ASSESSING ORGANIZATIONAL VARIATION IN LONG-TERM CARE: A STRUCTURAL RITUALIZATION ANALYSIS OF MALTREATMENT IN FOR-PROFIT AND NONPROFIT NURSING HOMES

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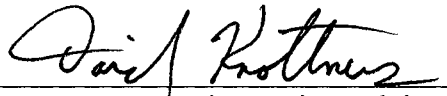

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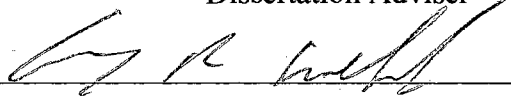

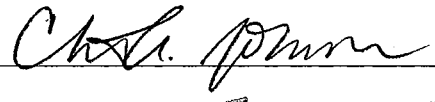

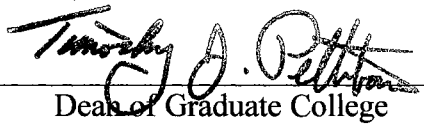

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CHAPTER 1

DEFINITION OF THE PROBLEM

Introduction

The elderly population is on the rise. By 2050, the aged will represent 20 percent of the U.S. population. Now, more than ever, Americans need access to long-term care (Giacalone 2001). An important issue to consider when thinking about long-term care is quality. Researchers argue that ownership influences the form of supervision provided in long-term care facilities such as nursing homes. Studies indicate for-profit nursing homes have levels of care that are equal, if not superior to nonprofit facilities (Holmberg and Anderson 1968; Gottesman 1974; Winn 1974). However, some analysts believe that nonprofit facilities offer the best services (Fottler, Smith and James 1981; Elwell 1984; Lee 1984).

This study focuses on nursing homes. It reviews the growth of the elderly population and its relationship to long-term care. It details the history of nursing homes while considering the impact of elder care legislation. The study also involves a comparison of for-profit and nonprofit nursing homes with a focus on ritual action. It uses literary ethnography and content analysis methods to describe interaction in nursing homes with a theory of structural ritualization. It considers the influence of ritualized

symbolic practices relating to organizational variation. It also emphasizes how bureaucracy contributes to maltreatment of residents in nursing homes.

The Age Wave and Its Consequences

To understand the relevance of nursing home maltreatment, it is important to know that a once young country is getting old. Dychtwald refers to this demographic shift as the "age wave" (1999:57). For the first time, the average person in the United States has more living parents than children. An American woman will spend more time caring for her parents than her own kids (Riekse and Holstege 1996). This is taking place because the population aged 65 and over is growing at its most rapid rate ever.

In colonial times, most of the American population was under the age of 16. Many people did not make it to old age (Riekse and Holstege 1996). As recently as 1900, life expectancy at birth was 48.3 for males and 51.1 for females (Bova 1998). Two factors kept us a young country: high fertility and high mortality. In relation to fertility, at the dawn of the twentieth century, there was an average of seven births per woman. By the end, the average dropped to two births per woman (U.S. Bureau of the Census 1993). People are having fewer children now because of more opportunities for women outside of the home. Also, consider medical advances such as the birth control pill (Quadagno 1999). This trend, coupled with the baby boom, is contributing to the age wave.

Dychtwald and Flower (1990) explain that the shift from a birthing to an aging culture gained momentum after World War II – the start of the baby boom. After World War II, millions of service personnel returned from overseas. These soldiers met young women in waiting and the result was a "fantastic boom in births" (Dychtwald 1999:58).

Between 1946 and 1964, the number of births was 70 percent greater than in the previous two decades (U.S. Bureau of the Census 1993). This increase put a large amount of strain on institutions. There was a shortage of schools when boomers reached school age (Riekse and Holstege 1996). Hospitals could not meet increased demands for child health care. Dwellings such as apartments did not have enough bedrooms for kids. Baby food supplies ran low, diapers were scarce, and stores could not keep enough toys in stock (Dychtwald 1999). When birth rates declined, people realized that the baby boom generation would be a concern at every stage of the life course. When they reached early adulthood, college enrollments swelled. In the 1970s, they purchased homes and the increased demand prompted a rise in prices (Quadagno 1999). In the 1970s, the average cost of a new home went from $26,000 to about $47,000 (Siegel 1993). The power of this demographic group continues to influence life in America. Some people think that they will sway most political and consumer decisions made in this century (Dychtwald 1999).

In relation to death rates and the age wave, the United States made dramatic improvements in mortality in the past century. For example, in 1900, the chance of living to old age was low. Nearly 20 percent of white children and 33 percent of non-white children died before their fifth birthday (Hobbs and Damon 1996). About 63 percent of white females and 32 percent of nonwhite females reached the age of 60. Only half of white males and 28 percent of nonwhite males could expect to live to 60 (Serow, Sly, and Wrigley 1990). By 1990, infants in the United States had a better chance of surviving to old age. Whites continued to have an advantage in life expectancy over nonwhites. However, the gap was shrinking. Reaching the age of 60 was possible for 93 percent of

white females and 88 percent of white males. Ninety-one percent of nonwhite females and 83 percent of nonwhite males would reach 60 (Serow et al. 1990).

