Communication and Environmental Positioning in Dementia Care Units: Dialogues Through Space and Place

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1 Introduction

Changes in communication with advancing dementia can cause unique challenges to the experience of home and place for people living in long-term care (LTC) settings. Communication includes more than just language and is affected by how one is positioned within the social and living spaces of a given environment. This chapter is guided by a social constructionist perspective and considers how position and place are socially constructed, negotiated, and performed by LTC dementia residents and care staff through various types of verbal and nonverbal positioning. Positioning theory addresses how identities and roles are enacted through language, often in conversations (Harre & van Langenhove, 1999; Sabat et al., 2011). Environmental positioning describes how identities and roles can be jointly constructed through dialogue and in relation to space and place (de Medeiros et al., 2013; de Medeiros & Sabat, 2016). Environmental positioning may be influenced by the rules that govern how physical space is used (e.g., Is it an area open to residents and staff or staff only?), the symbolic meanings of places (e.g., nursing homes as places of fear), the physical layout of place (e.g., walls, tables, personal items), the function of structural and decorative features within an environment (e.g., Do they serve as barriers, facilitators, or identity markers?), and the precarity or level of insecurity associated with being in a particular place.

To further consider positioning in LTC, we present an illustrative case example of Rosie (a pseudonym), an 86-year-old widow who resided in a 20-bed nursing home unit for people living with dementia. Specific interactions related to positioning between Rosie and a staff member and other residents were documented through observational notes and interviews. By considering positioning in light of Rosie's

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experiences, we consider ways in which LTC settings can move beyond the oversight needs of the staff to foster more equitable communicative possibilities for residents within the care environment.

1.1 Communication and Dementia

Changes in communicative abilities that occur with advancing dementia can cause challenges for staff and residents in LTC settings (Adams & Gardiner, 2005; Saunders et al., 2011; Savundranayagam & Moore-Nielsen, 2015). Many challenges are not related to language changes, but instead are shaped by social perceptions, stereotypes, and assumptions about the communicative abilities of people living with dementia. The literature on speech accommodation suggests negative stereotypes associated with conditions like dementia can cause a speaker make over-accommodations when speaking to someone living with dementia regardless of that person's actual language abilities (Coupland et al., 1988; Giles, 2016; Savundranayagam & Moore-Nielsen, 2015). For instance, a speaker may talk to a person living with dementia as if they were a child because of stereotypes that suggest they are childlike (Kemper, 1994; Williams et al., 2009).

Furthermore, people living with dementia have been depicted as akin to selfless "zombies" (Behuniak, 2011); as "tragic, weak, and completely incapable" (Bartlett & O'Connor, 2010, p. 98); and as "no longer people" (Bruens, 2013, p. 84). These and other damaging stereotypes create a type of separation between "us" (people not living with dementia) and "them" (those living with dementia) which contributes to stigmatization and social discreditation (Goffman, 2009; Gove et al., 2016; Young et al., 2011). Stereotypes like these reinforce the idea that people living with dementia have little or nothing to say of value since "they" are no longer like "us." This is especially true for people living with dementia who have been removed from the community and relocated to LTC, a particular type of place with negative associations, where they are unseen by the public.

It is also important to consider how power dynamics are negotiated, challenged, or reinforced through conversation. As mentioned briefly in the introduction, positioning theory has its roots in linguistics and social psychology. It broadly considers relationships and power as they are enacted through language, thoughts, and other communicative actions (e.g., gestures, facial expressions) (Harre & van Langenhove, 1999). Embedded in positioning theory is the notion that when engaging in conversational practices, people assume different roles which provide them with different rights and obligations (Adams & Gardiner, 2005). For example, a clinician may enact their role as expert by wearing a white coat and choosing technical words. In this way, the clinician positions themselves as having greater power in the conversation. As a conversation unfolds, participants may change their role in response to another's role, try to assume a more (or less) powerful position in the conversation, or enact other types of rights or obligations that they deem appropriate for the conversation. For example, the same clinician could position themselves as a "friendly expert" by dressing in layperson clothes and using nontechnical language as an attempt to achieve a more even power distribution in the conversation. If, however, the clinician over-accommodates and uses inappropriately simplistic language, they would be practicing a type of disabling speech or what Kitwood (1997) and Sabat and Lee (2011) have referred to as negative or malignant positioning.

Negative or malignant positioning describes a deficit view by one communicative partner toward another (Kitwood, 1997). It has been well documented in the research literature on communications between younger people and older people, regardless of dementia status (Young et al., 2011). Kemper (1994) coined the term "elderspeak" to describe the patronizing, childlike language often used by younger people when speaking to older people (Williams et al., 2003). Other types of over-accommodation that leads to negative positioning include using a high-pitched or exaggerated tone, choosing simple words, use of diminutives (e.g., "sweetie), interrupting, talking over the conversational partner, and disregarding the conversational partner altogether (Adams & Gardiner, 2005; Sabat, 2006; Savundranayagam & Moore-Nielsen, 2015; Young et al., 2011). Such over-accommodation not only reinforces unequal power dynamics between speaker and conversational partner, it also may contribute to withdrawal of the conversational partner from social interactions, thereby contributing to isolation.

