental abilities, home care being the way the welfare society managed their abnormal bodies. This assistance should ideally support their well-being and independent living at home for as long as possible ("*Længst muligt i eget hjem*") (Andersen and Nielsen 2006). However, the findings of this study indicate that the self-perceived needs of the elderly people were rarely met, and essential aspects of independent living were not supported in their

own view. In this chapter, I also intend to address the debate about home-care assistance mainly from the perspective of the elderly people themselves.²¹

Ageing as Disability

The elderly people in this study were disabled, as they all needed a wheelchair or a zimmer frame to move around their homes or to leave them, except for Anders, who was the only prospective resident able to walk unassisted. According to Whyte, physical impairment is “*an infirmity of the mindful body that inhibits a person’s social competence*” (Whyte 2005: 168). The infirmity cannot be cured but, as Whyte and Ingstad stress (1995), the disabled persons may be rehabilitated, a topic I will discuss further in Chapter 6.

For the elderly people in this study, old age and disability formed a single connected experience. In a Western context (which the Danish context forms part of (Konge Nielsen 2006)) old age is associated with losing status as a person partly due to impairment and consequent lack of independence and autonomy (Arber and Evandrou 1993), as I will discuss further below. Based on the discussion of ageing as disability, I suggest that Ritta’s replacement home care assistant embodied a bio-medical assessment in a particular way whereby Ritta felt treated as “*an old [disabled] wreck*”. Nevertheless Ritta did not feel old, although she was well aware that her body had become frail and that, due to her physical impairment, she was no longer able to perform the basic activities of daily living. Another of the prospective residents, Ole, was more explicit in this matter, saying: “*I am not old, but I have a handicap*”. Nevertheless, the context and the attitudes partly shaped their identity, as the home care assistants in different ways embodied the assessments for care. The assessment of the elderly in this study by the municipality representatives for both home-care assistance and nursing care was based on the assessment of their mental and physical abilities, which in its turn is based on a bio-medical neutralization of the body (cf.

²¹ See, for instance, Jensen (2004) and Andersen and Nielsen (2006) for recent contributions to this debate in Denmark.

Mogensen and Whyte 2007). In this way, aspects of the person's social identity are overlooked, as my ethnographic material illustrates.

Janzen (2002) argues that the western definition of the lifespan ends in decline. It can roughly be separated into three biologically and chronologically defined parts, namely development (childhood), maturity (adulthood) and decline (old age) (Janzen 2002: 116).²² An essential part of achieving maturity in adulthood is obtaining rights and duties. For instance, at the age of eighteen, young Danish people have the right to vote and the opportunity to obtain a driving licence. An absolute hallmark of this maturity is personal autonomy and independence, marked by, for instance, earning wages and the ability to sustain a family (Gergen and Gergen 2003). If autonomy and independence mark the peaks of the life course, with its idealization of youth, activity and energy, then the physical decline of the biological body represents the opposite (Hoff 2003). Upon retirement, people are characterized as elderly, despite the fact that, as in the case of Ritta and most of the other elderly people in this study, they may not feel elderly at all. In Denmark the driving licence, which can be obtained at the age of 18, must be renewed at regular intervals after the age of 70. This, I believe, can be interpreted as official monitoring of the way bodily decline influences one's ability to drive.

Murphy (1990) argues that to be disabled in North America or Europe is conceptualized by a loss of autonomy and becoming dependent. More generally, Arber and Evandrou describe the context for elderly people in similar ways as follows: "*Negative images of elderly people as redundant, dependent, decrepit and inferior abound in our society*" (Arber and Evandrou 1993: 11). In addition, when ageing is associated with a loss of mobility, this loss becomes an ominous signifier of helplessness and dependence (Paulson 2005).²³

²² Elderly people in 'decline' are not a homogeneous group: for instance, a span of thirty years separates recently retired elderly people from those in their nineties. Nevertheless, in the West people are often defined as elderly from the date of their retirement (Arber and Evandrou 1993).

²³ The fall of many social barriers by the turn of the 21st century have led to the emergence of old people still acting as younger than they are (Janzen 2002). This involves a basic assumption that the social environment is responsible for the impairment by reducing the disabled persons' possibilities (Bickenbach et al. 1999). This has led to definitions of

The Western context, in which ageing is connected to decline, disability and eventually illness with social consequences for the elderly, is perceived differently among other cultures, as illustrated further below. One of the ways in which anthropologists have analysed the life-span of individuals is by examining transitions between different social positions in society whereby individuals achieve statuses. Several analyses have accordingly indicated that in many societies elderly people are among those who are ascribed the highest status (Hardon et al. 2001, Dalsgaard and Gammeltoft 2007). These analyses both challenge the Western link between ageing and decline, but they also inform the understanding of the situation of the elderly people in the present study.

Whereas ageing in the West connects diseases with the individual ageing body, Cohen's (1998) work from the Banaras, India, indicates the existence of a sense of social responsibility for these diseases. He challenges the existence of a universal connection between ageing and Alzheimer's in a study entitled, "*No Aging in India the bad family, and other modern things*". Cohen states that the family is responsible if a relative is suffering from Alzheimer's (Cohen 1998). That is, the behaviour of the elderly person indicates a bad family, or a family in which the children are failing sufficiently to care for their parents or are not sufficiently devoted to them. One of Cohen's examples was an elderly woman ("*Somita*"), who was examined by a psychiatrist and also had a CT scan. Her diagnosis was Alzheimer's, and her relatives went to see different elderly people's homes to have her admitted. However, some institutions rejected her. At the institution where the elderly woman was finally admitted, members of staff often blamed her condition on the "*Bad Family*" (Cohen 1998: 299). Elderly relatives exhibiting strange behaviour can thus influence the

successful ageing as a process, according to Katz (2000), one that is linked to ageing actively and self-sufficiently. In other words, a continuation of a normal adult life with autonomy and independence should ideally be postponed into old age with a body that remains in proper shape without physical or mental impairment (Konge Nielsen 2006). By the coming move to nursing care, the elderly people in this study are unable to identify with the story about the good life as an elderly person (Konge Nielsen 2006). Konge Nielsen argues that a very basic element of this good life is a body that remains in proper shape without impairment, which provides the opportunity for continued engagement in different activities and additionally permits a high degree of independence. Consequently, it postpones a normal adult life from slipping into old age with only minor physical or mental changes. This idea involves a fantasy of everlasting youth and immortality (Konge Nielsen 2006). See Katz (1995) for further discussions of this perspective.

status of their families retrospectively. One of Cohen's arguments in this case is that the way the family behaves and solves their internal disputes and mutual jealousies – in this case between mother-in-law and daughter-in-law – influenced the condition of the elderly woman, as well the status of the family.

The menopause is a further example of diseases connected to ageing in the West. Margrethe Lock (1993) discusses cultural definitions of menopause in Japan and North America. She finds that whereas the menopause has been transformed into a disease in North America, thus linking ageing and disease, it is perceived differently in Japan. This North American construction is based, she argues, "*on a potent fear of aging, coupled with a quest for immortal youthfulness and several desires...driving the medication of the menopause*" (Lock 1993: 367). By contrasting the Japanese data with the North American, she finds that menopause does not exist as a defined illness in Japan. Ageing in Japan is associated with loss of social meaning in society. The menopause, she argues, is therefore not a universal event but an experience that must be interpreted in the cultural context to find out how ageing is perceived more generally.

Bodily impairments have overall negative consequences for the elderly in this study. Whyte (1995) stresses that the perception of disability differs among cultures. She argues for the need to consider the cultural context of the disabled person and uses two African examples to illustrate this (1994). First, in contrast to the dominant western context, the Yaka cult in Zaire integrates disabled bodies and ascribes them unusual powers. Secondly, among the Giriama on the coast of Kenya, the parents of disabled babies are encouraged to leave the society, as otherwise their baby is likely to be killed as a source of evil.

Summing up, ageing and disability are, as briefly indicated, attributed different meanings in different cultures, but in the West and especially Denmark, ageing is connected with disability and decline. As my aim here is to understand the elderly people's transition, I will account for both their subjective experiences and the cultural context, as the latter also shapes the identity of the elderly. In other words, I am concerned here with the elderly people's own experience of life with a disabled body and the ways in which they are assessed by Danish municipalities and perceived

by municipality representatives, which in this study means the home care assistants and subsequently the staff in the nursing homes.

The important question in the next paragraph is to offer an answer to the question, “*How important is individual ability as a source of social identity*” (Whyte and Ingstad 1995: 7) for the elderly people in this study? To be able to answer this question, I will define how I use the identity concept before I can begin a discussion of how the process of increasing impairment increasingly deprived Ritta and the other elderly people of important aspects of their agency and ability to express their identity via bodily engagement in their surroundings.

Identity

In this section I use as my starting point a basic definition of identity as outlined by Jenkins (1996). The important aspect of Jenkins’ position is that identity is continuously created in social processes. Identity is basically about distinguishing both individuals and collectives from one another, and this is constantly done through social relations: “*We cannot see ourselves at all without also seeing ourselves as other people see us*” (Jenkins 1996: 21). Jenkins mentions identities which are embodied and therefore play a significant part in influencing the way other people see us through “*gender/sex, ethnicity/race and disability/impairment*” (ibid.: 51). He stresses that aspects of identity are negotiated, as identity is socially constructed in an ongoing process “*in which individuals define and redefine themselves and others throughout their lives*” (Jenkins 1996: 20). Identity is created through a process in which mutual recognition and validation by the people with whom we have contact is essential. There are at least two important consequences of Jenkins’ position. The first is that the way in which others treat and see people will affect the way they see themselves. Secondly, without human relations, this construction of identity would not exist or, as Jackson notes (1996), that meaning lies in the relations as they are lived.

Jenkins further argues that “*individuals consciously pursue goals. They seek to ‘be’ – and to be ‘seen to be’ – ‘something’ or ‘somebody’, to assume successfully particular*

social identities” (ibid.: 22), i.e. in negotiating our identity we are provided with the opportunity to emphasize different parts of our identity, depending upon how we prefer to be seen by others. As indicated in the way Ritta was perceived by the replacement home care assistant, the body is hard to negotiate because “*Social identification in isolation from embodiment is unimaginable*” (ibid.: 21). The ability to influence the negotiation of an identity and seeking to ‘be’ further presupposes a basic ability to act. Holland et al. (1998) argue that “*identities are lived in and through activity and so must be conceptualized as they develop in social practice*” (Holland et al. 1998: 5). And later, “*Behaviour is better viewed as a sign of self in practice...*” (ibid.: 31).

I choose to see the creation of identity as involving negotiation between individuals. Different aspects of identity can be emphasized in different ways in social encounters, and one’s identity is negotiated on that basis. The situation for the elderly people is that their ability to act, i.e. the part of their agency that concerns their ability to move their body unhindered, is becoming increasingly limited due to increasing physical impairment. Furthermore, according to Jenkins, their impaired bodies are an inescapable aspect of their identity. Here I find it fruitful to distinguish further between self and person. According to Mogensen and Whyte (2007), the experience of the self is closely related to one’s bodily experiences, the self being created in social relations and negotiated as basically described above. The concept of the person is connected to one’s status as a citizen in a society. One is not born a person with status. A person achieves this by, for instance, transitions from one status to the next, and this becomes part of one’s personal identity. In the West, this status can be partly lost, by ageing and becoming disabled, as Murphy (1990) also experienced it. The elderly people experience a process which resembled that which Robert Murphy²⁴ experienced as he lost most of his physical abilities due to a tumour on his spinal cord. In his book *The Body Silent*, he describes the slow process of paralysis whereby he lost his ability to move and thereby gradually experienced increasing physical impairment. One of these was an increasing dependence upon help when he wanted to undertake different activities of daily living (Murphy 1990). In line with

²⁴ Robert Murphy was professor emeritus of anthropology at Columbia University. He died in October 1990.

Jenkins, Murphy argues that his physical impairment had consequences for his identity: “*The totality of the impact of serious physical impairment...gives disability a far stronger purchase on one’s sense of who and what he is than do any social roles – even key ones such as age, occupation, and ethnicity. It is not a role it is an identity... And just as the paralytic cannot clear his mind of his impairment, society will not let him forget it*” (Murphy 1990: 105-6). Murphy uses Goffman’s definition of stigma in his account. According to Goffman, a stigmatised person is someone who is “*reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive, sometimes it is also called...a handicap*” (Goffman 1963: 3). Jenkins points out the consequences of being stigmatized: “*others make demands on us...others don’t just perceive our identity, they actively constitute it. And they do so not only in terms of naming and categorising, but in terms of how they respond to or treat us*” (Jenkins 1996: 74). Goffman likewise states that stigmatized people are not shown the respect and dignity which their identity should normally require and which they would expect to receive (Goffman 1963). Following Murphy and Goffman, Ritta could be seen as an elderly person who has been stigmatized by the replacement home care assistant. Any sort of status as a person was disregarded, and only the self that was linked to the impaired body was paid any attention in this relationship.²⁵

Ritta and the other elderly people in this study were at times confronted with a negative perception of elderly people in Denmark, and generally I noticed that, when they felt treated as a body in need, they reacted against this and thereby intended to negotiate this stigma. Ritta felt uncomfortable when she was treated as “*an old wreck*”. This incident indicated that she was presumably unable to influence the way

²⁵ This aspect further underlines how the West tends to discipline and control the bodies of elderly people and consequently limit their ability to express themselves (Paulson 2005). This situation, with its emphasis on dependence, “*take(s) away the adult status and personhood of the elderly*” (Featherstone and Wernick 1995: 7). Similarly: “*degrees of loss impair the capacity to be counted as a competent adult*” (Featherstone and Hepworth 1991: 376). The attitude enclosed in these quotes is elsewhere defined as the “*Mask of Ageing*” (Featherstone and Wernick 1995: 7), that is, an attitude towards elderly people that they are unable to escape (Gergen and Gergen 2003). The low status of elderly people is then defined on the basis of the appearance of the ageing body, irrespective of actual personal perceptions of status. Although the elderly people in this study often perceive themselves as younger, this only points “*to the inability of the body to adequately represent the inner self*” (Featherstone and Wernick 1995: 7).

she was perceived by the replacement for her permanent home care assistant. In other words, the context of ageing shaped aspects of the identity for the old people (cf. Whyte and Ingstad 1995), as at times they were left with the impression that they were bodies incapable of taking proper care of themselves. The two different ways of treating Ritta further indicate the possibilities of the home care assistants and subsequently the nursing home staff to choose between ways of treating the elderly, a topic I will return to in Chapter 4.

Home-care Assistance in Denmark

As already mentioned, the assessment for home-care assistance was based on a bio-medical neutralisation of the body (cf. Mogensen and Whyte 2007). I found similar priorities in the way the municipalities treated assessments for home-care assistance. For instance, one of the four municipalities in this study defines elderly people as eligible for nursing care when they become unable to orientate themselves in relation to their surroundings, time and place on a regular basis. Their ability to remember is reduced, as is their physical ability to take care of themselves (Sundhedsområdet, Farum Kommune 2004). Dementia and an acute health crisis, typically a cerebrovascular event and subsequent paralysis, were other frequent predictors. As in Oline's case, relatives' preferences also strongly influenced the choice of when to enrol a person for nursing care.

Home-care assistance should ideally compensate for these losses and provide the elderly person with an ability to maintain his or her level of independence (Andersen and Nielsen 2006). In recent years, home-care assistance in Denmark has been provided by giving priority to those with extensive needs, with, for instance, cleaning assistance being reduced for elderly people with only limited needs (Andersen and Nielsen 2006). Another recent change concerns assessments for home-care assistance. These services are classified in a 'common language' (*Fælles Sprog*), and changes in the needs of the elderly have to be approved in a new assessment before the home care assistant can add new services to the assistance (Elle 2006). Since the early 1990s, a major target of social policy for the elderly has been to encourage them to remain in their own homes for as long as possible ("Længst muligt i eget hjem") and

to provide them with an opportunity to help themselves (“Hjælp til selvhjælp”), as far as possible in suitable homes (Poulsen 2002, Wagner 1998). To this end, there has been more emphasis on open care, specific home-care assistance and home nursing day and night. The services provided by home care can, for example, include cleaning every second week, doing the laundry, administering medicine, shopping, help in getting dressed and a weekly bath. Day-care centres and transport supplement the services. These are provided to maintain the elderly person’s level of independence, quality of life and personal network (Andersen 1998). Nevertheless, one result of this policy is the increased frailty and reduced cognitive functions of elderly people when they become nursing home residents in 2004 as compared to the situation in 1992-1993 (Beck 2008).

According to quantitative surveys, non-institutionalised elderly people prefer to remain at home for as long as possible (Ældre Sagen 2001; see also Gurney and Means 1993 for similar findings in the UK). They also prefer home-care assistance to assistance provided by their relatives. It is the municipal authorities in Denmark who assess individual needs regarding both the specific tasks and the number of minutes that home care assistants are supposed to take to complete these tasks.

In a restructuring of the care for the aged, there has been a political tendency towards care increasingly being documented for both home-care assistance (Jensen 2004) and the care provided in the nursing homes (Elle 2006). One aim is to identify best practice for care and to avoid cases of neglect (Elle 2006, cf. Foner 1995). However, one consequence of this, is that individualized care involving attention to individual needs tends to give way to a priority being placed on quality documentation with evidence-based care and minimum standards (Elle 2006; cf. Foner 1995 and Steffen 2007). It is argued that these tendencies reflect the Danish version of the philosophy of New Public Management, which is to be held responsible for this change in emphasis (Elle 2006, Krogh Hansen 2006, Liveng 2007). However, the present study leaves me little opportunity to verify to what extent the recent restructuring of care provision has influenced the experiences of the elderly. I was able to observe tight schedules, changes of home care assistants and staff, and staff often being on sick leave. This all influenced the ability of home care assistants and staff to attend to

residents, but whether and to what extent this was a result of the Danish version of the New Public Management is impossible to tell by the methods applied in this study.

As already mentioned, the elderly people did not want to burden their relatives. As a consequence, their relationship with their home care assistant became increasingly important as they waited to go into a nursing home. There are only a limited number of studies on this issue, some of which suggest that one of the difficulties is that the municipal authorities who define the time slots do not allow enough time for the home care assistants to complete their tasks in the elderly people's homes. That is, the assessments are defined solely on physical needs based on impairment, and the schedules are arranged according to these needs. Moreover, the professional and organisational rules which service providers are required to follow preclude flexibility. This leads to frustration among both home care assistants and the elderly people receiving the services (Jensen 2004, Andersen and Nielsen 2006; see also Russell and Schofield 1999).

From a different context, Aronson (2002) studied the consequences of reductions in home-care assistance in Ontario, Canada. She identified reactions from a group of elderly people who experienced “*not being in control of their...surroundings and not having the resources to create desired impressions of themselves [which] was a deeply reducing experience for many*” (Aronson 2002: 409-10). Her study indicated both a loss of independence and that elderly people were no longer able to maintain control over their homes, partly due to the insufficient assistance with which they were provided.

I also found that time constraints precluded flexibility, as I had an opportunity to observe a series of scheduled home care assistants during fieldwork. Typically one hour was scheduled to help an elderly person get out of bed and have a bath. On the next visit, fifteen minutes might be scheduled to assist with medication, and the third visit could be cleaning assistance for yet another citizen. It must be noted that the scheduled visits were shortened by the time taken up by transportation. Flexibility was precluded, as the schedule did not allow for unforeseen events, such as the first

elderly person falling ill and needing extensive medical assistance²⁶ (see Jensen 2004 for further discussion of this aspect).

Ritta`s Physical Impairment

To illustrate the context and some of the consequences of Ritta`s bodily impairment, I will describe some of my first impressions from her home. Ritta was living in an area of Copenhagen called Nørrebro. Her flat faced a narrow street with only one-way traffic, and the neighbourhood as a whole was quiet, being removed as it was from main roads and shopping areas. The block of flats presumably hosted a large number of elderly people. In the morning I often observed a series of vehicles providing transport for elderly people. Like Ritta, most of the people living there moved in when the block of flats was constructed in the early 1930s.

Entering Ritta`s home was like entering a world functioning at a very slow pace, where a life was being lived in loneliness. Waiting at the door to the staircase on to which her flat opened, I had to call her on my mobile phone, as she could not hear the doorbell. When I walked up the stairs, it occurred to me that she did not actually need to hear the doorbell, as the home care assistant, the food-delivery staff and her relatives all had keys of their own. She lived in a two-room flat with a kitchen and toilet en suite. The flat was dark. Although the winter sun was shining outside, most of the curtains were drawn, allowing hardly any light into the sitting-room. Additionally it felt as though Ritta rarely allowed outside fresh air in. The sitting-room was the only room that was heated. The bedroom, hallway, kitchen and toilet were cold, presumably also to reduce heating costs. The corridor was narrow, which made it difficult for me both to enter and to close the door behind me, as her zimmer frame took up most of the available space. It was obviously very exhausting for her to

²⁶ Daatland further argues that, due to the strict time schedules, the organisation of the home-care assistance has turned the focus from care itself to the more technical aspects, with an extensive documentation of minimum standards (Daatland 1997).

answer the door. Also, she was unsteady on her feet and often had to recover her balance by leaning on her zimmer frame. When eventually she sat down, she was extremely out of breath. With her fuzzy hair and grating voice she left a very frail impression, which was also caused by her unsteady feet and immediate loss of breath when manoeuvring the zimmer frame around her flat. She was indeed happy that somebody wanted to spend hours listening to her life experiences, and she turned out to be a very talkative person.



(A part of Inge`s flat)

Fear of Falling

Inge was another elderly woman who had been assessed for nursing care. Like Ritta, she needed a zimmer frame. It is the handgrip from Inge`s zimmer frame which is visible in the above photo of her home interior, along with the enlargement screen in front of her TV set. Zimmer frames are devices that allow elderly people to move

around in their homes and assist their balance. Nevertheless, the fear of falling was a characteristic of these elderly peoples' lives. One consequence of their physical impairment was their unsteady feet, an experience often touched upon by the elderly people themselves. They had all experienced falling. This was described as a nightmare. Ritta described a situation of lying on the floor being unable to pick up the phone, meaning that she was deprived of her most precious social contact with her relatives, the daily calls from her son-in-law.

The elderly people all wore alarms to provide them with immediate access to help. Nevertheless, at times they forgot these when they went into the bathroom, and some had experienced lying on the floor waiting for more than eight hours until a home care assistant arrived. The fear of falling was a constant dread, accompanied by a general fear of being left helpless and unable to communicate with others, especially if they lived alone.

Murphy also underlines the consequences of his bodily impairment for his access to his immediate surroundings. For Ritta there were parts of the flat which she could not reach, due to her physical impairment, making the familiar settings difficult to navigate in. If, for example, the home care assistant vacuum-cleaned and forgot to put her reading light back, Ritta had to wait until she was back the day after to obtain light again allowing her to read her weeklies. Due to her fear of falling, there were parts of her flat where, due to a lack of handgrips, she hesitated to go. Consequently, an insurmountable distance arose between herself and parts of her home. Distance thus became a question of the body's ability to reach out rather than of physical distance (cf. Merleau-Ponty 1994, Zahavi 2003). Zahavi further quotes Heidegger, who argues that closeness towards items is a question of one's ability to use and get hold of them. The important aspect is whether the different parts of the rooms are accessible and usable in a particular context. Merleau-Ponty (1994) emphasises further that the body moving in the room makes the room part of its subjective experience of appropriating the place as a home (cf. Casey 1996, 2003). For Ritta and most of the other elderly people in this study, moreover, they experienced being reduced to sitting in an armchair or lying in bed, thus increasingly being unable to appropriate their own homes (see further, Chapter 3).

Changes in the Home Layout

One means of overcoming this distance were tools and facilities. The quantity of these indicated a period of time leading on to the transition where tools and facilities had been installed and replaced on a regular basis. Tools and facilities played a significant role in the everyday life of the elderly.²⁷ For instance, Inge used glasses supplemented by several magnifying glasses or magnifying lamps. Despite having these tools available to her, she gave up reading, as her ability to see had been reduced to the extent where it was impossible for her to distinguish even the largest letters from each other in her weeklies. Another example of this tendency was the inability to use a zimmer frame followed by the need of a wheelchair. Consequently, new tools and facilities only temporarily extend the elderly people's presence in the world. They presumably established an intimacy with different tools, as Merleau-Ponty (1994) argues of the blind man and his stick. For the elderly they were necessary extensions of their bodies. Nevertheless, once they had ceased to function, the intimacy tended to be replaced by an awareness of the tools (cf. Zahavi 2003). Merleau-Ponty (1994) further argues that the aspects of one's surroundings which one is unable to reach out for both make one pay attention to the limp one is unable to control (like the paralysed arm mentioned in the introduction), and is at the same time a constant frustration, as this reminds the person of his or her inabilities. In this perspective the context of ageing reflected in a focus on tools and facilities reminds the elderly person every now and then about their bodily conditions.

The physical impairments were indeed reflected in the elderly people's homes by the quantity of tools and facilities they had. In cooperation with other service providers, home-care assistance and relatives had arranged for these changes in and to their homes. Based on a study of elderly Danish people assessed for home-care assistance, Buus (2001) argues that elderly people's homes become pre-institutionalised. He points out that, in a pre-institutionalised home, the furniture is crammed in, and there is a more or less constant flow of home care assistants and other service providers entering the home. A frequent occurrence in this study was the need for a hospital bed, which typically took up more space in the bedroom. This made some of the

²⁷ These subjects have, among others, been addressed in the field of environmental gerontology. See, for instance, Wahl and Weisman 2003.

furniture look as if it had been crammed into their flats. This was a common reason for the reorganisation, as furniture needed to be removed from the bedroom. Buus (2001) argues (also referring to Gullestad 1992) that elderly people lose control of their homes in this situation. This also highlights the aspect of the home as a place of privacy. This has to be abandoned, as elderly people are no longer able to choose who they want to have entering their homes (Buus 2001) (I shall return to a discussion of this in the following chapter). In Buus's (2001) terminology, Ritta's home had become pre-institutionalised, as was the case with the other prospective residents in this study. Additional hand grips were mounted on the doorways, and thresholds removed so that zimmer frames or wheelchairs could move across them more easily. Zimmer frames or wheelchairs also tended to dominate the layout of flats, as the furniture had to be moved out of the way to allow passage.

From physical to social change

Through the gradual change of the home into a place of work for the home care assistant, the elderly person was gradually reduced from a person with personal identity to just one in a series of disabled individuals, with limited agency to maintain social relations. Although in some rooms the furniture looked crammed, the settees and coffee tables were not pushed into a corner of the room. I see this as expressing an invitation. It seemed as though the elderly people were waiting for visitors to come for coffee, that is, for relatives to drop in. Conversely the dining-room suite was often crammed with boxes or the like, indicating on the contrary that the elderly people did not expect guests to come for dinner.²⁸

One of the many consequences of the bodily impairment of the elderly was that it prevented them from preparing and serving meals, so this activity was replaced by meal delivery. Ritta was excluded from access to most of the kitchen. She was able to reach for the fridge and the microwave oven, but the sink was out of her reach, as was most of the kitchen table. Further her inability to stand there deprived her of any

²⁸ This impression was shared by those home care assistants with whom, by chance, I had an opportunity to discuss the layout of flats.

ability to prepare meals or to act as a host if relatives or other guests were present. Nevertheless both men and women missed the opportunity to add a personal touch to the food they received from the meal-service provider, for instance, the opportunity simply to fry some potatoes or add some cream or additional flavouring to the gravy.

Ritta and the other women had been collecting household equipment like large dinner sets, tablecloths and the like, both before and during marriage. With this equipment they had once been able to serve meals for at times up to twelve people. Expressing identity by serving meals to selected groups of people, preparing special dishes for them and using the dinner sets was now impossible. Ritta and the majority of the other elderly people now had to put up with the ways the home care assistants laid the table for them, and their choice of food was restricted to the menu from the meal-service provider.

The inability to prepare meals and act as a host has two consequences concerning identity. Judith Okely (1994) describes a situation for elderly women in France who had become nursing home residents. In a similar manner, before they entered the nursing home, Ritta and the other women were silenced and divorced from the *“utterances which come from external or domestic labour and family household routines”* (Evers 1981, in Okley 1994: 54). *“There is”*, Okely further writes, *“a special gender helplessness when women, by contrast to men, have to abdicate domestic labour to others”* (ibid.). Due to their impairment, the women were deprived of the ability to express who they were through their cooking, i.e. this was one aspect they were deprived of using when they intended to present themselves as persons (see also Hockey 1989 for a similar argument). Another aspect of lost cooking abilities was the social element of sharing food with others. As I discuss in Chapter 5, Simmel (1998) argues that eating food with others is a symbol of coherence within that group. Anthropology and sociology abound in examples of how food and drinking express the character of the relationships they create and maintain among people who eat together (Jenkins 1999).

Lise was another elderly woman who had been assessed for nursing care. She experienced how a toilet could be replaced. She needed a wheelchair, but the widths of the doorways could not be altered. This left Lise with a problem, as the door leading to the toilet was too narrow for her wheelchair to pass through. She was

unable to enter the toilet, and therefore a toilet chair was placed in her bedroom. Commenting on this installation, she said that she had developed “*a diplomatic bladder*” to avoid unpleasant odours in her bedroom and she only defecated every ten days. She indeed felt it hard to accept the equipment she needed at this time in her life.



(Lise`s toilet chair in the bedroom)

Applying Goffman`s (1971) distinction between front stage and backstage, although the defecation which took place backstage did not move to the front stage, to Lise it became a visible part of her life to other service providers and relatives which she would much rather have preferred to hide.

Through the alteration of space, there was also an aesthetic clash involved in the elderly people`s homes. The new tools and facilities, like a hospital bed and a toilet chair in the bedroom, clashed with the minor figurines, old pictures and the like in their homes. The elderly people had in most cases arranged the layout of their flats together with their late spouse, and they all perceived their homes as proper.

However, maintaining a proper home was problematic for elderly people in transition. Gullestad states that the home in the Nordic countries is established through ongoing decoration, through which “*people create themselves as individuals...through the processes of objectification involved in creating a home*” (1992: 79). Furthermore, as Löfgren (2003) argues, the home display is a showcase to the outside world. In this symbolic understanding, the elderly people experienced being deprived of the ability to maintain this part of their individual identity, as their physical needs to a large extent influenced the layout of their homes and changed them.

Social Isolation

In the introduction, I underlined Jackson’s argument (1998) that it is never solely individuals but also relationships which are at stake by bodily impairment. In my view, this was another consequence of the elderly people’s impairment. Identity negotiation was also limited by their inability to leave their homes unassisted. Murphy (1990) argues that the barriers against having a social life are so strong as to drive many impaired people into isolation. This is a deprivation of social being and, he continues, “*What died was the social side of me*” (Murphy (1990: 125).²⁹

Only relatives and one of the elderly people themselves talked directly about imprisonment. Lise’s daughter talked about her mother’s flat: “*That prison...Oh, it’s really terrible*”. Lise was able to pull open the door to her flat, but the lift door leading on to the staircase was too heavy for her to pull open. Arne, another prospective resident, waited for seven months until he was offered a flat in the nursing home where his wife had been admitted as she was suffering severely from dementia. He described this waiting time like being held in custody, as he felt too unsteady on

²⁹ Unlike the elderly people in this study, Murphy was very concerned with maintaining his work and position within academia and the social relations he needed as an essential part of this work. His increasing isolation and inability to remain part of the working relations at university is a major concern throughout his book. The important aspect regarding the elderly people in this study is this increasing isolation.

his feet to leave the flat. At the last interview, he was being medically treated for stomach problems he believed had been caused by this stressful situation.

If the elderly people wanted to leave home, this was left in the hands of their relatives. However, if they preferred to leave their homes without the assistance of their relatives, they needed to enrol with *HUR Handicap Service*,³⁰ the local transport provider in the area of Greater Copenhagen. Trips had to be booked the day before at 4 p.m. at the latest, but spontaneous trips were also a possibility. Nevertheless, spontaneous trips still needed a prior booking of two hours (Hovedstadens Udviklingsråd 2005), and a substantial fee was charged. The elderly people had to plan their movements in their home, as well as outward movements.

Most of the elderly people were assessed for activities at a day-care centre once or twice a week. These mostly concerned rehabilitation activities and social activities and were prized highly as an interlude in their everyday lives and an opportunity to socialize with other elderly people. They had stopped seeking new communities apart from the activities at the day-care centres. According to Tjørnhøj-Thomsen's (1999) research on childlessness in Denmark, exclusion from participating in different communities can also be seen as a loss of identity. Furthermore, at their age they faced a situation in which "*There is nobody left...*" said Lise, continuing, "*because either the ones I knew have passed away or they have moved elsewhere*". Ib, another prospective male resident, likewise described how friends and acquaintances tended not to pay him visits any more. Although living within a distance of only a few miles, this distance became an obstacle, as his friends and acquaintances had lost their own mobility too and with it their ability to maintain their relationships.

³⁰ HUR is at present called Movia.

Not Becoming a Burden

By seeking not to become a burden,³¹ the elderly people also showed a reluctance to participate in the social gatherings in which identity was negotiated. They seemed to hand over essential aspects of their social lives to their relatives. They never asked their families to assist them outside the home. They happily accepted offers to do so, but did not ask directly so as not to burden their families any further (see also Jonas and Wellin (1980) for a similar argument). They knew that their relatives were anxious about their situations, as illustrated by Oline in the introduction. According to Reddy (1998: 130 ff.), this is a characteristic of Danish culture. Family members help each other through celebrations of family reunions, construction work, repairs, painting and removals. This help is often repaid, but some aspects of daily living, like the services provided by home-care assistance, is seen as a debt of gratitude. The elderly people did not want to create such a debt and thereby become a burden.

A highlight of their day was a telephone call, a visit by relatives or the visits to the day-care centres. For Ritta another daily highlight was when her son-in-law called at the same time every day. Then she had to wait a long time until her daughter finished work and could call her. An unexpected call could really make one day stand out among the rest, especially at weekends, as well as relatives turning up unexpectedly. Visits from relatives were received on average every fortnight. Three of the elderly people received visits nearly every weekend by relatives, others more rarely, like every second month, and one was visited on his birthday only. Although they always received visits, they were unable to pay them back. Or as Murphy describes the situation, “*they are always passive recipients, waiting for the world to come to them – in its own time, if at all*” (1990: 77).

³¹ See McPherson et al. 2007 for an extensive discussion of the burden aspect.

In a novel, Baunsbak-Jensen (2001) describes an elderly Danish man and his last three days in a nursing home before he dies. Among other things, he argues that today’s generation of nursing home residents try not to become a burden, and he stresses that the elderly man feels embarrassed whenever he needs assistance.

Control of Home

The process of physical impairment leading on to the transition was somewhat parallel to a process of increased distance from parts of elderly people's homes and increased social isolation, as they were unable to maintain exterior relations by their own means. Furthermore, most of them were unable to influence how the home care assistants assisted them. The relationships established with the home care assistants were one way in which the elderly people aimed to restore and "*to compensate for and to preserve... identity*" (Sacks 1986 in Jackson 1998: 17) by retaining some sort of control over their activities in their pre-institutionalised homes. I shall analyse how the homes were presented as an aspect of the elderly people's identity, inspired by Gullestad (1992: 79). They preferred not to bother relatives with this and preferred the home care assistant to do it. However, this was not part of the assessment.

Relationships with home care assistants

The majority of the elderly people experienced relative continuity among the home care assistants. This implied that when the regular home care assistant went on holiday or sick leave, different assistants attended, as Ritta experienced. Significantly, however, only two of the elderly people actually looked forward to the visits of their home care assistants. The others did not mention this service as an important social relationship. Ritta and another elderly woman, Inge, had, over a period of two to three years, developed a positive, personal relationship with their home care assistants, sharing jokes and teasing one another. Ritta and Inge both focused on situations in which "*my home care assistant*", whose name they mostly used, assisted them in undertaking tasks for which they had not actually been assessed by the municipal authorities. For instance, Ritta explained how her permanent home care assistant started her day at work by sharing her breakfast with her. Afterwards she undertook the assessed tasks in Ritta's flat. In other words the continuous relationships, were important, as somebody was there listening to their stories and attending to their needs. That is, somebody who knew who they were, through listening to their stories, gave them the opportunity to share parts of their daily life experiences with someone else. Nevertheless Ritta and Inge were the exceptions. The other eight elderly people

experienced that it was their needs caused by the physical impairment which was the issue for the home care assistants, and they often felt they were being treated as “*elderly wreck(s)*”. Nevertheless, they often talked positively about some home care assistants and prized the assistance of others, as well as there being personality clashes. However, they often referred to a situation in which, no sooner had they begun to become familiar with one home care assistant, “*then a new one turned up and I did not see her (the former one) again*”. These and other remarks about the home care assistants indicate that the elderly wanted to establish relations with their home care assistants, but when they had been assessed for home-care assistance and were waiting for the move to nursing care, they seemed to have lost most of their interest in this possible relationship.

To understand better the relation with the home care assistant which all the elderly people aimed to develop and the relationship with their contact people in the nursing home (Chapter 4), I will use Janet Carsten’s term ‘relatedness’ (2000). Carsten discusses theories of kinship in anthropology, based on her analysis of relatedness within the context of her Malay ethnography. According to the classical approach taken to kinship in anthropology, kinship takes its point of departure in the biological interconnections between kin. According to this approach, kinship provides a natural connection between people, the sense of continuity implying that, in many studies, relationships based on kinship have been seen as non-divisive (Edwards and Strathern 2000).

Creating relatedness means creating a relationship which individuals must work at to achieve. Relatedness may be created and maintained through practice by, for instance, small everyday interactions, and it is also based on daily interactions and local connections between people (Carsten 2000). Relatedness must be thought of in terms of a continuum (Carsten 2000). The central issue is “*how the people we study define and construct their notion of relatedness and what value and meaning do they give them*” (ibid.: 236). The content of the relationship may be composed of various elements: “*Substance, feeding, living together, procreation, [and] emotion...*” (Carsten, J. 2000: 34). Other studies suggest that the day-to-day sharing of sentiments like suffering, happiness and sorrow can also create relatedness (Tjørnhøj-Thomsen 2006).

The concept of relatedness may thus supplement the way we characterize relationships and clarify what these consist of when blood relations between home care assistants, nursing staff and residents did not exist, as was the case in this study. Relatedness is a perspective that allows me to focus on the different aspects of these relationships. The interesting aspect here is how people in practice feel and talk about the relationships they create, and what elements characterize them. Furthermore, Carsten (2000) treats the creation of relatedness as an ongoing process. Studies of relatedness emphasize creativity and negotiation, and generally focus on the way in which people create notions of continuity and kinship-like relationships, emotional ties or looser bonds. Social relations are fragile, and the maintenance of meaningful relationships requires intensive labour, without which they will dissolve and cease to exist. Consequently, some sort of reciprocity is essential in creating them (Tjørnhøj-Thomsen 2006).

One criticism of the concept of relatedness is that it simply refers to aspects which previous kinship studies have already taken into account. That is, recent studies have indicated that creativity, negotiation and choice are important parts of relationships of kinship as well (Tjørnhøj-Thomsen 2006). Holy (1996) argues that “*genealogical relations, which are central to the traditional anthropological definition of kinship, are a specific Western way of imagining relatedness among people resulting from their sharing of substance and its transmission over generations*” (Holy 1996: 170). He later argues that “*kinship has to be understood as a culturally specific notion of relatedness...*” (ibid.: 171). Similarly Edwards and Strathern argue that, in defining who should be included in a group and who excluded, relations of kinship “*depend on a diversity of factors, of which kinship per se could never be the only component...*” (Edwards and Strathern 2000: 157). In other words, kinship relations are not ‘just there’ but must also be maintained by, for instance, paying attention to and sharing different elements to keep such relations meaningful.

Despite the criticism, I shall adopt the relatedness perspective with the intention of identifying the constructions of their mutual relationships created by the elderly people, the home care assistants and later the nursing home staff. These entail mutual obligations and, for instance, humour and patience, which, as I will show below, can be exchanged.