As mentioned earlier, positions within a conversation are not one-sided or static. Building on the earlier example of a clinician using condescending talk, a person living with dementia may resist the clinician's position of "expert" and counter through conversational devices such as changing the subject, introducing humor, offering their own personal knowledge as a response, and so on. In these and other ways, power dynamics and roles in terms of one speaker's position to another unfold through discourse and other forms of communication (Harré & Van Langenhove, 1999). The clinician may practice enabling speech by recognizing that the person living with dementia is someone able to express input about their feelings and their care (Adams & Gardiner, 2005). In this way, the clinician would be positioning the person as someone worthy of talking with and listening to rather than talking at and disregarding (de Medeiros & Sabat, 2016).

Of course, language changes are likely to occur with advancing dementia which can present communication challenges for people living with dementia and their care providers. It is, however, important to note that language and communication changes differ according to dementia type and are not uniformly experienced. For example, around 36% of people in early stages and 100% of those in late stages of Alzheimer's disease are reported to have some form of aphasia or loss of ability to express or understand speech (Fraser et al., 2016). Other features of speech changes with Alzheimer's disease include difficulty with naming and word-finding and presence of "empty speech" or speech that lacks referential nouns, content words, and/or cohesion (Fraser et al., 2016; Klimova & Kuca, 2016; Mueller et al., 2018). Many of the speech changes associated with Alzheimer's disease are also experienced by people living with vascular dementia. In contrast, people living with Lewy body dementia or Parkinson's disease dementia are more likely to experience soft or non-articulated speech and lack of grammar cohesion which differ people living with Alzheimer's disease (Klimova & Kuca, 2016).

Overall, difficulties with language and communication can lead to frustration by people living with dementia and their caregivers, which in turn can lead to unpleasant interactions and social withdrawal (Savundranayagam & Moore-Nielsen, 2015). Consequently, improved communication is often identified as an important area in need of attention within dementia care broadly (Young et al., 2011). Stereotypical assumptions about communicative abilities have led many to erroneously assume that all people living with dementia experience similar types of language challenges and are unable to communicate in meaningful or insightful ways about their insights and experiences (Wang et al., 2019). Building on some of the ideas about communication and conversational positioning in this section, the next sections consider residential long-term care facilities (LTCFs) in terms of control through environmental positioning and communicative opportunities.

1.2 Residential Long-Term Care

Residential LTC dementia facilities such as nursing homes are what Goffman (1958) called "total institutions" – places where large groups of people are treated in similar ways; where sleep, play, and work occur in one location; and where the activities of the residents fall under one controlling authority charged with fulfilling the official aims of the institution (Agich, 2003; Eijkelenboom et al., 2017; van Hoof et al., 2016). Despite movements aimed at changing the nature of LTC, from total institutions to models that recognize and respect resident autonomy and personhood (White-Chu et al., 2009), residential long-term dementia care facilities are ultimately charged with providing appropriate medical and social care to people who are unable to care for themselves (Grubman, 2015). Consequently, such facilities are still institutions, even decades after culture change initiatives were introduced, and the staff still control daily schedules regardless of residents' preferences (Duan et al., 2020; Koren, 2010; Ward et al., 2008). Regardless of how "homelike" a facility might appear, institutions are a type of place but not a "home" (Kontos et al., 2021).

Home implies a private dwelling where one feels familiarity, belonging, safety, and comfort and can exercise choice and control (Eijkelenboom et al., 2017; Oswald & Wahl, 2005; Reed-Danahay, 2001; Rubinstein & de Medeiros, 2005). Place includes a particular physical location, locale or "the material setting for social relations" (Cresswell, 2009, p. 169), and the meanings associated with a particular place. Place identity describes how living in a particular community such as a nursing home influences a sense of identity associated with that community such that living elsewhere (e.g., in the community) would affect one's sense of identity (Andrews et al., 2007, 2017; Cuba & Hummon, 1993; Cutchin et al., 2003; Moore, 2014). In this way, understanding, or even questioning, who we are is related to where we are (Rubinstein & de Medeiros, 2003; Rubinstein & de Medeiros, 2005).

Unfortunately, as McParland et al. (2017) have observed, nursing homes are "the place where people with dementia must go when they have moved beyond manageable boundaries in our world … At their most cognitively impaired and thus most vulnerable, people with dementia are not regarded by the general public as 'of our world,' nor considered to be bound by the same rules, nor are their human or citizenship rights respected to the same extent as those without dementia" (p. 262). In addition, most LTC residents did not choose to leave their home in the community to live in the facility – a place. Once there, residents are constrained by the facility's rules and physical layout. They cannot leave without an escort, are restricted in access to other rooms and areas, and are dependent on others for care and social involvement (Ward et al., 2008). Regardless of the small choices that they may be given throughout the day (e.g., coffee or juice, participate in group singing activity or not), they have very little control over their living environment. Residents also will have had few of any opportunities to contribute to the design of a nursing home (van Hoof et al., 2016; Wang et al., 2019). When researchers do ask residents about their preferences within nursing homes, it is typically in relation to receiving care services or limited to their preferred interactions with staff rather than with regard to how residents would like to utilize space (Bangerter et al., 2016).

1.3 Environmental Positioning

Environmental positioning offers a way to further explore how LTCFs as places can become more like homes for residents by fostering communicative opportunities. As briefly mentioned earlier, environmental positioning describes "how the space and physical structures in an environment, as well as the sense of place that accompanies that environment, may enhance or limit a person's ability to express selfhood and identity and to engage socially with another person" (de Medeiros et al., 2013, p. 228). Environmental positioning considers how social roles are enforced through personal objects, how limits and opportunities are created through physical structures such as tables and walls, and the formal and informal "rules" that govern who has access to a physical or social space.