In the mutual relationship between the elderly person and the home care assistant, the elements exchanged were, for instance, happiness, mutual teasing, asking each other the same daily questions with a particular pronunciation, sharing jokes and discussing a television programme from the previous evening, and for Ritta the sharing of food. I see the establishment of a mutual relationship as an attempt on the part of the elderly people to influence that aspect of their personal identity which concerned the home and themselves as persons. That is, they attempted to ensure that aspects of their personal status were paid attention to and that they were not just treated as a disabled body. Furthermore there was a mutual interest in each other's persons. From the ethnographic material, I am unable to establish whether Ritta and Inge followed a certain tactic as described by de Certeau (1984), or whether the relationship was a result of the right chemistry between the elderly people and the particular home care assistants, or whether Ritta and Inge only paid close attention to the stress levels of the home care assistants. De Certeau discusses how the so-called "*weak*" (de Certeau 1984: xix), that is, people deprived of resources need to "*constantly manipulate events in order to turn them into 'opportunities'. The weak must continually turn to their own ends forces alien to them*" (ibid.). Elderly people are weak, as power is a very limited resource for the disabled (Murphy 1990), and it seems that the majority of the elderly people in this study were unable to manipulate situations in such a way that they could have the care undertaken as they preferred.

As already mentioned, only Ritta and Inge were successful in establishing these mutual relationships. The others mainly experienced this waiting time as stressful, as the examples below illustrate.

Drawing on Gullestad (1985, 1992), I suggest that there are at least two aspects of identity negotiation at stake in relations with home care assistants. One is, as mentioned above, the presentation of the home, which was compromised. The other was the wish of the elderly people to carry out activities as they used to. Gullestad (1985) discusses wealthy elderly women in Oslo, Norway, and the importance to them of having their meals in the very same manner each day. Gullestad (1985) points out that conducting activities in the very same manner every time gave the elderly women in the study the ability to tell themselves who they were. Both aspects are important, and I will deal with the latter aspect below.

Lise described a typical day in her flat, and her choice of words indicates that she would have preferred parts of the care to be conducted differently: *“Well, it starts at 8 a.m. The home care comes and pulls me out of bed”*.

Q: She pulls you out of bed?

“Yes...It is due to the poor condition of my back. I need help to get up, and then she must help me get dressed. So she makes coffee in the kitchen, butters a slice of bread and makes my bed...That’s it.”

Q: And the home care returns at 1 p.m.?

“They just look out for me...As they enter they shout ‘this is home care’...well, and I never know...whether it is somebody I know...”

The last visit of a home care assistant was at 8 p.m., when she was then put back to bed. She ended her description of this situation in the following way:

“They are back here at 8 p.m. to put me to bed. Nevertheless, when I hear the door close behind her, I switch the lights on again and call my daughter to tell her I’m all right.”

Visits by other service providers were observed during the interview sessions. I often found this a strange experience, as somebody suddenly opened the door. When interviewing Lise, for instance, all of a sudden the door was unlocked and somebody entered, saying *“Hallo”*. This somebody then started to do the vacuum-cleaning. Lise did notice, but her talking was not interrupted by this intermezzo, as it was part of her daily routine. At noon a hot meal was provided for her. This assistant left her flat in less than thirty seconds, rushing in and rushing out again.

Ending one of her descriptions of her daily life, she said *“There is no order in this”*, meaning that she could not control how the assistance was provided in her own home. This was very stressful for Lise, and she also pointed out that she never knew whether the home care assistants were in a hurry or not. Furthermore, she needed to follow the different assistants around the flat, making sure that, for instance, her underwear was placed on the proper shelf so that she could reach it afterwards. It was tiring to have to

explain her needs and wishes repeatedly. She also gave the impression that it actually compromised her sense of herself, as she had always valued having a presentable home. In other words, the way the assistance was provided did not allow Lise to do things the way she used to. Following Gullestad (1986), she was compromised in this way as both the allocation of home-care assistance and the attitude of the home care assistants themselves prevented her from controlling the situation so that it was tailored to her needs.

From her study of home-care assistance, Aronson describes another group of elderly people who are able to influence how such activities are undertaken. Those able to do this limited the access of the assistants to only a few rooms of their homes and were generally able to take charge of the situation and make sure it was tailored to their needs (Aronson 2002). However, in the case of the elderly people in this study, their physical impairment made it necessary for home care assistants to enter both bedroom and bathroom, which in Nordic countries are perceived as the most private rooms in the home (Gullestad 1992).

Unforeseen events happened for the home care assistants and changes of schedule occurred on a regular basis, according to the elderly. Consequently, some of them at times experienced long hours of waiting, and this further compromised the way they wanted assistance to be provided. It was evident that the elderly people structured their day in the morning, and this included the home care assistant. For instance, Åse another prospective female resident was provided with cleaning every two weeks, scheduled to start at 8 a.m. She got up early on that day, placed all her chairs on the tables to ease the vacuum-cleaning and waited. On some occasions she waited until 1 p.m. Describing this, she said: *“Well, you could have done something else”*. And, concerning the time of waiting: *“It was horrible...it was indeed unpleasant...well, you never knew who the assistant was...and when it was done, I was very relieved.”* Åse’s description left the impression that she tried to be in charge of this cleaning, but the situation ended up being too stressful due to the delay, and like Lise she experienced a loss of control over the situation. She was also assessed for a bath every week. Commenting on this being postponed, she said: *“It’s so ugly!”*

Åse, Lise and the other elderly people had their own standards in the home, which they wanted to preserve. One aspect of this was having the cleaning done in a

particular way, and the women especially had difficulties accepting this when it was not done in accordance with their own standards. Although the home had gradually changed into a pre-institutionalised place of work, it still reflected an order and the standards of a proper home. To keep up with this appearance, it seemed important that cleaning should be undertaken as they themselves would do it. On a few occasions, the elderly people referred to the home care assistant putting extra effort into the cleaning. This was rare, but for the elderly people it was seen as a recognition of their standards.

One married couple, Hans and Anna, were also provided with home-care assistance. The home care assistant helped prepare lunch for Anne but was not allowed to prepare lunch for Hans. He often stressed that it was a problem that the assessment did not allow this. Due to his failing sight, he was almost unable to see the different food items in the fridge. He was angry because his self-perceived needs were not being defined and met. His recent complaints concerned the tightening up of home care. After a few incidents, he had eventually given up complaining, as “*it’s no use anyhow*”. A few of the other elderly people also brought up their complaints, and I often heard this refrain, one that I believe reflected a frustration at their limitations of agency and lack of ability to influence the situation themselves.

These examples indicate that the elderly people were mostly unable to establish a relationship with mutual obligations. As a fieldworker, my time and interest was used by the elderly people. Ritta and the others were very pleased when they discovered that I had plenty of time to listen to their stories and thereby treat them as persons with a history. As mentioned in the introduction, the serious temporary interest in participating in interviews underlines this interpretation. Further to this, Randall (1997) argues that “*Storytelling...is central to our being human both guiding our interpretations of the events of our own lives and structuring our interactions with the lives of others*”. Without deepening this discussion, I will argue – inspired by Arendt (1998) – that elderly people were deprived of a witness to their lives, for instance, people hearing the same sounds, seeing the same things or just sharing the same daily experiences along with the stories of their lives. The schedules for home care did not leave any time for listening to elderly people’s stories. In this light, my role as a

fieldworker was important. I became a person whom the elderly could present their lives to.

I am also unable to tell whether the wish not to become a burden was a tactic for improving relationships with home care assistants. However, this situation of agency being reduced had a number of consequences for the relationship towards the home, relatives and service providers. Control of their own homes and lives was in decline, and with it their ability to present aspects of their personal identity. In their struggle not to be treated as bodies in need, the elderly people reacted in a similar way to Murphy (1990) when he felt guilty at bothering his wife as he lost his physical abilities. He knew that she was overwhelmed by her workload and by taking care of him. He experienced his former balanced relationship towards his wife change into a relationship in which he became the inferior party. When she entered the door, he waited to judge her mood. If she was in a good mood, he asked her for assistance. If on the contrary she was in a bad mood, he waited until she offered him assistance. Similarly Lise and the other elderly people waited to see how busy the home care assistant was on that particular day. If she perceived the home care assistant to be in too much of a hurry, there were a number of tasks which she didn't mention at all. She and the other elderly people then simply asked for their most basic needs to be met, thus paying attention to the stress level of the home care assistant, as they also had to do later to establish mutual relations with nursing home staff, as I will discuss in Chapter 4.

Conclusion

As the first phase in the transition, bodily disability deprived these elderly prospective residents of access to parts of their immediate surroundings, and they experienced an increased distance towards areas and possessions in their homes. They were deprived of major parts of their agency, which was based on bodily movements in the pre-institutionalised homes and the full use of their senses. This in turn isolated them as it confined their ability to engage in social relations and to present a personal identity. To counter this they tried to establish relationships with the home care assistants, but mostly these attempts proved unsuccessful. The first phase in the transition was

consequently a phase in the phasing out of the elderly person's identity, initiated by the impairments of their bodies. The phased out part was partly replaced by the adoption of the institutional practice they gradually learned.

In the previous discussion, I have applied a definition of identity which sees it as being negotiated in social relations. This definition opens up a range of possibilities in negotiating identity, but the analysis of the ethnographic material shows that important aspects of elderly people's individual presentations of identity were presenting their homes and having the activities of daily living carried out as they preferred. The discussion has shown that the elderly people wanted to give certain impressions of themselves, but that a lack of agency prevented them from doing so, as what they wanted most often needed more time than the care assessment provided for, as well as the agreement of the home care assistant.

At times, the elderly people experienced the negative perceptions of elderly people via the municipality representatives, as indicated by Ritta's experience. I have argued that this was shaped by a bio-medical assessment and a context with a predominantly negative perception of elderly people as disabled bodies in need of assistance. At times the majority of the elderly people experienced being faced with this attitude and being treated as bodies in need, so that becoming a burden felt humiliating. The consequence in these situations was that they had very limited opportunities to influence the presentation of their individual identities, as others "*actively constitute(d) it*" (Jenkins 1996: 74). In Goffman's terms, at times they experienced being stigmatised based on their bodily appearances.

The relationships between the elderly people and the home care assistants were a way to negotiate this stigma. These relationships were not dominated by a succession of strangers or curtailments. Nevertheless, only two of the prospective residents created a mutual personal relationship with "*my*" home care assistant. The remaining eight prospective residents perceived the relationship with their home care assistant as more or less stressful. Cancellations and delays compromised these relationships, and these situations also exposed the dependence and helplessness of the elderly people. As in the next phases of the transition, the elderly people who were in most physical need were also the most vulnerable.

The prospective residents did not leave me in any doubt concerning their efforts nonetheless to reach out to the world and create an everyday life situation that was endurable for them, for instance, by establishing mutual relationships with carers. Despite this predominantly stressful situation, they still struggled to influence their surroundings and thus present themselves as persons, instead of merely being seen as disabled bodies in decline. The hope of rehabilitation and intentions to participate in these activities – which I deal with in Chapter 6 – I also see as a part of their agency and as a way of making the present situation endurable (cf. Jackson 2005).

From the material, I am unable to establish to what extent recent political developments and restructurings in care for the aged have influenced the care that the elderly in this study experienced. But I am able to establish that the way the home care assistants chose to embody both assessments and political intentions influenced the elderly people. In the first phase of the transition, they felt like bodies that were unable to take proper care of themselves.

3. The Illusion of Home

Introduction

Inge was a very talkative woman. She had started work at the age of 14, and met her husband at the age of 21. Newly married, they bought a large red carpet for their living room in their new flat located in Copenhagen. She described how they were walking along a pedestrianised street and saw this particular carpet in a shop window: *“It looked incredible in the window. It was as though we simultaneously cried out, ‘This is our new carpet’ ...and the weather was beautiful...”*. After her husband’s death, the carpet reminded her of her happy marriage. According to her niece, Inge’s former husband had been stingy, and spending a large amount of money on a carpet was his way of declaring his affection for Inge. Inge spent Christmas with her niece, but New Year’s Eve was the evening she preferred to be left alone to remember her late husband and their marriage.

When she entered this study in June 2004, her husband had been dead for nine years, and at the age of 93 she had been assessed for nursing care. The carpet still covered her living room, although stains and other signs of wear showed its use over nearly sixty years. She indeed wanted the carpet to accompany her to the nursing home as if she wanted to move together with her late husband and in this way keep his memory alive. However, the carpet had to be cut in two due to the small size of her flat in the nursing home, one piece being moved there, the other going to the rubbish dump. Thus the memory of her former husband was also cut in two, and this particular experience was indeed painful for her.

This second phase of the transition concerns the dissolution of the homes caused by the imminent move into nursing care. This situation provoked a negotiation of the relationship with the material possessions that I used Inge’s carpet to introduce. I shall argue that the dissolution of the elderly people’s homes became a dissolution of themselves as persons, parts of them being placed with relatives, other parts condensed with meaning and placed in their nursing home flat, but the majority left at the dump. This implied a serious reduction in the number of their material

possessions, a part of the process that is, as for Inge, to some extent a painful experience (cf. Ross 1977 and Kraaij et al. 1997).³²

Before the elderly people were in need of home-care assistance, tools and facilities, they appropriated their homes via their everyday practices (cf. Casey 1996, 2003) without their bodies being a focus of this process (cf. Leder 1990). By engaging with their rooms and the possessions, these were gradually appropriated and transformed into a well-known place which were parts of themselves (cf. Grüenberg 2006). Hage (1997 in Grüenberg 2006) describes the home as a space of maximal bodily knowledge where subject and space literally leak into each other. This situation gradually changed through the introduction of the home care assistants, tools and facilities, who, by their work and presence, changed the homes as these were also appropriated into places of work and places through which a zimmer frame could pass, for instance. At this stage in the transition, the elderly were unable to establish the previous intimacy with their homes and possessions and they needed the home care assistants, tools and facilities to assist them in their pre-institutionalised homes. This chapter also concerns how the elderly people strived to control aspects of the phasing out of their identity. I will analyse the aspect of intersubjectivity that concerns relations with the material things that are their cherished possessions. I end the discussion at the point where relatives had rearranged their possessions in the nursing home flats.

³² Home display and the refurbishing of homes are major interests and activities to which serious attention is devoted in Denmark. Both media displays of these activities, and the time and money spent on, for example, extensions of kitchens indicate this interest and show that these items are used as markers of identity (Winther 2006). These all indicate processes through which the home is constantly being created. For the elderly, however, the situation is different, as in their case the process involves the dissolution of their homes.



(Inge in her home)

Among others, Marcoux (2001) provides essential insights into what the process of emptying the homes of elderly people means to them. From his work in Montreal, Canada, he analyses this process as a ritualized form of constructing the self of the elderly person by placing one's reminiscences of oneself with relatives. Giving away one's possessions is a way to donate, perpetuate or ancestralise oneself and one's family (Marcoux 2001). One aim of this chapter is to complement, rather than contradict this interpretation. I shall argue that this is also the case for the elderly

people in this study. However, what is also important is that they are involved in a process in which they animate, condense and imbue meaning (Parkin 1999, Verrips 1994) into a very small number of cherished possessions which can be accommodated in the flat in the nursing home. The possessions which nobody wants are again turned into things deprived of meaning, which the elderly people then can dispose of at the dump without too much pain.

In the nursing home, the new, self-contained flat is legally defined as a home. However, I find this to be an insufficient description of the practice in these flats, as their privacy and control became even more limited when compared to their previous pre-institutionalised homes. Consequently it is illusory to talk about there being a home in the flats where the elderly resided. This argument I root in the definitions of home by Douglas (1991) and Gullestad (1992) and in a concept of home-making. Furthermore it is an illusion, as their physical ability to appropriate the flat and convert it into a home was very limited.

The Meaning of Home

At this point I will discuss both the concept of 'home' and, later, the process of 'homemaking' (Blunt and Dowling 2006), as these aspects illuminate and foreground interesting parts of the ethnographic material.

Building houses or essentially 'roofs' has been seen as one of the most basic symbols of humanity, reflecting our basic human condition as dwellers (Heidegger 1971, in Swenson 1998). Practice below roofs or within buildings has been analysed from a variety of perspectives. The homes made in these buildings by, for example, kin groups, households or nuclear families have been seen as the stable foundation, or anchor, of kinship and domestic life (Miller 2001), and an examination of these activities offers rich comparative data for the study of culture (Gullestad 1992).

Anthropological analysis has applied a range of analytical strategies in order to understand the home. For instance, in structural analyses it has been demonstrated how, as a normative structure, the house culture reproduces itself through a social order that is present in the externalized order of the house itself, rather than through

some cognitive order inside the minds of its inhabitants (Miller 2001). Symbolic studies of homes have analysed the home and material possessions as the symbolic representations of the owner's identity (cf. Csikszentmihalyi and Rochberg-Halton 1981).³³

Based on migrant and refugee studies, it has recently been argued that there is a need to define home as something that is constructed by individuals in their continuous movement through mobile places. In this perspective, home is a 'narrative home', something 'plurilocal' and mobile "*to be taken along whenever one decamps*" (Rapport and Dawson 1998: 7). In this respect, then, home is "*where one best knows oneself – where 'best' means 'most', even if not always 'happiest'*" (ibid.: 9). Consequently home in this definition is not necessarily located in just one place.

Regional differences have contributed to the development of different theoretical concepts in anthropology. Following Gullestad (1992), a home in the Nordic context is connected to ideas of privacy and control. The owners will spend much of their leisure time here, as well as living major parts of their social lives in this place. In the Nordic countries, social life is generally not lived in bars, cafés or other public places. Becoming a friend of one of the members of the nuclear family often means being allowed inside the home. The distinction between the world outside the home and its possible excitement and dangers, and the inside of the home, where warmth, security and cosiness are the main attributes, is dominant in the Nordic countries (Gullestad 1992)³⁴.

Using Douglas as point of departure implies that I am addressing home in the sense of a locality and as the intimate appropriation of the place. This position has been

³³ Sommerville (1997) also stresses that political and family structures have influenced the meaning of home as privacy over time. For example, he mentions that "*the nature of the kitchen has changed (or is changing) from being a specialized back-region, 'cooking kitchen' to being the housewife's 'panopticon'*" (Sommerville 1997: 232). See also Löfgren (2003) for historical details on the use of the different rooms in Swedish homes and the development of domesticity.

³⁴ The home is often described in romantic terms. Douglas opposes this when she writes about the tyranny of the home and Olwig (1998) also points out that being at home and being obliged to take part in the homemaking is by no means always a positive experience.

criticized as being anachronistic, as it does not take the fluid constitution of the home sufficiently into account, where home is where one best knows oneself (Rapport and Dawson 1998). In only one case, however, were the elderly people in this study able to leave home on their own initiative, and they were therefore confined to one place. However, at certain times the elderly referred to their childhood home as their home, while at other times they referred to the home they were about to abandon. In this light it could be argued that they could feel at home in other places than the nursing home flat. But the way the home is described in the nursing home and the way the elderly mainly described their home turns Douglas's definition into an appropriate understanding of the meaning of home for them.

In her definition, Douglas pays special attention to both the space and the aspect of regularity. She discusses these two aspects of a home in her article 'The Idea of a Home: A Kind of Space' (1991). First, she writes about space: "*a home is located in space*". Secondly, "*there has to be something regular about the appearance and reappearance of its furnishings*" (Douglas 1991: 289). Below I will elaborate further on these two aspects.

Controlling the Private Sphere

Space is an important aspect of the meaning of home. Douglas writes that it does not necessarily need to be fixed, "*but space there must be, for home starts by bringing some space under control*" (ibid.). A tent and a caravan are among her examples of controlled but movable places.

Controlling a space also implies some sort of physical construction of the boundaries enclosing it (Sommerville 1997). Provided a building has doors, this implies the ability to close these doors between the home and the outside world. Entry through the door is restricted, as it leads to the private rooms of those who brought the space under control. The door can thus be seen as a boundary between the outside world and the inside. This also allows those within to regulate their interaction with the world outside in choosing who will be allowed access to the home and who will not. Furthermore, a closed and locked door towards an outside world can provide a feeling of safety to the person living there. Although it has often been pointed out that the telephone, internet and television all transgress boundaries (Miller 2001), the

occupant is overwhelmingly in control of the space concerning when to answer the phone or to switch on the internet or the television set.

Within the home, the occupants also have control over the material objects within it, which could be disposed of if or when they no longer cherish these. This is opposed to the situation in the outside world (Shenk et al. 2004), where, for example, a route to a chosen destination permits limited control over the persons or objects encountered along the way.

Consequently, there is also privacy within the space: “*The home gives people choices ...of friends, life style, when to eat, when to sleep... The most important aspect is that they can form social relations on a voluntary basis*” (Higgins 1989: 164). Along the same lines, it has been mentioned that good neighbours in the UK – as in Denmark (Reddy 1998) – are those who respect the privacy of one’s home (Allan and Crow 1989). Raising a family, however, implies that individual family members have limited access to individual private spaces within the home during the time when all members of the nuclear family are living within the same space.

The social relationships of those living in homes change over time, as when children leave home or a husband or wife dies, to mention a few examples that are relevant for the present study. In addition, a funeral can open the home to people who are not normally welcome in it. Therefore, in making a home over time, different people will be allowed within it, while relations with others will fade (Allan 1989).

In the Nordic context, Gullestad states that different levels of privacy are ascribed to the rooms in the home. A visitor who is allowed in is not supposed to go into the bedroom but to enter through the hall and possibly have coffee or eat with the occupants in the dining room. The hall and the dining and/or living rooms are the most public rooms of the home. The parents’ bedroom, on the other hand, is considered the most private room (Gullestad 1992).³⁵

³⁵ Goffman likewise discusses levels of privacy at home and different practices in these rooms using the metaphors of front stage and backstage. He writes about the bathroom: “*Bodies that are cleansed, clothed and made up in these rooms can be presented to friends in others*” (Goffman: 1971: 107).

The ten elderly people who were living at home were in many cases still living in the homes in which they had raised their families. This implied that important events in their lives took place in these locations. Decisions about the layout of the home and the possessions within it were now the decisions of these elderly people. However, while they were raising their families, the layout and possessions within their homes were the result of “*a turbulent sea of constant negotiation...*” (Miller 2001: 4) between the late husband or wife and their children. The control of space thus implies that there is privacy within the home and that there is a distinct split between its interior and the outside, that is, a split between the private and public spheres.

Home-making

Douglas (1991) uses the term ‘*regularity*’ as the second important aspect in her definition of a home. The regular appearance and reappearance of its furnishings indicates the aspect of making the home on a daily basis. She argues that the home and the activities within it have an important socialising aspect, where major social skills are being learned. For instance, all its members may be obliged to be present at its assemblies and to learn table manners. This implies that all members of the home are supposed to take part in its maintenance (cf. de Vault 1991).

However, I apply her term ‘*regularity*’ somewhat differently, as in my view the fact that something takes place in the same place at regular intervals is exactly what is important in the making of the home. One example is that breakfast is eaten in the morning, the occupants then leaving the house for most of the day and returning to eat dinner in the evening. They repeatedly return to the home and undertake the same activities, which all form part of the regularity involved in homemaking. In other words, the home needs to be created through regular ongoing activities where the space is appropriated and transformed into a home via everyday practice whereby intimate relations with place and possessions are established (cf. Casey 1996, 2003). Covering this aspect, I will use the term ‘*home-making*’ for this continuous process that includes cultivating, nurturing and preserving the home (Blunt and Dowling 2006).

It takes time to create a home, and one's attachment to and intimacy with one's home and possessions increases over time (Sommerville 1997; see also Gilroy and Kellett 2005). In a brand new home, visitors are often allowed in all rooms and are often invited to assist the owners in painting and arranging the layout of the home, for example. The privacy of, for instance, the parents' bedroom (Gullestad 1992) is then established over time. Nevertheless, closeness in relations also means that some rooms are more private in relation to some people than to others (Winther 2006).

The repetitious use of home also creates a familiarity with this physical space, with which an attachment is established. Along these phenomenological lines, Swensson (1998) argues that elderly people feel attached to their homes as if the houses were parts of their own bodies (Swensson 1998: 391). Shenk discusses elderly women's attachments to their possessions and writes about them as follows: It implies being able to "*find light switches in the dark...*" and feeling a "*sense of physical insideness, of being almost physiologically melded into the environment that results from an intimacy with its physical configuration stemming from the rhythm and routine of using the space over the years*" (Shenk 2004: 158). This phenomenological understanding underlines the very integrated part and close relations between the owners and their possessions. The point I intend to make here is that the relationships between the place of home and the possessions within it have been established over time. In other words, "*The lived experience of being-at-home hence involves the enveloping of subjects in a space which is not simply outside them: Being-at-home suggests that the subject and space leak into each other, inhabit each other*" (Ahmed 2000:89 in Grünenberg 2006).³⁶ 'Home-making', then, is not 'just' the place controlled by its occupant(s), but an ongoing process. Finch and Hayes (1994) write that the home is actively constructed through a process that turns the raw material of the house plus its possessions into a home. To specify the understanding of this part of the process, I am adopting the term 'animation' (Verrips 1994) for the possessions in the house. Meaning is inscribed into the accessible objects, and the elderly people

³⁶ De Certeau (1984) has added to this perspective. The home can be seen as a person's face, the doors and windows resembling the mouth and eyes. Furthermore, the person breathes through the chimney and ventilation system of the house. In this perspective, burglary can be seen as an assault on or even the rape of the house-owner.

gradually create an intimacy with these possessions as an aspect of making their homes. Hockey (1989) also discusses identity for nursing home residents. She mentions the “*selective oral accounts of what had gone before, in those remaining personal belongings through which memories were evoked*” (Hockey 1989: 202). This likewise underlines the importance of possessions as part of the history of their past.

In the analysis below I draw upon Verrips (1994) and later Parkin (1999) as their perspectives allow an understanding of how elderly people can end some of their relationships with their possessions and continue others.

A Pre-institutionalised Home

The whole idea of a home was challenged for the elderly people, as the homes were gradually appropriated into also being a work place for the home care assistants (cf. Casey 1996, 2003). Most of the elderly people in the present study were widows or widowers. As they lived alone, they were able to enjoy privacy. An aspect of the pre-institutionalised home was the daily transgression of the boundaries by the service-providers (cf. Buus 2001). Additionally, the home care assistants had access to and cleaned their most private rooms and often also their bodies, and, for some of them like Ritta, entered their bedrooms to help them get out of bed and get dressed in the morning. As they also needed to adapt to the schedule of the home care assistants, they consequently lost major parts of their control of how their homes were made.

The elderly people were therefore in a situation in which the idea of the home was being challenged and had been challenged from the time when they needed home care. At this phase in the transition their concerns were about their possessions and how they could transfer some of these into a small, one-room flat in a nursing home. This reduction in their possessions raised the question of their importance. It seemed as if their relatives had arranged their most precious belongings into the room they used mostly whereas other belongings were crammed into other rooms. This also indicated that the elderly had partly lost control over their homes and that the relatives, along with the home care assistant, had taken parts of this control.

Furthermore the elderly people were physically impaired and unable to carry out the activities concerning their removal, and their relatives needed to undertake all these activities. In Denmark this is accepted by the relatives as an obligation (cf. Reddy 1998), but the relatives talked about this situation as stressful and very exhausting due to the sheer number of possessions they needed to dump. For the elderly as well the situation was stressful, as they were unable to do this and had to trust their relatives to do it for them. These family members thus also exercised a great deal of influence on the process of moving into a nursing home. Furthermore, the nursing home regulations strongly influenced the future layout of their flats in the nursing home. These were motivated by access to the alarms and facilities in the flat, as the flat was also a workplace for nursing home staff. These regulations limited the type and size of possessions that could be accommodated in the one-room flat, as illustrated by Inge's carpet.

Cherished Possessions

In this paragraph I will discuss how the development in their relationship to their possessions can be understood.

Margoux (2001) states that the elderly people he studied “*create their sense of place with possessions... That it is the things themselves that make the house their house*” (Margoux 2001: 215). Hecht similarly argues that possessions are part of what transforms a house into a home (Hecht 2001). Following this argument, their possessions should be what turned the flat in the nursing home into a home, though on a minor scale for the elderly people in this study. In the following, I am not arguing that the possessions transfer the flat in the nursing home into a home. In sorting out their possessions in their pre-institutionalised homes, the elderly needed to condense meaning into a limited number of possessions that could be accommodated in their nursing home flat.

The situation in which the elderly people selected from among their possessions also resembled the experiences of refugees, “*where people in flight store, so to speak, their precluded social personhood within mementoes of mind and matter, including*

cherished small objects...” (Parkin 1999: 315). Like refugees, these elderly people faced a compulsion to sort out their possessions and inscribe and accumulate “*their sense of a personal future and identity in whatever remains...to invest emotionally, in other words, in accessible objects,...*” (ibid.: 308). In other words, they encapsulated stories about relations into a few possessions (see also Gullestad 1985 for a similar argument). However, the aspect of a very stressful situation was also recognizable for the situation of the elderly people (cf. Kraaij 1997), as well as for the refugees.

This process needs a little more clarification, since it actually describes the elderly people’s communication with the possessions around them: “*Through that act people endow lifeless things with a soul of their own*” (Verrips 1994: 40). This implies that elderly people humanize their possessions. Verrips uses the term “*animate*”(ibid.) to describe this process and writes about animists who “*do not make clear-cut distinctions between subjects and objects, but instead view the world in terms of interpersonal relations between `living agents` with particular intentions*” (ibid.: 38). And later she argues that, “*our everyday language abounds with expressions...that show we perceive our material environment as animate, as filled with `subjects`*” (ibid.: 46).³⁷

The elderly people waited on average four months from the time they enrolled for nursing care until the actual move to nursing care. During this period, they endowed a few of their possessions with the meaning of past relations, that is, they were in a situation in which most of their previous social lives needed to be fixed by a few possessions. The process also had to enable them to throw away most of their things. Thus the part of Inge’s carpet that went with her to the nursing home needed to contain all the memories of her late husband and their marriage.

The possessions of these elderly people could be said to have social lives, as they acquire meaning from those that human transactions, attributions and motivations

³⁷ In my view, the possessions do not have the quality of a fetish, as they were not “*possessed by spiritual, even supernatural forces, and command a unique reverence as a result of this magical attribution.*” (Pels et al. 2002: 4). They therefore do not become agents endowed with their own powers, though staff in the nursing home had to assist in re-articulating the meaning they were endowed with to make them the basis for social activities.

endow them with (Ples et al. 2002). However, the important question then becomes whether the memory of their social relations and the stories they carried with them are re-articulated in the nursing home and become a basis for social activity, as Parkin (1999) suggests.

I will now turn to the ethnographic material from the elderly people's own homes to illustrate how they negotiated the relations with their possessions. If they intended to give away their possessions, these were in most cases accepted, but problems arose when relatives refused to accept items that the elderly people perceived as important. To frame this discussion, I will briefly elaborate upon the ways in which the elderly people perceived their homes.

Home for the Elderly People

The elderly people talked about their homes in positive terms. They were cosy, comfortable, nice places, where they met and socialized (cf. Schwartz 1989). But it was interesting that words describing social gatherings and meetings still played a major part in their narratives of what a home represented to them. This contrasts with the situation at home, into which in practice no visitors were invited apart from relatives and home care assistants, who mostly came on their own initiative.

The Home as a Museum

All elderly people had lived in apartments before they moved into nursing care except for one. The smallest apartments had two rooms, the largest six. As previously indicated, the use of their homes had changed. Additionally observations in the homes of the elderly people showed that although they may have lived in a four-room flat they only used the living room during the daytime and the bedroom at night. An example was Ole. He was confined to the chair in front of the television set. The carpet below this chair reflected this, as it had nearly all worn away, and only the rubber backing was left. The rest of the rooms, apart from the bathroom and parts of the kitchen, were not used by the elderly people. Oline, for example, had been good at needlework, but the room she used for these activities had not been used for a long time. Another example was Hans and Anna's apartment. He had an office in one of

the rooms, but he had apparently not done any paperwork in this office for years. Nevertheless, he kept it the way it used to be when he was still working, to underline to the occasional visitor that he once had an important position. It appeared that the couple tried to retain the meaning of the home as it was in the past.

The homes of the elderly were also showcases for social status and ambition (cf. Löfgren 2003). For Hans and Oline, the home now provided confirmation of their former social status, ambitions and positions. Anders, as another example, had a room next to his kitchen. He once had a restaurant in an amusement park. The neighbouring building was a theatre, and actors often spent the late evenings and nights relaxing after their shows in his restaurant. He still kept a small room next to the kitchen decorated with photographs with autographs of these famous actors.



(The room next to Anders`s kitchen)

Anders`s home would, in Kirshenblatt-Gimblett`s terms (1989), represent some sort of museum of former relationships with a glamorous world. In this respect, the homes of the elderly had become museums, with themselves as the curators assisted by home care assistants and relatives of their own lives. However, compared to ordinary

museums the exhibitions never changed, and they would be closed down when the elderly people moved out.

In observing these homes, I was struck by the number of pictures and other decorations covering every possible area of the walls. They used up every free space on the walls, such as between two bookcases, around the shelves and the like. As previously mentioned, however, the pre-institutionalisation of these homes was visible in a sort of aesthetic clash between their elderly furniture and the new tools and facilities needed for their care.

Giving away Cherished Possessions: Establishing Inalienability

Giving away possessions occupied a great deal of narrative space in the elderly people's accounts of the dissolutions of their homes, a situation connected with feelings of anxiety (cf. Thomasma et al. 1990). These changes late in life can influence the health of elderly people negatively as a move exposes them to a high death risk (Choi 1996: 325). It was a situation hard to overlook. In all cases, possessions which they felt intimately related to, that is, possessions endowed with a special meaning like inherited objects, family heirlooms and the like, were items they tried to donate to close relatives and thus ensure their inalienability.

For instance, Lise was very concerned about her paintings, which she had inherited from her father. Apart from two, which went with her to the nursing home, they were to be given to her children and grandchildren. As they were highly prized, her relatives happily accepted them. They reminded her of her strong relationship with her father. She described him as a patriarch whose decisions were not discussed, but were the law to be accepted and obeyed by the family members. He was a wealthy merchant in a large provincial town in Denmark. He had a passion for the arts, and local artists often visited his shop, exchanging paintings for clothes, which they could not otherwise afford. Before his death he gave nearly all his paintings to the local museum and told his daughters that they could go there to see them. The paintings symbolised this relationship to her father, and they were passed on to her daughters. In passing the paintings on to her daughters, Lise wanted to make a statement to her father. Although still making a personal statement about the importance of the

relationship to her father, in opposition to his wishes, she decided that the paintings should remain within the family and not be given to a museum.

This part of the disposal she experienced as satisfying and as having been carried out according to the way she wanted it done. In agreement with Marcoux (2001), this seemed to provide continuity and a feeling of preservation and wholeness. The paintings had become the kinds of possessions which Lise intended to keep within the family and hand down from one generation to the next. In agreement with Weiner (1992), I suggest that Lise preferred to turn her paintings into inalienable possessions, that is, possessions which “*are kept by their owners from one generation to the next within the closed context of the family*” (Weiner 1992: 6).

Although the paintings can be seen as the gifts of a mother to her daughters, what was being exchanged was also a shared understanding of the meaning of the paintings. Lise was exchanging them for a last or lasting expression of appreciation (cf. Marx et al. 2004) and expected her daughters not to sell them off, thus preserving Lise’s relationship with her father within the family.

In the dissolution, Lise and the other elderly people also faced difficulties in saying goodbye to precious belongings. As an example, she mentioned a small cupboard that had been built by one of her grandparents. None of her children or grandchildren wanted to take it. Lise talked about saying goodbye to this cupboard as if she were having a conversation with her possessions: “*I would have preferred a little more time to go through my things to see which of them I wanted to be accompanied by in the nursing home.*” And further, she mentioned “*the time to sort of talk a little with the furniture and say a proper goodbye.*” “*I have been looking at them for many years, you know...*” Saying goodbye became hectic for her, as was the case for the other elderly people. Once she had accepted the flat in the nursing home, there was less than a fortnight for her to move her belongings.³⁸ Lise experienced the divestment

³⁸ The head of one nursing home informed me that the reason for this is that the nursing home loses grants if a flat is not let to a new resident within a fortnight of the death of another resident.

process as progressive, but also as stressful when it speeded up upon her moving into the nursing home.

In the case of the cupboard, Lise had lived with it and it had become a part of herself and consequently it needed a proper goodbye. This was so the cupboard could be turned into just an ordinary thing she could dispose of without too much pain, thus ending her relationship with it. The examples below serve further to illustrate how the subjects and persons “*inhabit each other*” (Ahmed 2000: 89 in Grünenberg 2006) and indicate the difficulties and pains involved in interrupting this relationship.

Women’s Kitchenware and Men’s Positions

Whereas Lise’s daughters happily accepted the paintings, her kitchenware became a matter of concern. Her grandchildren and the rest of her family did not share her perception of its quality style. Different tastes between generations (Csikszentmihalyi and Rochberg-Halton 1981) must also be taken into account as a reason for them not accepting it. It was therefore painful for Lise finally to see her son-in-law take it away and drive it to the rubbish dump.

Gender is another important aspect of how home was made for the elderly people in this study. For the women, the majority gave up working when they got married, as was normal in the 1930s. They cared for their homes, their children and their husbands. This meant that an essential aspect of home-making for the women was preparing daily meals for their families. Following de Vault (1991), by doing the cooking the women had the means to create a family, which was created as they ate together. Along similar lines, Swensson argues that the women had their own importance in making and tending the house, which reinforced “*their sense of being needed and useful in the world*” (Swensson 1998: 391; see also Evers 1981, in Okley 1994: 54).

It was indeed painful for Lise that she could not leave the kitchenware she cared for with her relatives. This also applied to most of the other women with large dinner sets, tablecloths and other household items. Their relationships were very strong and had been established over a long time, but were impossible to end in a fortnight. In

other words the appropriation of possessions and rooms took time and a reversed process of condensation, while giving away and dumping needed time as well.

For the men in this study, the most important possessions were those that represented the work positions they once held, and disposing of such possessions was as painful as for the women in their cases. For instance, Ole wanted his and his father's framed proof of fifty years' membership of the HK labour union to accompany him to the nursing home. There was also a drawing of a typographer, which illustrated his pride in his previous work. These items were small and could easily be accommodated on the nursing home's walls.

Conversely, Bo had to dispose of furniture he had formerly built himself.

Commenting on this, he described himself as a skilful carpenter: "*The skills of a carpenter, they're something you can't just dispose of... Just imagine a piece of wood and all the possibilities it holds, and the smell when running the plane over the plank.*" Bo was pained by the fact that disease prevented him from shaping wood any more. Nonetheless he had a table and a cupboard in his nursing home flat that he had made himself and was indeed willing to describe the details of their construction when the interview focused attention upon this aspect.

Due to his physical abilities, Anders was the only one who could undertake parts of the sorting out himself. He invited his daughter-in-law to take what she and her sons wanted. Then a second-hand dealer was invited, and the rest was left at the dump without much pain, as long as he kept a few items representing his former positions. However, his affection for his late wife was still visible in his relations with some of her previous possessions, and he chose to keep these. An interesting detail in Anders's bathroom was a bottle of lotion from his late wife, which he kept along with some dressing gowns in the wardrobe, presumably to remember her smell. The particular lotion stood beneath the glass mosaic of a naked woman in art nouveau style. Its position beneath the mosaic of a stylized woman reminded him, I suggest, of her looks and smell.



(The glass mosaic in Anders`s bathroom)

Although he was about to dump and sell most of his possessions, throwing out her dressing gowns was a difficult task for him. After a month in the nursing home, he had finally got rid of her last gowns and told me, “*That was it*”. However, later in the day he came to me and told me, referring to his new nursing home flat: “*There is a dressing gown of my former wife`s in my wardrobe. I haven`t been able to cope with just dumping it. I think I will donate it to the Salvation Army...so let us see what they are able to do with it.*” In the nursing home, the only thing that reminded him of their marriage thereafter was their marriage photo, placed right next to his favourite settee and within arm`s reach.

Inspired by Bloch and Parry, the giving away of possessions can also be seen in the light of preparing for a good death, that is, overcoming the biological unpredictability of death and achieving mastery over the arbitrariness of the biological event (Bloch and Parry 1982). Giving away possessions thus prepares one socially for death, but at the risk of not being remembered (Margoux 2001: 230). In Lise`s case, the good death was prepared successfully by the paintings. The kitchenware represented the opposite

situation. Generally the elderly people refused to beg their relatives to take their belongings, but given the pain with which they talked about their possessions, like Lise's kitchenware, different perceptions of these possessions could be a source of conflict. Therefore it is hard to define either a good or a bad death for the elderly people when applying Bloch and Parry's (1982) terms. Their processes represented both aspects.



(The marriage photo of Anders and his late wife)

Settling in

Layout of Flats in the Nursing Home

Above I described how some of the elderly people's cherished possessions were endowed and imbued with meaning. Below I will approach the interior of the flats by elaborating briefly on how actually moving into the nursing home was accomplished and how these possessions were arranged in these flats.³⁹ Finally, I will comment on which of their possessions were re-articulated (Parkin 1999).

³⁹ At this stage in the transition, the ethnographic material concerns all sixteen elderly people who became new residents in this study. I.e. the 6 elderly who were admitted from hospital or respite care were included in the material. Contrary to the other 13 residents Dorthe, Åse and Lis had suffered an acute health crisis. For these three their bodily impairment and

Generally the furnishings in the elderly people's flats in the nursing home were remarkable because of their similarity. The design of the flats privileged function and was dominated by considerations of access and safety issues. (cf. Ross 1977).

Typically there was a settee or an armchair next to a coffee table, with one or two chairs and a bookcase along the wall. Opposite the settee was a TV set combined with a video recorder operated by a remote control. Most often photos of family members were placed next to the TV set or on shelves close by, but visible from the settee. The telephone, a link between themselves and their relatives, was placed on the coffee table.⁴⁰ Furthermore, from the settee they could look out of the window and glimpse changes to the seasons.

It must be added that, among the possessions chosen, I could identify three kinds, which could be recognized in each of the flats. First, there were a few family heirlooms from their childhood home. Examples were a painting, a large grandfather clock and photographs of great-grandparents. Inge connected the ticking sound of a grandfather clock with her childhood, and she could not live without it. But, as hers was broken, she had the original sound replaced by a small old-fashioned alarm clock. A second kind of possession were items recalling the elderly people's marriages. Apart from Inge's carpet, another example was Åse's dog figurines, which reminded her of her late husband's interest in hunting. Thirdly, there were postcards and souvenirs received from children and grandchildren. As compared to their previous home, their few cherished possessions were moved physically closer to them in their new apartments, a rearrangement that allowed them to reach for many of these possessions.⁴¹

dependence upon nursing staff was a new situation and not the result of their gradual bodily impairment.

⁴⁰ These observations of similar layout have been confirmed at seminars for nursing staff. One staff member replied that personal things needed to be within arm's reach of the residents if staff were undertaking the layout for residents without relatives.

⁴¹ Contrary to this overall picture, I interviewed two other residents in wards who had no contact with their relatives. One of these had videocassettes in a large cupboard and her handicraft at the walls. Apart from this there was an armchair, a coffee table and a television set. In interviewing her I had to bring a chair from the aisle outside for me to sit on, as she did obviously not expect visitors.

Possessions re-articulated

The possessions which were of the greatest importance to the elderly people were things like Lise's paintings, Bo's furniture and of course Inge's carpet, all possessions animated with the greatest meaning. Nevertheless, what happened in the nursing home was in most cases that the photographs of children and grandchildren represented the issues that were re-articulated (cf. Parkin 1999). The staff, as Lise expressed it, "*Do not have a feeling for the paintings*". If the elderly people's remaining possessions were not ultimately talked about with the staff, then they only mattered to the former. Moreover, their cherished possessions did not become part of the residents' history and thus played no part in their social activities, such as conversations between the staff and the residents. That is this part of their personal identity that these items represented received no prominence. In addition, the staff saw relatives and grandchildren when they paid visits, which made them and their pictures in the flats an obvious theme for brief conversations.

In the elderly people's new flats, it seemed as if family members were looking down on them due to the way their pictures were arranged in the most prominent places, on bookcases or on shelves. There were portraits, marriage photos, and photos of children and grandchildren and their families on holiday. These reminded the elderly people of the family and of places they had once visited, recalling individuals and past relationships. Following Parkin (1999), some of these private photos took the place of interpersonal relations that were no longer there.

Inge's arrangement of the photographs above her bed was different from that of the other elderly people. The photographs hung symmetrically on the wall (see the illustration below), just above her head when she was in bed. Her mother's portrait was placed at the centre of the arrangement, due to which it was the last thing she saw before going to sleep. Surrounding this portrait were her ancestors, and the arrangement resembled an illustrated pedigree. She was not afraid of dying and hoped for a death like that of her mother, who passed away quietly in her sleep. Provided she died the same way, this portrait would be the last thing she saw in her life.



(Inge`s photographs)

Except for the way in which Inge and Anders decorated their walls, the density of decoration in the previous homes did not accompany them into the nursing home. Compared to their own homes, their new flats were sparsely decorated. This was due both to the limited number of possessions allowed and the newly painted white walls. Apart from Inge, the other residents were informed that carpets were undesirable and this lack of carpets further underlined this impression. Furthermore, the aesthetic clash between their elderly furniture and the new facilities became even more conspicuous in the nursing home, since facilities like lifts and alarms tended to dominate the scene and thus underlined the impression of the nursing home as a place of care work.



(Lise in her flat at the nursing home)

For the first half-year in the nursing home, the walls were decorated with only a few items. Gilroy and Kellett (2005) suggest that the arrangement of pictures and objects of special significance frames the way visitors see the residents, and that the objects on display provide an autobiography, a history of the self. In addition, for the elderly people, I would argue, their relatives jointly edited this presentation. Again, using the analogy of the museum, this could be seen as the final exhibition of what used to mean most to them in their lives, now represented by their chosen and most cherished possessions.

This editorial role of the relatives in arranging the layout of the flat did not represent an explicit conflict. However, the elderly people were in a position in which they felt obliged to accept certain arrangements. Dorte, who was confined to her bed, for example, laughed when she said that her daughters had to accept an obligation to clean, as they wanted all her figurines placed in her new apartment. Dorte's explanation was that her daughters wanted her flat in the nursing home to look like their previous home. This reinforces the impression, discussed in Chapter 2 that the

elderly people seemed to hand over aspects of their social lives and homes to their relatives and thus lost control of them.

The Institutional Home

I have argued that the homes of the elderly people were pre-institutionalised, as they were also appropriated and made into places of work by the home care assistants (cf. Casey 1996, 2003). In the nursing home, the situation was rather one of institutionalisation. The nursing home was dominated by the staff's working practices and thus their way of appropriating and making the place into a place of work, as I shall illustrate below. One aspect of this was that privacy and control of space were reduced even further. Based on the definition of home in the Nordic context, I therefore argue that it is illusory to define a flat in a nursing home as a home. Higgins (1989) argues more forcefully that in reality the ideal of providing a homely setting is a genteel façade behind which it is the institutional patterns of a nursing home, not the domestic ones that persist. The elderly themselves were only able to appropriate the place as a home to a very limited degree.

In the nursing home, the daily visits from staff amounted to more than ten daily visits, whereas at home they received between two and five daily visits from service providers. As was the case at home, the service providers had a key of their own and just opened the door on arrival and called out that they were now present. In the nursing home, the staff usually knocked at the door, but they did not wait for an answer, but entered right away (cf. Buus 2001). On rare occasions they found that a resident had locked the door. Staff would then in most cases just call out to their colleagues, asking: "*Who has got the [master] key?*" This key was always at hand, and the staff opened the door immediately in such cases. To ease their work further and enable them to enter and leave without hindrance, staff left the doors to the individual flats open, especially when assisting the residents with their morning toilet. Admittedly this is also an expression of care as the key allows staff to provide immediate assistance, but in using it they were more likely to leave open residents' private flats.

One staff member finished her description of the resident's flats by saying "*and the bathroom is ours*". Washing residents who were very unsteady on their feet implied using certain facilities. In addition, as this was a place of work, the cleaning materials had to be of a certain quality and a special brand according to nursing home regulations. This implied that control over this personal choice was restricted as well. On a later occasion I confronted this member of staff with her utterance. She thought for a minute and concluded: "*As long as I don't forget any facilities in their flats...I believe that it is still their home*". The bathroom, as a very private room in the home (cf. Gullestad 1992), increasingly became one of the most public rooms in the nursing homes, in which personal territory and dignity were frequently invaded (cf. Higgins 1989).

During weekends, the number of staff on duty were lower than on weekdays. Arne experienced his new surroundings as influencing his perception of himself. Where he had lived before, his neighbours, and especially his daughter, who lived close by, paid regular visits at weekends. Concerning the nursing home, he said: "*This place is completely lifeless at weekends.*" Arne also underlined the fact that the institutional surroundings differed substantially from those in his previous home and constantly reminded him of where he was now a resident and identified as such, as there were several doors, a lift and landings from his flat to the entrance of the nursing home. He mentioned this while comparing it with his former home, where he just needed to descend the staircase and walk out the front door. The meaning was that the doors of the other residents reminded him that he was a nursing home resident. He also talked about "*civilians*" visiting the nursing home at lunch times, that is, elderly people living in the community who had lunch with acquaintances in the café at Sølund. He stressed the aspect of no longer being identified with his previous neighbours, being "*uniformed*" like a nursing home resident.

Ways of Socialising

The ways in which the elderly people could socialize with their relatives also changed. As mentioned in Chapter 2, the coffee table indicated that the elderly people were waiting for their relatives to come by and have coffee. When they commented on the layout of the flats in the nursing home, they stressed that they preferred this

possibility still to be an option. Therefore, they indeed appreciated the kitchenettes in the flats. According to Reddy (1998), serving coffee is a necessity in welcoming visitors in Denmark (see also Jenkins 1999).

Although the elderly people may not have invited visitors to stay overnight while they were still living at home, in the nursing home they commented on this as a possibility that had now been lost. What was lost was additionally the choice of how to socialize in the flat. Although they might not have used more than two rooms in their former home, they were now confined to staying in just one room and undertaking all social activities there. Löfgren (2003) shows how children are brought up with an idea of which activities are likely to take place in which rooms in the home. Along these lines, the elderly people often perceived it as inappropriate to have visitors at their bedsides when relatives paid visits, as the bed and coffee table were in the one-room flat.⁴²

Anders and Jørgen had the largest flats of all the elderly people in this study. Anders also had room for a dining-room suite. However, he did not eat there because he followed the staff's invitation to eat with his fellow residents in the dining room.

⁴² Miller has likewise discussed the aspect of people feeling haunted by the sense that their flat belonged to the state and not to themselves (Miller 2001). In the following chapter and chapter 5 I will return briefly to this aspect of how place is also determined by what Casey (1996, 2003) defines as forces of spatialization i.e. expectations towards a particular behaviour.



(Anders` living room at home)



(Part of Anders` flat at the nursing home)

In Bo's ward, one of the elderly women had turned eighty. She wanted to celebrate this with her relatives, but there was no room in the ward for the approximately twenty relatives she wanted to invite. If the birthday was to be celebrated in the ward, she needed to cut down the number of relatives to be invited, "*as this dining room was also their dining room*", as one staff member put it, referring to the other residents on the ward.

These examples indicate that the possibilities for socializing with relatives became limited when the elderly became nursing home residents. In other words, the institutional layout did not invite relatives to the same extent as did their previous homes.

The relatives played a significant role in the dissolution of the homes, as they mainly undertook these duties. As the elderly became residents, their relatives almost disappeared from the elderly people's lives. That is, the elderly experienced visits from relatives as becoming rarer compared to when they lived at home. There are two reasons for this. One is that for the relatives it was an exhausting process to convince and move one's elderly relative into nursing care, and they were now relieved that others had taken over the responsibility. Secondly, the person they knew often changed considerably, and with it the relationship (cf. Whitaker 2004).

Conclusion

At this second phase of the transition, the elderly prospective residents had to dissolve a part of themselves, as they had to end their relationships with the majority of their possessions. A few could be accommodated among relatives and in their flat in the nursing home, but the majority had to be deprived of meaning, thus enabling the elderly people to dispose of them. Giving things away was to some extent a pleasant experience for the elderly. The possessions that were not dumped were condensed with meaning. But in the nursing home this meaning was most often not rearticulated and thus did not become the basis of a conversation between staff and residents. In this way the dissolution adds to the process of the phasing out of the elderly person's identity.

Due to the assessment for home-care assistance and for nursing care, essential aspects of home-making changed. At this stage the home care assistants gradually started to appropriate and transform the elderly people's homes into places of work (cf. Casey 1996, 2003), a process that was intensified in the nursing home, where the regulations also replicated those for a place of work.

I used Douglas's (1991) definition of home, applied to the Nordic context, to stress that control over time and space vanished and thus reduced privacy. Furthermore, through their physical disability, the elderly increasingly lost the ability to appropriate the flat and transform it into a home. This again underlines their limited agency and their inability to influence the home as part of their identity, showing that some of their intentions depended upon the acceptance by others to be carried out. This also poses the question of how we can come to terms with a definition of home at the nursing home that illustrates and deepens the situation for the elderly people. This aspect ought to be taken into account in the self-descriptions provided by the nursing homes.

As such, it is misleading to define a flat in a nursing home as a home. According to Parkin (1999), the elderly people's possessions needed to be re-articulated and even re-created, thus providing the basis for them to tell stories of their lives, that is, to represent themselves as persons with an identity and thereby gradually appropriate the flat.

In the first two chapters, I added some details to the ways in which the elderly people managed these first two phases of the transition. As I have mentioned, with two exceptions the elderly found the waiting time stressful at home in respect of the relationships with the home care assistants. Apart from Anders, who was moreover able to control the dissolution of his home by himself, the others also perceived this part of the process as stressful. This seemed mainly due to their physical inability to undertake any of this by themselves. The dissolution of their homes was a dissolution of themselves and this was a process over which they had partly lost control.



(Inge at the nursing home with her red carpet)

Inge continued to talk about her husband, and she appreciated having at least part of her red carpet, as, according to herself and her niece, it still invoked memories for her on New Year's Eve, as well as in her everyday life in the nursing home.



(Inge after six months at the nursing home)



(Anders at the nursing home)

4. Becoming “a Good Nursing Home Resident”

Introduction

Hans and Anna, an elderly married couple from Copenhagen, enrolled in nursing care in May 2005. Hans described their expectations of life as nursing home residents in humble terms: “*I think, well... we do not expect anything as long as they treat us properly*”. As new residents they indeed appreciated life as nursing home residents, and Hans described Sølund as “*probably the best nursing home in Copenhagen*”. However, within one month their appreciation had turned into disappointment. They began to find members of staff reluctant to answer their calls for assistance.



(Hans and Anna at home)

By again applying a relatedness perspective (Carsten 2000) in this chapter, I shall argue that Hans and Anna’s disappointment was caused by their unwillingness to establish a mutual relationship with the staff. Hans and Anna’s expectations were directed towards the ideal practice of the nursing home, and their expectations would have been fulfilled if the presentations in the leaflets could have been believed. However, these intentions regarding ideal care practice were achieved through social

relations that were often characterized by mutual obligations, and Hans and Anna only acknowledged this at the end of the transition. Most of the new residents acknowledged this and used their relations with their contact persons to influence nursing home practice in a battle with the other residents to gain attention for themselves. The word 'becoming' in the title of this chapter thus refers to their becoming aware of this situation and accepting it and adapting to nursing home practice. I see this acceptance and adaptation as a way in which the new residents used their limited agency to influence the care and made their present situation endurable (cf. Jackson 2005). The pre-institutionalised homes of the elderly people had been integrated parts of themselves, and through the necessity for home care, they were also gradually made into a place of work over which they had partly lost control, as I have already shown. The nursing homes were places of work, as staff's working practices appropriated and dominated them (cf. Casey 1996, 2003). By adapting to daily practice, this also became a bodily experience and an integrated part of their identity.

To illustrate this, I will use Hans and Anna as examples, supplemented by the other sixteen new residents in this study, to show how they tried to establish and maintain these relationships differently. At this third phase of the transition the vast majority of these new residents succeeded in establishing a relationship with their contact person. In which the bureaucratic regulations and the institutional mode of thought (cf. Douglas 1987) of the nursing home were set aside, with empathy and individuality becoming the core elements of the care. I.e they mostly succeeded in negotiating the stigma of being bodies in need to their advantage. During the six months residents strove and indeed had a genuine wish to create a personal relationship characterized by exclusiveness and intimacy with their contact person. Staff also partly shared this wish, but at times they made the relationship a professional one and treated the residents according to bureaucratic regulations as bodies in need. From the Maussian gift-economy perspective, residents could only enter such relationships through an exchange in which they could hope for their gifts to be returned (cf. Godbout 1998). The staff, on the other hand, had two options: they could engage in this exchange or cling to bureaucratic regulations in which residents were treated according to their bodily needs. What is more, these relationships were fragile due to the staff turnover,

and they only existed, were maintained and developed in so far as the parties behaved according to mutual expectations. In addition, it was the members of staff who had the upper hand. They possessed the power to define relationships and to end them. For their part, residents were unable to choose among the members of staff they preferred as their contact person.

In the present analysis I will refer mainly to Goffman's (1961) discussions of total institutions, as it is necessary to take his perspective on the institutional context of the mutual relations into account to understand better the way they developed in this third phase of the transition. For instance, residents had to relate to other staff members besides their contact person.

Danish nursing homes are entitled to have a Relations Council (*Bruger-pårørenderåd*) to provide residents with an opportunity to discuss the quality of care. These are supposed to discuss matters of general care, protect the interests of the elderly and inform working relations between staff, residents and relatives (Farum Kommune 2004). However, none of the residents I followed mentioned this during the study, and I presume that they did not claim their rights through these channels.

The move into a nursing home generally enabled the new residents to increase their bodily movements, whereby they could perceive and engage with an increased proportion of their surroundings (cf. Merleau-Ponty 1994) as the distance from some of these became surmountable. For instance, the physical layout of Bakkegården enabled Lise to enter the toilet unassisted, and she could likewise attend the rehabilitation centre and the café, albeit slowly. Consequently the physical layout of the nursing homes made the residents less dependent upon assistance, as it enabled them to undertake some activities themselves and also to appropriate some parts of the place. I will discuss this further in Chapter 6.

The Institutional Context

Before I discuss Goffman's concept of a total institution, I will add a further description of the nursing homes to demonstrate better the context of the following analysis and briefly indicate how staff and residents walk and act in the nursing homes differently and thus appropriated the place differently.

Bakkegården, a traditional nursing home, hosts a café at the entrance which residents and elderly people living in the community can visit. The corridor leads on to one of the nursing home wards. On the way one passes two doors which open automatically, and just to the left there is a long corridor, which is one of the nursing home wards. As compared to the talking and activities in the café, the ward was quiet. Observing staff's and residents' encounters in these areas, staff's greetings were brief. I often saw them greet residents they knew, but they did not stop to exchange a few words but kept on walking, thus indicating to the resident that they had important duties to undertake which they were unable to postpone by casually stopping. Right at the entrance to a ward, one member of staff was talking to a resident about her duvet. She had received the wrong one from the laundry service, she claimed, but she was uncertain what her duvet looked like. She described how it felt and explained that she had inherited it from her mother. Nevertheless, the member of staff handling the laundry seemed even more confused by this information, and it was evident that the name tag, which had to be added to all the new residents' clothes, had become separated from the duvet.

By coincidence I had to walk behind another resident with his zimmer frame, and I found the slowness of the motion remarkable. Walking from the café to the end of the ward would take less than three minutes for me, whereas this resident in front of me took approximately ten minutes to cover the same distance. A staff member coming from behind was not as patient as I was and quickly overtook us.

It was also noticeable that the residents who had a zimmer frame in most cases walked around with the same items in the small basket attached to the frame, such as glasses or a magnifying glass, a mostly blank calendar, i.e. without appointments, and finally their medical insurance card. This card was kept handy, as all the residents had prescriptions and staff asked for their cards whenever they needed to contact their general practitioner or the pharmacy. The glasses enabled the residents to read a paper or the menu in the café, for instance.

Next to the door opening on to the corridor, there was a list with the names of all the residents on the ward, and next to their names the numbers of their flats. I am fairly tall (1.88 metres) and the list was placed where I could read it. Most of the residents

either walked with a zimmer frame or were confined to a wheelchair, and from that position the list, as well as other notices on the notice board, were placed too high and therefore difficult to see. The slow motion allowed me to observe that most residents were watching the same TV programme in the morning after being helped out of bed.

This particular morning one resident was continually walking up and down the corridor. There was a distinct smell of urine about her. She looked at me as she passed, but it was as though she did not see me. This smell became more persistent as she approached, and disappeared as she walked down the corridor. Later the cleaning assistant and her cleaning of the floors replaced the smell of urine, and at around 11.30 a.m. the smells of lunch came from the kitchen from onions being cut into slices and bacon being fried.

There were rush hours in the nursing homes, interspersed with long periods when things were very quiet which residents had to adopt to. In the early morning at around seven, the staff met and discussed the day's programme in the dining room. Later in the morning, it became quite busy when the staff assisted the residents with their morning toilet and breakfast. Thereafter the wards became quiet again, as the staff had their breaks. Lunch was the peak period of the day, but the next two hours were quiet again, as the residents had their after-dinner naps. New members of staff arrived in the afternoon, and after the afternoon coffee, it was quiet again. Both in the mornings and afternoons staff assisted residents with activities and to visit the rehabilitation centre. Dinner was also quiet, and after dinner most of the residents returned to their own flats. During weekdays these rush hours were evident, but at weekends residents and relatives to a larger extent dominated the appropriation of the nursing home.

Nursing Homes as Total Institutions

Goffman (1961) argues that nursing homes are total institutions that accommodate elderly people who are "*aged [and] both incapable and harmless*" (ibid.: 4). His essential argument is that these total institutions strongly influence the residents' perceptions of self and that relationships between residents and staff are characterized by mutual hostility between the two groups because the staff embody the institutional rules and aims, thus adversely affecting the residents' selves (ibid.:14). Below I will elaborate upon the way in which Goffman defines total institutions and their

characteristics, as his perspective on them has been seminal for major parts of the literature on nursing homes (Reed and Payton 1996a and 1996b). Thereafter I will criticize Goffman's concept by discussing some of the nursing home literature.

As I have already indicated, the elderly people enrolled in nursing care were unable to take proper care of themselves, even when they received extensive home-care assistance: They therefore needed to be cared for in institutions (cf. Paterniti 2003). Goffman's use of the institutional concept is confined to an analysis of the social practice in institutions. He defines "*A total institution...as a place of residence and work where a large number of like-situated individuals, cut off from the wider society...together lead an enclosed, formally administered round of life*" (Goffman 1961: xiii). These institutions have encompassing tendencies, as institutions provide "*something of a world for them [with] barriers to social intercourse with the outside...*" (ibid.: 6). All aspects of life are carried out in this world, and activities are tightly scheduled (ibid.). Being a resident has its consequences for residents' selves, as "*the individual has to engage in activity whose symbolic implications are incompatible with his conception of self*" (ibid.: 23). In line with my argument in Chapter 1, one consequence of these schedules for social activities is that opportunities for expressing identities become limited in this type of institution. Goffman's choice of words to describe this consequence is a little more dramatic: "*The processes by which a person's self is mortified are fairly standard in total institutions*" (ibid.: 14).

Concerning relationships within total institutions, distinctions between inmates (residents in this case) and staff are continually developing. Goffman states: "*There is a basic split between a large managed group and...a small supervisory staff*" (ibid.: 7). One of the main results of the activities of total institutions is that two different cultural and social worlds emerge, based on the distinction between staff and residents. This implies that a difference is maintained between two types of people within the institution. Goffman argues that "*Each grouping tends to conceive of the other in terms of narrow hostile stereotypes*" (ibid.: 7). What is more, there is a high degree of anonymity between staff and residents because they have not chosen each other. Communication between the two groups is restricted, as is "*The passage of information, especially information about the staff's plans for inmates*" (ibid.: 9).

Douglas (1987) further assists my understanding of staff's attitudes as a mode of thought they share by having beliefs, values and categories in common. These again sustain the pattern of interaction in such institutions and basically agreements about how residents ought to behave and develop. I will argue that although individual staff members basically agree upon a mode of thought, the mutual relations they establish with the residents indicated that they also interpret these modes of thought in their own way.

From Goffman's descriptions of the ways in which relationships develop within such institutions, it appears that these consist more or less of a game of roles, positions and possibilities of presenting oneself as a person in one's own right, as well as a continuous struggle against the influence of the institution upon the self (see also Jacobsen 2006 for a discussion of this aspect from a different context). According to Goffman, the preconditions for establishing mutual relationships between staff and residents seem very limited in total institutions. One reaction to this practice is that residents apply different lines of adaptation in opportunistic combinations that allow them to "*have a maximum chance... of eventually getting out physically and psychologically undamaged*" (1961: 64-5). Although nursing home residents are residents until the end of their lives, Goffman's definitions of strategies supplement my understanding of the reactions of the residents in this study. He defines four lines of adaptation: "*Situational withdrawal*" (ibid.: 61) represents regression, where the resident "*withdraws apparent attention from everything except events immediately around his body*" (ibid.). The "*intransigent line*" (ibid.: 62) represents protest against the practice of the institution, while "*conversion*" (ibid.: 63) is the acceptance of the practice of the institution. "*Colonization*" represents the residents who are relatively content with never thriving very well in the institution (ibid.). I will return to these at the end of the analysis, as I found the "*conversion*" and the "*intransigent*" approaches applicable, where the former generally represents the good residents and the latter generally the opposite.

Goffman's analysis of mental hospitals was published in the late 1950s and early 1960s. His works have been, and still are, invoked in the analysis of different types of institution. Since their publication they have come in for a good deal of criticism

(Reed 1996a). For example, it has been suggested that institutional residents lack a history and act according to the rules of the social game only (Jacobsen 2006), a position which leaves aside individuals' ad hoc improvisations and the unpredictable aspects of social life (Jenkins 1996). For the nursing home residents, parts of their history were represented by, for example, Inge's carpet. As I have shown, their history is adopted to fit the institutional layout and mostly not articulated as a part of their personal identity in the conversations between staff and residents.

Other researchers have argued that Goffman's account is insufficient in relating to how the types of total institution he describes can be compared (Davis 2006).

Stokholm (2006) argues that since the 1950s the authority of staff over inmates has been reduced in Danish institutions. Nevertheless, I find basic elements of Goffman's definitions useful concerning the strategies adopted by nursing home residents in the face of the institutional practices they experienced, even though he developed his concept in relation to a mental hospital, which is a different context.

An important part of the nursing home context is the number of residents suffering from dementia, which makes these institutions differ from the mental hospitals. These residents were mostly unable to negotiate a position in a relation to staff, as they were mainly unable to identify who they were and often also where they were. Goffman's argument that relations between staff and residents are perceived in terms of narrow hostile stereotypes is, however, insufficient to provide an understanding of the nursing home context. Below I will briefly support this argument by discussing some of the nursing home literature.

The nursing home Literature

In the literature on nursing homes, there has been a tendency to follow primarily Goffman (1961) and Townsend (1964). These works inspired a range of research on institutional care as a form of provision which is inherently depersonalizing, reducing residents' identity to the status of merely passive recipients of care in the 1960s and 1970s (Reed 1996a). Townsend states that the different types of elderly people's homes in the early 1960s (in England and Wales) were unsuitable as a way of meeting the needs of elderly people. Based on a large survey he argues, in line with Goffman, that a resident "*receives an initial shock which causes him to adjust quickly to a new*

level of behaviour and to adopt certain new attitudes,” [which] “*do not change drastically thereafter*” (Townsend (1964: 189).⁴³

Goffman’s and Townsend’s perspectives have been challenged with reference to relations between residents and the influence of residents upon daily practice in these institutions. A series of ethnographic works have looked closely at these aspects. Among these are Ross (1977), Myerhoff (1979), Jerome (1992), Foner (1995) and Paterniti (2003), who, among other things, oppose the idea of institutions having a uniform process strongly limiting the way in which residents can establish themselves as persons and their ability to influence institutional practice. In these works, residents actively appropriate parts of the nursing home through their response to institutional practice, and their acceptance or resistance to care activities may actually change some daily institutional practices and the meaning attached to them.

Ross (1977) and Myerhoff (1979) discuss relations among elderly people in institutions. For instance, Ross argues that major aspects of social life in a French retirement home reflect opposition and disputes between communist and non-communist groups of elderly people. The seating in the dining room marks attachment to one of these groups, which further represents the person’s position in the community. The seating is very difficult to alter once a resident is seated. It would involve a change in the person’s position within one of the two opposing groups, which Ross considers nearly impossible (Ross 1977).

Writing about a home for the elderly in the USA, Myerhoff discusses what she calls “*bench behaviour*” (1977: 4), where groups of men and women discuss different topics in a vivid and highly stylized manner. Men discuss politics, religion and economics, whereas women discuss children, food and health. On these occasions, factions are formed and dissolved, thus making the home a centre for protracted village life and very important daily social events. These examples also indicate that the formation of social relations is an important part of life for residents in institutions

⁴³ Similar positions have been put forward by Robb (1967, in Reed 1996a), who describes the disempowered nurses who are forced to perpetuate depersonalized and highly institutionalised care regimes. Evers (1984, in Reed 1996a) describes a care model which reflects the metaphor of the warehouse. Bond et al. (1989, in Reed 1996a) describes care as consisting of routines motivated by the single theme of prolonging the life of the patients.

for the elderly. Dining in the dining room is not just about eating, but a way of demonstrating one's relationships.

Gubrium (1975) also discusses different relationships in nursing home wards. For instance, he indicates that regular visitors from outside are perceived as prestigious as they are a source of news, the ability to spread which is an element in improving and maintaining one's status in the hierarchy among residents. This all indicates that a stress on the mortification of the resident as an analytical perspective (Goffman 1961) is insufficient, as this overlooks some negotiations of personal status (cf. Paterniti 2003).

Goffman's argument that the staff act as a single group towards the residents as another group is also questioned in the literature. A recent example of this is Foner (1995), who discusses two different attitudes among staff towards nursing home residents from her work in a nursing home in New York. She argues that it is the attitude of the individual staff members towards the residents that influences the character of the relationships that are established. That is, staff's individual interpretations of the institutional modes of thought determine such relationships.

With the nursing home literature, I have questioned the applicability of Goffman's total institutions in understanding the relationships between staff and residents, as well as how the former influence the "*enclosed, formally administered round of life*" (Goffman 1961: xiii). With the aim of achieving a better understanding of these relationships, I therefore now turn to the ethnographic material, applying again the relatedness perspective, as it adds to the understanding of the character of the relationships that the literature indicates are established in nursing homes.

The Move to the Nursing Home: The Residents' Perspective

Hans and Anna

Hans and Anna had been married for 45 years and still lived in the street where they once met and fell in love before they enrolled nursing care. Their five-room basement flat had been a porter's lodge and a place of work for Hans. He worked as an inspector of a number of building blocks in the centre of Copenhagen. He had held a

senior position, and his advice was respected. By the age of 88, this position had been abandoned since his retirement more than twenty years ago. Nevertheless, it was hard for him to accept that his advice was now without significance and his loyalty towards his former management no longer appreciated.

He felt that he had lived a good life with his wife and their only son. Parts of his leisure time he had spent taking care of other frail and poor people, among whom he mentioned an elderly, lonely, disabled baroness who lived outside Copenhagen. For several years he decorated her flat a few days before Christmas and recalled that “*her grateful eyes were so rewarding*”. Some years after her death he found a canvas portraying an elderly lady in the waste disposal. He retrieved it and some months later found the missing frame, also in the waste disposal. He restored the painting and gave it a prominent place on the wall, as it reminded him of the baroness and the way he had helped others.



(Portrait of the elderly lady)

Anna was mostly confined to her bed. She was frail and had lost most of her appetite. Despite the home-care assistance, it was very difficult for Hans to assist her and take care of her. Moreover, his sight was failing, and he could hardly read the prescriptions for her medication.

At their son's request, they decided to enrol for nursing care. Hans had recently suffered a stroke, they, and especially their son, experienced the situation as stressful.

In addition, Hans felt that his physical abilities were increasingly diminishing. Apart from his son's persuasions, a further argument for enrolling in nursing care was that those now working in the company should not see his decay increase in the building where he once held an influential position. He liked them to remember him the way he had been before.

Entering a Contract with the Nursing Home

The first binding contact with their future nursing home was the contract defining the details concerning the flat, assistance needs, meal preferences and requirements for other facilities in the nursing home⁴⁴. The prospective residents signed the contracts upon a visit to the prospective resident's home, where a representative from the nursing home, the future contact person in the nursing home ward and often a relative attended. The representative took information from home care into account and paid special attention at these meetings to the medical prescriptions required.

The needs of the prospective resident were regulated at these meetings, and the contract indicates both that the prospective resident could claim certain assistance and that the relationship between new residents and staff starts off from a bureaucratic regulation according to which all residents are treated alike, with equal justice (cf. Foner 1995).

At these meetings, they were transferred from a client assessed for home care assistance into a client category reflecting the possibilities of assistance which the welfare state had at its disposal for nursing home residents (Järvinen and Mik-Meyer 2003: 10),⁴⁵ as well as being treated as bodies in need who had to be managed.

⁴⁴ These meetings were also held at hospitals and at respite care for the prospective residents enrolled from these places.

⁴⁵ The prospective residents experienced a similar process when municipality authorities assessed them for home care. In their pre-institutionalised homes, the prospective residents were used to a care system with limited possibilities of providing individualized assistance. Their life with home care then already resembled certain aspects of Goffman's total institutions (Goffman 1961) as regards the tight schedules and lack of influence upon daily activities as mentioned.

Issues not mentioned in the contract tended to become problematic later, as I observed in the case of Birthe, who decided to postpone her enrolment into nursing care immediately after the meeting, which I describe in part below. Birthe wanted to attend evening class once a week. This raised the question of transport, as well as the numbers of meals to be provided. Concerning the latter, the representative ended the discussion by saying “*for the present you are on full board*”. Birthe also had to discuss transport with staff on the ward upon moving, but it was stressed that this matter was her own responsibility. Similarly, as Järvinen and Mik-Meyer (2003) argue, prospective residents are transformed into residents by the representatives of the welfare state, who continually compare the information given by clients with the categories of problems already defined by the institution and the possible solutions (see also Douglas 1987). Järvinen and Mik-Meyer mention how clients find that institutions pay special attention to some aspects of their personality and intend to improve these, whereas others are neglected (Järvinen and Mik-Meyer 2003). Birthe's interest and need for transport was not a form of assistance that was provided, and therefore it was not mentioned in the nursing home contracts, as all the necessary assistance was provided within the care facilities according to the nursing home representative.

In the nursing homes, as far as solutions to transport arrangements and other practical aspects were concerned, it depended greatly on the particular nursing home staff whether the prospective residents could pursue their individual interests, as indicated in the above meeting. This influence on the part of individual staff members was obviously also reflected here, as the representative ended her description of the daily practice concerning assistance and services in the nursing home by saying that “*We are not always able to provide this level of assistance*”. These meetings and the possible solutions indicated the possibilities of the nursing staff in their relations with the residents. The contracts and the self-descriptions of nursing homes (see below) allowed them to treat residents alike according to bureaucratic regulations. The fact that Birthe's transportation requirements had to be arranged through the staff indicated the possibility of establishing relations and being treated individually.

Expectations of a Life as a Nursing Home Resident

“I expect nothing, as long as they treat us properly.” This was Hans’s immediate reaction to my question about his expectations of the nursing home. In addition, he expected Anna’s physical condition to improve so that he, and hopefully Anna, would be able to walk around the nursing home premises, chat with the other residents and eventually make acquaintances. As already mentioned, the prospect of improving physical abilities was expressed by all prospective residents except Anders. The prospect of making acquaintances was also expressed by all sixteen of them.



(Hans)

Hans's expectations would have been fulfilled if the self-descriptions in the nursing home brochures and information leaflets could have been believed. Typically the prospective residents received two leaflets, for instance, one with the headline; "*Welcome*" and another called "*Advice and information before you move in*" or just "*Service information*". The leaflets described the nursing homes in terms of the latter's visions, ideas and values, and several items of information on apartment layout and regulations were included, along with additional information on service opportunities and the monthly plan of activities.

Although there are two different types of nursing home in this research, the descriptions were very similar concerning the aim of the institutions, which was to provide good care for the residents in the respective leaflets. A frequent sentence in the folders is: "*Our care aims at starting with your resources and not your weaknesses*" (Farum Kommune 2004). The SLE further emphasises the influence of the residents on their daily lives on the ward and their expectations towards their ways of being social: "*You will influence the daily life on the ward*", and later under the headline "*Staff (:)*" "*All staff members are here to care for you and assist you with your needs...*" (Helsingør Kommune 2005b). Concerning training at the rehabilitation centres, it reads: "*If you need rehabilitation to maintain your physical abilities, an individual programme will be designed for you in cooperation with a physiotherapist*" (ibid.). The new residents are told that they will be able to follow their daily routines as they prefer and "*eat breakfast at the time they prefer. Staff and residents dine together at lunch and dinner*" (Farum Kommune 2004). Similarly residents can choose privacy or the company of the other residents as they prefer. In the day-care centre, "*you meet staff and other residents...and when walking the aisles people meet on occasion*" (Helsingør Kommune 2005a: 10).

Empathy and sensitivity concerning residents' needs and preferences, as well as time for listening, are also mentioned in the leaflets. Two nursing homes invite new residents to write down the story of their lives, since "*This allows us to help you in the*

best way in the daily life on the ward” (Helsingør Kommune 2005b: 3).⁴⁶ The brochures further describe the nursing home in terms of visions. For instance, one of the visions at Sølund is to fulfil residents’ needs and preferences regarding having a proper flat, care, practical help, rehabilitation and activity. Residents are to be treated with dignity and respect, and cooperation between staff, residents and relatives is guided by open dialogue between them (Sølund’s Værdigrundlag 1999).

Thus far Hans’s expectations would have been fulfilled. He was used to the home care assistants not always fulfilling self-perceived needs, but given the descriptions above and his undemanding attitude, everything seemed hopeful.

⁴⁶ Residents and their relatives were encouraged to write the former’s life histories for the staff to read. However, if relatives and residents failed to do this, the staff did not remind them and my impression was that, even where they existed, they were very rarely used.



(Anna)

Moving in

Hans's and Anna's son had arranged the interior of the flat before Hans and Anna arrived. I witnessed their arrival on their future ward: as they entered the ward from the lift, they passed the other residents in the dining room. Hans nodded towards the other residents while passing, without receiving any response from them. Anna just passed the tables, walking slowly in small steps. They walked along the corridor to their flat and entered. From this moment they became residents of the nursing home.

Their contact person had mentioned their arrival during the preparations for lunch, which she herself was unable to attend. None of the other staff members present responded to this information, and the staff did not greet Hans and Anna as they entered. The same evening, however, they accepted an invitation to dine with the other residents. They were shown two seats at a table occupied by an elderly woman to whom they were introduced, but they were not introduced to any of the other residents by the staff. However, on the following day their contact person actually introduced herself to them. Introduction to other members of staff and residents was left to their own initiative.

Hans commented on the events of the day with disappointment. However, his disappointment was not due to a lack of any formal introduction ritual on the ward but to the fact that his former management did not give Anna a bunch of flowers when they moved out of their previous home. Staff and fellow residents would then have seen that his work had been recognized and that he had been influential and held a senior position. In other words, Hans wanted his former position to be part of the narrative that was to be created about him in the nursing home. Hans wanted to present himself in a particular way to the other residents and staff, but was prevented from doing so due to a lack of politeness on the part of his former employer. He intended to present himself as a person with social status, not as a body in need of extensive care.

Despite this initial disappointment, Hans and Anna expressed themselves very positively towards the staff and their flat in the nursing home at the first interview. When I arrived they were in their flat, with the door open, and during the interview one of the staff members entered with information concerning Anna's medication. She accepted some sweets from the bowl on the table. These were for the staff, a sort of perpetual invitation along with a bottle of port accompanied by glasses.

Hans felt it was a great relief that there were now staff to assist Anna. Her medication was taken care of and food was prepared for both of them in the dining room. With the open door and staff passing just outside, they were able to hear Hans as he said with confidence, "*This is probably the best nursing home in Copenhagen*". The relief and gratitude Hans felt was shared among the other fourteen new residents in this

study, who were relieved at not being alone any more and grateful for the assistance being provided to them.

Hans and Anna intended to establish a relationship with the staff. The open invitation to sweets and port invited the staff to pass by and listen to the stories of their lives. I suggest sweets and port could be seen as a gift, and Hans and Anna hoped for this gift to be returned by staff's interest in their stories (cf. Godbout 1998). The story did not start with a bunch of flowers, but Hans and Anna nonetheless intended to tell it again.