In addition, while the structural layout and décor of a given space can contribute to feelings of belonging or alienation (Chaudhury et al., 2018), they can also be sites of power. Staff exert tremendous control within nursing home spaces. They determine resident seating arrangements at meals, arrange furniture in particular ways for activities, and decide whether music is playing (and what type of music is played), all of which influence environmental positioning (Chaudhury et al., 2018; Doyle et al., 2012). For example, placing chairs too far apart could create a sense of distance rather than community (de Medeiros et al., 2009). Seating a noncommunicative resident next to one who enjoys conversation can silence both residents (de Medeiros et al., 2009). These and other acts of environmental positioning affect communicative opportunities and reflect one's superior (or inferior) social position within the environment, which in turn influences who gets to talk and whose talk is worth listening to.

Another important consideration of environmental positioning is the presence of precarity in a place. Nursing homes are typically viewed as terminal last stops – places where people go to die. Yet, living within a nursing home may also bring a high degree of precarity or uncertainty not related to death. Precarity has been described as "life worlds characterized by uncertainty and insecurity and as a concept that implies both a condition and rallying point for resistance" (Grenier et al., 2020, p. 2). People living with dementia may be positioned as failing socially as a result of negative positioning by caregivers, which in turn could lead to a precarious change in room assignment or relocation to a different facility altogether.

2 Research Objective

The research objective was to get an in-depth perspective on social and environmental positioning through the observed experiences of an LTC resident living with dementia. Of particular interest were the ways in which objects and structures in the environment were used by the resident, staff, and other residents to negotiate or challenge social positions.

3 Methods

An illustrative case study (Yin, 2017) of Rosie (a pseudonym), an 86-year-old woman living with dementia in a secured LTC facility, highlights several aspects of environmental positioning and communication via space and place. An illustrative case study describes the selection and use of a descriptive example which can provide unique insight into one or more key concepts (Yin, 2017). A key criterion when selecting a case example is having sufficient, rich material related to the phenomenon of interest (Flyvbjerg, 2006) or, in this chapter, environmental positioning. Rosie's case was identified through transcripts and observational field notes that provided clear examples of how space and place were experienced and sometimes contested by Rosie and staff. It is important to note that a case does not need to be linked to the study's original research question (Yin, 2011). In fact, case studies can provide needed insight into questions that were not asked by the original study since case studies are not bound by researcher preconceptions in the data-gathering phase of a study (Merriam, 1998).

Rosie was a participant in a 6-month ethnographic study designed to better understand friendships among residents living in a dementia care unit. Data were gathered through direct observations, resident chart reviews, and interviews with staff, family, and residents (de Medeiros et al., 2011). Rosie's unit, one of three 20-person assisted living units within a large (N = 167) dementia care facility, was selected since it was anecdotally known by staff as the “highest functioning” unit, although there were no data to corroborate this. All residents in the unit had a formal diagnosis of moderate to advanced dementia and were able to complete some activities of daily living (e.g., eating, dressing) on their own or with directed assistance. They also all had a legally authorized representatives (LARs) (e.g., relative, court-appointed guardian) who made care decisions on their behalf. LARs also provided written informed consent to participate in the research. Data were obtained through video and audio recordings of public spaces within the unit (e.g., dining room area, common hallways), detailed note-taking, and one-on-one interviews. Residents provided assent before each observation or interview. The original study was approved by the author’s institutional review board. Pseudonyms are used throughout.

4 Results

4.1 The Notebook

Rosie had lived in the same assisted living unit for 3 years at the time of the research. She was widowed and did not have any children. Her LAR was her nephew who did not reside locally. Table 1. includes the transcript and notes from an interaction between Rosie and a staff member involving a notebook, an environmental artifact.

According to the observational notes, lunch had finished. Residents were being directed back into the dining room for an activity. Rosie entered the dining room area at 12: 09 p.m. She picked up a staff member’s notebook from an empty table. The notebook contained brief biographical details and care notes for each resident. Lines 1 through 3 capture the start of communication, whereby the staff member positions Rosie as someone who is not worth her full attention when she responds to Rosie by saying “Mmmm Hmmm” (line 3). When Rosie tries to reassert her position by posing a question to the staff member (line 4), the staff member uses a disabling response (ignoring Rosie’s question, lines 5–6) to negatively position her. When Rosie persists by looking at the notebook (line 7), the staff member first questions Rosie’s action (line 8) and then dismisses Rosie’s ability to find her own name (line 10). When Rosie affirms that her name is in the book, the staff person tells her that whatever Rosie might be looking at is not her name, even though it is (line14). In this way, the staff person discredits Rosie’s statement as false, suggesting that Rosie lacks the ability to recognize her name in the book. The staff then positions herself as even more powerful than Rosie by asking her if she knows her (the staff person’s) name. She holds her nametag up for Rosie to read. Rosie does not read the name (lines 18–20) for reasons that are unclear in the transcript.