Expectations of Staff: Time

The residents were each allocated a contact person from among the staff as the person who would take most care of the resident. The expectations that residents had of the staff were mainly directed towards this person, with whom the former tried to create a mutual relationship. Hans and Anna soon realised that there were no other residents on the ward with whom they could become acquainted. As this was the case for the majority of the new residents in this study, the contact person and other members of staff provided the only opportunities for residents to establish relationships.⁴⁷

Among the residents, there were different expectations regarding the sort of attention the staff paid to them. Mogens, a resident on Anders's ward, whom I found gave the most precise description of residents' expectations, described how a male member of staff ought to behave towards him: "*He must be helpful and quick. Additionally he must live and feel with the man and understand his pains, and his assistance must be based upon this understanding*". I will elaborate and discuss these expectations in two parts.

First a staff member who is "*helpful and quick*" did not leave a resident waiting a long time for assistance. This included residents expecting staff to be aware of the proper

⁴⁷ Although the new residents expected to find equals among the other residents, this did not happen. Part of the explanation is the large percentage of people suffering from dementia. Another reason is that this was not a part of staff's expectations towards residents. As Inge replied, when I repeatedly asked her why she did not pay her neighbour a visit: "*This is not a custom in this place*" (see also Reed and Payton 1996b for similar observations).

treatment of their illnesses. The treatment of wounds, the correct medication and additional knowledge of the different types of medicine were appreciated.⁴⁸ If one of the residents was to be treated in hospital or just needed a regular check up on the progress of their illnesses, their fear of this treatment was an issue they also expected staff to take into account. I often observed how residents would inquire several times whether transport had been arranged and confirmed for a visit to the hospital, and a polite answer like *“It has been properly taken care of”* was indeed appreciated several times.

The importance of being quick was another crucial issue. Waiting often occurred, and this was perceived as humiliating, as illustrated by the following interview with Dorte. I also use Dorte to illustrate Foner’s argument that the choice of attitude of the individual staff member towards the resident influenced the character of the care, as well as of the relationships that were established. That is, the bureaucratic attitude was felt humiliating, whereas the individual approach was appreciated.

Dorte was suffering from a unilateral paresis caused by a cerebrovascular event. She was the interview person in this study who had been most deprived of her physical abilities, as she was only able to move her right arm. Furthermore she could only sit in a chair for an hour at the most, due to the poor condition of her back. The majority of her time was therefore spent in bed.

For the first two weeks after being discharged from hospital, she was admitted to respite care, her permanent flat being on another ward. On this ward, she found it difficult to accustom herself to the way the staff wanted her to carry out her morning toilet. She said: *“Yes, they had bedpans”* (at the respite care). *“And, well, I got used to it and I found it very comfortable. Then I got the largest shock, when I arrived here – they had no bedpans”*. Commenting on this situation, she said: *“This thing about the toilet was hard for me to accept”*. Here she was lifted on to the toilet and left there for approximately ten minutes, while staff assisted other residents. She found it uncomfortable, as *“it hurts my back, sitting like that for so long”*. She was then lifted

⁴⁸ The MDS assessments indicate that the residents in this research were being treated with up to ten different medicines every day, and some of them several times a day. Therefore medication was a major issue in staff’s daily contact with residents.

into the chair in front of the sink and left once again after being encouraged to wash. Afterwards she had to wait until the assistant came back to help brush her set of dentures. Finally, she was lifted back into bed. She felt that she had to accustom herself to a different set of routines and also felt reduced to an item (a body in need) on a production line. According to Foner (1995), this way of treating residents satisfies bureaucratic rules, according to which residents are treated alike, impartially and impersonally. I will elaborate further on how Dorte felt about this kind of assistance.

I asked her to elaborate on the time she spent waiting on the toilet, which she felt humiliating:

“Then it feels as if it takes ages. I have had to get used to waiting.”

Q: But Dorte, what do you think about sitting out there [on the toilet] and calling, and then no one comes to assist you?

“Well... yes, do you know what: It’s something I have stopped thinking about”.

Q: Well, yes. But to me it sounds as though it is humiliating in a way to be sitting there unable to do anything but wait.

“Yes, it is.”

Q: But it is as though you tell me that you’ve stopped thinking about it, and that complaints would be a waste of time?

“Yes, it is hard to reach that point...when you have been able to manage on your own for 91 years.”

Q: That's true, you are 91 years old.

“In addition, I have myself decided etc. etc. and then,... all of a sudden, other people make the decisions.”

Q: I see.

We continued the conversation focusing on the ward where her permanent flat was:

“Yes, well it’s obvious here that this ward, although they all [staff members] make a serious effort, it’s not a life worth living.”

Q: It’s not a life worth living? In what way do you mean?

“In the way that you just sit here...and you are assisted from one place to the next.”

Q: Well, I think I understand what you mean, but what does it take to make a life at this place?

“That I can do something on my own initiative.”

A basic characteristic of the good staff member was not to keep residents waiting a long time, as Dorte experienced, and which she felt humiliating.⁴⁹ Residents also expected their contact person to prioritise their needs, even though high staff turnovers, understaffing and frequent meetings often forced staff to choose between residents’ needs. In other words, they preferred a personal relationship similar to that which Ritta and Helga had created with their home care assistants, in which they had additional home care provided which met their self-perceived needs, apart from those they had been assessed for. In a similar manner, when they became nursing home residents, they preferred staff not to stick to the rules and what was written in the contract, but to be flexible and to take their individuality into account in caring for them (cf. Foner 1995).

⁴⁹ Goffman comments on the aspect of waiting time and dependency in some detail: “...ways in which one’s economy of action can be disrupted in the obligation to request permission ... for minor activities ..., such as...going to the toilet...” (Goffman 1961: 41). He continues “This obligation not only puts the individual in a submissive or suppliant role ‘unnatural’ for an adult but also opens up his line of action to interception by staff” (ibid.).

I have indicated that staff selected the attitude they would adopt towards residents and that this attitude was decisive for the kind of relationship they established with them. But it is not a question of whether it is the one or the other. As Lipsky (2003) argues, staff working with individual human issues “*Have discretion because the accepted definitions of their tasks call for sensitive observation and judgement, which are not reducible to programmed formats*” (ibid.: 507). Applied to the nursing home context, Lipsky’s position emphasises that to a certain extent staff treat residents with respect to their individuality by means of their mutual relations with them. They embodied the institutional intentions differently, as care was accomplished in social relations.

Expectations of Staff: Empathy and Respect

The second aspect of Mogens’ expectations emphasised staff’s discretion, that he: “*Feels with the man and understands his pains*”. This implied a genuine interest in the resident and attention being paid to the resident’s individual needs and preferences. Residents expected a lasting interest in their own persons and previous social status, as indicated by the missing bunch of flowers. Staff should also know the resident’s needs and preferences, so that there was no need to explain them over and over again. In other words, showing genuine mutual interest in each other seemed to be very basic in residents’ expectations of staff, for example, knowing the details of their previous lives, and they expected staff to take an interest in family events that had taken place.

At mealtimes too, residents expected staff not to put them in positions or ask them to do things they were unable to do because of their restricted abilities. They wanted to avoid the exposure of frailty in the presence of the other residents. Additionally, residents expected staff to make sure that activities at the rehabilitation centres had been arranged, i.e. as soon as the new residents had entered the care facilities, they expected staff to arrange a scheduled training programme for them at a rehabilitation centre.

The appearance of residents in the dining room was also a matter in the hands of the staff. Most women residents paid close attention to their hairstyle and dressing and expected staff to assist them in this matter before taking them to the dining room

where the other residents were waiting. In Goffman's (1971) terms, residents expected staff to assist them to get ready for their front-stage appearance outside their private flats. Backstage, in their flats, they expected their intimate needs to be cared for and talked about. (I will elaborate further on this aspect in the next chapter.)

Expectations of Residents: The Staff's Perspective

One staff member, referring to Oda, described how "*she had become good in the way that she took part in the activities...*", thus living up to the staff member's expectations about being a good resident and thereby adopting to the institutional practice. Other residents did not wish to accept the role assigned to them by the staff and were consequently not favoured, since, for instance, they used the nursing home like "*too much of a hotel...*" I will elaborate on this aspect later, but below I shall analyse how becoming "good" implied residents empathising with the staff and acknowledging their work as important.

When staff described the 'good resident', this was, broadly speaking, a reference to those who had initiated and accepted close contact with the staff in their flats. They also made a great effort to use their own resources and improve their physical abilities by engaging in rehabilitation activities. In addition, they should accept that at times staff were unable to provide this level of contact and proper care. Accepting this implied that they paid close attention to the stress levels of the staff and refrained from calling for assistance when they knew that the staff were busy or that a meeting was imminent. That is, the good resident had empathy with the staff.⁵⁰ Kydd (2006) presents similar findings from a study of a hospital ward providing long-term care for elderly patients. The ward was about to close down, and she argues that the main area of stress was the moods of staff, which the patients constantly needed to take into account when they called for assistance.

⁵⁰ Relatives were faced with similar expectations. The good ones came on a regular basis, understood the staff's working conditions and did not complain. Those who, on the contrary, did not live up to these expectations were those who only visited on rare occasions and complained extensively.

The “*Good Resident*” was also characterised by a certain sociability: “*It is my duty to convince her that she should eat with the others...but only if it is her need.*” Other quotes along these lines indicated that staff preferred talkative residents to attend the dining table. However, the argument was somehow different: “*It is unhealthy to be alone in the flat, as they get too lonesome*”.

Contact

In respect of contact, members of staff seemed to agree that the residents should be willing to talk about their inner feelings when staff were ready to listen. However, residents needed to take the initiative: “*If residents want to talk, then I am willing to listen*”, said one staff member.

When staff were ready and residents opened up to them, mutual confidence and thus contact were created. As Janni mentioned about Dorte, “*She is sweet and she is honest...and she tells me everything*”. With residents’ confidence, staff then used the contact to “*Open up to the stories they like to tell me*”. This level of contact was needed in order to undertake proper care: “*Care means obtaining their confidence, revealing their personal needs and spending time talking with them*”. Daily talking was also needed, as it allowed the staff to discover what was bothering the residents. Just listening was also often defined as a way of “*Taking proper care of them*”.

Through knowing their needs, it became possible to assist residents in a proper manner, and the importance of the work of the staff could be confirmed. Janni said: “*When I am working, then it has been a good day, because now I have done a little for them the way I wanted to and the way they preferred me to assist them*”. Another staff member said, about visiting a resident in her flat: “*Now I have helped somebody, and it is indeed a pleasure for me*”. This also points to the general motive for the staff’s choice of their profession: It is indeed interesting to work with elderly people. Rikke said, “*I love to listen to their stories and their experiences*”. Along the same lines, Gorrica cited the importance of giving them the impression that they were still interesting people.

Nevertheless, there was general agreement among the staff that residents should be prevented from seeking too close contact. One staff member elaborated on this by saying: *“I will not allow them to take it all”*. There was, in other words, a clear definition of the level of intimacy that could be allowed, especially when residents’ initiatives became too stressful or mentally exhausting for staff. Applying a distinction of Jacobsen’s (2006), staff accepted personal communication in which residents openly talked about their lives. The aim was to listen and assist the residents by allowing them to talk freely. Staff could talk about personal matters in terms of family relations, but they kept private matters out of the conversation. What from a resident’s perspective could be perceived as an invitation to exchange intimate details was from the staff’s perspective at times just a professional part of the care. However, basically I found that staff shared residents’ preference for a personal relationship, though they also appreciated their ability to cling to the bureaucratic regulations.⁵¹

Appreciation of Staff’s Efforts

A basic incentive for staff to provide care for the residents was that the latter appreciated these efforts. When staff listened and had close contact, they felt that they had *“receive[d] something”*. Apart from the recognition mentioned above, their most favoured residents were those with a sense of humour – *“she makes me laugh”*, *“Every day she has new interesting things to tell me about”* – or those in a good or cheerful mood. Gitte said with a smile: *“When Jens recognises me in the morning, he smiles at me and asks me why we never married.”*

What the staff looked for in the good resident was a confirmation of their importance, that is, residents who appreciated their assistance in the right way (cf. Kydd 2006). Liveng (2007) argues that the institution of the nursing home provides very little recognition of the work of staff, and staff consequently seek this recognition from the residents. Foner (1995) supplements this argument, as she argues that there are two ways of being recognised as staff. On the administrative side, appreciation is achieved when residents’ rights to care are

⁵¹ The relationship between residents and staff can also be analysed as a classic asymmetric relationship of exchange as defined by Marcel Mauss, in which staff constantly have the upper hand because they constantly give to residents, and residents are unable to repay these gifts. See Christophersen (1999) for a further discussion of this position.

substantially documented. From the other side, what is important is recognition from the residents, where the latter emphasise passion, affection and enthusiasm.

As already mentioned, becoming a good resident implied an active attitude towards the assistance being provided and undertaking as much of one's own personal care as possible (cf. Christophersen 1999). Residents had to be willing to keep on trying and never give up. If residents did this, then it was described as a positive outcome of care, and the resident was considered to be moving in the right direction. If, on the contrary, residents chose not to or became unable to fulfil this expectation, then "*It is annoying if they don't do anything on their own initiative. Then this gives us so much work...*". Mostly residents strove to fulfil this expectation and assisted staff's work by cooperating. The importance of this aspect is indicated by the observations of the staff meetings described in Chapter 5.

In summing up the content of the relatedness perspective - expressed in the mutual relations - it was preferred that staff should prevent unpleasant exposures of residents' frailty on the front stage (Goffman 1971) and avoid keeping them waiting for a long time. Furthermore, staff should not stick to bureaucratic rules and administrative appreciation (Foner 1995), but use empathy and treat residents as individuals whom they respected and found interesting. From the staff's point of view, on the other hand, residents ought to accept close contact and strive to become good residents using their own resources and maintaining these by going to the rehabilitation centres, thus adopting the nursing home's aims. Furthermore, they needed to take the stress levels of staff into account and appreciate staff's care for them in a proper manner.⁵² Such relationships contained mutual obligations, and it must of course be mentioned that residents and staff who enjoyed such a relationship indeed appreciated each other's company.

⁵² At this stage of the analysis I must stress that I tried to identify residents' perspectives of the transitions primarily during fieldwork. Staff's perspectives were investigated by interviews and observations of their care for residents. Presumably I could have gained further insight into their expectations of residents by following staff's work more closely. In a similar vein, the staff's constant high stress levels in residents' perceptions could have been nuanced (see, for instance, Plough Hansen (1995) for an investigation of nurses' perspectives on a Danish cancer ward). But as mentioned in the introduction, following staff more closely was not an option for my investigation.

This type of relatedness, then, was based on the sharing of daily activities, where, for instance, care is provided and humour received. There is, however, one aspect of the concept of relatedness that needs to be underlined in the nursing home context, and that is the relation of power. Staff had the upper hand, and if they wished to dissolve the relationship, they had the ability to do so. Residents, on the other hand, had to put up with the contact person appointed to them, just as they had to accept the home care assistant they were allocated, as described in Chapter 1. As Paterniti further suggests (2003), staff could exercise power by exposing residents to extensive waiting. Staff were also in charge of the schedules and the priorities, as well as being in a position to define what was important enough to be scheduled as a care activity (Paterniti 2003).

“I do wonder what they think of me”

That the staff were in charge of their relations with residents made the latter reflect repeatedly on how the staff regarded them. This indicated how very attentive residents were towards staff’s perceptions of them, and that good residents in time realized that they had to wait for what they perceived as excessive amounts of time. Furthermore, the examples below provide insight into the meaning of the social in establishing and maintaining social relations, and new residents really needed to apply this ability in the nursing home context in the battle for staff’s attention with the other residents, that is, for the attention of the contact person and other staff members when their contact person was off duty.

Dorte provides good insights into this. Upon entering the new ward, she was told to call the staff for assistance whenever she needed to. A few days before our first interview on her permanent ward, she had been rudely told by another member of staff that she summoned the staff too often. Her contact person confirmed this incident in a staff interview. On her behalf, she had soothingly told her that this was definitely not the case. She was entitled to call for assistance whenever she needed it. The contact person said: *“She should not be scared of calling. I tried to convince her. It is much better to call one time too many. We will be there as soon as they call”*. Nevertheless, the contact person did not succeed in convincing Dorte, who concluded

about this: *“It has to be very, very necessary when I call if I know that they are busy”*. In other words, Dorte carefully considered her needs, based on her perception of the stress levels among the staff. Asking her to mention the situations in which she considered it necessary to justify calling for assistance, she replied: *“When I have to visit the toilet, if I have insufficient light, if I lose something and... if I am thirsty”*. The interesting aspect here is that, in this internally negotiated hierarchy, food was placed at the bottom, i.e. although nursing home residents have extensive need of food due to their poor nutritional status, they hesitated to ask for it. I also asked her when she refrained from calling for assistance. She mentioned when the sun was shining in her eyes, and when she felt like something from the fridge. Interestingly she said that she also had to pay attention to her relatives, who provided her with her favourite yogurts, candy and the like, which were placed in her fridge. When she felt like having some of these, she had to call the staff. This illustrates a very difficult and stressful situation for Dorte.

Similarly, Anders described how he also paid attention to the staff's expectations: *“I stopped walking in the afternoon. I had to restrain myself. I started walking late in the evening instead”*. When he was living at home, he used to go for short walks twice a day. After moving into the nursing home, he felt he had to forego one of his walks in order not to be seen as too fit and therefore unsuitable for being in a nursing home. In the evenings, however, he walked the corridors.

Overall these quotes indicate that residents reflected upon the staff's expectations and mostly accepted them and adopted to the nursing home practice i.e. to the ways in which they were expected to behave. In addition, they were very attentive to staff's perceptions of whether they were behaving in accordance with the latter's expectations. The residents who lived up to these expectations were rewarded by extensive contact. That is, as long as they were able fulfil these expectations, they would win the battle for staff's attention among the residents. Like Ritta, they talked positively about the situations in the morning, when the staff assisted them with their morning toilet. Paterniti (2003) suggests that residents were, if not able to manipulate staff, then at least able to influence situations. They were thus also able to transform routine work, like the morning toilet, into minor social occasions. This way of

influencing daily practice was also a recognition of how the elderly people wanted to be nursing home residents (Paterniti 2003) with respect paid to them as persons, and not just bodies in need.

“All the nonsense that they are here to take care of us only”

But the residents did not all meet staff’s expectations, as I shall illustrate below. Although Hans’s and Anna’s expectations were modest, and although the leaflets and brochures stressed individual resources and needs, relations between Hans and Anna and the staff were characterized by Hans’s protests in the first months.



(Hans and Anna in their nursing home flat)

Ritta was an example of a resident who accepted the expectations of the staff and was rewarded with extensive contact and a relationship prized by both herself and the contact person. Like the majority of the new residents in this study, she was mainly a representative of the “*conversion*” line (Goffman 1961: 63), according to which residents accept the practice of the institution. Hans and Anna, conversely, illustrated the “*intransigent line*” (Goffman 1961: 62) in the first months, which involved a resistance to adapt to the practice of the institution.

Hans's attitude changed dramatically after the first month. At this interview, Hans closed the door. He started by saying that maybe he had been a little too positive at the previous interview. They had now realized that at times the staff didn't respond to all their calls. Hans once suffered a stroke, and he couldn't help thinking what would happen if he had another one and if Anna called for help and no one came. In addition, he said that the staff were too few. Hans underlined his point with his perceptions of the quality of the food in the home, which was not properly heated up sometimes. Commenting on this, Hans said: "*This is how much they think we are worth*". Additionally, after six months, none of the staff members had taken the time to talk to them or take any particular interest in their lives. This had been evident, as the bowl of sweets remained nearly untouched, as was also the case with the bottle of port on their table.

Hans moreover experienced regular conflicts with the staff. Often these concerned Anna's care, which he considered insufficient. He was convinced that she needed to get out of bed on a daily basis. Staff argued that her rheumatism was best cared for by her remaining some days in bed. When Hans didn't know of staff's plans, time spent waiting for Anna to receive care became stressful for him. He referred to an incident when he had asked staff to come and assist several times, which only happened at 10:00 a.m. instead of the normal 08:30 a.m. On that day, however, the staff had decided that she was to stay in bed.

As it is evident, Hans did not pay attention to the stress levels of the staff. Nevertheless, he had to agree that everything was done eventually. He referred to another incident when this became very evident. He needed a piece of sticking plaster and was rudely told that he had to wait. This made him feel like a burden, it was highly unpleasant and he felt distressed. The staff's reactions towards residents who did not meet their expectations were a lack of attention, empathy and care, as Hans experienced it. Rather, he and his wife were being treated by the book, as the staff stuck to the bureaucratic regulations.

Oline likewise resisted to adopt to the nursing home practice until just before her death, when she nearly lost her ability to communicate. Before this she really

succeeded in attracting the attention of both staff and residents. A few days after her admission, she decided that she wanted to go shopping for groceries in the local supermarket. She did not inform the staff of her intention but, according to the latter, just left the ward to go for a walk. A regular bus service providing the transport stopped close to the nursing home. After two hours, staff realized that she was not coming back from her walk. The alarm was raised among all the staff in the nursing home. Having a resident go missing is among the worst incidents that staff can imagine and was seen as totally unacceptable behaviour by residents not suffering from dementia. Shortly afterwards, however, she was found at the local supermarket. After this episode, Oline faced a difficult time. Both the staff and the other residents became hostile towards her. The staff because she really did not meet their expectations, while one resident who had a mutual relationship with her contact person felt that, through her behaviour, Oline had offended her contact person: “*She should not treat our staff in this manner*”, she said.

Residents felt that the staff were nearly always busy, and as far as I could observe, most of the participants in this study refrained from calling for assistance when they knew the staff were busy. However, at the same time some residents gave the impression that the other residents called upon staff too frequently. One frequent way of expressing a dislike of other residents was to dismiss them as always summoning the staff, meaning that they did not pay any attention to the staff at all and thus may have gained more attention from staff than they themselves did.

Nevertheless, proper care was mostly only given to a limited number of residents. Often staff gave the impression that all the residents were treated alike and that positive relationships always developed, like Ritta’s with her contact person. Nevertheless, when asked directly, members of staff admitted that it was “*more than half a year*” since they had had the time to undertake proper care: “*For the last months there hasn’t been enough time for...*” The reasons were a lack of staff, illness among staff, meetings and the like.

Concerning Goffman’s description of practice in total institutions, this has been useful in understanding the experience faced by residents who applied a strategy contrary to staff’s expectations of good residents: they faced the practice that Goffman describes

as experiencing extensive waiting. If they complained, this was brushed aside by staff with reference to the tight schedule (Goffman 1961) or staff members having to stick to bureaucratic rules (Foner 1995). Furthermore residents acted on an individual basis in their relations with staff, and staff mostly on an individual basis towards residents. Therefore I did not find narrow, hostile stereotypes (Goffman 1961) in my ethnographic material, apart from residents like Hans, Anna, Lis and Oline, who, for the majority of the research period, resisted to adopt fully to the nursing home practice. I observed groups of residents on only a few wards.⁵³ Rather, residents acted individually, as they knew that they could take advantage of different staff members in different ways.

Summing up the relatedness perspective enabled me to understand the relationships created between residents and their contact persons in the best cases. These were mutual relationships, which needed to be maintained on a regular basis or they would otherwise dissolve. Staff and residents on both sides expressed a desire to create good, positive relationships. At the same time, the idea of positive relationships became one of the strategies that were adopted. This paradox can be explained by the residents both wanting the relationship, while on the other hand facing competition from other residents to be given the greatest possible amount of exclusive time with “*my staff member*”. However, residents were exposed and vulnerable to the high turnover of staff. After some months Ritta experienced a change, and Lis likewise acquired a new contact person. The two residents gave the impression that it was stressful to them to have to establish relationships all over again, and Lis especially was frustrated by this change, as I indicate in the end of Chapter 6.

Conclusion

In this chapter, I have followed the process of institutionalisation of the new residents whereby they had to adopt to the nursing home practice i.e. the aspect of

⁵³ I have previously mentioned the groups of elderly people in Ross' (1977) and Meyerhof's (1979) works. Gubrium (1975) likewise discusses cliques at institutions for elderly people, “*groups of clientele whose members consider themselves special in some way. The clique serves to identify members as separate from other patients or residents*” (Gubrium 1975: 107). Of the sixteen residents I followed only Anders and Arne were part of a group for fairly short periods of time.

intersubjectivity that concerns relations towards staff. The schedule of the institution and the expectations towards their behaviour became a bodily learned experience whereby further parts of their previous identity were phased out. As discussed in the beginning of this chapter, the elderly people strove to be treated as individuals instead of being treated as bodies in need on a basis of sameness, with all residents being treated alike in accordance with the bureaucratic regulations (cf. Foner 1995). To avoid the latter situation, residents sought to establish mutual relationships, primarily with their contact person, that is, a relationship in which the staff exposed residents to a minimum amount of time waiting and generally allowed them to influence nursing home practice. The majority of the new residents became good residents, which also indicated that they intended and succeeded in establishing this type of relation. In the battle for attention between residents, the majority of those in this study gained more attention from staff than those who chose otherwise or were unable to establish these relationships with staff.

In the analysis, I have applied Goffman's concept of total institutions, as this has provided me with an understanding of the nursing home context in which these relationships were established, despite my emphasis on relationships throughout the chapter. The relatedness perspective assisted me in understanding the fragile and temporary character of these relationships. In the analysis, I underlined the need for residents also to be sensitive regarding the staff's stress levels and to restrict their calls for assistance accordingly; i.e. staff members had the upper hand and would eventually decide whether the residents had their demands met. The elderly couple, Hans and Anna, did not pay attention to staff's stress levels in the first months, and thus did not attempt to accept the staff's expectations of residents. That is, they chose not to engage in this type of exchange. However, at the end of the research period Hans realised that they needed to pay attention to staff's stress levels. At the last interview he was changing his mind. Two weeks prior to this interview, two staff members went round to the residents to say goodbye. Hans now realised that: "*We have to take care of the staff, otherwise they will resign*".

Hans's experience opens up the aspect that residents needed to relate to the self-descriptions of the nursing homes, institutional modes of thought and the practice of

staff and their expectations they experienced on an everyday basis. I will deepen this distinction between ideal and practice in the two following chapters.

Like Hans and Anna, Lis and Oline, who for most of the research period resisted the expectations towards their behaviour, faced difficult times at the nursing home. The other new residents, who established relationships with staff, were mainly successful and mainly achieved being treated as persons with a status and not just as bodies in need.

Here I wish to emphasise that, through these relationships, residents made aspects of the life in the nursing home endurable by applying a part of their agency. The fact that these relationships were established at a place of work meant among other things that residents had to relate to at least two different staff members during the day. Mainly, however, the relationship concerned the contact person only.

5. The Nursing Home Meal

Introduction

Lis was an elderly Danish woman, 93 years of age. She had suffered a stroke in her home, and when I first met her in respite care, her face was swollen, the bluish-green colour of her cheeks and forehead showing the signs of a serious fall presumably caused by the stroke. She was now unable to manage in her own home and was being assessed for nursing care.

She had two daughters and a son, but had divorced her husband when the children were still small and managed their upbringing on her own. According to herself and one of her daughters, she worked successfully as a waiter until the age of 62. She said about this period of her life: *“I have always managed on my own. Well, there were no other options, I just had to.”* This describes an essential aspect of Lis’s personality.

The stroke left her unable to walk or to use her right arm, though she still had the use of her left arm. Therefore she was confined to a wheelchair and needed extensive assistance from staff. For instance, she needed help in cutting up her food. In addition, she was suffering from faecal incontinence, defective hearing and failing sight. The adjustments to her hearing aid caused her and the staff serious trouble, and its malfunctioning left her generally unable to participate in conversations at the dining table. However, during my interviews I realized that her hearing was selective rather than defective, as she tended to choose those of my questions she was able to hear. Consequently, she was aware of what was happening around her.

Lis, like the other new residents, was encouraged to eat her meals with the other residents and the staff at the wards. Eating together – that is, sharing food with others – has generally been seen as an occasion for creating community among the participants in a meal (cf. Simmel 1998), and this was also the intention of the staff judging by the way they described such meals. Staff invited Lis and the other residents to enjoy their meals in a cosy (*“hyggelig”*) atmosphere created by mutual involvement and the flow of conversation governed by the advice on etiquette for meals.

In this third phase of the transition, I ask why Lis, like a number of other residents, was reluctant to participate in the meals after doing so on only a few occasions and why these meals were often perceived as embarrassing situations.

By their behaviour at meals, the staff at times turned mealtimes into situations dominated by work-related issues including mentioning residents' intimate details. The meals were a part of staff's work. But meals were fragile processes that needed more than just talking about cosy situations in order to establish them. Compared to other types of care, staff faced difficulties in incorporating the meals into their work, as it was difficult to play the role of a host at all convincingly.

As good residents, the majority of the elderly people participated, as this was part of the mutual obligations in their relations with the staff and a way of adopting and accepting the institutional practice. When work-related issues took priority staff did not follow etiquette advice. Residents mostly reacted by remaining silent. This reaction took the form of protest, of not being convinced that these were actually meals, of apathy and even despair. Whatever the reactions may have meant, Lis and the other residents influenced the meaning of the meals and influenced the institutional practice.

The present chapter thus continues the analyses of the aspect of intersubjectivity that concerns mutual relations between staff and residents. It also concerns how residents used a part of their agency and strove, with limited success, to turn the meals into more endurable situations (cf. Jackson 2005).

As mentioned previously, residents' reduced senses made the grounds for eating and participation in conversation uncertain (cf. Merleau-Ponty 1994). In addition, their ability to taste, smell and see the food was reduced, which presumably made eating it a less interesting experience. They were also well aware that their motor abilities were increasingly making them unable to behave in accordance with etiquette: For instance, Lis needed help in cutting up her food, and two of her fellow residents needed staff's assistance just to eat. In this way their civilized bodies, in which etiquette was inscribed (cf. Lupton 1996), became subject to oblivion, as this etiquette was now partly being un-learned. In other words, their disabled bodies were unable to

fulfil the appropriate bodily behaviour at meals (cf. Merleau-Ponty 1994). In this way, they nearly became unable to establish social relations at meals, as they were unable to behave in accordance with etiquette prescribed for these occasions.



(The Dining room at Grønnehaven. Breakfast at Anders's ward)

The previous research on meals in nursing homes has only rarely referred to impaired bodies in the analysis (except for Sidenvall 1994). Mainly the focus has instead been on the nutritional perspective concerning those aspects of the meal that might increase residents' energy intake. For instance, there have been discussions as to whether eating alone or eating in the company of other residents improves nutritional status (see, for example, Pliner et al. 2006; Pearson et al. 1998). More recently, it has been argued that having the company of others has a positive effect on residents' energy intake (Nijs et al. 2006). In addition, there are strong indications that a homely eating environment has a similar effect (Elmståhl et al. 1987; Gibbons and Henry 2005). To establish family-style meal times, the staff are given a significant role in moderating the conversation, and eating with the residents can also positively influence and maintain residents' nutritional status (Nijs et al. 2006; see also Shatenstein et al. 2001). These conclusions indicate the importance of staff in making meal times in nursing homes significant in terms of residents' experiences and their intake of food and drink.

Before I approach the analysis of the meal on Lis's ward, I will briefly consider selected positions within anthropology and sociology on the importance of sharing food with others. Here I suggest that the circumstances in which food is eaten, with whom and in what amounts indicate with whom individuals and groups prefer to identify and from whom they want to distance themselves.

Eating Together as Establishing a Sense of Community

Eating food is a necessity for human survival, and as such it is indeed an important biological activity (Douglas 1991b). Simmel (1998) argued for the importance of the meal as the original form of socializing (cf. Holm and Iversen 1999). In a classic article on the sociology of the meal, Simmel (1998) suggested that a civilized meal was characterized by prohibitions and rules that elevated it above the level of the physiologically primitive and raised the inevitably common to a level of social significance. People who shared no common interests whatsoever could find each other by sharing a meal and thus create a sense of community among those present. According to Simmel (1998), sharing food and drink is a basic socializing force. The meal thus becomes a sort of event in which it itself has an impact and becomes a medium between the private and the public, or, as Douglas describes the barbecue, "*bridges between intimacy and distance*" (Douglas 1991b: 257).

Several anthropological studies have indicated the symbolic importance of sharing particular food items among people and thus emphasising group identity. I will only briefly draw attention to a few examples and begin with Levi-Strauss' position from his famous book, *The Raw and the Cooked*. In this book, he analyses what roughly speaking could be called the cultural phenomena of food and eating. Food is treated as a language that illuminates central cultural principles of classification based on binary oppositions. He analyses the structural principles that characterize food in terms of elementary oppositions between culture/nature, human/non-human, edible/non-edible and so forth (Levi-Strauss 1986). In this way, according to James (1997), he also provides explanations for different cultural divisions of food items into, for instance, edible/non-edible or pure/polluted. Groups of people can make symbolic statements by means of the food they perceive as edible, in contrast to other groups of people who perceive the same food as non-edible.

An example where kinship groups are of major importance is the Dobuans of Milne Bay Province, Papua New Guinea. They prefer to share food with members of their matrilineages (*susu*). When members of the matrilineage marry and move to the spouse's village, they feel they are surrounded by sorceresses and witches. And although a married couple grows common gardens, they keep their two lineage yam seeds in different parts of the gardens. Yams are perceived as having human qualities, and growing yams involves magic for growth, but also magic for enticing other lineage yams, thus persuading the latter to join one's lineage. The ideal situation for Dobuans seems to be to eat privately among members of their own matrilineage, in this way confirming membership and close relations within this lineage, out of the sight of sorceresses and witches from other lineages (Fortune 1963).

From India, Dumont (1980, cited in Douglas 1991b) gives an example of a middle-ranking caste's restrictions concerning whom they will accept food from and what they prefer to eat. He refers to an example where members of a middle-ranking caste are invited to a family ceremony, puritanically insist on being given their share of the food raw and retire to cook it themselves in their own homes. In this case the purity of food is seen as an index of the hierarchy among the castes. The differences between the levels in the hierarchy are marked symbolically, both by whom food is shared, but also by the way these food items are cooked.

Giving a British example, Douglas elaborates on this position, as she argues that food and drink are used as markers expressing the structure of social relations both inside the household and between members of the household and outsiders: "*The meal expresses close friendship. Those we only know at drinks we know less intimately*" (Douglas 1991b: 256). Different items of food and drink therefore express the character of the relations.

Eating and drinking together in a family has also been analysed as an activity bringing the individual members together in a daily ritual. Holm and Iversen (1999), in line with DeVault (1991), describe how family members in Danish and Canadian families live everyday lives separated from each other during the day. The possibilities of gathering are often limited due to different activities after school and the work of the members of the household. The family meal then often becomes the only occasion at

which the family gathers. Times of eating may be altered from day to day to provide all members with the opportunity of attending. Conversation about the activities of the day is considered an important part of eating together. According to DeVault (1991), the family is re-created and relations confirmed on a day-to-day basis during family meals. Furthermore, Reddy (1993) argues that in Denmark too, organized getting together at meals is aimed at creating a feeling of community among participants. Jenkins suggests that it is the social event of getting together and confirming social relations that matter to Danes, rather than the actual quality of the food (Jenkins 1999). Summing up the selected literature thus indicates that sharing food during meals should, in general terms, create some sort of community among those involved. And applying Simmel's (1998) terms, the very private eating is mediated in a social event at which people share the same food. Using this general approach, I will now return to the context of the Danish nursing home.

The Ideal nursing home Meal

The cosy meal

All staff members in one way or another used the word cosy (*hyggelig*) when I asked them to describe how a nursing home meal ought to be. For instance, one staff member answered, "*We are all supposed to eat and create a cosy (hyggelig) atmosphere when we eat*". The Danish word *hyggelig* has no exact English translation. "*However, `cosiness` and `cosy` more or less convey the meaning*" (Reddy 1993: 138). A cosy situation is linked with subdued lighting or candlelight. In Denmark it is also connected with small groups of people sitting together (*ibid.*), and according to Friedman Hansen (1980) a cosy atmosphere is nurtured by thoughtfulness and mutual involvement. The nursing staff described an extremely cosy (*hyggelig*) evening in the nursing home having been created when staff and residents in a small group are watching their favourite television programme and eating sweets together in the TV lounge.

Another member of staff added to the obligations of those eating together and convincingly elaborated: "*Everyone present must feel as a participant in the meal and add part of themselves to the sense of community at the table*". According to research

on Danish meals, a meal creates a sort of egalitarianism among the participants, and normal social hierarchies cease to exist (Knudsen 1996, Reddy 1993, Friedman Hansen 1980).

Danish Meal Etiquette

As already indicated, the cosy atmosphere was a very important aspect of the nursing home meal. However, it is also important to take into account Danish meal etiquette. In the following, I will identify etiquette on the basis of both etiquette books and anthropological research on Danish meals and other similar social events. The aim is twofold: First to open up a discussion of the ideal versus the actual practice at nursing home meals; and secondly, to identify the meal as a fragile, social event in which the participants (staff and residents) know their roles beforehand.

Staff in practice defined the course of the meals and thus which advice to follow concerning etiquette, as well as how they embodied and interpreted this. That is, they held the upper hand in this matter, as they also decided the form that mutual relations between staff and residents should take. At meetings and in staff interviews I found Gad's advice (see below) concerning proper manners to prevail. I will pay attention to staff's descriptions and ultimately sum up the core elements in their definition of how a meal ought to be.⁵⁴

Meal etiquette was still recognized by the elderly people. Etiquette advice, like calling on staff for assistance too often, was important for residents in their expressions of dislike for other residents, such as how another resident “*eats like a threshing machine*” or as Just, a resident on Jørgen's ward, felt distracted by the bad manners of his table companions.

In Denmark, proper manners at meals are set out in different sources. Emma Gad's work has been among the most influential since its publication in 1918 (cf. Jenkins 1999, Kaivola-Bregnehøj 1997). Entitled *Tact and Manners (Takt og Tone)*, it gives

⁵⁴ One leaflet in another nursing home in the area of Greater Copenhagen (Omsorgscentret Hjortespring 2006) reflected this as well, as it described table manners and how staff ought to behave at meals.

advice on etiquette in social and domestic life, including good manners at meals. Her book was a typical confirmation gift for young people at the time of its first publication, and some of the elderly people would have been given it as a present, or at least have been made aware of its contents, as it was a major work in the definition of Danish etiquette (Den store Danske Encyklopædi 1997). Although Gad's work can be described as normative, both staff and residents invoked proper behaviour at meals. In the following, Gad will be used as the prime source, but I will supplement it with the work of other researchers to show that her advice is still recognized.

Etiquette books appeared outside Denmark well before Emma Gad published her own works. Davidoff (1973), Elias (1978) and Mennell (1985) have comprehensively discussed their emergence in the historical context. Here I will only briefly mention some of the issues related to meals. Table manners were basically intended to conceal the primitive, bodily aspects of eating and to transform meals into social rituals: "*Control of bodily movements and powerful emotions were elements of the necessary self-discipline...*" (Nordström 1996: 82). "*Upbringing sought to teach children to comply, to restrain their impulses and to feel distance when in the presence of bad manners*" (ibid.). In this same vein, Douglas (1991b) argues that meals require a seating order and restrictions on alternative occupations. The meal is a structured occasion with "*limited scope for bodily expressions*" (ibid.: 103). Or, as Lupton (1996) expresses it, etiquette rules are inscribed in civilized bodies as learned behaviour.

According to Gad (2006), the meal starts with the host or hostess making an announcement when all the guests have assembled at the well-provisioned dining table. Likewise the meal is brought to a conclusion by a similar announcement and, as an absolute minimum, it is required that those eating express their appreciation by saying '*Thank you for the meal*' ('*Tak for mad*') and the host replying '*May it become you well*' ('*Velbekomme*'). However, the host or hostess waits until all those present have finished eating (see also Jenkins 1999: 44; Redlich 1948 for similar observations). Concerning the amount of food consumed, according to Gad it is wrong to eat more than the other meal participants.

Both when the family is eating in private and when other people have been invited, the conversation needs to flow by means of cheerful, merry and spontaneous comments and unexpected answers (Gad 2006: 157). Guests should also be seated so that they are well matched for conversation, and this should enable them to add to the conversation with “...a breath of fresh air...” (ibid.: 97). The host leads the conversation in such ways that nobody at the table is left with the uncomfortable feeling that they are being left out. When anyone else is talking, they should not be interrupted (see also Reddy 1993 for similar observations).

More recently, from her work on Danish sociability Knudsen has argued (1996), that everybody present in a group of people should be provided with an opportunity to speak. She also argues that Danish people need to sit together rather than stand when they need to talk. Sitting together promotes conversation and it is a model for Danes to get together, with hierarchies among them being concealed (Knudsen 1996). Knudsen further argues that Danes literally form circles, indicating that they identify themselves as groups and that it is inappropriate to try to take part in the conversation if one is standing on its fringes.

Gad (2006), Friedman Hansen (1980) and Knudsen (1996) agree on the need to create a continuous flow in the conversation at meals. Gad further advises that private matters should be left out of the conversation. For guests a basic assumption should be that the host and hostess do not have any private life whatsoever. Issues of this kind should be kept confidential and only debated between close friends. In this vein, it is inappropriate to comment on the peculiar looks of other guests, as these guests are perfectly aware of their peculiarities (Gad 2006). More generally, I suggest that Goffman`s (1971) distinction between front-stage and backstage behaviour is applicable here. As indicated in the previous chapters, residents expected staff to share intimate details with the resident in the flat, or “back stage” in Goffman`s terminology. They preferred staff not to mention intimate details on the “front stage”, that is, in the dining room, as Gad also suggests.

According to Gad, conversation also ought to flow without angry comments or complaints being made about poor economic abilities and other inconveniences. Likewise, remarks that would annoy or upset other people should be avoided and

replaced by more pleasant topics (Gad 2006: 146). Furthermore, the host is obliged to lead the conversation sensitively and to avoid private matters or guests themselves becoming issues during meals (Gad 2006: 149; cf. Redlich 1948). More recently, Kaivola-Bregnehøj (1997) has supported the rule about leaving the more personal matters out of the conversation. As a hostess, she experienced questions about the progress of her work as inappropriate. Questions concerning the food typical of her home country were much more appropriate for Danish meal guests to ask.

Knudsen's (1996) later definition of the issues that are allowed in conversation in groups softens Gad's (2006) prohibition on mentioning private matters. According to Knudsen (1996), the important aspect is that everyone in the group is provided with an opportunity to participate in the conversation. If a guest does not participate, this is perceived as outspoken criticism or hostility. That is a disagreement upon the event agreed upon among the participants.

Part of the etiquette is also to eat the courses in the right order. In her research on British meals, Douglas underlines the proper succession and combination of courses to create a 'proper' British meal. No matter how simple it is, the form must be recognizable (Douglas 1991b). Knowing the basic form then also provides instructions for choices about which courses to serve in which order. These influence the responses of the meal participants too (cf. De Vault 1991), for example, by replying, "*This was a delicious meal*" (Douglas 1991b: 61) if the form was recognizable, or "*Good Heavens! What sort of a meal is that?*" if not (ibid.).

Similarly, Danish meals follow certain forms. Briefly here, the Danish hot meal in the evening reflects the pan-Nordic pattern of a starter, a main course and a dessert. However, this order of succession is indeed open to other options and creativity (Jenkins 1999). Lunch, the cold meal, consists of open-ended sandwiches, fish and/or meat, and/or cheese. These food items should be eaten in the right order, as indicated in an article about the Danish lunch entitled, "*You are not supposed to start with the cheese*" (Schwartz 2003; see also Vestergaard 1995 for similar conclusions).

The Danish meals and other similar eating occasions ought to be predictable, rigidly organized social occasions. According to Jenkins (1999), the cosy, relaxed, familiar

atmosphere covers a tightly structured order (cf. Reddy 1998), being what Goffman defines as “*a system of enabling conventions*” (Goffman 1983: 5, in Jenkins 1999) “*in the sense of the ground rules of the game,*” (ibid.), which is a helpful organizing and meaningful social activity (Goffman 1983: 4). Barth (1966) describes social processes, of which I see meals in the nursing home as one example. There are simple contracts about basic rules, which make individuals establish role stereotypes afterwards. This indicates that both staff and residents in the nursing home have no need to discuss whether the situation is actually a meal or not when they assemble at the laid dining table. They knew the etiquette and intended to behave according to the prescribed roles. The meal, as Douglas puts it, “*puts its frame on the gathering*” (1991b: 255), as both staff and residents in the nursing home know their roles.

Summing up, Danish meals are social processes governed by advice concerning etiquette where individuals assemble around a table eating courses in a certain order with forks and knives. Conversation needs to flow, with all the participants being expected to add to the flow, and the host is supposed to provide all the participants with the opportunity to talk and to encourage everyone present to take part in the conversation. From the chosen literature, I am unable to conclude anything regarding the issues recommended for conversation. However, Goffman’s (1971) distinction between front stage and backstage and Gad’s 2006 restrictions concerning private affairs are likely still to influence the residents, whereas Knudsen (1996) would argue that the much younger staff members might not be influenced by these restrictions at all.

Rethinking staff’s definitions, they also follow the above advice concerning the obligation of residents to add to the conversation and thus create a cosy atmosphere. In accordance with the views of Rubow (2000), who refers to Rosch 1978 and Ardener 1989, for the staff the cosy atmosphere created by conversation would be the core aspect or prototype representing the rest of the meal category – indeed, it is the most important element in the category. The succession of courses, the topics that may be discussed and the proper behaviour would then be elements still contained within the category, but of lesser importance to the staff. When staff invite residents to take part in meals, the most important issue for them is to create a cosy situation

through conversation and thus convince the residents to participate. Below I will approach the nursing home meal as a social process governed by advice on etiquette.

Daily Eating Practise

Eating at Home

To put the nursing home meal into perspective, I will provide a condensed description of the way Lis and most of the elderly people ate while awaiting nursing care at home. Lis ate by observing etiquette. Before the stroke disabled her, she managed to go shopping and preparing simple hot meals for herself on a regular basis. She took pride in still being able to cook traditional meals at the age of 93 and to decline to have her meals delivered by the municipality.⁵⁵



(Part of the dining room at Bakkegården at Lise`s ward)

As mentioned in Chapter 2, the elderly people had become increasingly unable to maintain social relations in recent years. On average they had relatives visit every fortnight on Saturdays or Sundays for afternoon coffee. Besides, they had also been assessed for home care and most of them for meals delivery by the municipal

⁵⁵ Apart from Lis, only Anders, Bo and Arne still managed to carry out very simple cooking activities on their own.

authorities. Therefore the choice between different courses was reduced to the choice provided by the municipal meal-delivery service. Furthermore, their shopping activities were reduced to a call to a nearby grocery store, and the goods were then delivered to their homes.

The home care assistant prepared breakfast and a cold meal (lunch) in the morning. For instance, Lise had two slices of bread buttered with the crusts cut off, and the assistant served her coffee for breakfast. The cold meal was prepared by the home care assistant and placed in the fridge. Lise also received hot meals on a daily basis. Consequently, a glass, a cup, a plate, a fork and a knife were the only kitchenware used, and the home care assistant washed these items and placed them on the kitchen table within her reach after use. The remaining kitchenware and dinner sets were left unused in the kitchen cupboards, as was the dining-room suite in the dining room.

In agreement with Holm and Iversen (1997), the daily eating practice of the elderly people reflected the lack of social relationships and their reduced physical abilities. As they expected nursing care, they looked forward to socializing with other residents, and the meals in the nursing home became the occasion in which this was supposed to happen.

The Nursing Home Meal: The Staff and Residents Eating Together

Staff members in the nursing homes identified the meal as an occasion on which both new residents like Lis and staff could meet and socialize. Staff invited residents to participate in two daily meals. That is, they strongly encouraged residents to take part. Members of staff saw this encouragement as part of their work, and some of them even considered it unhealthy for residents to be left all on their own, without participating in any kind of social activity. What is more, it was a basic requirement for new residents at the SLE to remain actively involved with other residents (Hjorth-Hansen and Nielsen 2002).

One staff member on Bo's ward said: "*When a new resident moves in, we indeed like to invite him or her out here as soon as possible*". Staff complained when those who might add to the conversation at the dining table turned down their invitation. For

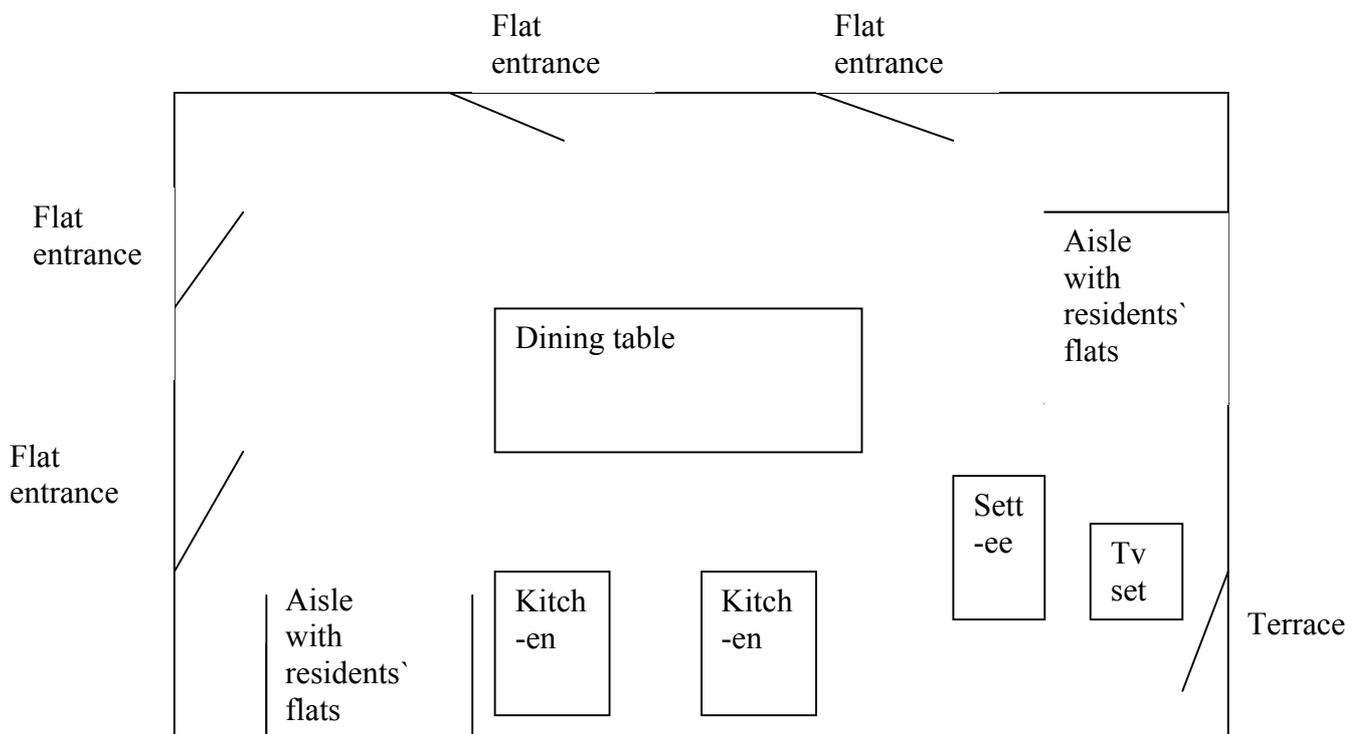
instance when, Oda preferred to eat on her own, staff said, “*She uses this [the nursing home] as too much of a hotel...She could be a resource at the table...*” About Dorte, a staff member commented on her practice of declining invitations: “*It is impossible to inveigle her into the dining room...She is definitely not fond of company*”. Staff could take advantage of talkative residents, and I myself was invited on some occasions, presumably for the same reason.

Despite the staff’s intentions, one or two residents on the small wards with eight residents chose to eat on their own, and on the larger wards four to six of the thirty residents preferred to eat individually in their flats. According to the staff, this was because of their individual needs and illnesses, including sometimes the terminal nature of the latter. These reasons made sense to the residents, but they often mentioned their dislike of other residents and their inappropriate table manners as the main reason.

From my observations, it was evident that the vast majority of residents accepted the invitations, although some were reluctant to do so, like Lis. Another member of staff described how they also encouraged residents to stay at the table for as long as possible, as they seemed eager to be assisted back into their flats as soon as they had finished eating, as it was the case with Lis.

Lis’s Ward

Above I argued that the flow of conversation was one of the core elements in the etiquette for the meals, as well as in the staff's description of the cosy meal they tried to create on the wards. In the following, I have chosen a few examples to illustrate the flow of conversation, beginning with Lis's ward, where six residents and two staff members formed the group at lunch and dinner. The criterion for seating was typically a free place. But it also happened – as was the case with Lis and Bo – that the size of residents' wheelchairs necessitated increasing the table space, and other residents needed to change seats accordingly.



(The kitchen facilities at Lis's ward at Lillevang)

Like the other ward residents, Lis had her breakfast on her own once staff had assisted her out of bed and into the dining room. A staff member further helped her to come to the dining table for lunch at 12 noon, for coffee at 3 o'clock in the afternoon and for dinner at around 6 o'clock in the evening. She spent most of the remainder of the day in her flat.

The layout of the kitchen facilities in the nursing homes were inscribed with references to how it makes sense to move and how the facilities could easily be used (cf. Casey 1996, 2003 and Mortensen 2008). I return to these inscriptions for behaviour later, but for the moment I would like to emphasise the amount of free space around the dining table, which made movements with wheelchairs and zimmer frames easier. The kitchen facilities and the dining table were situated close to each other, thus providing Lis and her fellow residents with an opportunity to observe the ongoing meal preparations in the open kitchen.

The location and the activities in the dining room were very similar in the four nursing homes in this study, despite the different number of ward residents. At Lillevang all participating residents and staff (as described from Lis's ward) shared one table. On the larger wards in the other three nursing homes, residents and staff sat at small tables with three to five residents at each table and from one to four staff members eating at the different tables. However, at Sølund the kitchen activities were only visible for a few residents seated in the dining room. Nevertheless, irrespective of the number of residents, the staff conducted their social activities in very similar ways during the meals on the wards.

The dining room hosted a range of different functions, and in my notes on the observations I made, I often felt as if I was in some sort of waiting room at a railway station. During the daytime there was a constant flow of staff, residents, relatives and different skilled workers passing through the dining room.

The important aspect was that the rush hour at lunch created a substantial flow, whereas the meals at 6 o'clock p.m. were not affected by these distractions to the same extent. So although it can be argued that the dining room is inscribed with references to its use, the kitchen facilities were used differently on a weekday. The sense of a place of work prevailed at lunch due to the movements of the different groups of staff and the conversation, whereas the evening meals were not interrupted to the same extent (Casey 1996, 2003).

Staff took part in the meals I observed in the four nursing homes in different ways, and accordingly it was possible to distinguish between different meal situations. The situation most often observed was one in which the staff joined the residents at the

table and sat down with them for most of the meal. In the following, I will concentrate on the most common meal situations in which staff and residents ate together in the four nursing homes.⁵⁶

The Meal on Lis's Ward

On Lis's ward, the staff sat down and shared the meal with the residents. This implied that they laid the table, served the residents and asked them several times whether they wanted any more to eat. Once the meal was finished, they cleaned the table, stored the leftovers and cleaned up the kitchen facilities. These meals lasted up to 45 minutes, and although the conversation was often interrupted, especially at lunchtime, this meal gave the impression of people eating together.

The way the staff, Lis and her fellow residents behaved at the dining table resembled the roles of invited guests and hosts. They initially followed the etiquette for this kind of social process. Lis and her fellow residents waited for the staff to be seated and then began to eat. Staff also initiated conversation by bringing up different topics for conversation, such as the preparation of traditional dishes, the weather, or a television programme from the evening before. Most often, the staff member asked the residents directly for their opinions on a certain topic and in this way tried to produce a flow of conversation. Residents readily answered the staff's questions, but they remained silent if the staff did not elaborate further on the issues in the conversation. Residents rarely took up a new issue for conversation themselves.

This implied that the majority of the residents accepted staff's expectations concerning the good resident, as discussed in the previous chapter. If staff wanted residents to talk, the latter behaved accordingly. If the opposite was the case, they did not say a word. At times residents used the meals as a protest, or they were not convinced that they were part of a social event. I will use two cases to illustrate this.

⁵⁶ On some occasions staff apologized for not undertaking the meal activities as they wished due to the low level of staffing, imminent meetings, the introduction of new staff members etc. However, the below description seemed to be more or less the permanent situation at meal times.

In one case, I observed two staff members talking among themselves and asking residents questions during lunch. Just before three o'clock, the staff member who was working the evening shift attended. For nearly two hours, Lis and three fellow residents sat at the dining table having their afternoon coffee. The staff member was mostly absent, and when she was present in the kitchen, she was kept busy with administrative tasks. They did not say a word between them, despite being able to talk. Nor did they read the papers or fall asleep. A mobile phone rang. One of the residents talked with a relative about the weather, hung up and the silence continued. The four residents waited for the staff to take the initiative and remained seated until the staff served dinner.

On Anders's ward, one member of staff encouraged the residents themselves to initiate the conversation. She told the residents at breakfast that her chocolate gateau would be ready just before 11 o'clock and invited them to come for a piece of freshly baked cake. Other residents occasionally passing through were invited as well. Five residents were present when the cake was ready, and the member of staff waited on them with the coffee and cake, saying: "*Now you can really enjoy yourselves*". The residents ate their cake and drank their coffee, then took a further piece and confirmed that the cake was indeed delicious when staff enquired. Among themselves, however, the residents did not say a word. The staff member provided more coffee and asked if anybody wanted any more cake. As no one did, the member of staff started asking whether she could take their cups and plates away.

These examples show the member of staff inviting the residents for a social event. The latter accepted the kind invitation, but used the event for a different purpose. If all present agreed that a social event had been established, then their attitude was one of articulating the unspoken criticism or hostility of the group and the leaders. In this case, the protest was directed towards the staff. If they were not convinced that this was a social event, their silence indicated this. Either way, the residents changed the event into something different from what the staff meant it to be. At times the staff's response was to offer food and drink, as in the case just described, and then put them away again.

In the nursing home context, other reactions may also apply, such as apathy, despair or just sadness of the confused condition of fellow residents. In particular, protest or apathy was a reaction to staffs' discussions of residents' intimate details, as I shall describe below.

Intimate Details at Meal

During fieldwork, I was struck by residents' silence at meals if staff did not directly ask them for their opinions. In the following, I will show further that this was partly because of staff mentioning residents' intimate details, which meant they were being referred to as bodies in need.

Staff turnover and understaffing necessitated regular instructions between staff. I often heard these before, during and after the meals. On Lis's ward, one new member of staff asked the colleague who was preparing the final food items how she should invite Lis to the table. The other staff member answered, "*You are just supposed to tell her that lunch is served, and then you assist her out here*". The meaning was that the new member of staff should avoid discussing any individual needs that might postpone Lis's arrival at the dining table and just push her in her wheelchair into the dining room.

At one lunch on Lis's ward, one staff member apparently suddenly thought of something and interrupted herself in the middle of an argument about the proper quality of sausages. She addressed her colleague at the other end of the dining table. "*The sanitary napkins you ordered for Lis were of the wrong size. Did you remember to change this order in accordance with my instructions?*" The colleague replied: "*Absolutely*". Contrary to Gad's advice on etiquette (2006), this entailed discussing matters of privacy and should have been left out of the conversation. In addition, the remarks drew other residents' attention to the embarrassing fact that Lis was unable to control some of her bodily functions (cf. Lupton 1996).

I often observed incidents when members of staff who had just finished attending to the residents and had been asking a resident about a certain matter immediately changed the subject and asked a colleague about other problems concerning groceries

or important instructions for the new member of staff arriving in the afternoon. It was also evident that residents were used to topics of conversation being changed in this way. Residents accepted such interruptions and kept quiet until asked something again by the staff.

One observation from Oline's ward indicates that residents preferred to keep intimate details between residents and staff within the confines of the private flat. On this occasion, staff and residents had gathered for dinner. One female resident started to leave the table. A few feet from the table, a member of staff called out in a loud voice: "*Do you need to go to the toilet, dear?*" The resident made no answer. The member of staff then left the table and caught up with the female resident further down the corridor, where I heard them discretely lowering their voices. The member of staff asked again, and the resident nodded her head and confirmed that she indeed needed to go to the toilet.

These examples show that private matters were revealed which residents preferred to be discussed elsewhere, preferably in their flat with their contact person. Residents seemed to follow Gad's (2006) advice by trying to keep these private matters out of conversations. Following Goffman (1971), they preferred backstage information and related activities to be kept backstage. Lis's reactions indicate a similar intention. As soon as she had finished eating, she asked to be assisted back into her flat and kept on saying so until assisted by the staff.

When these private matters were mentioned, the rules of etiquette described by Gad (2006) were broken, and the situation became embarrassing for the residents. As an embarrassment, their silence could be a way of criticizing the staff (cf. Knudsen 1996) or of indicating that they were not convinced that a meal as a social event was established.

Discussing the Residents Present at the Meal

The following example illustrates the breaking of another piece of etiquette, that is, clearly leaving a resident out of the discussion and talking about her over her head. Six residents were gathered together at the dining table on Bo's ward. Two members of staff were also present. One of them asked Anna, a resident, "*Anna, how many*

potatoes would you like? Anna in a low voice said, *“Please, I would like three.”* Staff: *“Oh three, it seems you are well again, I am so happy to hear that.”* The member of staff finished waiting on the other residents and a little later addressed her colleague at the other end of the table while nodding towards Anna: *“She’s much better today, don’t you think?”* The colleague agreed by nodding her head.

Wackerhausen (2002) and Paterniti (2003) add to our understanding of residents’ protests. They both argue, from studies of patients and nursing home residents, that it is embarrassing to be talked about when one is physically present without being talked to directly.

Summing up so far, nursing home meals were not cosy situations, as staff and residents did not follow the proper etiquette mostly. Residents did not add to the flow of conversation, and by failing to do so expressed their disapproval of the staff (Knudsen 1996), while the latter exposed residents’ private affairs to the general public assembled around the dining table.

By further talking over residents’ heads, staff sometimes excluded the residents who were present from the conversation. Consequently, the nursing home meal did not seem to create the community among residents and staff by sharing meals together that Simmel (1998) suggested. As a social process in which all the participants knew their roles, the staff and residents seemed to go beyond these expectations.

During fieldwork it also struck me to ask why residents did not protest more loudly. I believe that a fear of endangering their mutual relations with their contact persons could be the main reason. Remaining silent could be a way of making the situation more endurable by indicating that they were not convinced that a meal as a social event was established.

In this respect, it must be stressed that residents’ ability to speak was not generally influenced by their disability. Therefore speaking or remaining silent during meals and expressing a wish to leave the table was in many cases their only possible way of influencing what happened at meals. As already mentioned, apathy, despair and

eventually a loss of hope (see the next chapter) could presumably also account for the silence.

Lydia, a resident on Oline's ward, expressed the view that staff generally failed to convince them that it was a meal they were being invited for: "*We don't need to come together. We are here because we are unable to manage on our own.*" And further, in a later interview: "*They have told us that it is supposed to be cosy. But you can't force people into such an atmosphere.*" Dorthe, who turned down such invitations, said: "*What should I be doing out there? They [the other residents] are unable to say two reasonable words in a row*". At times Lis reflected upon her behaviour in the interviews and her desire to be assisted back to her flat as soon as she had finished eating: "*I know that some of them [the staff members on the ward] see me as tiresome.*"

What Were the Obstacles?

In the preceding, I identified two obstacles to establish the ideal meal on the nursing home wards: First, the exchange of residents' intimate details among staff members, and secondly the residents' silence, which was a breach of the etiquette of maintaining the flow of conversation. To the list of obstacles preventing the ideal meal from becoming a reality in the nursing home, I will add the interruptions to meals by staff passing by, the hierarchy among the residents and the flow of new residents below.

Before I turn to these obstacles, I would like to stress how fragile the meals situation was. As was the case with the mutual relations, staff were able to choose between invoking such relations or treating residents with respect to bureaucratic regulations. Concerning the meal, staff could discuss residents' different experiences while preparing food, for instance, or make the meal a place of work. The consequence for residents was to pay some attention to their personal status or mostly to accept their being treated on grounds of sameness, that is, as their all being disabled bodies in need of food.

Frames of Communication

The meal also involves communication and the establishment of fragile communicative frames. Applying Bateson's (1972) concepts of framing to the nursing

home context, I find that an implicit aspect of staff's invitations is that the situation is framed by rules of etiquette that should be observed by the participants in the meal. A frame in Bateson's definition is meta-communicative and helps the participant understand the messages exchanged within it. A frame consists of the number of messages exchanged within a certain period of time (ibid.: 186). The frame is not necessarily defined by words, but also by non-verbal communication consisting of a well-provided dining table, denoting non-verbally that a meal is about to begin. In other words, the advice on etiquette is but one element defining the frame.

Bateson (1972) further argues "*That human verbal communication can operate and always does operate at many contrasting levels of abstraction*" (Bateson 1972: 177-8). He defines three levels of abstraction, and I will use the invitation to a typical meal on Bo's ward as an illustration of these levels. A staff member would typically cry out from the kitchen that lunch or dinner was now ready, thus denoting that it was time to eat and that those residents who were able to walk unassisted should come to the table. Furthermore it often included a comment to her colleague to start assisting the other residents who were unable to come up to the table on their own. Bo would typically reply: "*Thank you, I'll be right there,*" from his flat, indicating that he would come to join the others at the dining table as soon as he was able to. Above this level of denoting the actual situation, an additional meta-linguistic message from Bo can be identified, namely that Bo felt well today, and further that he preferred the company of the others to eating alone. According to Bateson, messages of this kind often carry implicit meanings (ibid.). Another meta-communicative level can also be identified above this level. This could be a message sent by the staff indicating that we are now supposed to eat like a group, talk, discuss things and create a cosy atmosphere as part of a social process where we all know our roles.

An important aspect of the frame is its labile nature and the fact that it can change several times during a communicative sequence (ibid.). The frame breaks down if the meta-message is misunderstood, there are disagreements about the message or when work-related issues assume a priority during meals, as I shall argue below.

Parallel Frames

The nursing home actually has different meta-communicative frames, of which the meal is but one. As MacAloon suggests (1984), a number of frames can exist simultaneously. MacAloon elaborates on Bateson's position and defines genres in his analysis of the Olympic Games. These genres are closely related to Bateson's meta-communicative frames. Genres "*can be seen to have specifiable, meta-communicative frame markers that organize the variable contents of the frames*" (MacAloon 1984: 259). These genres "*have the additional properties of pretypifying and including fitting actions*" (ibid.: 260). This means that the genre "*also orders us to expect reverential demeanour from the actors within the frame and to conduct ourselves accordingly*" (ibid.). The genres are also interrelated, and "*certain features are shared between genres*" (ibid.).

Staff and residents move between different frames during the day. To illustrate this aspect of nursing homes, I draw primarily upon a general description of the SLE outlined by two consultants who have worked on how these nursing homes are constructed. I see their description as a sort of guideline for staffs' behaviour that is an expression of how they intended the nursing home to be appropriated. i.e. how staff and residents ought to behave and move in the facilities (cf. Casey 1996, 2003). They describe the layout of the nursing home in terms of "*zones defined according to level of privacy*" (Hjorth-Hansen and Jensen 2002: 43). Within each zone, there are rules defining levels of residents' privacy. In this respect, I use the zones as frames described by the level of privacy, but also by meta-communication concerning the implications for conduct within these zones.

A resident's own apartment is the most private zone. The meta-communication advises staff to respect privacy and to ensure that personal care and intimate details only be exchanged between the resident and the contact person in the flat. The door is a non-verbal communicator. By being left either open or closed, doors express residents' openness to visitors or their desire to be left on their own respectively (Hjorth-Hansen and Nielsen 2002).⁵⁷ Immediately outside the door in the semi-private

⁵⁷ See, however, Buus 2001 for an interesting discussion of staff's lack of respect of this non-verbal communicator. As already mentioned, I also observed this lack of respect for residents'

zone, there is a niche allowing residents to step aside, observe the life in the corridors and greet other residents. Communication here is semi-private between residents and staff and among the residents themselves. This zone also includes the dining table, “*which is a part of the flat for those residents living there*” (Hjorth-Hansen and Jensen 2002: 44). According to the description of one of the SLEs in this study, conversation and behaviour is friendly, peaceful and includes consideration of others. In this zone, residents and staff meet by coincidence (Helsingør Kommune 2005b). Hjorth-Hansen and Jensen (2002) further argue that the semi-public zone is the area outside the wards, which contains the activity centres and other facilities such as the hairdresser, café and physiotherapist. Meetings in the local residents’ association allow residents to talk about topics such as food quality, staff care and the like. The public areas are the areas outside the nursing home.

The dining room is in the semi-private zone, and according to the above definition of zones, the privacy of the flats should be respected in the dining room. The meals contained the potential to bridge the private and the social (cf. Simmel 1998). Nevertheless, work-related issues tended to assume priority, as I shall underline below.

Other members of staff passing by

There was a constant flow of different members of staff passing through the dining room. These coincidental encounters prompted mutual greetings, and in most cases a little small talk was exchanged. During the day, the staff discussed everyday occurrences on the ward in the dining room, their schedules, and often forthcoming changes, afternoon meetings or other events. They also gathered for minor breaks in the dining room, whereas the regular weekly meetings and longer breaks were held in meeting rooms, in a vacant apartment, on the terrace or in an otherwise rarely used television lounge. Staff discussed residents’ external activities, their functional status with their relatives, and their medication with their general practitioners and at times with the pharmacy by telephone in the dining room. This was also where staff answered residents’ calls for assistance.

privacy in staff knocking on the door and in the vast majority of cases entering the flat straightaway without waiting for residents to answer.

If residents needed staff's assistance, they looked out for them in the dining room, where the staff met and exchanged brief messages or asked each other for assistance. Sometimes they called each other from further down the corridor, and I often heard a call for assistance or an inquiry about a residents' medication from one end of the ward to the other. The dishwasher in the kitchen started at regular intervals, the sound echoing like a jet engine. From the kitchen came also the sound of plates, forks and knives. A scream of pain and another resident swearing loudly about something, a long fit of coughing or similar loud outbursts, also mingled with the constant sounds.

Residents also used the dining room as a sort of sitting room. In the daytime, there were typically from one to three residents present in the dining room on the larger wards. Mostly these were the same residents, who watched television every day, listened to the radio, read a paper or just watched the ongoing activities from one of the settees in the dining room. Furthermore, one or two of the residents might be asleep, and in some cases the sound of their snoring became increasingly prominent. A few residents passed the dining room, as they were able to walk unassisted to the next-door café or the grocery store nearby.

These observations indicate that there were at least two parallel or overlapping frames in the dining room. The residents used the dining room as their living or sitting rooms. The room was also an informal meeting room for the staff. This made the invitation to the meal an additional frame, one which stood in opposition to the two existing parallel frames.

The following observation on Bo's ward indicates how easily the meal frame broke down. While questions and answers went back and forth about a particular type of tasty pickled herring and residents' experiences in preparing these themselves, a member of staff from the ward next door entered and interrupted. She asked one of the members of staff at the table about the staffing situation for the afternoon by interrupting a resident's answer. On these occasions, any ongoing conversation stopped and the staff started a conversation with the member of staff who had interrupted. Later the staff at the table continued this discussion.

It was evident that the member of staff had broken the meal frame by giving priority to work-related issues. Furthermore, by standing on the fringe of the group, she had behaved inappropriately in the Danish context (Knudsen 1996). However, the interesting aspect of this example is that staff continued the work-related discussion. This illustrates both the labile nature of the frame and the change of frames during the communicative sequence (Bateson 1972). As staff then continued their discussion, residents were left out of the conversation, contrary to Gad's (2006) and Knudsen's advice on etiquette. Since this was not followed, the meal as a meta-communicative frame ceased to exist and the work frame took priority.

The reaction of residents to these situations was yet more silence. In this case I see this not only as a protest, as they were now left out of the conversation and not asked to participate. Also, this could be a sign of apathy or even despair.

The Hierarchy among Residents

My observations and interviews indicate that hierarchies existed among the residents. The hierarchy also influenced the flow of conversation at the dining table, as residents at the top of the hierarchy often chose not to answer questions from residents at the bottom of the hierarchy. Presumably as a consequence of the struggle to obtain staffs' attention, residents were anxious if their contact person paid other residents too much attention. In this way the meal was a constant negotiation of the social hierarchy among the residents (cf. Mäkelä 2000), leaving the impression that the residents were watching one another.

The hierarchy among the residents was based upon their respective mental and physical abilities: For instance, being able to express oneself or to leave the dining table unassisted created a position at the top of the hierarchy and vice versa. Often residents at the top of the hierarchy set the table, played the piano and distributed free samples of daily papers, or sometimes they assisted residents suffering from dementia. In this way, they assisted staff in running the floor.

On Lis's ward, Cecilie was at the top of the hierarchy, as she was able to express herself and leave the table unassisted. If Cecilie decided that she did not want to

attend an event, then staff often supported her wish while at the same time trying to persuade the others to attend. Lis could express herself but was unable to leave the table unassisted, and this left her in the middle, with the residents suffering from dementia at the bottom of the hierarchy.⁵⁸

Karen on Anders's ward was one resident who was suffering from dementia. She was nearly always present in the dining room, saying, "*Hello, who are you*" to everyone entering or passing through the room. Then a new resident arrived on the ward. Normally one or two other residents would become angry with Karen's constant questioning and told her in a more or less polite way to stay silent. Hans normally said nothing in these disputes, but as there was a new resident present, he also gave her the sharp end of his tongue to show the new resident that he was part of this group and intended to keep Karen at the bottom of the hierarchy.

Residents at the top of the hierarchy were appreciated by staff, as they usually added to the flow of conversation and like Bo helped set the table and passed the trays around during the meal. In this way, they assisted staff to keep the floor in order, as Gubrium has also argued (1975). When residents preferred not to communicate with those at the lower end of the hierarchy, the hierarchy became evident, contrary to Simmel's (1998) and later Knudsen's (1996) arguments. It should be pointed out that the mutual relations established between staff and residents supported these hierarchies, as the residents who were mostly prized by staff were also those at the top of the hierarchy.

Some residents used the advice concerning etiquette to distinguish themselves from other residents. Gullestad (1985) provides a good illustration from a discussion of a wealthy elderly woman in Oslo. Etiquette and the search for perfection were the basic ideas explaining the way she ate. This was a form of non-verbal communication, through which the elderly woman expressed her status. As she was a widow, most often only the servant was left in the house, and she preferred to eat alone rather than with the servant (Gullestad 1986). According to Jenkins (1999), this use of etiquette can be an indicator of class-based lifestyle hierarchies. As already mentioned,

⁵⁸ See also Gubrium 1975 for a further discussion of hierarchy on a nursing home ward.

residents who preferred to eat alone referred to other residents' bad manners to justify their doing so. Following Holm and Iversen (1997), this could be seen as their way of defining a social position and at the same time marking a distance from those whose eating habits were different.

As another example of this, Erna preferred to eat in her flat, as she felt that her lack of physical abilities was evident in the dining room from the mere fact that she used a wheelchair and needed the staff's assistance to enter the dining room. In addition she lacked an appetite, but according to etiquette felt that she had to finish all the food on her plate in the dining room, whereas in her own flat leftovers were more acceptable. Oda similarly restricted her eating in the dining room, as she felt exposed to the other residents' criticisms. This interpretation is further supported by studies of geriatric care in Sweden, where elderly patients restrict their eating to avoid exposing their mental or physical impairments (Sidenwall et al. 1994).

The Flow of New Residents

As I had the opportunity to observe the wards for six months, I was able to observe how some of the new residents influenced mealtimes. Flats for elderly people in temporary respite care also influenced the wards. This meant that a new resident was enrolled every second week for a two-week period. Some of these new residents changed mealtimes completely, as in some cases staff constantly had to tell them how to behave, whereas others were helpful in adding to the flow of conversation.

Bo added to this flow, as he was indeed talkative. However, one of the elderly women became angry with him, as he now received a lot of attention from the staff compared to before he entered the ward. Although a lot of the conversation consisted of small talk, staff on Bo's ward found it much easier to get through the meals, "*as they didn't need to do all the talking*".

Finally it should be stressed that participation in nursing home meals requires some basic social competence. Given the high number of residents suffering from dementia, a flow of conversation was difficult to establish. Furthermore, defective hearing and failing sight increased staff's problems in this respect. The new residents had been

living alone previously, but the transition to the nursing home still required adjustments to their hearing aids. Consequently, they were uncertain as to which topic was being mentioned, and they hesitated to answer staff's questions. One female resident showed how sensitive this matter could be: Bo's wheelchair took up more space than an ordinary chair, and she had to move hers to allow him in. This left her unable to hear and answer many of the questions, and she felt left out of the conversation.

Staff decided on a common denominator concerning residents' physical eating behaviour or the acceptable level of un-learned etiquette. In other words, they decided which residents they would help with eating and cutting up their food, and accordingly which ones would be allowed to eat on their own and to help themselves to food items from the trays. Furthermore, residents suffering from dementia were at times reduced to being in their flats before meals began if staff considered they were becoming too dominant.

Summing up, I suggest that nursing homes contain a series of obstacles to creating the idea of a meal among ward residents that could ultimately create some sort of community among them along the lines suggested by Simmel (1998).

Conclusion

When Lis's napkins became an issue at one nursing home meal, it occurred to me why she was reluctant to accept invitations to meals by staff and why, as soon as she had finished eating, she expressed a wish to be assisted back to her flat. Like the majority of the residents in this study, she stayed silent during meals and only answered staff's questions. By not adding to the flow of conversation, she and the majority of the residents expressed their criticism of the staff, or indicated that they were not convinced of the existence of the meal based on the staff giving priority to work-related issues, which included mentioning intimate details about the residents. Through their criticism, residents added a different meaning to the meal and, contrary to Simmel's argument (1998), most often no community came into existence among the meal's participants. In many cases the meals were consequently reduced to their purely biological component, with the feeding taking priority. In this way the dining

tables were appropriated and dominated mainly by staff and turned by them into places of work through this behaviour (cf. Casey 1996, 2003). This also illustrates staff's difficulties in incorporating the meals as social processes into their work and residents inability to negotiate the stigma of being bodies in need in these situations.

The meal was a social and very fragile process (cf. Zahavi 2003), with certain conventions for the roles of the staff and the residents respectively. However, etiquette, a confusion of front-stage and backstage information and a series of obstacles prevented the meal from becoming the cosy affair that staff described being one of the ideal ways of being together with the residents. In this way, the majority of the meals I observed reflected a distinction between the ideal situations described in the nursing home leaflets and the way meals were organised in practice. I will return to this distinction between ideal description and practice in nursing homes in the next chapter.

The meals could also be seen as a test of the mutual relationship between staff and residents, which, from residents' reactions, indicated that they did not intend to accept serious deviations from their expectations towards the staff. These reactions were not observed on every occasion as a silent protest, or were just not perceived as convinced of the existence of the meal. At times I also observed a sign of apathy or even despair and sadness in their reactions, as they had been residents for several months. Furthermore, maintaining their position in the hierarchy could also be a reason for them keeping silent. As suggested, residents used silence as virtually their only possible way of using agency and influencing the staff to create a more endurable situation, while also being aware of not endangering their mutual relations. From this perspective, by choosing to eat on their own, residents could also be seen to be expressing a kind of protest or a failure to be convinced of the existence of the meal.

Hans, Anna, Lis and Oline mainly resisted the nursing home practice at the meals, as shown by Lis. Nevertheless, often the meals were embarrassing situations for all sixteen residents, and thus a daily aspect of their lives they had to endure nearly irrespectively of how they adopted to the nursing home practice.

However, they hoped to improve their physical abilities and to a larger extent influence the day-to-day life on the wards. As Jackson suggests (2005), their struggle for being was expressed in a hope, as I shall discuss in the next chapter.

But, as more than 60% of Danish nursing home residents suffer from under-nutrition, I believe it is worthwhile discussing how this meal could be turned into a more pleasant event for both residents and staff, which in turn could influence residents' consumption of food and drink in a positive way.

The meals analysed in this chapter were those I most often observed in the four nursing homes. On a few occasions, however, staff succeeded in creating the ideal described in the early part of this chapter. This was observed in both a traditional nursing home and in one SLE when, for instance, four staff members remained seated during the meal, protecting the meal from all distractions and overcoming the identified obstacles as much as possible. The individual staff members talked with two or three residents in small groups, and both the staff and the residents seemed to enjoy the event, which all those present agreed was indeed a meal.