Although the staff person again ignores Rosie and begins talking to another staff person, Rosie is undeterred. Rosie asks the staff person what she is doing (line 22). This is interesting since the dining room is theoretically Rosie’s living space. Instead, the staff person again asserts her position by providing Rosie a confusing

Table 1 Interaction between Rosie and a staff member

1	Rosie:	[Looks at the binder and reads aloud the name of the unit that was printed
2		on the notebook cover]
3	Staff1:	Mmm hmm.
4	Rosie:	What do you have in there about me?
5	Staff1:	I should not get the sheet out for nobody…I'm very upset. Don't ask
6		me. I'm very, very upset.
7	Rosie:	[Looks at a paper in the binder]
8	Staff1:	What are you looking at?
9	Rosie:	My name.
10	Staff1:	Your name is not there.
11	Rosie:	Yes it is [Rosie says firmly.]
12	Staff1:	No.
13	Rosie:	Yes it is.
14	Staff1:	That's not your name. [Staff1 is not looking at the notebook.]
15	Rosie:	[Points at the paper]: Rosie Albertson.
16	Staff1	[Starts speaking to another staff member, ignoring Rosie]
17	Rosie:	[While looking at the notebook] I think I might have been married.
18	Staff1:	[Speaking to Rosie] Do you know my name?
19	Rosie:	No, I don't know your name.
20	Staff1:	[Holds up her name tag for Rosie to read. Rosie tries to read it but is not able to.]
21		Shirley. [Staff1 then talks to another staff person.]
22	Rosie:	What are you supposed to be doing?
23	Staff1:	A triple.
24	Rosie:	What is it?
25	Staff1:	Triple.
26	Rosie:	Well, triple doesn't tell me anything.
27	Staff1	[Laughs]. A double. I am working 16 hours.
28	Rosie:	And how many days?
29	Staff1:	Just 1 day.

response related to her work shift (lines 23–27). Rosie is once again able to reassert her own power within the conversation by following up with the question, "And how many days?" (line 28). In this way, Rosie demonstrates that she is interested and capable and does have some control over her environment: She can pick up and read the notebook.

With regard to environmental positioning in this example, the rules of place are at first in conflict. The staff member attempts to assert dominance only to be challenged by Rosie. The staff member's goal of providing care to the residents was in conflict with Rosie's desire to engage in a social interaction in a space that is supposed to provide Rosie with a sense of belonging. The staff member seemed to show no regard for Rosie's interest in the notebook possibly because she didn't think that Rosie was capable of or interested in reading the information. The staff member certainly did not seem to recognize that she, the staff member, was intruding on Rosie's living space rather than the other way around.

4.2 Where Am I?

A few days after the previous example, Rosie was guided back to the dining area by another staff member after having her hair done at the on-site beauty parlor:

> Staff 2 (to Rosie): Sit down. (Staff 2 then has another resident, Donna, sit next to Rosie.)
> Donna (to Rosie): Good afternoon.
> Rosie: I don't know. Where in the world am I?
> Donna: The same place I am.
> Rosie: Where's that?
> Donna: A nursing home. A very nice place. How did you get here?
> Rosie: I don't know. What's this place I'm in?
> Donna: I don't know,

In this excerpt, Rosie is directed into her place (her seat) next to a potential conversational partner, Donna. Donna and Rosie try to define where they are. Donna knows it's a nursing home, although Rosie is unsure where she is. A few days later, Rosie began setting the dining room tables with plates but was told by a staff member to stop, that the dining staff would bring the food on plates. Once again, Rosie was trying to be actively involved in her living space but was prevented from doing so by staff.

4.3 The Easter Card

Later in the month, Rosie was again unsure of where she was:

> [Rosie has an Easter card that says it's from her sister, but Rosie insists that she doesn't have a sister. She does not according to her files. Rosie reads the card aloud, but the other residents and staff aren't listening.]
> Rosie: Can someone tell me where we are? Don't all speak at once.
> A few seconds later:
> Rosie: Can someone enlighten me as to where we are?
> Daniel (a resident): I don't know the name of the place.

In this example, it is unclear whether Rosie may have picked up someone else's Easter's card, since she did not have a sister, or if staff gave her the wrong card, but the staff did not respond to her question. As in the previous example with Donna, Daniel does not know the name of the place. Whereas the staff could have provided him with the name and more of an explanation of where they were, they did not, making it difficult for Rosie to make sense of her space and place.

4.4 The Kitchen Remodel

Approximately 3 months into the study, the kitchen area in the assisted living unit was remodeled. The kitchen and surrounding dining room were the center point between two corridors of resident rooms. The kitchen area functioned as a thoroughfare for residents to access a living room, located to the right of the kitchen area. Prior to the remodel, the kitchen featured an open design, whereby residents could pass from one side of the kitchen to the other in several spots. A counter-height, half-wall enabled residents to see across the dining room to the living.

Part of the kitchen remodel involved raising the height and depth of the half-wall and closing the shortcut through the kitchen. These changes closed off residents' access to the kitchen area and created a barrier between the two corridors of resident room hallways. Residents who lived to the right of the kitchen could still access the living room. However, residents on the left side were no longer able to see the living room and therefore were not able navigate across the kitchen area. This reduced their physical space and their social world. Seating arrangements during meals also changed following the remodel. The ten residents from hallway A now exclusively ate together at one side of the kitchen, while the ten residents from hallway B sat at the opposite side. The care facility's official reason for the change was to reduce the spread of germs and make it easier to locate residents for medications. In practice, the remodel reduced the residents' access to other residents with whom to socialize, from 20 residents to 10 residents.

Four months after the kitchen remodel, Rosie began a relationship with a male resident, Robert, one of the nine other people from her side of the hallway. In one observed conversation, Rosie sat by Robert, held up a leaf that was used in an earlier activity, and asked him, "Does this belong to you?"

"No," Robert said. "It belongs on the tree," to which Rosie laughed and responded, "Well run out there and put it on the tree."

Over the course of the next several weeks, Rosie and Robert spent much of their time together, sitting next to each other at meals, during facility-led activities, and nonscheduled free time. Through this relationship, Rosie seemed to have gained some control over her own space by spending time with a resident of her choice. Despite there being no objections to the relationship by Rosie's and Robert's family members, staff became uncomfortable. They said that the relationship interfered with their ability to perform caregiving tasks, especially at night when staff needed to prepare residents for bedtime. They often separated Rosie and Robert for reasons that were not made clear.

4.5 *Rosie Is Transferred*

Around 1 month after the kitchen remodel (3 weeks after meeting Robert), Rosie was transferred without notice to another assisted living unit within the facility. At first, Rosie's care chart provided no official reason for the transfer. When asked, nursing staff said that Rosie was relocated because her dementia had worsened. This seemed unlikely to the researchers since they had not recorded any cognitive changes in a recent series of assessments with her. Later, however, a staff member confided to one of the researchers that Rosie was relocated to make room for a new person whose family wanted him to live in the "highest functioning" unit. When the researcher suggested that Charles, a nonverbal and nonmobile resident, would have seemed to have been the more appropriate person to move given due to his functional abilities compared to Rosie's, the staff member explained that it was easier to get Rosie's nephew to agree to a move than Charles' daughter.

After a week of being in the new unit, Rosie was documented in her care chart as being "isolative during adjustment period" and that "there has been a decrease in her eating and weight recently." A few weeks later, another care provider noted that Rosie was "more depressed, isolative, less activity participation since moving," that she had lost 5.5 pounds, and that she remained in her room much of the time. Unfortunately, Rosie was ultimately positioned as less important than Charles because of potential advocacy of a family member rather than ability. Since Rosie had no way of finding or accessing her former living unit within the larger facility, her relationship with Robert was terminated by environmental and social barriers enforced by staff. Despite resisting being treated as "other" within her "home" on several occasions, the final move to a new unit where most of the residents were in advanced stages of dementia and unable to communicate positioned her in a way that she could not effectively counter. The precarity of her living situation which resulted in her being removed from her familiar surroundings led to her rapid decline.

5 Discussion

The chapter has argued that a key aspect of place involves communication; communication is an important way that power and social positions are negotiated, challenged, and resisted. One way to understand how speakers communicate power to their conversational partners is through positioning theory, which considers how speech practices (e.g., word choice, tone) assert one's identity in relation to another. For example, a nursing home employee who addresses a resident as "sweetie" is positioning the resident as childlike: endearing but in need of help. Subsequently, the resident's response can be to challenge the staff member's position (e.g., "Don't call me 'sweetie.' My name is Mary.") or to support it by not responding. How residents living with dementia in LTCFs are positioned within conversations is often overlooked. However, even the smallest acts of conversation can provide insight into the social standing of residents and staff within LTCFs.

In addition to understanding more about power construction through conversational practice, it is also important to consider how environmental features contribute to conversations and ultimately to power. Environmental positioning considers the ways that structures can facilitate or hinder what types of communication are possible. It considers space and place with regard to social positions. For example, on the one hand, nursing homes are places of employment; nursing home staff are charged with ensuring the safety and care of the residents. Staff can come and go at will. They decide when residents eat, what activities will take place, who will sit by whom, who will be relocated to a different room, and so on. On the other hand, nursing homes are a particular type of place with homelike spaces where residents live. Home implies a sense of familiarity, belonging, safety, comfort, choice, and personal control (Eijkelenboom et al., 2017; van Hoof et al., 2016). Residents like Rosie who ask other residents "Where in the world am I?" might receive an answer such as "The same place … A nursing home" or "I don't know the name of the place." As these conversations illustrate, the nursing home is a place but not a home where residents feel a sense of belonging or familiarity. This reinforcement of place rather than home could also be seen in the description of Rosie being told by staff to stop setting the table. In this example, Rosie was trying to exercise some control over her environment by participating in a familiar task – setting the table – but was reminded that she had little control over her space. Since residents don't have much control over their space, it begs the question of whether the goal of a creating a home environment within nursing homes is appropriate or if another environmental strategy would be better suited. More specifically, given that a person visiting (or living at) a hotel expects to be waited upon by staff, a resort model, rather than one based on an unrealistic idea of home, might be more satisfying and more desirable to residents. Environmentally, it might do a better job of communicating position within space than the illusion of home.

Consider some of the other examples of staff challenging Rosie's actions within her "home" such as the notebook left by staff on a dining room table. The staff member negatively positions Rosie through her responses and does not seem to appreciate that the notebook was placed in an area that was supposed to be Rosie's (and other residents') dining room. To the staff member, the dining room was one of many workspaces that she was responsible for. Despite the staff member's conversational rebuffs, Rosie resists the negative positioning and asserts herself as a capable person in the environment. As mentioned earlier, the tension between spaces within nursing homes functioning as work versus home can be seen in the staff/resident interaction within the environment. A worktable to a staff person is a dining table to a resident.