6. Quality of Life at the Nursing Home

Introduction

Upon her transition to the nursing home called Bakkegården, Lise described her new flat there as a “*Good exchange*” (“*Et godt bytte*”). She was so pleased to get rid of the toilet chair in her previous bedroom. The door now leading into her toilet had enough width for her to enter with her wheelchair. She was also able to leave her flat unassisted, and the areas outside her new flat were accessible to her. At the rehabilitation centre, if she felt tired after the training, she did not need to wait for the bus to arrive. She could leave for her flat whenever she wanted to. In her previous home she was unable to leave the flat unassisted. In my view Lise’s “*Good exchange*” reflected the improvement in her mobility that was made possible mainly by the physical layout of the nursing home. These improvements also supported her hope of bodily improvements.

Prior to the transition to Bakkegården, Lise and the other sixteen new residents expressed the hope of improving their physical abilities, in which the rehabilitation facilities in the nursing homes played a significant role.⁵⁹ Lise was looking forward to intensifying her training at the rehabilitation centre upon her transition. With improved physical abilities, she intended to visit her daughter entirely unassisted in her wheelchair and eventually be able to walk again with a zimmer frame. However, after six months she was becoming increasingly impatient concerning the anticipated improvements: “*They tell me that it takes time and patience to improve. My legs will get better. But do you know what? The thing is, I have no patience, they know that ... and it is difficult for me to see any improvement whatsoever*”. At the end of the research period, Lise described her physical situation as: “*Just worse than ever...*” In a similar vein, the other residents shared Lise’s experience after six months. At the most the new residents were provided with an opportunity to attend the rehabilitation centre twice a week, and among them there was a general understanding that this was not enough: “*It does not help to improve anything*”, as Lis commented of her

⁵⁹ Individuals in Nordic welfare states enjoy rights to rehabilitation (Ingstad 1995). In the nursing home context, it is the municipality that has this responsibility.

rehabilitation activities, in despair.⁶⁰ This reflects that the part of their agency concerning maintaining the hope for improvements also began to decline at the end of the third phase in the transition.



(Lise before the move to the nursing home)

⁶⁰ Intensive and moderate physical training have positive effects on muscle strength and mobility for the elderly (70+) in institutions with multiple diagnoses (Rydwick et al. 2004). Lise and Lis therefore had every reason to believe that the rehabilitation activities would improve their physical abilities.

Political discussions regarding restructuring and priorities in Danish care for the aged often apply the argument that the ability to move independently will eventually improve residents' quality of life (Fromholt 1998). A good quality of life is defined in terms of independence - i.e. that in only a few cases do elderly people need to ask for assistance in meeting demands - and the physical ability to choose between activities and social relationships (cf. Crogan 2003). In the present chapter I will argue that Lise's (and the majority of the other fifteen residents') quality of life improved upon the transition and later declined along with the physical decline of their bodies. To understand this shift, I apply respectively a qualitative and a quantitative perspective on the issue of quality of life. The argument I pursue is that a quantitative perspective on quality of life alone means a focus on physical decline. This perspective needs a phenomenological supplement to understand temporary improvements in the quality of life.

As a quantitative indicator for developments in the quality of life during the transition of the sixteen new residents to the nursing home, I have used the part of the Minimum Data Set (MDS) called 'Resident Assessment Instrument' (RAI) (Crogan 2003). For a qualitative perspective, I have used an approach inspired by phenomenology mainly represented by Leder (1990), Good (1994) and Merleau-Ponty (1994). The MDS data provide an average perspective on residents' development based on figures, whereas the phenomenological approach highlights the importance of the elderly people's own perceptions of their surroundings through bodily perception.

By attending the rehabilitation activities, the aim of the elderly people was to reverse the process in which bodily disability increased their need for assistance and eventually led to assessment for nursing care. A process which had brought along the increasing institutionalisation of them and the phasing out of their personal identity. Following Jackson (2005), a major aspect of what made the transition endurable for the elderly was the hope for improvements of their physical abilities, a hope that held a vital role for the elderly (cf. Jackson 2005).

Their surroundings were perceived through the body's own conditions. But in this process their bodies increasingly became prisons, as they blocked their access to and interaction with these surroundings. The important point here is that their bodies were

also their tool for re-establishing this access (cf. Merleau-Ponty's 1994), in this case through rehabilitation. To reverse the process also meant improved agency to move and appropriate their immediate surroundings from places dominated by staff's work into places also dominated by their own movements (cf. Casey 1996, 2003). It further entailed the prospect of distancing themselves from the stigma of being treated as bodies in need.

Presumably they could also learn some of the appropriate behaviour they had unlearned at meals and thus keep their position in the hierarchy on the wards. To a greater extent they intended, in Jackson's words to "*experience themselves as world makers*" (Jackson 1998: 8).

In addition, by being active in the rehabilitation centres, the residents fulfilled one of the staff's expectations of what it was to be a good resident. Staff seemed to be rewarded if, as Mattingly suggests from a study of occupational therapists in Boston, USA, they succeeded in uncovering residents' own resources and motivated them into hoping for a better life by use of those resources (Mattingly 1998). The nursing staff in this study saw this as a positive outcome of their care, as it eased their work. Nevertheless, staff perceived it as realistic for residents just to maintain their present physical abilities, not to improve them. I.e. residents' prospects of actually improving their abilities were not supported by staff, as staff saw this as residents' own responsibility. This lack of support presumably also influenced Lise's attitude at the end of the research period. Again the aspect of intersubjectivity concerning relations played an important role in keeping residents active in rehabilitation centres and fulfil this mutual obligation.

Lise at the Rehabilitation Centre

Below I will give a brief description of Lise's activities in the rehabilitation centre. The facilities were different in the four nursing homes in this study, but the time that Lise spent there and the exercise she carried out provide an illustration of the residents' bi-weekly activities in the rehabilitation centres. All the new residents

attended this type of activity, and only illness prevented them from doing so.⁶¹ This is remarkable, as both good residents and those who resisted to adopt to the nursing home practice attended, and this indicates the importance of these activities for all residents.

Approaching the nursing home by car, signs informed me of the presence of elderly people, and road humps prevented me from speeding. In the late morning, I saw two old people slowly walking along the pavement with their zimmer frames, while another was driving an electric wheelchair. I met up with Lise in her flat in the nursing home. We had an appointment for 10 o'clock in the morning, but although I was on time, she was impatient to leave for the rehabilitation centre, where she was scheduled for training a quarter of an hour later. For me the distance of a little more than 200 feet would have taken approximately two or three minutes to walk, but Lise was only able to drive her wheelchair very slowly, and we arrived just before she was scheduled to start her training.

The staff greeted her cheerfully. She waited a while, and one member of staff asked her to stand up. Lise tried once but was unsuccessful. She paused and with a helping hand finally succeeded and was assisted to one of the exercise bikes, where, along with three other elderly people, she 'rode' the machine with both legs and arms for approximately ten minutes. The residents were nearly lying down in a kind of armchair, and as their feet were strapped to the pedals, they did not need to worry about their balance. While she and the other elderly people were doing this, the two members of staff were helping other residents, who were walking with zimmer frames.

Afterwards Lise had a short break and was assisted with the zimmer frame. This zimmer frame was adjustable, and Lise was able to lean her arms on to it while she was still standing in an upright position, as it supported her just below her elbows. A belt was strapped behind her back to help her retain her grip. She was very anxious for the assistant to remain right next to her during the exercise, as a year ago she had twisted her ankle during a similar exercise. They started at one end of the room and

⁶¹ Staff informed Dorte that she had to wait for a training programme designed for her, which she did not in fact start during the research period. Another resident, Anders, had no need of rehabilitation.

walked to the other end, paused for a minute and then walked back again. The assistant made a serious effort to encourage Lise and cheered her up when she felt exhausted. They had both lived for several years in the eastern part of Jutland, Denmark and when Lise complained to the assistant, she convinced her by saying: *“Oh Lise, we only had our lunch at this pub. Now do you remember their cakes at that restaurant further down the road?”* Lise remembered, and the assistant continued as they reached the other end of the room again. *“So Lise, it is about time for our supper. The inn at the top of the hill. Can you see it... Their steaks are so delicate and the view is marvellous...”* As they were just about to reach the end, the member of staff said: *“Oh Lise, I can see it is closed. We need to move further on...”* By the time they had reached the end of the room again, Lise was exhausted. She was praised by the assistant and helped back into her wheelchair. This final exercise lasted approximately fifteen minutes, and Lise rested for a while in her wheelchair. She started to drive it even more slowly than before, and as we reached the lift she asked me to push the wheelchair inside for her, as she felt exhausted and we were out of sight of the staff at the rehabilitation centre.⁶²

Quality of Life

In this section, I will turn to a discussion of the quality of life definitions that have been adapted and reformulated to fit different purposes and cover many aspects of human life (Forchhammer 1995). This reflects the group of people being investigated (Forchhammer 1995) and the disciplines involved in making the definitions (Rydwik

⁶² I observed two incidents underlining residents' extensive need for the assistance of staff. The first was at a cinema event in *Midtpunktet* at Sølund, where a film was being shown to residents. Looking at the residents on this occasion was strange. Only a few of them were actually watching the film. Most of them were looking elsewhere, as there was a lot of distraction while the film was on. On one occasion, a resident wanted to leave, but her electric wheelchair became tangled up with another wheelchair. There were no members of staff there, and they had to wait for one to turn up to assist them.

The second was at a Shipyard Club for retired workers at the former shipyard in Elsinore. Here the residents were sharing stories of their work. The talk in the club had a staccato flow, which reflected the residents' unsteadiness and disabilities. One member of staff was assisting the club members, serving beers and a few bitters, which interrupted the discussions. Further interruptions occurred when residents needed assistance to go to the toilet, which often happened when fourteen elderly residents were gathered together. Others with defective hearing constantly encouraged the participants to talk one at a time. Otherwise, they lost track of the story. As they were also watching documentaries, it was difficult to agree on the appropriate level volume for everyone.

2004). The variety of aspects makes it difficult “to pin down an agreed meaning” (Phillips 2006: 1).⁶³ Also from an anthropological perspective, it seems rather illusory to define a sort of general well-being for all cultures in light of the different perspectives applied in understanding disability, ageing and a home as previously discussed.

Qualitative perspective

For purposes of the present discussion, I will refer to Phillips’ (2006) distinction between qualitative and quantitative perspectives, beginning with the former. According to Phillips (2006), the hedonistic principle, with a focus on the fulfilment of individually perceived needs, is a substantial element in the qualitative perspective. Conversely in the quantitative perspective, the focus is on healthy people who are at the recommended BMI level and consequently have limited exposure to illness, for instance.

As a starting point for the discussion, I have adopted the WHO definition of quality of life, in which the qualitative aspect is prominent:

"An individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns. It is a broad-ranging concept, incorporating in a complex way the person's physical health, psychological state, level of independence, social relationships, and their relationship to salient features of their environment."

(WHOQOL Group 2000)

This definition is aimed at defining a situation in which an individual experiences a basic, meaningful situation characterised by well-being, a good situation worth desiring where something happens as the individual anticipates. An individual in this kind of situation would be experiencing a good quality of life (Forchhammer 1995,

⁶³ In the literature, there is general acceptance of the fact that a universal definition of the quality of life concept is impossible to reach. As Ciaran illustrates (quoting Joyce et al. 1999 and Waldron et Al, 1999), with a touch of frustration: “*Patients vary significantly in the importance they attach to different aspects of their lives.... It cannot even be guaranteed that a seriously ill patient will nominate health as an important feature, let alone the most important determinant of their QoL...*” (Ciaran et al. 2005: 225).

Henriksen 1992), that is, situations in which individuals are active, have high self-esteem, are basically happy and are mutually related to other people (Næs in Henriksen 1992). These aspects of the concept have been strongly influenced by hedonistic and utilitarian perspectives, which explain positive situations based on needs being fulfilled and pleasures enjoyed. An example of this is Maslow's well-known and strongly criticised hierarchy of needs from the early 1950s. He states that there is a general pattern of needs recognition and satisfaction that people follow in the same sequence: physiological, safety, a sense of belonging and love, and esteem on the basis of which self-actualization can develop (Maslow in Forchhammer 1995). One of the major objections to this position is the implication that a constant definition of goals or hopes for future life is a basic human characteristic. Nevertheless, these goals will change during a lifetime under the influence of different life situations (Forchhammer 1995, Ciaran et al. 2005). In addition, the definition of human needs has been criticised because it is insufficient to see them as an independent part of the context people are a part of (Forchhammer 1995).

The situation for the elderly people in this study needs to be taken into account since their physical abilities were limited, and their goals are likely to have changed over the years. According to Fromholt (1998), moving into old age generally deprives people of some of the most essential physical and often also mental abilities. Fromholt further (1998) argues that this does not imply that elderly people perceive their lives in overwhelmingly negative terms, nor that old age and increasing impairment necessarily entail a poor quality of life. She further argues that life as an elderly person is characterised by bodily deprivation and loss, which, no matter how we put it, are uncontrollable, for instance, losing health, a spouse and other close relatives and in the end life itself. Consequently, pursuing autonomy and a high level of independence become less possible for elderly people (Fromholt 1998; cf. Agich 1993).

Quantitative perspective

I will use the results of the MDS assessments as the quantitative perspective upon quality of life. According to Morris et al. (1999), it is appropriate to identify improvements or deteriorations in residents' physical conditions, levels of independence and quality of life through these assessments.

Similar quantitative perspectives are often used to determine how many quality-adjusted years of life individuals can expect from a certain treatment effort (Forchhammer 1995). For instance, the quality of life concept has been used to distinguish between groups of cancer patients who would be improved by a certain treatment and groups whose condition would not be improved through it. In this way, quality of life concepts are applied in deciding which groups should receive which treatment. In addition, according to Forchhammer (1995), in cancer treatment side-effects are another significant aspect that needs to be considered, thus involving a sort of cost-benefit analysis for improving patients' health.

This reflects a tendency to invoke the quality of life concept in order to fulfil specific goals, a tendency that is closely connected to political debates over the good life and is also influenced by a demand to fix the correct priorities in welfare states that are short of resources. Furthermore, one aspect of this tendency has been to define the basic levels needed for people to be able to develop a good quality of life. This implies the identification of a series of measurable quantitative factors, as is the case with the MDS assessments. Despite an intention to create a holistic concept focusing upon all aspects of patients' lives, often the physical and mental functions are emphasised, the social aspects being more or less neglected (Forchhammer 1995).

Below I will elaborate on the quantitative perspective by first looking into the MDS assessments in more detail.

Quality of Life for Elderly People

MDS assessments

In this study I have used the American Resident Assessment Instrument (RAI) as a quantitative indicator of progress in the quality of life of the elderly people and the other residents in the wards on which they became new residents.⁶⁴ RAI is just one of a series of instruments used to define quality of life for nursing home residents. The part used here is the Minimum Data Set (MDS), which consists of a battery of questions covering 120 items organised into 23 sections. Crogan and Pasvogel (2003) regard MDS as covering a core set of demographic, clinical and functional status items that form the foundation for the comprehensive assessment of all residents in long-term care facilities. The answers to the questions in the MDS, or just parts of them, thus provide an opportunity to characterise the residents and, if used on a regular basis, provide a measure of residents' improvement or decline (Morris et al. 1999), so that treatments can be initiated accordingly. Furthermore, the instrument enables nursing homes to compare their own group of residents with, for instance, a state or national average. Below I will go into more detail with the results and later briefly mention the residents who were living on the wards when the new residents arrived.

A trained nurse carried out the MDS assessments at three stages during the transition. At first an assessment was carried out one to three months before the elderly people entered the wards, that is, at home, in sheltered accommodation or in hospital. A second assessment was carried out approximately two months after arrival in the nursing home ward and a third when six months had passed in the nursing home. The three assessments are set out by means of an average below in Table 1 in the top

⁶⁴ MDS was chosen for two reasons. First, the Institute of Food and Veterinary Research, where I am employed, has used MDS in a series of projects and gained experience from working with the instrument (see, for instance, Beck 2007). Secondly, I was able to obtain funding for the assistance of a trained nurse to work with the questionnaires.

vertical line, and the figures below cover a period of seven to eight months for the elderly people who became new residents during this study.⁶⁵

Table 1. Characteristics of the new residents

| | First assessment | Second assessment | Third assessment |
|------------------------------------|------------------------|----------------------------|----------------------------|
| Number of residents | 13 | 13 | 13 |
| Average age (min and max) | 87.9 (68-94) 1) | 88.2 (68-95) | 88.5 (68-95) |
| Number of men | 4 | 4 | 4 |
| BMI Average (min and max) | 23.2 (16.5-34.1) | 23.5 (17.7-35.5) 1) | 22.4 (17,3-27.2) 2) |
| ADL-K Average (min and max) (0-16) | 3.3 (0-12) 3) | 4.2 (0-11) | 4.6 (0-13) |
| ADL-L Average (min and max) (0-28) | 7.5 (0-23) 3) | 8.5 (0-22) | 8.9 (0-24) |
| CPS Average (min and max) (0-6) | 0.5 (0-3) | 0.9 (0-3) | 1.1 (0-3) |
| SE Average (min and max) (0-6) | 3.1 (0-6) | 3.4 (0-6) | 3.4 (0-6) |

- 1) n= 12**
- 2) n=10**
- 3) n=11**

The functional status of the residents is described by the ADL-K and ADL-L. ADL-K covers the ability to undertake personal hygiene, the use of the toilet, mobility in getting around the ward and the ability to eat. The ability to dress and undress oneself, the ability to transfer between bed and, for instance, wheelchair and mobility in bed are covered by ADL-L. The CPS concerns cognitive functions, namely the abilities to remember, to take decisions and to express oneself.

The scaling of the ADL-K and ADL-L in the questionnaire ranges from independence to total dependence. The principle is that the lowest numbers indicate independence of staff's assistance to carry out activities of daily living. That is, lower numbers indicate

⁶⁵ There are different versions of the MDS questionnaire. The one used here is the MDS-NH, that is, the version for nursing home residents. The reason was that this questionnaire enabled me to identify residents' improvements or deteriorations in the nursing home. This, however, leaves the SE results uncertain, as before the elderly people enrolled the nursing home, they would not be able to take part in the activities there, which is one of the SE questions. Through my choice of questionnaire, an increase would be expected from the first to the second assessment, as the new residents were able to answer many of the SE questions positively when they became nursing home residents.

that residents can manage on their own. Contrary to this the highest numbers show total dependency upon staff to undertake any activity in terms of daily living (despite the fact that the scales are different due to the scoring design). The CPS scaling is in principle the same, but the lowest numbers indicate that the cognitive functions are intact (0) and the highest that they are seriously damaged.

The scaling for the social engagement (SE) is the other way around, with the lowest number representing the highest level of initiative and ability to contact other persons and vice versa.

The figures in Table 1, which I will focus on, are first the BMI (Body Mass Index), secondly the development in ADL-K and ADL-L, and thirdly the SE figures. It must be stressed that the number of residents varies for the BMI, ADL-K and ADL-L, and therefore results need to be treated as indications of a development.^{66 67}

Below I discuss the figures and the experiences of the elderly people. The aim is to explain overall trends. Generally physical decline continued for the new residents. That is, the process that had led to their being assessed for nursing care did not seem to end. In other words, Lise and her fellow residents' complaints about anticipated improvements are confirmed by the figures, despite their rehabilitation activities.⁶⁸ In the MDS assessment, on average the new residents did not experience any

⁶⁶ Not all the sixteen new residents were able to participate fully in the three MDS assessments in this study due to sickness and subsequent death. The number of residents varies from ten to thirteen, as indicated in the footnotes to Table 1. Further limitations in these statistics are the low number of residents participating and the non-random way in which they were selected.

⁶⁷ To provide an impression of the level of the sixteen elderly people in this study, I will briefly compare their levels with a recent study of 441 Danish nursing home residents in different Danish nursing homes with an average age of 85 years (Beck 2007). At the second assessment, the residents in this study were on average better compared to those in Beck's (2007) study as regards ADL-K (7 (ibid.) versus 4.2 in this study) ADL-L (12 (ibid.) versus 8.5 in this study), and CPS (3 (ibid.) versus 0.9 in this study). SE was at approximately the same level (3 (ibid.) versus 3.4 in this study) and likewise BMI 23.4 (ibid.) versus 23.5 in this study).

⁶⁸ A certain decline can be expected, as muscle wasting probably results from the ageing of the neuromuscular system, combined with a decreased level of physical activity. However, to some extent this depends on individual factors for individual persons (Rydwik et al. 2004). Furthermore Morris et al. (1999) argue that the changes that can be anticipated are minor. Consequently, a change from independence to total dependence cannot be expected even over twelve months.

improvement in their quality of life, due to an overall decline in their functional status and, consequently, their increased dependence on the staff.

Lower BMI Levels

At an average BMI of 23.2, the prospective residents were close to the recommended level of between 24 and 29 (Ingerslev et al. 2002). The figure of 23.2 is an average, however, and the figures that make up this average show that nearly 60% of residents have a BMI of below 24. This resembles the average for residents in Danish nursing homes (Beck and Ovesen 1998). During the research period, their BMI declined to 22.4. Based on the decline in the BMI figures, the nursing home meals did not seem to affect residents' energy intake and thus BMI levels in a positive way. As indicated in Chapter 5, the meals were in most cases perceived as an embarrassing event and, according to Sidenvall et al. (1994), this might have restricted eating, with residents consuming very small amounts of food and, like Lis, preferring to end their meals as soon as possible. Consequently, the meals may provide some of the explanation. Multiple diagnoses and medication, depression and an inability to chew or swallow are among the other possible explanations that may influence residents' energy intake negatively (Beck 2007). MDS covers these, but it was impossible to determine which aspects were of greatest importance from the data.⁶⁹

Lower Functional Status

In the interviews, residents mainly reflected on the aspects covered by the ADL-K and ADL-L and SE. Below I will discuss these three aspects. In the first columns of Figure 1, at 3.3 the ADL-K level reflects the fact that residents needed some

⁶⁹ In this discussion of BMI levels, it should be mentioned that recent research on Danish nursing home residents indicates that those with a BMI of and above 29 seems to have the highest levels of SE, as well as a higher level of ADL-K (Beck 2007). If the decline in BMI continues, the SE level and ADL-K, ADL-L and CPS levels would nevertheless be expected to decline accordingly (Crogan and Pasvogel 2003) and to expose residents to illness and eventually death.

assistance from the home care assistants, staff in sheltered accommodation or nursing staff in hospital. The decline from 3.3 to 4.6 therefore indicates that this need for assistance increased during the research period and thus indicates a further physical impairment. The decline in ADL-L from 7.5 to 8.9 indicates the same tendency.

ADL-K

ADL-K covers, among other things, mobility within the ward. In this paragraph I will use Arne and Oda to develop a phenomenological understanding of these figures and thus supplement the quantitative figures with their lived experiences. I intend to extend briefly the basis of the temporary positive development in residents' quality of life. The examples indicate that, through its layout, the nursing home permitted increased perception of the elderly people's bodies. That is, their appropriation of their surrounding space was increased due to the change in their physical surroundings, for instance, smooth, long corridors with suitable widths, automatic doors without thresholds and lifts with automatic doors. Previously the dominant experience was that an increased, insurmountable distance arose from parts of their homes. In the nursing home, however, they could appropriate their surroundings and ultimately socialise with others to a greater extent. Furthermore, through the constant presence of staff, they knew that assistance was close by if they fell.

At Sølund, Arne was able to visit the café with his zimmer frame. He walked slowly and frequently took advantage of the benches and chairs along the walls for residents like him who needed to pause. He often invited me to join him for lunch at the café, and on a few of these occasions I realised that he had made slight acquaintances here, whom he preferred for shorter periods to the ward residents and staff. At these times, they met at the same time at the same table and thus claimed the same seats, which the other residents respected.

This situation formed a contrast to my first interviews with him in his previous home. At the first interview, Arne vividly illustrated the attention he paid to his body when I visited him at home, and I complimented him on his ability to move around in it. He answered: "*They have spoiled my body...mine and my wife's*". Here he was referring

to the doctors' surgery. He complained about the consequences that had left him nearly unable to walk along pavements for more than a hundred feet. When I asked him to describe his situation further, he underlined his difficulties in keeping his balance and how he and his wife constantly needed to pay attention to their bodies so as not to lose their balance. If he did not use his zimmer frame, he needed to think ahead as to what he could hold on to and where he could pause when he wanted to move through his flat. As described in Chapter 2, Arne and the other elderly people waiting for nursing care at home restricted their movements to a minimum. As was the case for Arne, his once familiar environment was becoming difficult to navigate, and adaptations, tools and facilities were vital in helping him to cope with this situation.

Oda was yet another example of someone who enjoyed the increased access when she moved into the nursing home. She had been waiting for nursing care at a respite care centre for three months. A walk outside this institution involved the assistance of staff, who considered her too unsteady on her feet to walk unassisted, although she had a zimmer frame. She had to give notice two days in advance if she wanted to go on an assisted walk outside the institution. However, staffing levels on the day actually determined whether or not she would receive assistance for her walk or not. This changed entirely when she entered Sølund. Using her zimmer frame, she could walk the corridors and use the lifts unassisted. She could buy her beer and wine at the newsagent and enjoy these with her acquaintances. Furthermore, she found that she could leave the institution, though only within a distance of a few hundred feet and from the pavement, to look to a flat which she previously inhabited with her late husband.

Oda's and Arne's bodies enabled them to interact with and appropriate the corridors in the nursing home and thus to some extent make the place their own, and not only dominated by the staff as the latter's place of work (cf. Casey 1996, 2003). This happened in accordance with the body's own conditions. The previous *I cannot* temporarily changed to *I can*. Through the altered surroundings in the nursing home, walking with a zimmer frame or driving a wheelchair enabled residents to appropriate parts of the surrounding corridors, which became accessible places due to the physical layout. Through increased mobility around the ward, their perception was extended.

This increase and positive development in the quality of life is not represented in the ADL-K figures, which indicate a continuous decline.

ADL-L

The residents who had suffered a stroke or a cerebrovascular event faced difficulties in moving from bed to wheelchair. Lis, for instance, needed assistance in getting out of bed in the morning and in the afternoon after her after-dinner nap, and likewise she had to be helped into bed in the evening. She also needed assistance to dress and undress. In particular for these residents, the body was indeed a focus for them, as many intentions needed assistance to be carried out because their disabled bodies prevented them from undertaking these activities.

By applying mainly Leder's perspective, I will establish an argument for the temporarily improved quality of life. As illustrated by Arne and Oda above, new residents increased access to their surroundings.

As previously argued, it is basically through the body that people are able to gain access to the world as it is: "*The lived body is...not a located thing but a path of access, a being-in-the world*" (Leder 1992: 21). Consequently, perception and experience work primarily through the body when, for instance, we walk, run, reach, grasp or speak. "*We cannot understand the meaning and form of objects without reference to the bodily powers through which we engage them – our senses, mobility, language, desires. The lived body is not just one thing in the world, but a way in which the world comes to be*" (ibid.: 5). Our experience and perceptions of the surrounding world are shaped by our practical engagement in the world as we live "*from the body to the world...*" (ibid.: 74) and involve ourselves with physical objects and places in our surroundings (Simonsen 2001). The body thus knows itself via actual practice in the surrounding world and, as previously argued, it appropriates the home or institution and thus exerts an influence over them.

Leder argues for the "*body-as-experiencer*" (Leder 1990: 5), meaning that the body and its activities in its surroundings are the basis of human experience or "*the very medium whereby our world comes into being*" (ibid.). The world is perceived first

through the body, and Leder refers to Merleau-Ponty's clear argument: "*Consciousness is in the first place not a matter of 'I think that' but of 'I can'*" (Merleau-Ponty 2002: 159). Leder repeatedly underlines that the world is experienced primarily with the body and only secondarily with the mind. We orient most of our daily lives on the basis of the body, without the mind reflecting on this. The body thus has qualities such as cognition and intentionality, which are commonly seen as being confined to the mind. This further implies a basic assumption, which Good, paraphrasing Heidegger, expresses as follows: "*The world is constituted prior to our entry into it. It is not a result of our thinking – we are thrown into it*" (Good 1994: 122-3).

Earlier I underlined the process itself and its consequences for the elderly people. Here, however, I will briefly use the example of Oline to stress how difficult it was for the elderly people to accept these deteriorations in their functional abilities. Sclerosis had deprived her of her ability to speak, and she could only produce incomprehensible sounds, which was indeed hard for her to accept. According to her daughters, she was indeed talkative and had the ability to convince everybody of her point of view. When she lost her ability to speak, she was offered an Easy-writer⁷⁰ to assist her communication with staff and relatives, but refused to use it until a month before she died. Before she was given the Easy-writer, I interviewed her in her home by exchanging handwritten notes, as described in the first chapter. Although her feet were unsteady, after some writing she suddenly insisted on walking with me around her flat, showing me her room for doing her embroidery. On one occasion, as she was pointing towards a large piece of embroidery, she lost her balance and started to fall. I managed to intervene and prevent her from crashing into the bookshelves and helped her regain her balance.

One consequence of the elderly people's increasing physical impairment was their hesitation in undertaking certain activities. In a study of chronic pain sufferers, who have many similarities with the nursing home residents as regards perception, Good (1994) points out that the frailty of their bodies "*flows out from the body into the social world...*" (Good 1994: 123) and is "*infiltrating everyday activities...*" (ibid.).

⁷⁰ The Easywriter that Oline had installed had a small screen and a keyboard which enabled her to type words and sentences and thus communicate.

One of the consequences of the fear of falling was that, like the elderly people in this study, they had to refrain from many everyday tasks and eventually from fulfilling basic needs. *“Pain sufferers’ everyday life goals are subverted by the prominence of pain”* (ibid.: 126).

Normal Functioning

Apart from Oline, the fear of losing their balance made the elderly people focus on their bodily limitations. Leder illustrates the opposite situation from that of the elderly people in this study. He argues that, when the body has its normal, ordinary function, then it is the routine actions of the body that make it possible for humans to orient themselves towards the world surrounding them. Leder describes how people incorporate skills and exercise actions without reflecting upon them. These skills, like walking and swimming (and, as I have argued, behaviour at meals), are *“finally and fully learned when something that was once extrinsic, grasped only through explicit rules or examples, now comes to pervade my own corporeality”* (Leder 1990: 31). Leder’s very interesting assertion, which I briefly touched on in the first chapter, is that in everyday life our experience is characterised by the disappearance of our body from awareness. That is, our body becomes out of focus. He describes the situation of a body that is functioning normally with the phrase *“bodily disappearance”*, which describes the absence of the body in the mind. This means that it is not necessary to consider every step one takes if one’s feet are steady and one feels in control of the movements of one’s legs and is also able to keep one’s balance. *“Well-being is in general synonymous with my noticing nothing about my body... When functioning well this body is a transparency through which we engage in the world”* (Leder 1990: 82). Leder further describes this situation of non-reflected bodily presence as *“the absent presence of the perceiving body”* (ibid.: 13). This is ambiguous, as in one sense the body is the most inescapable presence in our lives, though according to Leder it is also essentially characterised by its absence from our minds.

Bodily Non-functioning

Following Leder's argument further, the body was indeed a focus for the elderly people. Leder's concept of bodily "*dys-appearance*" applies to the elderly people's increasing physical impairment. "*Dys-appearance*", he writes, "*is a mode, though by no means the only one, through which the body appears to explicit awareness. As such, it effects an attentional reversal of all the types of disappearance...*" (ibid.: 86). The approach towards one's surroundings then changes, as Good also argued above. Or, in Leder's geographical terms: "*A landscape is viewed not as a field of possibility but of difficulties to negotiate. The ordinary sense of free and spontaneous movement is now replaced by calculated effort; one does not want to take chances...experience of world-as-opportunity is precisely what dis-ease calls into question*" (Leder 1992: 81).

Leder's distinction between the normal and the non-functional is useful in illustrating the difference between the two modes of functioning. Nonetheless, for the elderly people, there were degrees of permanent non-functioning. Applied to the nursing home residents, the periods in which they paid limited attention to the body were brief. For instance, as Lise's training indicated, the elderly people soon became tired of walking with their zimmer frames, which increased their attention towards their balance and thereby their body. Therefore, I suggest it is more fruitful to discuss the intensity of their attention to their non-functioning bodies.

SE: Increased Social Isolation?

The only quantitative indication of an improvement in MDS was the figures representing the social engagement (SE) of the elderly people, which increased from 3.1 to 3.4.⁷¹ This change could reflect the fact that the layout of the nursing home made it easier for Lise and the majority of the other residents to take their own

⁷¹ Mor et al. 1995, in their discussion of SE levels, define a level below 4 as characteristic of low social engagement.

initiatives and participate in and ultimately be positive about the planned activities in the nursing homes. It should be realised that most of the activities outside their flats in the nursing homes did not need the assistance of staff, as had been the case when they were still living at home. Nevertheless, this improvement might also reflect my choice of questionnaire, as an increase should be expected from the first to the second assessment, making this increase, as indicated in the figures, dubious.

Defective hearing and failing sight added further to the elderly people's social isolation. In Chapter 4, I mentioned that the new residents perceived visiting other residents as not being the custom in the nursing homes and thus not one of the staff's expectations regarding the residents. In further explaining their reluctance to visit, residents often cited their defective hearing and failing sight. That is, their bodily condition prevented them from seeking acquaintances on the nursing home wards, as it made their movements and proper behaviour uncertain.

Before they entered the nursing home, their use of a zimmer frame, confinement to a wheelchair or experience of being very unsteady on their feet left all but one of them unable to leave their home on their own initiative. One consequence was that most of the public space surrounding their homes, such as pavements, the local grocery stores and the like, became completely inaccessible. Another important result of their physical impairment was their increasing social isolation, as their bodies actually needed assistance to attend places of social interaction. Their social relationships had been declining over the last few years, as already mentioned in Chapter 2. The consequence was that their bodily 'dys-appearance' hindered them in socialising outside their homes. Or, as Paterson and Hughes put it (1999): "*The body undergoes a mode of 'dys-appearance' which is not biological, but social*" (ibid.: 603). They elaborate further on this position in more general terms: "*Any body that is excluded from making a contribution to the construction of the social world cannot find a home in it*" (ibid.: 604). This again emphasises that the bodily decline that not only concerns the elderly individual also is a matter of intersubjective relationships (cf. Jackson 1998)

Finally, I will compare the new residents in this study with the other residents on the wards. Two residents on each ward were assessed parallel to the second and third assessment shown in Table 1.⁷² These are described in Table 2 below:

Table 2: Characteristics of the other residents

| | First assessment | Second assessment |
|------------------------------------|--------------------|------------------------|
| Number | 28 | 26 |
| Average age (min and max) | 81.3 (60-100) | 81.4 (60-100) |
| Number of men | 12 | 11 |
| BMI Average (min and max) | 25 (16.5-39) 4) | 23.9 (15.4-38.8) 6) |
| ADL-K Average (min and max) (0-16) | 2.4 (0-11) 5) | 2.5 (0-11) |
| ADL-L Average (min and max) (0-28) | 5.2 (0-22) 5) | 5.5 (0-21) |
| CPS Average (min and max) (0-6) | 0.57 (0-3) | 0.65 (0-3) |
| SE Average (min and max) (0-6) | 4.6 (2-6) | 3.9 (1-6) |

4) n=26

5) n=27

6) n=23

Although the BMIs of this group of residents were higher than those discussed above, their ADL-K, ADL-L and CPS levels were lower. This is to be expected for this group of residents, who have been residents longer than the new residents. I will not

⁷² As was the case for the new residents, not all the anticipated other ward residents were fully able to participate.

go into details regarding the different levels, but will just mention that the difference in development between the two groups concerns the SE levels.

However, increased independence and consequently an improved quality of life were still prospects for the new residents, even though the MDS assessments overall indicate that they did not improve. Below I will develop an understanding of the context of the rehabilitation activities and of staff attitudes towards residents' hopes.

Longing to Appropriate Space Again

As illustrated at the beginning of the chapter, Lise and the other residents were anxious to regain their physical abilities, and this aspect runs strongly through the interviews with both residents and staff. Following Jackson (2005), this hope (as I also define as a part of their agency) had a vital role in making the stressful situations they have experienced in the transition endurable, i.e. the hope to become "*world-makers*" again (Jackson 1998: 8). Following Good (1994), residents' expectations were to be able to contribute to the construction of the social world around them, from which their physical impairment had excluded them. In this light, their continuous efforts in the rehabilitation centres were both a way of applying their limited agency and their capacity to manage these difficult circumstances (Jackson 2005: xi).

As underlined in this thesis, ability to establish mutual relations with staff were another aspect of their agency in which the new residents strove to influence their daily lives. Concerning the rehabilitation activities, the staff also played an important role, as I shall illustrate below.

Everyday life in the nursing homes for the elderly people was shaped by medicine, but in the transition they preferred rehabilitation to play a more significant role. In an interesting article Good (1994), discusses the difference between people suffering from chronic pain and those who are not. He describes how the world is organised in terms of intentional projects for non-sufferers. He further argues that the sufferers' prior social worlds are replaced by a world of medicine. That is, their lives are increasingly shaped to the world of medicine (Good 1994).

Creating the Same Future

Residents expected the staff to arrange rehabilitation activities as soon as they entered the care facilities. Later they expected staff to assist them concerning changes to these activities as part of the mutual relationship. During her first six months as a nursing home resident, as I mentioned at the beginning of this chapter, Lise started to doubt whether her activities in the rehabilitation centre would ever result in any progress. One aspect of this is presumably an insufficient amount of training. Another is the paradox that residents needed to convince staff that they actually needed these activities. The staff felt that residents had to be realistic about their expectations, i.e. that in most cases it was unrealistic to expect to regain walking abilities, for instance. Below I use Mattingly's (1998) perspective on rehabilitation to understand meetings in the nursing homes at which staff discuss how residents could improve their physical abilities.

In a discussion of occupational therapists and their work with patients in different rehabilitation contexts, Mattingly writes: "*Therapists battle hardest with despondency, times when their patients evince a loss of direction, even a loss of interest in their lives*" (Mattingly 1998: 107). I believe that Lise was about to lose that direction or any hope that her activities in the rehabilitation centre would eventually enable her to walk unassisted with her zimmer frame. She explained her hope of regaining parts of her previous walking ability: "*When somebody [a member of staff from the rehabilitation centre] is right next to me, then I am able to walk with the zimmer frame. On my own, I wouldn't dare to. This was what I hoped...that I could get more intensive training...in such a way... that my legs could improve and I could walk with the zimmer frame on my own... No, it does not work out. They tell me that it takes time and patience to improve...but at present I think it is just worse than ever*". Nonetheless Lise still struggled on and paid a physiotherapist to undertake exercise activities with her once a week additional to those in the rehabilitation centre.

In the following, I will draw on observations from a series of staff meetings I attended. My intention is to show how a plan was agreed between supervisors and staff and how this reflected staff's perspectives. These plans covered residents who, in

my view, had what Mattingly describes as “*a loss of interest in their lives*” (ibid.). In the nursing homes, at times there was a lot of meeting activity going on. I have observed different types of meetings, but here I will focus on just one type, which was held on a more or less regular weekly basis. The intention at these meetings was to give staff the opportunity to discuss one or two residents and the problems they faced in their daily work with these particular residents. Also attending were one or two supervisors who were seeking to help to improve the staff’s work with these residents through questions. The example I have chosen addressed the problems of an elderly female resident called Ulla, who was refusing to leave her bed. One member of staff, Lonie, started to describe the problems she experienced in her daily care of Ulla: “*She resists our intentions.... She is very heavy, and two of us need to help each other when she needs to go to the toilet. But she hesitates to do anything which could ease our work, and she will not say a word.... It’s very annoying....well... It’s strange...when I attend on my own, she is very talkative.*” Another staff member added: “*She hates this place. It’s hell for her*”. Yet another staff member elaborated: “*She will turn a hundred years in March*”. Lonie continued: “*She prefers me to wash her. When I returned from holiday she had a urine infection, as she had refused several baths*”. Thereafter the supervisors started asking questions: “*As I understand you, we are discussing a courageous elderly woman with her own opinions? And further her mood changes rapidly? Is that a correct interpretation?*” The members of staff confirmed this by nodding their heads. Then one of the supervisors started asking whether there was anything she was fond of in particular, and then she asked the questions which came up repeatedly at these meetings: “*Are you able to bring out her resources?*” and “*How can she be motivated?*” This last question was often asked in different ways, but the meaning was how to motivate this resident to improve her own situation. For Ulla the agreed solution was multifaceted, and the supervisor appointed Lonie to write a care plan. The important part of this plan was to set a target for Ulla’s activities. At first the supervisors convinced the staff to define the target as getting Ulla out of bed every second day. This should progress into getting her out of bed every day. A physiologist, her general practitioner, special food and a dentist were all parts of the plan for improving Anna’s situation.⁷³

⁷³ There were two obstacles to Ulla’s plan, which seemed to be more or less general obstacles to all these plans. Primarily, as the plan involved many different people, the need to coordinate their activities often postponed the implementation of the plan for several weeks.