The kitchen remodel is a good example of how a change to the physical space created change in social opportunities for residents. Because of the raised wall (which was formerly counter-height) and the sealed access to the kitchen, residents experienced a profound truncation of their physical and social world. Although there was still a small walkway from one side of the dining room to the other and to living room, many residents could not spatially navigate the change. In this way, the environmental features of the newly remodeled kitchen negatively positioned them while positively positioning staff. Staff could now secure the kitchen, which could potentially lead to better protection of the residents against harm such as germ exposure. However, resident safety came at a social cost and further reinforced the notion of institution versus home. It is therefore important to strike a balance between ensuring the safety of residents while also providing social spaces. Considerations may include creating spaces with lower barrier walls that could serve as compartmental meeting areas for residents while also providing staff with the ability to monitor residents' safety. Such smaller social spaces could also help families and visitors experience a sense of having more privacy (Van Hoof et al., 2016).

The sense of precarity embedded within the institutional structure is another aspect to consider with regard to LTCFs. Despite often being challenged or ignored by staff, Rosie did develop friendships and relationships with others in the care unit. Unfortunately, she was ultimately moved without warning to make room for someone new. Although staff used the language of expert opinion (i.e., declining cognition) to justify the move, their reason was actually based on convenience since Rosie's nephew was not actively involved in her care. Such disregard for Rosie's wishes and her place within the environment underscores the unconscious bias that institution hold, reinforcing the message, explicitly or implicitly, that residents are not really people in a full moral sense but rather bodies living that can be controlled for their "own good."

A bold approach to creating environments that could address the social needs for residents through space would be to have architects, designers, and staff member spend a day living like a resident – being restricted to same spaces, having to rely on another for food, being guided on where to sit, and having to look at all the cues of place that reinforce position. While this would certainly be a fabricated situation and differs in myriad ways from an actual resident's experience, it may provide insight into the importance of place and space in communicative interactions. It would also give nonresidents the opportunity to communicate with residents outside of providing care-related tasks, which may also provide a deeper sense of empathy and understanding of the lived environment.

Another approach is to include people living with dementia who are living in LTCFs in the co-design of physical and social spaces. As stated earlier, most people who live in nursing homes did not choose to do so. Most people who are not living with dementia cannot imagine what their lives would be like with dementia or the challenges that they may face in LTCFs. Living with dementia in an LTCF is an experience that only truly be understood by people who are living it. In addition, although some people living with dementia experience some challenges with language, language change alone should not be a reason for excluding their perspectives. As noted earlier in the chapter, language abilities, and loss in communicative abilities, differ among individuals and by types of dementia. As the case example of Rosie illustrated, she was able to communicate quite effectively even though staff did not acknowledge her abilities and insight. Imagine if the staff member would have asked Rosie what she thought of the dining room, if she felt like she belonged, or what would make her environment more comfortable or satisfying for her.

Overall, LTC settings must move beyond rigidly controlled, oversight models that emphasize on controlled safety and interactions and policies that restrict communicative and social possibilities for residents. With its emphasis on detailed observations aimed at better understanding how social worlds evolve within the environmental confines of institutional settings, ethnographic-type research allow investigator to rely less on staff input and more so on ways place and space impact interactions, power, and well-being of these residents. To be successful, this approach involves partnerships between architects, designers, stakeholders (i.e., administrators, staff, residents, families, and future potential residents) who can sit back, observe, and design environments that equalize power differences, allowing one party (e.g., staff, administrators) to consider the in-depth needs of others.

6 Conclusion

How place is communicated to and by people within nursing homes is greatly affected by what is contained within spaces. Overall, if we truly are going to rethink how to move forward in considering LTC environments, we need to reconsider the "person" as an active participant in their environment, not as an object to be cared for or objects of activities we provide or move. By recognizing how dialogues are shaped by space and power within space, we can better consider how the built environment directly influences the lived environment. This means inviting residents to be co-creators in their space and in their social interactions. It also means challenging nonresidents involved in decision-making about space to become residents, even for a short time, to truly appreciate what it means to live in a particular place like a nursing home.

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References

Adams, T., & Gardiner, P. (2005). Communication and interaction within dementia care triads: Developing a theory for relationship-centred care. *Dementia, 4*(2), 185–205. https://doi.org/10.1177/1471301205051092

Agich, G. (2003). *Dependence and autonomy in old age: An ethical framework for long-term care*. Cambridge University Press. https://doi.org/10.1177/1471301205051092

Andrews, G. J., Cutchin, M., McCracken, K., Phillips, D. R., & Wiles, J. (2007). Geographical gerontology: The constitution of a discipline. *Social Science & Medicine, 65*(1), 151–168. https://doi.org/10.1016/j.socscimed.2007.02.047

Andrews, G. J., Cutchin, M. P., & Skinner, M. W. (2017). Space and place in geographical gerontology: Theoretical traditions, formations of hope. In M. W. Skinner, G. J. Andrews,

& M. P. Cutchin (Eds.), *Geographical gerontology: Perspectives, concepts, approaches* (pp. 11–28). Routledge. https://doi.org/10.4324/9781315281216-2

Bangerter, L. R., Van Haitsma, K., Heid, A. R., & Abbott, K. (2016). Make me feel at ease and at home: Differential care preferences of nursing home residents. *The Gerontologist, 56*(4), 702–713. https://doi.org/10.1093/geront/gnv026

Bartlett, R., & O'Connor, D. (2010). *Broadening the dementia debate: Towards social citizenship*. Policy Press. https://doi.org/10.2307/j.ctt9qgmrg

Behuniak, S. M. (2011). The living dead? The construction of people with Alzheimer's disease as zombies. Ageing & Society*,* 31(1), 70–92. https://doi.org/10.1017/S0144686X10000693.

Bruens, M. T. (2013). Dementia beyond structures of medicalisation and cultural neglect. In J. Baars & J. Dohmen (Eds.), *Ageing, meaning and social structure. Connecting critical and humanistic gerontology* (pp. 81–96). Policy Press. https://doi.org/10.1332/policypress/9781447300908.003.0005

Chaudhury, H., Cooke, H. A., Cowie, H., & Razaghi, L. (2018). The influence of the physical environment on residents with dementia in long-term care settings: A review of the empirical literature. *The Gerontologist, 58*(5), e325–e337. https://doi.org/10.1093/geront/gnw259

Coupland, N., Coupland, J., Giles, H., & Henwood, K. (1988). Accommodating the elderly: Invoking and extending a theory 1. *Language in Society, 17*(1), 1–41. https://doi.org/10.1017/S0047404500012574

Cresswell, T. (2009). *Place International encyclopedia of human geography* (Vol. 8, pp. 169–177). Elsevier.

Cuba, L., & Hummon, D. M. (1993). A place to call home: Identification with dwelling, community, and region. *Sociological Quarterly, 34*(1), 111–131. https://doi.org/10.1111/j.1533-8525.1993.tb00133.x

Cutchin, M. P., Owen, S. V., & Chang, P.-F. J. (2003). Becoming "at home" in assisted living residences: Exploring place integration processes. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 58*(4), S234–S243. https://doi.org/10.1093/geronb/58.4.S234

de Medeiros, K., & Sabat, S. (2016). Understanding the person with Alzheimer's disease from a cause and consequence perspective. In F. Moghaddam & R. Harré (Eds.), *Questioning causality: Explorations and causes and consequences across contexts* (pp. 221–236). ABC-CLIO.

de Medeiros, K., Beall, E., Vozzella, S., & Brandt, J. (2009). Television viewing and people with dementia living in long-term care: A pilot study. *Journal of Applied Gerontology, 28*(5), 638–648. https://doi.org/10.1177/0733464808330964

de Medeiros, K., Saunders, P. A., Doyle, P. J., Mosby, A., & Haitsma, K. V. (2011, September 20). Friendships among people with dementia in long-term care. *Dementia*. https://doi.org/10.1177/1471301211421186

de Medeiros, K., Rubinstein, R. L., & Doyle, P. (2013). A place of one's own: Reinterpreting the meaning of home among childless older women. In G. Rowles & M. Bernard (Eds.), *Environmental gerontology: Making meaning places in old age* (pp. 79–104). Springer.

Doyle, P. J., de Medeiros, K., & Saunders, P. A. (2012). Nested social groups within the social environment of a dementia care assisted living setting. *Dementia, 11*(3), 383–399. https://doi.org/10.1177/1471301211421188

Duan, Y., Mueller, C. A., Yu, F., & Talley, K. M. (2020). The effects of nursing home culture change on resident quality of life in US nursing homes: An integrative review. *Research in Gerontological Nursing, 13*(4), 210–224. https://doi.org/10.3928/19404921-20200115-02

Eijkelenboom, A., Verbeek, H., Felix, E., & van Hoof, J. (2017). Architectural factors influencing the sense of home in nursing homes: An operationalization for practice. *Frontiers of Architectural Research, 6*(2), 111–122. https://doi.org/10.1016/j.foar.2017.02.004

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry, 12*(2), 219–245.

Fraser, K. C., Meltzer, J. A., & Rudzicz, F. (2016). Linguistic features identify Alzheimer's disease in narrative speech. *Journal of Alzheimer's Disease, 49*(2), 407–422. https://doi.org/10.3233/JAD-150520

Giles, H. (2016). *Communication accommodation theory: Negotiating personal relationships and social identities across contexts*. Cambridge University Press. https://doi.org/10.1017/CBO9781316226537

Goffman, E. (1958). Characteristics of total institutions. *Symposium on preventive and social psychiatry*. The National Academies Press. https://doi.org/10.17226/20228.

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. Simon and Schuster.

Gove, D., Downs, M., Vernooij-Dassen, M., & Small, N. (2016). Stigma and GPs' perceptions of dementia. *Aging & Mental Health, 20*(4), 391–400. https://doi.org/10.1080/13607863.2015.1015962

Grenier, A., Phillipson, C., & Setterston, R., Jr. (2020). *Precarity and ageing: Understanding insecurity and risk in later life*. Bristol University Press. https://doi.org/10.1332/policypress/9781447340850.001.0001

Grubman, J. F. (2015). Methods for managing risk and promoting resident-centered care in nursing homes. *Columbia Journal of Law & Social Problems, 49*, 217–249.

Harre, R., & van Langenhove, L. (1999). *Positioning theory: Moral contexts of intentional action*. Blackwell Publishers.

Harré, R., & Van Langenhove, L. (1999). Positioning theory. *The Discursive Turn in Social Psychology*, 129–136.

Kemper, S. (1994). Elderspeak: Speech accommodations to older adults. *Aging and Cognition, 1*(1), 17–28. https://doi.org/10.1080/09289919408251447

Kitwood, T. (1997). *Dementia care reconsidered: The person comes first*. Open University Press.