Thus the meetings were aimed at pinpointing the basis of the problems with this troublesome resident. The plans agreed on during the meetings were to assist residents to re-establish an interest in their own lives. The staff were to focus on the resources and determine how they could motivate the residents to use these and improve their own situations step by step.⁷⁴

I deliberately use the word ‘convince’ in respect of supervisors’ assistance in defining the targets and putting together a more detailed plan for the more troublesome residents. The staff could envisage possible improvements by implementing the plan, but their attitudes at the end of the meetings often reflected a lack of commitment. Lonie confirmed my impression when, at a later meeting, she said: “*If you define a goal, then you have a problem*”. In later interviews, staff confirmed that, in their everyday practice, they faced a serious workload and consequently found it hard to implement the plans in detail. This was further indicated in the succeeding meetings, when previously agreed plans were discussed and it was found that substantial elements of them had obviously still not been implemented.

At one level, one aim of the plan was to improve Ulla’s mobility in the hope of improving her quality of life, as discussed earlier. I therefore argue that plans for the improvement of nursing home residents’ physical abilities included a quality of life discussion.

Mattingly’s (1998) work on rehabilitation also helps us see what goes on at such meetings and provides us with one part of the answer as to why the planned activities were often unsuccessful: “*Effective therapy requires that patients be committed to a long path where gains are so slow they are difficult to perceive or are counteracted by a faster rate of deterioration*” (ibid.: 78-9). She then argues for the necessity to “*construct a narrative of the situation accurate enough to be reliable*” (ibid.: 80). Applying Mattingly’s perspective to the nursing home, members of staff were allocated the role of therapists. However, what happened after the meetings was that staff “*explained*” to the residents that by next Tuesday, for instance, they were

Secondly, staff had to write the plans on a personal computer, which was a difficult task for them.

⁷⁴ In the introduction I mentioned residents’ own responsibility for participating in the social life at the SLE as part of a general trend in the care for people in need (cf. Mattingly 1998, cf. Jöncke 2007). The aspect of motivating residents to see and use own resources also represents this trend.

supposed to initiate training in the local rehabilitation centre, and at times they described the plan further. What was missing was the therapist asking “*the patient to participate in creating a particular kind of story, one in which progress is being made*” (ibid.: 81). What was also missing was a joint target, defined in consultation between staff and resident, which might ultimately make the matter meaningful for the residents, that is, an answer to the question concerning what any activity might do for a resident and what might make sense in a story of improvement when they were not at the rehabilitation centre. Mattingly underlines the importance of residents becoming co-editors in their own life-stories.

The plan for Ulla had no social commitment, as Ulla did not become co-editor of the story. This required commitment to a mutual social relationship with a member of staff. Mattingly further argues, though for much younger patients, that they had to “*imagine new lives for themselves, begin new life stories*” (ibid.: 98). The important aspect being underlined here is to imagine a different future, and hope in this regard is of the utmost importance. This did not work for Lise, and although she and the other residents struggled on, the answer to the question of why these activities were still meaningful started to fade away for Lise, along with the prospects for her rehabilitation. Rather death as the end of the story presumably began to loom eventually.

Mattingly’s position gives us one part of the answer to the question of why Lise and the other residents became sceptical of their future prospects. The staff’s attitudes form another important part of the answer, as I will discuss below, one consequence being that residents actually needed to convince the staff of their own expectations. Thus the discussion below underlines the need of residents to pay attention to staff’s attitudes as part of their mutual relations with them.

Åse’s Hope

Staff had their own perceptions of how realistic improvements in residents’ physical abilities were, and I believe this partly explains their lack of commitment. In principle, care plans needed to be written for each resident, but the effort that staff put into the implementation of each plan differed according to their evaluation of how “*realistic*” expectations of their abilities actually were. As already mentioned in Chapter 4, in my discussion of Lipsky’s terms, “*discretion*” (Lipsky 2003: 507)

implied that the staff embodied the institutions differently in their relations towards residents. At this point, I shall move on to the staff's use of their discretion because this concerns residents' rehabilitation.

One staff member, Lone, described her impression of a new resident's hopes of future physical improvement based on a meeting we both attended two days prior to my interview with her. This was the kind of meetings described in Chapter 4 defining residents' needs for assistance, meal preferences and requirements for other facilities in the nursing home. The meeting took place with Åse and her daughter in hospital. As Åse's future contact person, Lone attended with another representative from the nursing home, and I observed the meeting. I asked Lone to comment on this meeting in the subsequent interview. She perceived Åse as a resident who was describing her hopes and anticipations for the near future. Lone meant the hope of regaining her abilities so as to become less dependent upon the assistance of staff and be able to walk again and thus regain the initiative in social relations. Based on her nine years of experience in the nursing home, she immediately knew that Åse's descriptions of her own abilities were "*completely unrealistic*" when compared to her present situation of being confined to a wheelchair. For instance, Åse said that she could dress and use the toilet unassisted.

I had the opportunity to verify Lone's interpretation of Åse's hopes with other members of staff. The vast majority of the 44 members of staff recognised this idea of hope as an adequate description of most of the mentally fit residents and their "*unrealistic*" expectations.

The second part of Lone's description concerned how these hopes broke down and how residents reacted with disappointment. She stated that, when the majority of residents realised that these hopes would not be fulfilled, they turned in on themselves and usually died some months later. This happened when residents realised that the care facilities were insufficient to provide the amount of rehabilitation and staff support needed for any actual improvement in their abilities to take place. This last argument was agreed to by less than half the staff, the majority of whom preferred to express matters differently. Staff needed to provide residents with a realistic

perspective of their situation: *“They should not be unrealistic concerning their own situation”*. This meant that they should not expect any improvement in their conditions.

Along with failing to become the co-editors of their own stories, in my view a lack of support from staff seems to be another part of the explanation for improvements not being made. One member of staff commented on this in the following way: *“She has got a hope and I will not ruin this hope. I thank the Lord that she has not yet asked me for my opinion as to whether it is realistic or not.”*

My aim here is not to prove the actual existence of a hope among new nursing home residents in Denmark. Rather, I will argue that Lone’s description of hope and the interviews with residents indicate that the residents desire to improve their physical abilities. This should happen, it is thought, primarily through rehabilitation and secondarily by using tools like wheelchairs, zimmer frames or the like. This further implied that the elderly people basically had an intention to improve their conditions and thus recreate their access to the world. Good (1994) describes this in basic terms when he argues that: *“The dissolution of their world is countered by a human response to find or fashion meaning, to reconstitute the world”* (ibid.: 128). Leder puts forward a similar argument in citing how Merleau-Ponty *“refers to a ‘basic’ or ‘operative’ intentionality founded in the body...”* (Leder 1990: 21), adding later: *“But the very nature of the body is to project outward from the place of standing”* (ibid.: 22).

Three quotations from residents support this interpretation. Dorte’s condition confined her to her bed for most of the day. She said about her future that: *“My dearest wish is actually that I could move around in a sort of electric wheelchair...”*.

Lis mostly remained silent at meals. However, on one occasion I heard her say: *“I wish I could do that”* when she observed another resident bending down for a fork which another person at the meal had dropped on the floor.

Bo was eager to be able to climb into his electric wheelchair himself. He repeatedly mentioned the beautiful places he intended to visit. In achieving this prospect, strengthening his leg muscles was the crucial point.

Realistic or not, residents wanted to retain their access to both their physical and social surroundings in order to improve their quality of life by increasing their independence and consequently being able to fulfil more of their expectations. Nevertheless, Leder rather devastatingly points out the aspect which is impossible for Lise and the other new residents to ignore: “*with chronic suffering, there is no way to go, nothing to do, no escape*” (Leder 1990: 75). Merleau-Ponty’s (2002) argument regarding the paralysed arm, mentioned in the first chapter, elaborates further on this perspective, as the residents’ intentions constantly reminded them of the limp with which they were unable to move or with which they could only make uncertain moves.

Although Lise had nearly had lost faith in her prospects of being able to walk unassisted again by the end of the research period, she still carried on at the rehabilitation centre, as did most of the other new residents. However, I am unable to determine whether she and the other residents reflected on their own hopes, paid more attention to the staff’s expectations or felt guilty at not improving, given that they regarded this as their own responsibility.

One of my last interviews with Lise took place when she had a change of contact person. She had indeed appreciated the first one and described how she had assisted her in the mornings to get out of bed, but the new contact person thought she was not being flexible enough and that Lise ought to be able to raise herself up in bed on her own. Lise became furious and said, “*That is not how I want to improve my abilities. She should rather assist me when I try to walk. With her [the new contact person] it is as though I need to pay more attention to her well-being!*”

Conclusion

Lise and the other residents continued to strive for improvements in their physical conditions and stop the physical decline and re-establish the body as access to the surroundings. But it seemed to be an uphill struggle. The amount of training she

received was presumably insufficient to improve her physical condition. Additionally, the staff's perceptions of how realistic the hope was indicated that she had to convince them of these prospects as well, which thus became a lonely process.

Both the quantitative and qualitative perspectives on developments in the quality of life of the new residents indicated that quality of life was in overall decline in the transition. The MDS figures (ADL-L and ADL-K) demonstrate the decrease in residents' physical abilities, that is, their abilities to carry out the activities of daily living, but the figures for social engagement are unclear. However, from a qualitative perspective their quality of life improved a little at the beginning of the third phase in the transition. This improvement was to be accounted for mainly by the changed surroundings, that is, the physical layout of the nursing homes. The width of the corridors and the facilities provided enabled a few residents to retain some of their previous bodily contact with their surroundings. This improvement did not last, however, as they experienced the expected improvements failing to materialize. Consequently, the process of physical decline, which had led to the assessment for nursing care in the first place, continued increasingly limiting this part of their agency. The dissolution of themselves as persons with identity and the increasing institutionalisation likewise continued. That is, the physical process of decline did not end in the nursing home, as the elderly people had anticipated. The decline in BMI will eventually further add to this decline and the prospects of increased independence, and thus residents' increased ability to fulfil their intentions by their own means seemed to vanish. In other words, death presumably turned out to be the end of the story as the part of their agency reflected in maintaining hope faded.

The hopes and the way the new residents managed the transition differed. In this matter Anders and Dorte represented the range. If Dorte intended to do anything she needed assistance of staff whereas Anders mostly managed on his own. Dorte was therefore very vulnerable to changes in her mutual relations to staff as compared to Anders.

This chapter again points to the contradiction between ideal descriptions of the nursing homes and practice within them, as shown in Chapters 4 and 5. That is, a paradox was presented in which residents enjoyed rights to care and rehabilitation, but needed to pay serious attention to staff's attitudes towards their own prospects as part of their mutual relationships with the latter. One aspect of this intention is the aim of

not becoming a burden on staff and of keeping their position in the hierarchy on the wards. Maintaining the mutual beneficial relations was the part of their agency they were left with at the end of the third phase in the transition in a struggle to be treated as individuals by their mutual relations..

This chapter also stresses that the rehabilitation activities provided in the nursing homes seemed insufficient to enable the elderly people to extend their bodily perceptions of their surroundings. These are the residents` rights, but the above analysis indicates that further resources still need to be added if improvements is an aim of the care for the aged. At their present level, the activities presumably did little more than prevent a more rapid decline in the residents` physical condition.

As argued in Chapters 2 and 4, the role of the staff was important. One conclusion is that staff need to improve their understanding of the self-perceived needs of nursing home residents so that they can pay attention to the aspects which the residents identify as being of the greatest importance. Another aspect of importance here is the information they were given that gave them these expectations in the first place, which seemed unrealistic in terms of the amount of rehearsal activities provided. I will go more deeply into this and make more substantial recommendations in the following conclusion.



(Lise after six months at the nursing home)

7. Conclusion

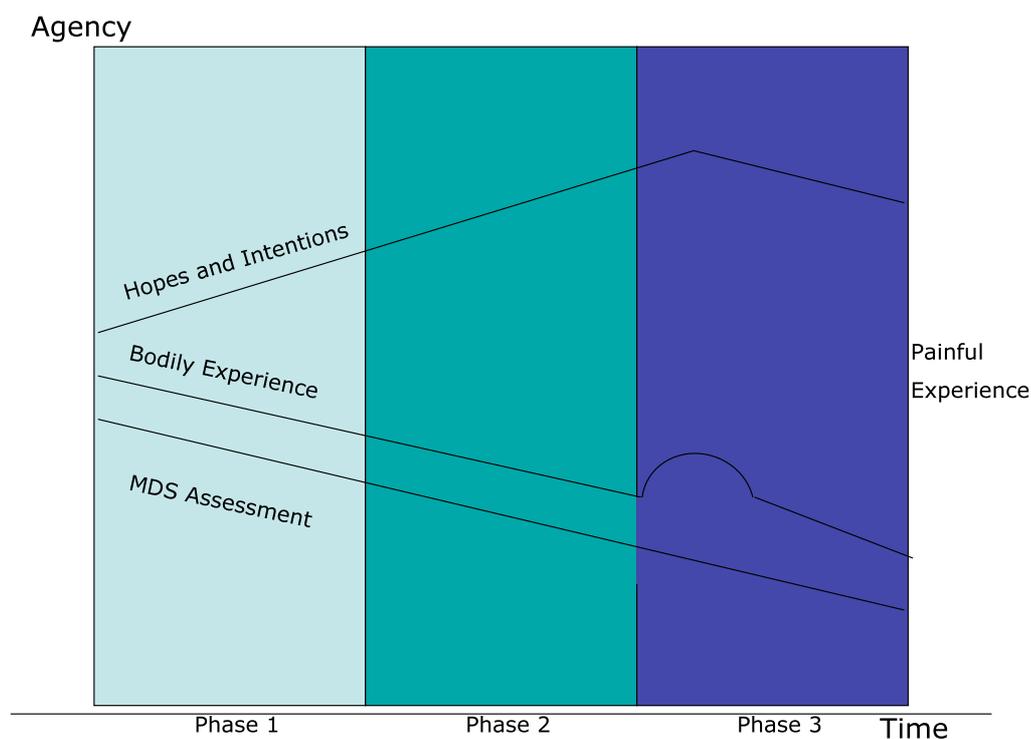
Future demographic trends predict an increase in the proportion of elderly people in Denmark as in other industrialised Western societies. This is due to falling fertility and mortality rates, increasing longevity and the recent arrival of medical technologies like organ donation and other life-sustaining treatments (Harper 2004, Steffen 2007). By projecting these trends, it is likely that the number of elderly people in transition will also increase.

At present approximately 26,000 elderly Danish people become nursing home residents each year, and in 2004 and 2005 the sixteen elderly people in this study were among them. The Danish welfare state managed these elderly disabled people through the provision of home care, nursing care and rehabilitation facilities by the municipalities in the transition period. The aim of the present study has been to investigate how the elderly people themselves experienced the transition when they became nursing home residents.

In this thesis I have used the perspective of intersubjectivity (cf. Jackson 1998) as my major conceptual approach in the analysis of the transition. I showed how their impaired bodies further changed the relationships that the elderly engaged in throughout the transition (ibid.). These impaired bodies occupied a significant position in the lived subjective experience (cf. Merleau-Ponty 1994, Leder 1990). The intersubjective perspective, in combination with phenomenological concepts, allowed me to develop an understanding of the link between the lived subjective experience of the elderly people and their possibilities for agency. I showed how this increasing impairment reduced parts of their agency by limiting their abilities to reach out for, appropriate, influence and experience the immediate surroundings. In addition, I showed how another part of their agency was to preserve their hopes for the future until close to the end of the transition, despite irreversible bodily impairment. A major part of the analysis concerned how they strove to influence existing relationships by applying the last part of their agency and establish new ones to make the transition endurable (cf. Jackson 2005).

The Results

To show how the elderly people experienced becoming nursing home residents, I have chosen a model to illustrate my analysis.



Model 1

I have divided the horizontal line into the three phases of the transition. The line thus illustrates the approximately ten months during which I followed the elderly people. The vertical line illustrates two of the aspects of their agency.

I defined the transition analytically to begin with the assessment whereby the elderly people entered this study, and to end when they had been residents for six months. The first phase concerned the waiting time at home for nursing care in connection with the assessment. The second phase is the dissolution of the home, the third their experience as nursing home residents.

Because of their bodily impairment, the municipal authorities assessed the elderly people for nursing care, as they perceived them to be unable to take proper care of themselves at home. However, the process of bodily impairment had been going on for a considerable period, as the municipality authorities assessed them for home care, meal delivery and day care-centre activities prior to the assessment for nursing care. Some of the residents died during fieldwork, whereas others were still in the nursing home when fieldwork ended. In other words, I analysed a period close to the end of their lives that was characterised by increased physical impairment and reduced agency.

From the vertical line, three other lines emerge. The line reaching upwards illustrates the elderly people's intentions and hope for a life as a nursing home resident. The line below illustrates their bodily experiences, and the one below that the MDS assessments. This means that I base the latter on quantitative data, whereas the two lines above are based on my analysis of their experience throughout the transition.

There are two general aspects I would like to underline. The first is the increased gap between the elderly people's expectations and their bodily experiences. The second is the minor increase at the beginning of the third phase in the transition in their bodily experiences. The latter indicates that the elderly people were able to extend their access to their immediate surroundings in the nursing homes temporarily, but despite rehabilitation activities their overall decline continued.

The line reaching upwards illustrates the part of their agency that concerns their hopes and intentions for the near future in the nursing home. This entailed a consideration of their prospects for improvements in their bodily conditions, i.e. they hoped that rehabilitation would stop or even reverse the process of increasing physical impairment which had led to the assessment for nursing care. Another hope was that they would be able to find equals at the nursing home, and thus, through improvements in their physical conditions, be able to make acquaintances and relationships and eventually visit relatives again. The hope of improving their physical conditions was also a story they tried to edit, assisted by the staff in the rehabilitation centres (cf. Mattingly 1998). However, at the end of phase three, the

decline in the line indicates that the story needed a new ending, i.e. that this aspect of their agency had been reduced.

I suggest that their relatives and the descriptions of the nursing homes in leaflets and brochures both nourished these hopes. The responsibility to improve their physical conditions, staff's encouragement of this hope and perhaps indications that rehabilitation activities could actually help in this respect (cf. Rydwick et al. 2004) also nourished them. In this respect, however, I am unable to say whether the overwhelmingly negative press coverage of Danish nursing care (cf. Ældre Forum 2003) had any influence over these hopes.

The line below, which indicates overall decline, represents the bodily experiences of the elderly people in the transition. From the intersubjective perspective, the bodily impairments had major consequences for both the impaired elderly people and the relationships they engaged in, for instance, relationships with their relatives, home care assistants, nursing staff and other residents, as well as with their material possessions, homes, institutional settings, food etc.

That the line is in decline illustrates the increasing limitations of the part of their agency that concerned their ability to move. One consequence of this was that their bodies became prisons for them. They were increasingly unable to answer the invitation of the world (cf. Merleau-Ponty 1994) or pursue their intentions to reach out for, appropriate and perceive their immediate surroundings. Reduced senses and uncertain motor abilities further made their attempts to appropriate uncertain, and in phase one this was illustrated by their fear of losing their balance and their regular need of a series of new tools, facilities and other facilitators. What also happened in this process was that previous learned abilities became unlearned (cf. Leder 1990 and Lupton 1996), such as, in part, their ability to appropriate their homes and to behave at meals, though they gradually learned the schedule of the institution. In the pre-institutionalised home, they had to learn and adapted the schedule of the home care assistants. For instance, when the home care assistant arrived the elderly person had to get out of bed, and at the last visit go back to bed again. Their institutionalisation increased in the nursing home, where they also had to adapt to expectations regarding their ways of being social, eating with other residents and engaging in rehabilitation

activities. Relationships that nearly ended at the end of the second phase were those with relatives, who were not well accommodated for as visitors in the nursing home flat.

Another tendency was the phasing out of parts of their identity. As I have shown in the first phase of the transition, the homes were part of themselves. Nevertheless, their reduced agency made it impossible for them to appropriate them and thus present them the way they preferred. Through the work and movements of the home care assistants the latter transformed the elderly people's homes into places of work (cf. Casey 1996, 2003). The elderly people were never able to appropriate their nursing home flats to the same extent as they once had in their previous homes.

In the second phase of the transition, they had to dissolve this part of themselves further by parting with the majority of their possessions. Consequently, parts of their identity were either dumped, placed among relatives or found room for in the nursing home flat. This meant aspects of their identity being phased out, and they were literally only able to take minor parts of it with them into the nursing home flat. However, their ability to undertake homemaking was to some extent replaced by the institutional skills they learned in the nursing home, which thus became a part of their identity.

Another tendency they faced was the experience of being treated as a body in need throughout the transition. This also began before the transition. The municipality assessment for home care and adjustments to this care, as well as the assessment for nursing care, were based on assessments of their mental and physical abilities. These assessments disregarded aspects of their personal identities, as was the case in the contracts defining their needs in the nursing home, for instance.

Another aspect of their agency, through which they aimed to counter this tendency, was the aim of establishing relationships. I have not illustrated this part of their agency by a line, but the reader must imagine this part countering the increasingly painful experience of the wider gap between the lines that represent hope and bodily experiences in the model. The elderly people tried to establish relationships with people who embodied care aims in different ways. Their intention was to prevent the home care assistants and nursing home staff from treating them only as bodies in

need, and also as living persons, i.e. to negotiate the stigma of being a disabled elderly body and thus eventually challenge the stigma and maintain their range of this aspect of their agency, at least.

The staff had two options regarding these mutual relationships, either to engage in them or to stick to the bureaucratic regulations (cf. Foner 1995 and Godbout 2000). Mostly they chose to do the former and acknowledge the mutual obligations, but they were also quite capable of clinging to bureaucratic regulations and treating all residents in the same way if they preferred to, thus bringing the relationships to an end.

The relationships were paradoxical. They were at the same time based on the idea of a positive relationship based on mutual personal interest, but simultaneously they had a strategic purpose. For their part, the staff expected residents to pay attention to their stress levels and to summon their assistance accordingly. Residents for their part participated in rehabilitation and other activities and generally made a serious effort to reduce staff's workloads. Such residents received more attention from staff than other residents who were unable to maintain these relationships. The former experienced that more respect was paid to their individually perceived needs, and they felt they were being recognised as individual persons. The majority of the sixteen elderly people who became new residents in this study succeeded in establishing mutual relationships with staff at the nursing homes.

The first two phases in the transition seemed predominantly stressful for the prospective residents, among other things because the decision to enrol in nursing care and to dissolve the home was mainly imposed upon them by their relatives. The situation as a resident with an established relationship seemed less stressful in this respect, as through these relationships they regained their ability to govern a small part of their lives.

Nevertheless, the range of possibilities for action was not the same for all the elderly people. Those who were unable to establish a relationship or who opposed the staff faced the hardest time. In addition, those who were most in need due to their physical impairments were very exposed to these relationships, which had a fragile character,

as well as to changes in their contact person.

I would like to underline two essential aspects of these mutual relationships. First, the care for the elderly people was provided through social relationships. Secondly, these relationships were established in an institutional context, which limited the space for this part of their agency.

The SLE and the traditional nursing homes featured in this study were different as regards architecture and interior design. Furthermore, residents in the SLE faced expectations regarding their ways of being social, and their aims regarding the social life in the wards were different as well. The analysis of this aspect shows that the decisive aspect in residents' experience was to what extent the staff transformed the different nursing home settings into places dominated by work (cf. Casey 1996, 2003), that is, how individual staff members embodied the intentions regarding social life and care differently. Whether the residents were successful in establishing a relationship with the staff or not was in my view more influential in their perceptions of their situations than was the architecture and interior design. That is, the coincidental encounter between the elderly and the staff, and the way the latter embodied the care intentions on the wards through their everyday work, were decisive. This argument is supported by the similar expectations regarding residents expressed by staff in interviews at both types of nursing home (Chapter 4) and the very similar ways in which meals were served and eaten (Chapter 5). In the perspective of the residents, it was the care that mattered the most, and they needed to cope with this by engaging in social relations in an institutional context. In addition, neither type of nursing home invited relatives to take part in residents' lives.

However, the painful experience in the transition for the elderly people was the increased gap between their hopes and their bodily experiences, as the lines in the model illustrate. The decline indicates that a return to their former position and improvements in their physical abilities were not possible, despite the minor rise at the beginning of the third phase in the transition. From this perspective, meals and rehabilitation activities represent the very painful experiences of losses. At meals some of the elderly had unlearned proper behaviour and were unable to fulfil expectations regarding behaviour. The rehabilitation activities seemed to offer no

hope of improving their physical abilities, despite their efforts at the end of phase three. Their hopes of forming relationships among the other residents were likewise broken. Both the fact that there were very few equals on the nursing home wards, and their own inability to fulfil behavioural expectations at meals, for instance, prevented these hopes from being fulfilled. In other words, they also lost major parts of their capacity to function as social entities.

Consumption of food and drink became an aspect of a more important relationship, i.e. that with the nursing home staff. The participation of residents in meals was a way to influence the mutual relationships with staff. Food and drink did not have a prominent position, despite being the point of departure for this study, but the recommendations regarding nursing home meals gain more validity when placed in an intersubjective perspective.

The notion of New Public Management is but one aspect of a restructuring of care for the aged in Denmark, which has been going on since the early 1980s. In very recent literature on Danish nursing care, it is argued that New Public Management has strongly influenced the way care is provided (cf. Elle 2006, Krogh Hansen 2006 and Liveng 2007). However, it is still problematic to assess whether and to what extent New Public Management actually has an effect on the quality of care for elderly provided with either home care or nursing care (Andersen and Nielsen 2006). In addition, despite the overall trend towards reconstruction, the four municipalities in this study administer care aims for the aged differently, for instance, regarding the priority given to care work and staff working with administrative duties. Furthermore, for a more marked influence to be identified, a different study design would have to be applied. Therefore New Public Management presumably influenced care for the aged, but the focus of this study does not allow me to identify to what extent this was the case. New Public Management is one part of the overall aims for care for the aged embodied by home care assistants and staff respectively.

Major Findings

A contribution of this thesis is the analysis of reduced human agency in the coming into being of sixteen nursing home residents who are close to the ends of their lives.

Despite the argument that the phasing out of their identity could also be analysed as social preparation for their imminent biological deaths (cf. Marcoux 2001), I have followed the lead of existential anthropology (cf. Jackson 2005) to focus on elderly people's abilities to live in difficult circumstances in institutionalised surroundings. That is, I paid attention to the different aspects of their agency and emphasised their remaining agency aspect to establish relationships with the individuals who embodied the aims for care of the aged in the Danish welfare state.

More generally, Merleau-Ponty's (1994) argument about the intention to reach out for the world and to remain a world-maker (cf. Jackson 1998) made sense. Despite the fact that the elderly people were approaching the end of their lives, they still strove to influence their institutionalised surroundings and thus establish enduring situations. In this light, their social abilities to form relationships were nearly the last remaining aspects of their agency when this study of their transition ended.

Foner (1995) and Paterniti (2003), among others, have emphasised residents' attempts to influence the care they receive. But the relationships I define as mutual have, to my knowledge, not been defined to the same extent as in the present study. The literature concerning nursing homes as institutions has to a large extent paid attention to relationships among residents (cf. Gubrium 1975, Ross 1977).

My study underlines the importance of Nolan's (1996) work. He argues that elderly people need to be actively involved in a series of phases, both regarding the exploration of alternative nursing homes and providing them, as prospective residents, with clear, detailed information about the different institutions available to enable a successful transition to take place. My study supplements this work by means of the recommendations below. In this way, I hope that it helps fill some of the gaps in the transition literature identified by Lee et al. (2002).

The Welfare State: Considerations

With an increasing proportion of elderly people expected in the near future, I will set out the ultimate aim of this study, namely to transform the results into

recommendations which might ease and improve future transitions for prospective residents.

An most important aspects to consider before I outline the recommendations is that the sixteen elderly people I have followed in the transition are a minority, as 60% of nursing home residents suffer from dementia (Ingerslev et al. 2002). Those suffering from dementia were more or less successfully interviewed during fieldwork, but the results presented here concern those elderly who were still able to establish relationships and express themselves on the wards, mostly, that is, the middle and high end of the ward hierarchies. This is important to consider, as care for the elderly in Denmark is described in ideal terms as being guaranteed through rights to care and rehabilitation. But as I have shown, the practice of care is accomplished through social relationships, which at times some residents are able to influence and others nearly unable to influence.

The elderly people were also vulnerable to changes in the amount and quality of care allocated them. Allocations being changed through changes of schedule or just a home care assistant not attending on a particular day have severe effects on the elderly people's everyday lives. In a similar manner they were vulnerable to changes of their contact persons in the nursing homes.

In the light of the indications that mental and physical status is reduced on some elderly people becoming nursing home residents today as compared to the early 1990s (Beck 2008), it is also worth considering whether expectations regarding the sociability of residents is at all realistic at the SLE.

The recommendations must consider how the aims and hopes of the elderly people can be applied fruitfully in the nursing homes to improve their physical abilities and enable them to establish new social relationships. This is contrary to some of the indications of the present study, where the loss of their abilities and hopes provoke resistance and resignation among new residents. Generally this would involve challenging the overall tendency towards institutionalisation of the elderly in the transition, and more concretely to make use of the minor rise in the line (Model 1) representing their bodily experience in phase three.

The Welfare State: Recommendations

Home care and nursing care could assist the elderly people's aims and hopes more adequately. A further consequence of this perspective is that the members of staff are under an obligation to find out which aspects of residents' lives are the most important for the latter (cf. Henriksen 1992). At present, assistance is provided in accordance with physical needs. This tends to leave out the identity aspect, as well as many social needs.

This study indicates that the quantity of exercise activities provided for residents in the nursing homes is insufficient or possibly not well adapted to the elderly people's particular needs as a means of improving their physical abilities. It is therefore crucial to consider whether it is possible to increase the amount and provision of these facilities.

At times those residents who were suffering from dementia dominated the social life on the wards. One consideration is therefore whether these residents could be separated from the other residents (cf. Møller and Knudstrup 2008), that is, whether residents could be separated by level of physical and or mental impairment to a greater extent.

The Role of Staff

Continuity in contact with both the home care assistant and the contact person in the nursing home is an advantage for the elderly people. It was stressful for the elderly people to repeat their needs over and over again, and this further complicated the establishment of the mutually valued relationships.

The new residents' attempts to establish social relationships should be encouraged by staff when the new residents enter the care facilities. This is a matter of staff building bridges between the residents' past lives and their present life experiences, as well as providing support and encouragement in establishing relationships *between* residents by introducing the new residents for the other residents for instance. According to the nursing home literature mentioned in Chapter 4, such relationships would improve

residents' perceptions of their everyday lives on the ward. Encouraging mutual relationships between staff and residents is a further recommendation, as both staff and residents praised them.

Staff also need to behave in accordance with their own descriptions of ideal meal situations. In other words, there are a number of work-related issues which need to be left out of conversation at these events, as bringing them up disregards resident's own priorities. This could be resolved by a meal guide being drawn up for staff members to follow, or at least substantial information be provided about how work-related issues influence residents' preferences for eating and participation in meals. In other words, staff must recognise that most of the residents would place a priority on presenting themselves in a particular manner.

At regular intervals, staff could also consider whether residents are best shown respect by being allowed to eat alone or with other residents.

Information about the Consequences of Transition

Overall this study indicates a need for substantial information about the consequences of becoming a nursing home resident, especially in the light of the increased and painful gap between hope and bodily experience I outlined above.

The problem of the disposal of the elderly people's cherished possessions requires information on the limited number of possessions that can be accommodated in nursing homes. Material possessions have been parts of themselves, and their division into three parts was painful to some extent for them, especially as limited time was allowed for the disposal of such items once a nursing home flat had become vacant.

Substantial information about practice in the nursing homes is also required, since the elderly people in this study experienced disappointments with regard to both the lack of equals among the other residents on the wards and the lack of physical improvement for them. This calls for a description of both the number of people suffering from dementia in Danish nursing homes and of actual opportunities to engage in rehabilitation activities.

One way of doing this could be to extend the activities in the day-care centres where prospective residents at present visit once or twice a week from late morning to early afternoon. This could be extended to include regular care on the ward, beginning in the early morning and allowing the prospective residents to participate throughout a whole day spent in the nursing home.



(Lise at the last interview)

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Appendix

In this appendix, I present parts of the life stories of the sixteen elderly persons who became nursing home residents in this study. The life-story interviews are the basis for these stories. The details presented here were those for which room could not be found in the previous chapters. Nevertheless, I consider it important to provide the reader with a little more than just a glimpse of the elderly people who took part in this study. I therefore intend to provide a characteristic idea of the identity they preferred to present to me. The elderly people at times presented this identity in their relations with home care assistants and the nursing home staff with whom they were in contact in the transition.

| Name | Facilities needed | Age | Nursing home |
|---------------|--------------------------|------------|---------------------|
| Oda | Walked with zimmer frame | 85 | Sølund |
| Ritta | Walked with zimmer frame | 93 | Sølund |
| Ole | Walked with zimmer frame | 71 | Grønnehaven |
| Inge | Walked with zimmer frame | 93 | Bakkegården |
| Åse | Confined to wheelchair | 87 | Sølund |
| Arne | Walked with zimmer frame | 91 | Sølund |
| Hans and Anna | Walked with zimmer frame | 88,86 | Sølund |
| Jørgen | Walked with zimmer frame | 100 | Bakkegården |
| Lise | Confined to wheelchair | 95 | Bakkegården |
| Anders | Walked unassisted | 93 | Grønnehaven |
| Lis | Confined to wheelchair | 94 | Lillevang |
| Bo | Confined to wheelchair | 75 | Lillevang |
| Dorte | Confined to wheelchair | 91 | Lillevang |
| Oline | Walked with zimmer frame | 91 | Lillevang |
| Ib | Confined to wheelchair | 91 | Grønnehaven |

Oda, age 85. Entered the study on June 6, 2004 until last interview January 29, 2005. Died in February 2006.

When I first met Oda at the sheltered accommodation, it was all quiet around us, as the institution was about to close down. Residents who had moved out were not being replaced, the facilities were slowly being emptied and Oda experienced becoming increasingly isolated. This was only one source of frustration for her. Another was that she needed assistance to leave the premises, and the staff did not have the time to help her.

She seemed depressed at first and answered my questions by using one or, at the most, four words such as “No” or “*I don’t remember*”. In the following interviews, she gradually extended her answers. The frustrations mentioned above, coupled with her reluctance to accept her increasing physical impairment and the fact that she was now unable to manage in her home any longer, presumably caused her depressed mood. Since she had fallen a number of times (according to her son) and was unable to get to her feet unassisted, she and her son had agreed (again according to her son) that she had to apply for nursing care.

Oda had been one of four children. She had grown up in Copenhagen and married at the age of 18. Her two brothers and one sister had all died, and she did not mention any other family relations. From her childhood, she carefully picked her friends, and later she chose whom she preferred as colleagues at work. She described herself as a “*hard nut to crack*” and took pride in managing on her own.

Her marriage lasted for nearly sixty years until the death of her husband in 1998.

They had one son. She indicated that their marriage had been a happy one, and in the nursing home she had a painting above her armchair that reminded her of her former husband. His death and the illness that had preceded it was the worst period of her life. She said about his condition before he died, “*He couldn’t even drink a beer*”. In the interviews, she was unwilling to describe any further her sadness over the loss of her husband.

Activities, having many people about and constant talking made her feel well. This was also a description of her work, in which she distributed food samples at market

places in provincial towns in Denmark. In this occupation, she left home on Monday mornings and returned on Friday evenings. She appreciated having full responsibility for her working day, as well as being able to work with nice people.

She preferred not to become acquainted with other residents in the nursing home ward. She ate with the others for the first few days, but felt it was terrible, as *“nobody says a word... and some of them are even unable to eat unassisted”*.

She and her contact person (*“The one who takes care of me”*) had a mutually valued relationship. Nevertheless, according to the other members of staff, she used the nursing home like *“too much of a hotel”*. They found her too resourceful to eat on her own, and would have preferred that she joined in the staff’s conversation at the dining table.

She was able to walk around the nursing home thanks to its physical layout. This provided her with the ability to visit her acquaintances in the café, and she was able to leave the premises unaided. In other words, again she had the ability to choose her relationships, which presumably improved her mood, and she became quite talkative in the later interviews in the nursing home. She recaptured parts of her independence and *“felt more free”* in the nursing home. Additionally, successful eye surgery enabled her to read and do crosswords again, as well as giving her the feeling that her walking had become safer.

I did the last interviews with Oda immediately after New Year's Eve on one of the first days of January, and her depressed mood had returned. This time her son's failure to visit was the cause. He promised to come but did not show up on either Christmas or New Year's Eve, and, according to her contact person, this made her solitude evident to the other ward residents, who had relatives visiting them at these times.

Her relationship with her son was the one thing left in her life that she intended to maintain and develop further. According to her contact person, she was indeed disappointed for a prolonged period of time after Christmas, and she consumed excessive amounts of alcohol thereafter.

She was never enthusiastic in describing her stay in the nursing home. About the rest of her life, she said “*The game is over*”. She did not like to make a fuss about anything, was aware of the stress levels of staff members and adjusted her behaviour accordingly. She saw how many of her fellow residents became hysterical complaining loudly about the time they had to wait for the staff to assist them.

The last time I saw Oda, she was lying in bed. According to her contact person, the previous day's drinking had given her a headache. Although she was avoiding the light from the window, she was happy about my visit, and one of the last sentences I heard her say was, “*They want me out of bed in the early morning. What for? I have nothing to do.*”

Ritta, age 93. Entered the study on March 12, 2005 until last interview September 13, 2005.

Ritta's social isolation was very evident when I first visited her. Entering her home was like entering a world functioning at a very slow pace, where her life was lived in loneliness. The old woman with her fuzzy hair and grating voice left a very frail impression, caused by her unsteady feet and immediate loss of breath when manoeuvring her zimmer frame in her small flat. She was happy to have someone wanting to spend hours listening to her life experiences, and she turned out to be a very, very talkative person.

Her flat contained evidence of her long marriage, and this was where she and her husband had lived, in the same place for many years. Pictures of family members and reminders of her marriage decorated every possible area of the walls.

She had been adopted as an orphan and grew up in Jutland, Denmark. As an only child, she remembered how she manipulated her parents for her benefit. Further she vividly described having enjoyed a happy childhood, but at the early age of fourteen she went into domestic service. Here, the good positions were characterized by a mistress paying her respect and appreciating her work. Her working life stopped when she married and became pregnant with the first of her two daughters. Mutual respect was the basis of her happy marriage, in which she and her husband were responsive to one another. She described herself as easy-going and her husband as a “*good*

husband”, implying that he preferred her company to his friends and drinking acquaintances in the local pubs.

She had created a very close relationship with her two daughters, in her opinion, by being present every day when they returned from school. The most important issue during the rest of her life was the lives of her daughters and their families.

She prized regularity in her life, e.g. she spent her vacation at the very same hotel in the Canaries every winter for a period of thirty years. Avoiding debts was another recurring theme in the story of her life, and she never staked everything on one goal. With all her A-levels from school, she had the ability to acquire further education, but always chose the safe option in which she incurred no debts. I could not help noting in my interview notes, “*Lost opportunities*” several times during the interviews.

In the nursing home her loneliness persisted. She expected fellow residents to pay her visits, and I believe the way she set the table reflected this anticipation. During the first months in the nursing home, her best place-mats were ready for visitors` cups and plates. However, nobody paid her visits. Weeklies covered the table before her transition to the nursing home, and they covered the table again at our last interview.

She was also disappointed that none of her fellow residents paid any attention to her when she dined with them on one of her first days on the ward. Later, she decided not to take part in the meals any longer, as nobody said a word to her. Also, as her hearing aid had gone missing, she thought it useless to eat with the others. She also made it clear that other people found her boring, as she did not experience anything new on the nursing home ward.

After some months, staff on the ward described how she “...*became good in the way that she took part in the activities...*” This meant that she readily accepted the staff’s invitations to participate in the activities at the activity centre twice daily. She found these activities a pleasure as she had the company of other residents, and she therefore felt less lonely. Staff on the ward accepted her reluctance to participate in the meals.

At some interviews, she seemed depressed. There were minor disagreements with staff concerning toilet visits; the staff thought that there was no need for her to be assisted more often. However, at the last interview, there was a heavy smell of urine around her.

For her future as a nursing home resident, she expected to improve her walking abilities with the zimmer frame, but according to the members of staff, this was unrealistic. She took active part in the rehabilitation activities, but improvement was hard to see.

She also expected and hoped that the daily calls from her daughters and son-in-law would continue, as these were a daily pleasure for her.

The last time I saw Ritta was at the Midpoint activity centre. Observing her with other residents in the activity centre, I had the impression that she was pleased with their company.

Ole, age 71. Entered the study on October 22, 2004 until last interview June 16, 2005.

“I am not old, but I have a handicap.”

I first met Ole in his small flat in Bagsværd. I was astonished that a home could be that dusty. Layers of dust covered the wine bottles, as in the cellar of a French chateau. Either this part of the cleaning was impossible for Ole to undertake, he did not approve of this sort of cleaning, or perhaps it did not matter much to him.

The air was thick with smoke from his heavy smoking and, as I entered, the beer bottles on the table made me instantly think of a pub. The walls were all yellowed from the smoke. He had switched the television set on and had spent his whole day watching sports programmes. He was a supporter of the local football club and was looking forward to having an electric wheelchair, which would enable him to attend some of their matches.

It was difficult for Ole to move around the flat, and he spent most of his time in a chair in front of the television set. The carpet below his chair provided evidence of this as it was nearly worn away, the only remaining part being the rubber backing. He had been living in this particular flat since his divorce, and, for the last eight years, he had been unable to descend the stairs unassisted. His son and a sister visited once a year on his birthday, and he felt very lonely in his flat. By enrolling in nursing care, he expected somebody to take care of him and ask him how he felt on a daily basis.

He was reluctant to describe his childhood in detail, but he mentioned briefly how he, his brother and his sister at times had to defend their mother from a violent father with serious alcohol problems.

Ole took pride in his previous occupation as a compositor, at which he had worked for nearly forty years. His career came to an end one night when he injured himself while crossing the railway tracks as a train approached after a night at the pubs. After this incident he retired.

He also took pride in having been a member of the same union for fifty years. His membership badge hung on the wall, alongside his father's proof of membership in the same union.

He was divorced and did not hide what he believed had caused the divorce--his heavy drinking and preference for drinking acquaintances. He also left no doubt that he only visited his wife for sexual intercourse, thereafter again preferring his drinking acquaintances and a game of pool. He and his wife had one son. He proudly perceived himself to be a macho type, although he admitted that this attitude had left him alone in his old age.

In the nursing home, he became acquainted with a man living next door to his wife, who suffered severely from dementia. This man regarded Ole's flat as a kind of refuge from a wife who was constantly asking the same questions. The head of the nursing home banned smoking in the dining room and the corridors, and staff therefore welcomed Ole's invitation to smoke in his flat. He described his flat as a "*smoking compartment*". As a result, he had plenty of contact with staff.

He was very aware of how little he called upon the staff for assistance. He mentioned how he deliberately undertook activities which he did not necessarily need to undertake in order to ease the workload on staff, which they appreciated. He described himself as not being the type who repeatedly called for assistance, and he accepted the staff's stress levels and waited for them with patience.

He preferred to eat on his own, but sometimes he accepted the staff's invitations to dine with the other residents. At these events, the staff appreciated his ability to talk and tell jokes.

The last time I saw Ole, he was sitting in his wheelchair at the café outside on a summer's day. He seemed happy, relaxed and talkative as I sat at the table. The nursing home layout had made it possible for him to move outside his flat, and he did not feel as lonely as before his transition. He also knew that the staff valued him for his behaviour, and now there was somebody to ask him how he was every morning.

Inge, age 93. Entered the study on June 2, 2004 until last interview January 14, 2005. Died on July 11, 2007

My first contact with Inge was a strange experience. A few days previously I had written an introductory letter, and the day before I had made an appointment by telephone. When she opened the door, she talked as though the conversation had never taken place and was about to close the door, claiming that there must have been some sort of misunderstanding. I finally convinced her that we had had a conversation the day before, and she allowed me into her flat. This was repeated every time I visited her. At one of the last interviews, I gave her the tapes with the previous interviews, which I had already transcribed. On my final visits, I could then refer to the tapes. However, I was unable to convince her that it was I who asked the questions and that the recorded conversation was between the two of us. She enjoyed listening to the tapes, as "*the woman* [recorded on these tapes] *certainly was reasonable*".

Inge was also the first of the prospective residents in this study, and as I only acquired three prospective residents during the first six months of fieldwork, I had a great deal of time for interviews with her. I took pleasure in talking to her, as she was very

positive and humorous. She had a positive attitude towards her surroundings: for instance, on her balcony she fed the birds, described how she could talk with them and showed an interest in the different species. She was happy with her life. She had been one of many children and, like her brothers and sisters, started working on different farms at the age of fourteen. She considered herself a clever person. Everywhere she worked, she became the one who knew everything and from whom her colleagues always asked advice. Every time somebody had a question, the answer was, “*Ask Inge*”. She compared herself with an owl, the clever bird, and she had a number of illustrations of owls on her walls.

Her niece and her children paid her regular visits, which was very pleasing to her, especially as she had told them that they should visit her only if they took real pleasure in doing so.

After she married, she stopped working. She and her husband did not have any children, but the marriage was happy. The red carpet in her flat reminded her of her late husband, and although the nursing home flat could only accommodate half of it, she was still happy with the piece that was left.

After becoming a widow, she preferred to spend Christmas with her niece and her family. New Year's Eve she spent alone, remembering her husband.

In the nursing home, she was one of the good residents. She was talkative, and she realized that this was the reason why staff made sure that she attended all social events. They openly admitted that she could entertain all the other residents for a while.

Although she did not recognize either me or my photographer at our last visit, she seemed happy. She had lost some more weight and had become even frailer.

The last I heard of her was when her niece called the day before I left for summer vacation. She had died on July 11, 2007. She died as she wished, just falling asleep and not waking up again. Her family was around her when she stopped breathing, as she had been ill for a while. As the conversation with her niece ended, I hesitated for a

minute, then called her back to ask for the red carpet. Unfortunately it was gone. The previous day (July 15, 2007), the part that remained was left at the rubbish dump when her flat in the nursing home was emptied and made ready for the next resident.

Åse, age 87. Entered the study on January 6, 2005, died in hospital March 4, 2005.

I first met Åse in a hospital in Copenhagen. Her treatment for a cerebrovascular event had ended, and she was waiting for a flat in the nursing home. I felt as if she was looking at me with a prayer in her eyes: *“Please get me out of this place”*. In the interviews, she told me that she was looking forward to leaving the hospital.

It was evident that she had close contact with relatives. Fresh flowers stood close to the bed, and she talked of daily visits from her daughter and her son. She did not dare return to her home again, as the cerebrovascular event had nearly paralysed her. She had now, in agreement with her daughter, enrolled in nursing care, as she was also afraid to be alone.

Before she was hospitalised, she was bussed to the nursing home twice a week, along with three other women from her neighbourhood, where they participated in various activities. This was the highlight of the week, and these pleasant mornings were what she thought of when we discussed her expectations of the nursing home.

Åse was talkative and a very kind person. She asked about the project and talked openly about her life, family and future expectations. A nurse at the hospital said, *“They will be having a very positive old woman in the nursing home”*.

However, according to her contact person, her expectations of future physical improvement were very far from realistic. It was as though Åse had described a dream.

Her father had been a lorry driver and managed his own business. Her mother took care of her and her three brothers. Before Åse married, she had different jobs and was trained as a shop assistant. She had pleasant memories of her career, with positive relationships with her colleagues. Her husband had been a police officer. After they

married, she took care of their home and daughter. Holidays were always spent in Denmark, and in fact she never left Denmark even once in her life. She was proud of her late husband: he was a passionate hunter, and some of her most precious belongings were two figurines of dogs, which reminded her of his dogs, his passion and their happy marriage.

In the nursing home, she developed a very positive relationship with her contact person. Lone (her contact person) felt that her own importance was confirmed when she was caring for Åse. Åse was humorous and talkative, and they conversed about classical music, a mutual interest of theirs.

Through the efforts of her family, only a few days after the move, Åse's flat was decorated the way she preferred. Her daughter was aware that she was not eating much food, and it seemed that making her feel at home immediately at the nursing home would improve her eating from the daughter's point of view.

She suffered from defective hearing and, since she ate very little food, she soon became very weak. Before I interviewed her for the last time, she dined with the other residents on the ward. I remember her sitting at the end of the table, completely left out of the conversation. She could not hear which topics were being discussed, and she faced severe difficulties in eating.

When she entered the nursing home, she nearly stopped eating altogether. Her awareness of her surroundings faded rapidly during the last month she was in the nursing home. At the last interview, it was as though she had entered a different world, one of fantasies. She talked about the previous day's walks with her daughter. She sat in the sun telling me how she had lost her sight on the walk. The next moment she began a completely different story. On the table in front of her was a selection of sweets and she had tried to eat some porridge, but it was dripping out of her mouth and she had forgotten or had given up further eating.

Her daughter's voice was shivering as she told me that she was now hospitalised. What made her shiver was that she felt she had lost contact with her mother. The contact they had had was when she fed her mother, but as she was unable to swallow

her food, her daughter had finally given up feeding her. Åse died after three weeks in hospital.

Arne, age 91. Entered the study on February 25, 2005 until last interview December 28, 2005.

Arne welcomed me into his apartment on the fourth floor, where he felt as if he was being held in custody while he was waiting for a flat in the nursing home. His wife, who suffered seriously from dementia, was already a resident there. He was the prospective resident who had to wait for the longest time, seven months in all. The flat was prepared for his niece to take over, and he had arranged for the bathroom and the kitchen to be painted and refurbished. Just before the move, a serious pain in his stomach was treated with medication. He was convinced that the extensive waiting and not knowing when he would be reunited with his wife was the cause. He was worried about her well-being and, as he said, "*I have all the time in the world to think about it...and it hurts me deeply*".

Arne described himself as an entrepreneur. One day he went to a large factory seeking employment. He saw a long queue of people, all with the same aim, and decided to find another way. He found the management entrance and knocked on the door. By coincidence the guard was not there, and he found his way to the director's office. He vividly described the large table behind which a small man was sitting. He asked for a job and the director got confused. He hesitated for a minute, and then called the head of the engine department and asked him to find a position for Arne. After this incident, the director greeted him every morning.

He left the factory and found a position with the Danish railways. He started his career shovelling coal into the engines of steam trains and finished as a train driver. He took great pleasure in this last position, and it was a pleasure to listen to his stories.

He had been building model ships during his leisure time, and every time I visited him I promised him to go and see one of his models, which was at an exhibition at Kronborg in Elsinore. I still have not made it there.

Arne was proud of his skills in trading things to his own advantage. The painting on the wall he traded for some clothes just after the war, and he walked me through his flat pointing to every piece of furniture, telling a story about the trade: with whom he had done it and how they all came about.

He and his wife had one daughter. Although his wife was unable to recognise him any longer, he still loved her and was very proud of her. Every time we talked about her, he mentioned that she had attended courses at the university.

He got a flat a few days after his wife died at the nursing home. He had visited her twice a week and daily called the ward. The last time he called, her contact person told him that she had died just five minutes before.

With his zimmer frame, he was able to walk to the café at the nursing home if he paused at every bench on the way. He found an acquaintance in the café, but missed his former home. He also missed life outside, where the “*civilians*” were. Weekends at home had been characterised by life in the yard and possibly a few visitors. In the nursing home, everything was quiet. The neighbours no longer paid any visits, and he started to feel more isolated, especially as he also realised that the vast majority of the residents were unable to communicate.

He insisted that he would maintain and improve his physical abilities in the nursing home. For instance, he strongly refused my assistance as he served a beer at one of my interviews, saying, “*I need to maintain this ability*”.

He was pleased to see me at the last interview. He was sitting in the hallway he had told me about to watch the birds outside the windows. However, staff normally gathered here at this time of the day, and I believe he was waiting for a chance of a brief chat with one or two of them. We had a beer in his flat; I asked him about his wife, and he instantly started to cry. He was so sad that he was not the last person in this life she had talked to. He invited me for lunch, and we went in slow motion down to the café. I told him that I was off to Oxford next week for further studies, and I really felt sorry for him as I was leaving the premises.

Hans and Anna, age; 88 and 86. Entered the study on June 12, 2005 until last interview December 12, 2005. Anna died on May 23, 2007.

Hans and Anna were the only married couple in this study. They had their basement flat close to the royal castle in the centre of Copenhagen. I remember having great difficulties finding a parking space in the neighbourhood, and I ended up walking a long distance at high speed to keep our appointment. It was hot in the flat, and I was sweating profusely at our first encounter.

Hans was very talkative, and I had to address questions directly to Anna, otherwise Hans would only start talking, and I soon realised that he could continue for a long time without my needing to add any further questions.

I was shocked the first time I saw Anna. Suddenly, while Hans was elaborating extensively upon a part of their previous life, she stood in the doorway. She was wearing light nightwear, and I could see that she was extremely thin. Her hairstyle made her look scary.

Hans's sight was failing. He had suffered a stroke, and they did not feel safe in the flat any more. If Hans had another stroke, she would be unable to make an emergency call. Further, Hans did not want the people around him to witness his physical decline.

Their whole life had taken place in that exact street, and they had lived as a married couple in the flat for sixty years. They first met in this street. Their only son was born in the flat, and Hans had his office in the basement flat, from where he worked. From here, they drove their car to their summerhouse on Saturdays.

Although he had been retired for years, he kept his office the way it used to be. Although it is hard to explain how, it was strikingly apparent that the office was not in use any more. I believe that he kept it this way to remind himself of his former position.

At the beginning, it was a relief to them to be in the nursing home, and Hans praised the institution. However, they did not turn into good residents and soon faced a

difficult time there. He complained if the staff did not assist Anna at approximately the same time every day.

By the end of my fieldwork, Hans had realised that his complaints were useless. After six months, he realised that they actually had to take care of the staff members. Otherwise they left the ward, and it was a sad experience for them to say goodbye to a staff member they felt they had just started to know.

I had my final contact with Hans after my fieldwork had ended. The photographer and I intended to do a final round of portraits. Anna had just died at hospital the day before we planned to come by. Hans was sad, but was able to inform me about the funeral and her future grave site.

Jørgen, 100 years. March 8 until his death on October 12, 2005

I first meet Jørgen in respite care. He was a hundred years old and gave the impression of vulnerability. I felt a little sorry for him. Interviewing Jørgen was a difficult task, since his poor hearing made it very hard for him to hear my questions. His sight was also failing, so he was unable to read any of my hand-written notes. In respite care, he shared a flat with another prospective resident. Much to his discontent he disapproved of this fellow, because he felt that the man spoke to him in a very impolite way.

He was unable to remember much of his past life and often used the sentence, "*Oh, my head has stopped working*" when there were questions he could not answer. For instance, he had great difficulties remembering when his wife died. At the first interview it was twenty years ago, at the next only five years ago. I soon stopped asking these types of question.

He had worked with lifts, which, at the time he started, were still a fairly new thing in Denmark. He was proud of his work and the company he worked for. They provided him with a car, which was also unusual at that time.

He also told me that he had worked in Greenland for some years, but his relatives informed me that this was not the case. They also informed me that his home had

been sold, and that he enrolled in nursing care following their advice, as he had lost his balance several times and was unable to get to his feet unassisted any longer.

In the nursing home, he was pleased with his flat and I observed that he was extremely grateful for all the assistance the staff provided him with.

The meals at this particular nursing home struck me: Jørgen sat together with three other residents. There was no conversation during the meal. Staff were mostly absent and only asked residents if they wanted anything more to eat. Then the staff left the dining room and the residents ate all on their own. Jørgen needed assistance to participate in any sort of conversation, and, due to his defective hearing, refrained from saying a word, although he was asked a question a few times by one of the other residents. The general impression was that at this meal he was eating alone, although his defective hearing would not necessarily leave him isolated to this extent.

The last time I saw Jørgen was in his sparsely furnished flat in the nursing home. He said that this was the best place for him, and he could not expect anything better in the world than this place. He was obviously pleased to have his own flat, and, in comparison with the first time I saw him, seemed more relaxed. The layout of his flat gave an institutional impression, and I could not help thinking that there was nothing furnishing it apart from the sofa and a photograph of his former wife. His clothes were presumably in the wardrobe, but apart from these items, I saw none of his own possessions in the flat. The flat was dark and the last interview left a sad impression, as Jørgen seemed isolated.

I remember talking to his contact person about his death. She told me that it was as though he knew what was going to happen. She was very pleased that she made him relax and managed to summon his relatives in time for them to be present as he passed away.

Nearly a month after his death, I interviewed one of the other residents on his ward. I mentioned Jørgen and he said, *“Oh, little Jørgen, I have not seen him for a while. (pause) He must be on vacation”*.

Lise, age 95. Entered the study on October 11, 2004 until last interview June 2, 2005.

At the first contact, Lise left an upper-class impression. The paintings on her walls and her clothes indicated a wealthy background. She was very kind, and talking to her was a pleasure. Lise was related to a famous Danish painter, who had lived and worked in Rome for many years. At the time of the first interview, I had, by coincidence, read a book about the painter and the group of painters he belonged to. This issue turned out to be a substantial basis for our future conversations about her paintings.

She was confined to her apartment, as the door leading to the lift was too heavy for her to pull open. If the building caught fire, her life was dependent on the help of her neighbours, and she felt this was a frightening thought.

Her life made for an interesting story. She was married at the age of 21 to a German doctor and moved to Germany. The marriage was happy and they had three daughters. Her husband was the personal doctor of members of the German aristocracy, and she was pleased to live there. When the war came things changed, and by the end of the war she and her husband ended up living in the Russian sector. Because of her husband's patients, the Russians arrested him one evening just after the war, and she never saw him again. She was later informed that he had died in a concentration camp. Soon after her husband's arrest, she decided to flee to Denmark. She vividly told how, with her small children, she walked through the woods somewhere south of Lübeck and was caught by a Russian patrol. She was arrested, and after a few days escorted back home. She hesitated for a few days and tried again, this time further south, and finally succeeded in reaching Hamburg, where the British authorities provided transport to Denmark.

She began her education again and started working close to where her parents lived. Some years afterwards, she met her second husband and moved with her children to a small provincial town in Jutland. She continued working part time until her retirement. When her second husband died, she left Jutland and moved to a flat in the greater Copenhagen area to be close to her daughters.

In the nursing home, she was pleased with her first contact person. Although she had worked as a waitress in a pub for several years and had a completely different social background than Lise, they appreciated each other's company. The next contact person was different. She was always sticking to the rules, and Lise, after some discussion with the contact person, got the impression that she was the one who had to take care of her.

Lise made a serious effort at the rehabilitation centre, but she realised that the training and intensity provided was not improving her ability to walk. She was eager to leave her wheelchair and start walking with the zimmer frame, but only dared to do so when a staff member was walking right next to her.

Nevertheless, at the beginning she was very pleased with the nursing home facilities, where the even corridors enabled her to decide for herself when she wanted to leave the rehabilitation activities and undertake other activities on her own.

The last time I saw Lise, the photographer and I were doing an additional round of portraits. She was pleased to see us, but complained about the poor condition of her leg. She had broken her leg nearly eight months before our visit, and it would not heal properly. She said that she had given up ever being able to walk again.

Anders, age 93. Entered the study on April 2, 2005 until last interview December 28, 2005.

Anders sounded like a man of around sixty years old when I made an appointment by telephone for our first interview. He lived in a small house and was the only prospective resident who still had the ability to walk the streets of the neighbourhood.

He was very talkative, and was able to tell a series of interesting stories from a long life. When I first met him, he was walking twice a day, once in the morning and once later in the afternoon. Once a week he attended an evening meeting, but due to his poor hearing he had become hesitant about going there any more. He was a man with a very positive attitude, talkative and interested, and the fact that he had lost his wife and both children did not seem to have had a negative influence on his mood.

He had suffered from depression, which was the reason for his referral to nursing care. However, as the move approached, he started feeling well again. When he entered the care facilities, he only needed a nurse to assist with medication for his eyes. Apart from this, he was able to manage everything on his own. In this respect, he was not a typical nursing home resident.

He had been married but was widowed. He loved his wife, and a picture of the two of them, which he kept next to him in the nursing home, was evidence of their mutual affection. They had a son and a daughter. They were both dead, but Anders still kept in contact with his grandchild, whom he was able to visit unassisted.

He had had a number of different jobs during his life. The one I found the most remarkable, and the one we talked and laughed about the most, was as the owner of a large restaurant at an amusement park to the north of Copenhagen. Next door there was a theatre, and the actors often spent late evenings and nights at Anders's restaurant. He had pictures and autographs from these actors, and knew a series of intimate details about them.

In the nursing home, he started to feel old. Although he was 93, he did not feel it until he began to identify with the other residents in the nursing home. In his adoption of the routines of the nursing home ward, he felt he had to refrain from one of his daily walks. However, he missed the afternoon walks badly and started to walk the halls late in the evening instead. He laughed as he told me about the staff's reaction. They thought that they would have to guide yet another resident suffering from dementia back into his flat.

In the nursing home, there was a group of old men who had worked in the shipyard. They met each week and Anders joined them, as he had also worked there. One of his former colleagues, Erik, was very pleased to see Anders again. He was used to people dying around him, and with them their memories. When Anders arrived, it felt as though some of his past had reappeared and that the process had been reversed for a time.

Anders was one of the good residents. He assisted in keeping order at the table, and at times he helped his fellow residents who were suffering from dementia. Although other residents treated one old female resident very sharply, Anders never behaved in this manner towards her.

I decided to go and visit him two hours before I had asked the photographer to come for a final round of portraits. We talked and talked, and he was happy now with the nursing home. I asked how many of the approximately thirty residents had died since he entered the nursing home. He counted and counted and ended at around twenty. I asked whether this was not rather strange. He disagreed and said that he did not bother about the others, as he only knew a few of them anyhow. Just before the photographer arrived, we talked about some relatives of his in Australia. They had paid him a visit the previous summer, and he stopped talking for a second and said, as if directed to himself, "*Maybe that was the last time I'll see them?*"

Lis, age 94. Entered the study on December 14, 2004 until last interview June 3, 2005.

As at our first interview her face bore the signs of a recent serious fall, Lis gave me the opposite impression to Jørgen. She was a large woman who had been able to manage on her own for most of her adult life. That is, her will to manage on her own was strong, at times too strong, she said, and pointed to her face. This happens, she said, "*when you prefer to do everything on your own.*" Her daughter completed this picture by saying that she had turned down the home care assistance she had been assessed for. She just wanted to manage on her own. Lis felt that the assessment for nursing care represented a defeat for her. "*When you have managed on your own all your life, it is hard to end like this*". She had suffered a cerebrovascular event, which left her unable to walk and with only partial use of her right arm. This was the reason for the assessment.

She had managed on her own most of her life. She divorced her husband when their three children were still small, and had also managed that situation.

She told me about her childhood and how her parents disagreed whether she should be adopted by another couple or remain with them. Her mother had wanted her to go, but her father decided that she should stay. After a while, she said that *“when your parents' relationship is problematic, it is like a burden you carry for the rest of your life”*.

She had various different jobs after her divorce. She had worked as a waitress, among other places in Tivoli amusement park in Copenhagen. The supervisor appreciated her work, which she was apparently good at. However, it was difficult to have different people looking after her children, as they were still small and she worked in the evenings. She told of one incident when the police came to see her at work because the woman taking care of her children had left them. A neighbour had called the police, and Lis needed to find somebody else to look after them.

In the nursing home, she did not become one of the good residents. She was very much aware of the staff's expectations, and when I asked if they treated her properly, she answered with irony, *“If I behave in accordance with their expectations”*.

She had a hard time in the nursing home. Her poor hearing and a maladjusted hearing aid was a source of constant frustration for the staff. Lis turned the volume and the hearing aid made a noise that annoyed the staff. They often took the hearing aid out of her ear in a harsh manner. Nevertheless, when a member of staff helped Lis to the dining table the next time, the volume was again at the same high level.

Lis preferred to finish her meals and leave the table as quickly as possible. Often the only thing I heard her say during these events was, when she had finished eating, *“Can I be helped back into my room again, please?”*, often repeating this wish. I never heard Lis take part in a conversation on the ward. She made a few comments to the other residents, thanking somebody for giving her a napkin, for instance, or when another resident picked up a fork from the floor, saying, *“I wish I could do that”*.

There was a social event for all the residents of the nursing home at Shrovetide (*“Fastelavn”*). I remember the group of six residents leaving the ward with two members of staff. It was very complicated, as walking to the next building with

wheelchairs and zimmer frames was hard for the staff to control. A major part of the event was eating a special kind of sweet bun. These were hard, and very difficult for the residents to eat. I remember seeing Lis give up doing so.

Lis wanted to regain her independence. She struggled seriously at the rehabilitation centre, but after half a year she realised that it did not improve her abilities.

The last time I saw Lis, I could see her from the dining room. She took her hairbrush and started to comb her hair. She soon put the hairbrush back on the table again, then picked it up once more and leaned back. I interpreted her reluctance as an indication that her looks did not mean much to her any more.

Bo, age 75. Entered the study on February 21, 2005 died July 20, 2005.

Bo thought that I was connected with the municipality authorities and was therefore very talkative at the first interview. When he realised that I did not possess the supposed influence, he was reluctant to accept further interview appointments. When I met him in the hallway, he told me, "*You've already asked enough questions*".

At the time of these interviews, I was doing some minor construction work at a house and, as Bo was a skilled carpenter, I took great pleasure in discussing possible solutions with him. He was proud of being a carpenter. He talked in detail about his work and described a staircase he had constructed in oak.

He felt very isolated from the social world outside the nursing home. He felt that, as a carpenter, he had contributed through his physical work to creating and influencing his surroundings. His mood was very positive most of the time, but he told me that if anything could depress him, it was the fact that he could no longer use his skills as a carpenter.

He had managed his own business for years, but constant illness prevented him from continuing. He lost his physical abilities and, after a fairly long process, was referred for nursing care. He described his helplessness through a situation which occurred before he moved into the nursing home, when the home care assistant did not turn up.

“Imagine you have to defecate in bed. You can't hold it back any longer. It was disgusting”.

He had been hard-working all his life. The phrase *“It doesn't harm anybody to work hard”* was a kind of bon mot for him. As a pupil, he distributed morning papers before he went to school. After school, he worked as a caddy at a golf course. In the nursing home, his presence made a great difference on the ward. He was talkative, and the staff were very pleased with his contributions at the dining table. He helped pass the trays around and talked with the members of staff about the other residents. The staff also enjoyed talking to him, and they found that meals had become longer since his arrival. Bo once prepared a variety of herring dishes, a Danish delicacy, for his fellow residents. They approved of this initiative, and the staff encouraged him to repeat it.

However, his positive attitude and close contact with the staff created jealousy among the former staff favourites. I had the opportunity to observe Bo's ward both before his arrival and afterwards. The female resident whom the staff used to approach when trying to start up a conversation kept quiet after Bo's arrival on the ward, and she became very reluctant to answer the staff's questions.

He had many expectations concerning his immediate future. Above all he wanted to ride his electric scooter again, as this would enable him to leave the nursing home on his own initiative. Rehabilitation played a significant role in the fulfilment of this wishes for the future. He needed to improve to be able to climb on to the scooter, as well as to get off it again. He also planned to drive around the premises and take photographs of the residents in order to show the others what it was like to live in a nursing home.

Dorte aged 91. Entered the study on August 20th 2005 until December 29th 2005. Died in June 2006.

I rarely visited residents while they were lying in bed. Nevertheless, in both my first contact and all the other interviews with Dorte, I sat beside her bed. She had suffered a cerebrovascular event, and I was shocked when, during the first interview, she told

me that she would have preferred not to have woken up after this event. Instead of the physical abilities she was left with, she would much rather be dead.

She was only able to move her right hand. It was therefore difficult for her to read her daily paper, and when I visited her in the morning, this paper was left untouched on her bed. It seemed that she never touched this newspaper, but kept her subscription so as to somehow maintain the appearance of keeping in touch with her surroundings, however symbolical this might be. She was left totally dependent upon the assistance of the staff. When I came in the morning, I had to raise one end of her bed for her to be able to see me.

She and her husband had two daughters, and the two daughters visited her often. She had worked with telecommunications in an office. She joked and told me that she was “full of numbers,” which in Danish means that she played many jokes.

One vacation she visited Oxford, and since I was on my way there a few weeks later, we spent a long time discussing Christ Church College and the immediate surroundings of these buildings.

In recent years, she and her husband had been living in a flat fairly close to the nursing home. Her daughter had helped her sell her previous home, which highlighted her dependence. She knew that “*it will be sold, but it takes time*” and she found it devastating that she was unable to do anything about it.

Dorte's situation in the nursing home made me think about the significance of dependence. Once, when I came for another interview, the sun was shining right in her face, and she had difficulty seeing me when I entered. I asked whether I should draw the curtains for her, and she was very pleased that I did this for her. It dawned on me that Dorte was lying in her bed, negotiating in her mind whether she should call the staff for assistance. She only called when it was “*really, really necessary*”. As a new resident, she had been told that she should not call on the staff too often. For instance, her daughter provided her with some of her favourite yoghurts, putting them in the fridge for her to eat later on. But she was hesitant about accepting this. To eat a

yoghurt, she needed the staff's assistance, first, to take the yoghurt out of the fridge and give her a spoon, and afterwards to help her get rid of the leftovers.

In an interview with one of the staff members, we discussed Dorte's dependence. She declared that she would rather die than experience this sort of dependence. She could not imagine herself needing to call somebody new every time she wanted anything. Dorte became one of the good residents. But she preferred to stay in bed instead of eating with the other residents, saying, "*What should I do out there? There's nobody to talk to*". Staff sometimes complained that they found it too hard to persuade her to socialize in the dining room.

She hoped that the activities at the rehabilitation centre would improve her situation. However, she was informed by the occupational therapist that she had to relax and not try and make progress too rapidly.

My last interview with her was just before Christmas 2005, as I was concentrating on packing up my books and field notes. I promised to come back and tell her if Christ Church College was still looking the same. It was, but Dorte died before I could go back and tell her.

Oline, aged 91. Entered the study on January 4, 2005 died April 6, 2005.

The first interview with Oline was in her flat, just after Christmas in January 2005. I had the opportunity to speak with all the other elderly people in this study, but due to sclerosis Oline had lost this ability. She was only able to burst out with some incomprehensible noises, and we had to communicate by written notes. The sclerosis had also affected her ability to eat and drink. She had difficulties in swallowing, and as we sat at the table in her kitchen, the coffee she tried to drink was constantly dripping from her mouth. Therefore, all the papers we passed between us had coffee stains on them.

The first time I visited her, she insisted on walking me round the flat. She lost her balance as she tried to point to a patchwork on the wall, and I just managed to prevent her from falling into the bookshelves. I discussed this matter with the home care

assistant, and she expressed the opinion that “*This is not working out for her any more. She keeps falling and one day she will hurt herself badly*”.

The home care assistant suspected that Oline was collecting a large number of pills to kill herself with. Her daughter was of the same opinion, as Oline had already tried to commit suicide twice before she had been assessed for nursing care.

Oline had taught classes in patchwork. She showed me a series of leaflets from exhibitions she had either held on her own or contributed to. Patchwork was her whole life, but the sclerosis had made it impossible for her to do it any more, which was evidently a great loss for her. She was a widow, and her late husband had worked as an engineer. They had two children, a daughter and a son.

In the nursing home she did not become a good resident. She protested, did not accept the regulations, and if, for instance, the radio was on in the dining room, she just pulled out the plug if the music was annoying her.

A few weeks after she was admitted, she felt like shopping. She left the nursing home, and when the staff realised that she had not come back, they all started looking for her. Oline was later found in a local supermarket. She did not feel that she had done anything wrong, but after that she encountered opposition from both the staff and the other residents.

I visited Oline the day before she died. She was very weak. She was thirsty but did not have the strength to burst out with noises any longer. She tried to write things to me, but her handwriting had become totally illegible. However, I recognised the word teat glass (“*suttekop*”) and I asked the staff for something for her to drink (see the scanned document in the introduction).

The member of staff told me that Oline had been refusing to eat for some weeks. She also preferred not to drink, but this had proved too painful for her, as the prescriptions she was given did not work without some fluids. By refusing to eat, she finally succeeded in killing herself.

During this visit, I had a rather long conversation with Oline, being the last person to do so. Her daughter told me that she did not arrive until after her death at the nursing home a day later.

Ib, age 89. Entered this study on May 30, 2005 until last interview December 15, 2005

“How could such a thing happen?”

In asking this question, Ib was referring to the fact that he had been partly paralysed as a result of a cerebrovascular event. I met him first with his wife in respite care at the same nursing home where he later had his permanent flat. It was very difficult for him to come to terms with his situation. His speech had also been affected by the cerebrovascular event, and it was hard to hear him. On the first occasion, his wife was present and was quite curious about my project, which also made our conversation difficult.

Ib was a tall, strong man. He had played sports all his life and had lived a healthy life. This healthy living made it even more difficult for him to understand his present situation. Before he entered respite care, he had been hospitalised and admitted to a rehabilitation centre, and he was now being assessed for nursing care.

Ib was one of the residents who thought that I was able to influence the assessments of the municipality representatives, and he was therefore very talkative at the beginning. In the last interviews, however, he did not like to say much other than that he felt well and was pleased with the place.

Ib had spent all his working life in the local shipyard: he had been trained as a skilled worker there and was proud telling me that he had worked for fifty years. Working in the shipyard was hard, he told me. Ib finished in the engineering department, where it became his job to build the huge engines for the ships.

He and his wife had two children, who had also had children, plus a great-grandchild now *“on the way”*, as he expressed it. The children lived within a distance of a few miles, and during the time when I used to visit Ib in the nursing home, the fresh

flowers, sweets and cake on the table in his flat were evidence of the frequent visits his family paid him.

Ib and his wife had a small house just to the north of Elsinore. Ib had enjoyed taking care of his garden and spending time with his grandchildren. He had been doing this for nearly 25 years after he had finished working at the shipyard, but this suddenly changed. For his wife the situation was difficult. Ib would rather have been cared for by his wife, but she had to tell him at regular intervals that she was physically unable to do so. Ib knew this, but still mentioned the idea in the interviews.

To begin with he was placed at a table with a group of female residents in the nursing home ward, but he felt uncomfortable in their company. He referred to them as a group of “*bitches*” and would have preferred to sit at a table where two of his former workmates sat. He was angry about this, and I told staff about his preference. I was told that his wheelchair was too large to seat him at the other table, and others had to move to make way for it. Nevertheless, when I saw Ib a few weeks later, he had a seat at the table with his former workmates.

In the future, he hoped to leave his wheelchair and be able to walk unassisted again, and therefore made a great effort at the rehabilitation centre. However, he did not experience any improvements.

The last time I saw Ib, I observed him just after the last, very short interview, in which he preferred his newspaper to answering my questions. He had joined the Bingo event at the café, on which he was very focused, apparently enjoying himself playing the game.

Summary

Becoming a nursing home resident

An Anthropological Analysis of Danish Elderly People in Transition

Present and future demographic trends predict a substantial increase in the number of elderly people within the next forty years in Denmark and other industrialised Western societies (Teknologirådet 2002, Harper 2004). Researchers and policy-makers predict that this increase will intensify the demand for nursing care, and consequently a larger number of elderly people will be in transition and eventually become nursing home residents.

The aim of this study was to investigate how sixteen elderly people experienced the transition into nursing care.

The methods applied were ethnographic, with fieldwork lasting from June 2004 until December 2005. These methods consisted of repeated interviews and observations in order to investigate the process of transition from the elderly people's perspective. These methods were supplemented by a quantitative assessment (Minimum Data Set) of the elderly people in order to identify how their mental and functional status developed.

I applied the perspective of Intersubjectivity (Jackson 1998) in the analysis of the transition. This perspective indicates the need to see the increasingly disabled elderly people as engaged in several relationships, though influenced by their increasing mental and physical impairments. These relationships were with persons, material things, homes, institutions and food. To identify the lived experience of the elderly subjects in these relationships, I have used phenomenological theory inspired primarily by Merleau-Ponty (1994) and Leder (1990). These two perspectives in combination enabled me to develop an understanding of the link between the lived subjective experience of the elderly people and their possibilities for agency.

Analytically I divided the transition into the three phases. The transition began with the assessment by the municipal authorities, which was where the elderly people entered this study, and it ended when they had been residents for six months. This meant that I followed each of the sixteen elderly people for approximately ten months. The first phase concerned the waiting time for nursing care at home. The second phase was the dissolution of the home, the third related to their experience as nursing home residents.

In Chapter 2 – the first phase of the transition – I pursued the argument that the physical decline of the elderly people's bodies led to social isolation and pre-institutionalisation (cf. Buus 2001) of their homes. This in turn restricted their ability to engage in social relations and to present their personal identities.

In the second phase of the transition (Chapter 3), I argued that the material dissolution of their homes represented a dissolution of themselves as persons. Parts of them were placed among relatives and other parts condensed with meaning and placed in their nursing home flat, but most of them were left at the dump. The dissolution of their homes implied a serious reduction in the number of their material possessions. Furthermore, the perspectives of Parkin (1999) and Verrips (1994) enabled an understanding of how prospective residents could dispose of the majority of their possessions without too much pain.

Phase three in the transition concerned the elderly people's experiences as nursing home residents (Chapter 4-6). In Chapter 4 I elaborate upon the relationships between nursing home residents and staff that I started discussing in Chapter 2, with a focus upon the relationships between the elderly people and their home care assistants. In Chapter 4 I argue that the aims in terms of providing ideal care were achieved through social relationships that were often characterised by mutual obligations. The majorities of the new residents acknowledged this. They were able to establish relationships with their contact persons in order to influence nursing home practice in a battle with the other residents to draw attention to their own persons. These relationships were fragile and temporary and only lasted when the mutual expectations involved were fulfilled.

In Chapter 5 I analyse the meals in the nursing homes and argue that the behaviour of staff on these occasions made residents reluctant to participate. Through their behaviour at mealtimes, the staff sometimes turned the meals into situations dominated by work-related issues. The meals were a part of the staff's work, but also fragile social processes that needed more than just talking about a cosy situation to establish. Compared to other types of care, staff faced difficulties in incorporating the meals into their work, as it was difficult to assume the role of host with any conviction.

By attending the rehabilitation activities (Chapter 6), the elderly people wanted to reverse the process whereby their bodily disability increased their need for assistance and was what had ultimately led to their assessment for nursing care. Their surroundings were perceived with regard to the body's own conditions, but their bodies increasingly became a prison, as they blocked their access to and interaction with these in the process. The important point here was that their bodies were also their tool for re-establishing this access (cf. Merleau-Ponty 1994), in this case via rehabilitation. Reversing this process also reflects an intention to appropriate their immediate surroundings from places dominated by the work of the staff into places that were also dominated by their own movements (cf. Casey 1996, 2003). They anticipated that they would be able to learn some of the unlearned appropriate behaviour at meals again. Mostly they intended to "*experience themselves as world makers*" again (Jackson 1998: 8).

One of the contributions of this thesis is its analysis of reduced human agency in the coming into being of sixteen nursing home residents who were close to the end of their lives. I have followed the lead of existential anthropology (cf. Jackson 2005) regarding elderly people's abilities to live the difficult circumstances in institutionalised surroundings. That is, I paid attention to the different aspects of their agency and emphasised the remaining aspect of it in establishing relationships with the individuals who embodied the aims of care for the aged in the Danish welfare state.

The recommendations must consider how the aims and hopes of the elderly people can be applied fruitfully in nursing homes to improve their physical abilities and

enable them to establish new social relationships. This implies challenging the overall trend towards institutionalisation of the elderly during the transition. The recommendations also address the role of the staff and the question of more substantial information being provided to the elderly as they await nursing care.