Klimova, B., & Kuca, K. (2016). Speech and language impairments in dementia. *Journal of Applied Biomedicine, 14*(2), 97–103. https://doi.org/10.1016/j.jab.2016.02.002

Kontos, P., Radnofsky, M. L., Fehr, P., Belleville, M. R., Bottenberg, F., Fridley, M., Massad, S., Grigorovich, A., Carson, J., & Rogenski, K. (2021). Separate and unequal: A time to reimagine dementia. *Journal of Alzheimer's Disease, 80*(4), 1395–1399. https://doi.org/10.3233/JAD-210057

Koren, M. J. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs, 29*(2), 312–317. https://doi.org/10.1377/hlthaff.2009.0966

McParland, P., Kelly, F., & Innes, A. (2017). Dichotomising dementia: Is there another way? *Sociology of Health & Illness, 39*(2), 258–269. https://doi.org/10.1111/1467-9566.12438

Merriam, S. B. (1998). Qualitative research and case study applications in education. In *Case study research in education*. Wiley.

Moore, K. D. (2014). An ecological framework of place: Situating environmental gerontology within a life course perspective. *The International Journal of Aging and Human Development, 79*(3), 183–209. https://doi.org/10.2190/AG.79.3.a

Mueller, K. D., Hermann, B., Mecollari, J., & Turkstra, L. S. (2018). Connected speech and language in mild cognitive impairment and Alzheimer's disease: A review of picture description tasks. *Journal of Clinical and Experimental Neuropsychology, 40*(9), 917–939. https://doi.org/10.1080/13803395.2018.1446513

Oswald, F., & Wahl, H.-W. (2005). Dimensions of the meaning of home in later life. In *Home and identity in late life: International perspectives* (pp. 21–45). Springer.

Reed-Danahay, D. (2001). 'This is your home now!': Conceptualizing location and dislocation in a dementia unit. *Qualitative Research, 1*(1), 47–63. https://doi.org/10.1177/146879410100100103

Rubinstein, R. L., & de Medeiros, K. (2003). Ecology and the aging self. In H.-W. Wahl, R. J. Schiedt, & P. G. Windely (Eds.), *Annual review of gerontology and geriatrics* (Vol. 23, pp. 59–82). Springer.

Rubinstein, R. L., & de Medeiros, K. (2005). Home, self, and identity. In G. D. Rowles & H. Chaudhury (Eds.), *Home and identity in late life international perspectives* (pp. 47–62). Springer.

Sabat, S. R. (2006). Mind, meaning, and personhood in dementia: The effects of positioning. In J. Hughes, S. Louw, & S. Sabat (Eds.), *Dementia: Mind, meaning, and the person* (pp. 287–301). Oxford University Press. https://doi.org/10.1093/med/9780198566151.003.0018

Sabat, S. R., & Lee, J. M. (2011, September 20, 2011). Relatedness among people diagnosed with dementia: Social cognition and the possibility of friendship. *Dementia*. https://doi.org/10.1177/1471301211421069.

Sabat, S. R., Johnson, A., Swarbrick, C., & Keady, J. (2011). The 'demented other' or simply 'a person'? Extending the philosophical discourse of Naue and Kroll through the situated self. *Nursing Philosophy, 12*(4), 282–292. http://onlinelibrary.wiley.com/doi/10.1111/j.1466-769X.2011.00485.x/abstract

Saunders, P. A., de Medeiros, K., Doyle, P., & Mosby, A. (2011). The discourse of friendship: Mediators of communication among dementia residents in long-term care. *Dementia, 11*(3), 347–361. https://doi.org/10.1177/1471301211421187

Savundranayagam, M. Y., & Moore-Nielsen, K. (2015). Language-based communication strategies that support person-centered communication with persons with dementia. *International Psychogeriatrics, 27*(10), 1707–1718. https://doi.org/10.1017/S1041610215000903

van Hoof, J., Verbeek, H., Janssen, B. M., et al. (2016). A three perspective study of the sense of home of nursing home residents: The views of residents, care professionals and relatives. *BMC Geriatriatrics, 16*, 16. https://doi.org/10.1186/s12877-016-0344-9

Wang, G., Marradi, C., Albayrak, A., & van der Cammen, T. J. (2019). Co-designing with people with dementia: A scoping review of involving people with dementia in design research. *Maturitas, 127*, 55–63. https://doi.org/10.1016/j.maturitas.2019.06.003

Ward, R., Vass, A. A., Aggarwal, N., Garfield, C., & Cybyk, B. (2008). A different story: Exploring patterns of communication in residential dementia care. *Ageing & Society, 28*(5), 629–651. https://doi.org/10.1017/S0144686X07006927

White-Chu, E. F., Graves, W. J., Godfrey, S. M., Bonner, A., & Sloane, P. (2009). Beyond the medical model: The culture change revolution in long-term care. *Journal of the American Medical Directors Association, 10*(6), 370–378. https://doi.org/10.1016/j.jamda.2009.04.004

Williams, K., Kemper, S., & Hummert, M. L. (2003). Improving nursing home communication: An intervention to reduce elderspeak. *The Gerontologist, 43*(2), 242–247. https://doi.org/10.1093/geront/43.2.242

Williams, K. N., Herman, R., Gajewski, B., & Wilson, K. (2009). Elderspeak communication: Impact on dementia care. *American Journal of Alzheimer's Disease & Other Dementias, 24*(1), 11–20.

Yin, R. K. (2011). *Applications of case study research*. Sage.

Yin, R. K. (2017). *Case study research and applications: Design and methods*. Sage.

Young, T. J., Manthorp, C., Howells, D., & Tullo, E. (2011). Developing a carer communication intervention to support personhood and quality of life in dementia. *Ageing & Society, 31*(6), 1003–1025. https://doi.org/10.1017/S0144686X10001182