Big declines in death rates appeared in the 1940s and 1970s (Quadagno 1999). During the 1940s, medical technology led to gains against infant and maternal mortality. In the 1970s, death rates from heart disease lowered because of prevention and treatment methods. People were smoking less than before, and new prescription drugs controlled high blood pressure (Treas 1995). People were healthier. Segments of the population expanded. This included the elderly. In fact, the fastest growing part of the population is now people 85 years of age and older - the oldest old (Quadagno 1999).

One hundred and twenty two thousand persons 85 and older lived in the United States in 1900. Nearly a century later, that number increased to over 3 million. It will reach 6,480,000 in the year 2020 (Riekse and Holstege 1996). The number of people over the age of 100 is also increasing. In 1879, the odds of living to 100 were 400 to 1. In 1980, the odds were 81 to 1 (Spencer, Goldstein, and Taeuber 1987). Now there are more than 50,000 people 100 years of age and older in the United States. With advanced technology, those numbers will rise (Bova 1998). As we begin the twenty-first century, the number of elderly is growing faster than ever. Also, the goal of life extension is becoming more popular.

We are not just concerned with better health. As the age wave continues, people are trying to control aging. We are on the verge of touching the outer limits of the human life span. Five breakthroughs are pushing this movement. They include super-nutrition, hormone replacement, gene therapy, bionics, and organ cloning (Dychtwald 1999).

Super-nutrition involves a diet rich in nutrients, but low in calories. A correlation between specific food ingredients and disease prevention indicates that vitamins C and E, beta-carotene, and selenium can "fortify the immune system, prevent heart disease and possibly cancer" (Dychtwald 1999:38). Hormone replacement involves filling the body with chemicals. Regelson (1996) indicates that hormones injected into the body can slow and even stop the aging process. People use estrogen, testosterone, and the human growth hormone as hormone supplements (Dychtwald 1999).

Gene therapy focuses on changing "cellular clocks" found at the tips of chromosomes (Dychtwald 1999:46). Scientists call them telomeres (Lewis 1998). Cells rejuvenate at astronomical rates when they are genetically changed. When splitting, the potential to increase the production of aging cells exists. This allows an increase in human life span (Bova 1998). Bionics involves the use of artificial limbs and organs. Cloning involves the creation of human tissue in a laboratory setting. Dychtwald (1999) explains cloning has the ability to benefit elderly people with brain diseases or cancer patients needing healthy cells.

With these technologies, life expectancy in 1996 reached 75.7 years for males. That same year it reached 82.7 for females. If the average American lives to 50, he or she can expect to live even longer (Bova 1998). Regardless of medical breakthroughs, not everyone reaching old age will be able to care for him or herself. Portions of the elderly will still require intensive supervision. This will be due to cognitive impairment and severe health problems (Ulsperger and Ulsperger 2002). Coupled with the age wave, this will prompt a rise in the demand for long-term care (Giacalone 2001).

Variations of Long-term Care

Long-term care involves a range of health care, personal care, and social services given over a lengthy amount of time (Montgomery 1992). Individuals receiving it can not care for themselves (Kane and Kane 1987). Informal long-term care, which friends and relatives give, is the most common form (Brubaker and Brubaker 1992). It is a myth that Americans focus on youth and autonomy while disregarding the needs of aged family members (Lee 1985). Studies show that young family members still provide a majority of care for the aged in the contemporary United States (Brody 1984, 1990; Soldo 1984; Stone, Cafferata, and Sangl 1987). American women provide the most.

One survey shows 72 percent of long-term care providers are female family members (Stone et al. 1987). Emotional labor can take its toll. When looking after the aged, studies indicate that women have a hard time distancing themselves from care-giving tasks (Zarit, Todd, and Zarit 1986). Regardless, family obligations do lead to care by younger generations, but trends imply there will be fewer families caring for the elderly. Family size is shrinking and more women are spending time in the labor market. Couple these trends with the age wave, and fewer families will care for the elderly in coming years (Cicirelli 1990). This corresponds with an increased need for formal long-term care. This includes a continuum of care ranging from home care, adult day care, respite care, assisted living, and nursing homes (Montgomery 1992).

Home care refers to in-home health and supportive services. This includes professional, paraprofessional, and long-term care in a recipient's home (Kane and Kane 1987). Home care is hard to define because it includes a wide range of services. For example, it includes physician and nurse visits. However, home care involves house

cleaning services as well (Montgomery 1992). The use of home based services is not widespread. Only 2.9 percent of all elderly persons report the use of visiting nurse care, 1.6 percent use home health services, and 1.9 percent receive home delivered meals. Of the individuals receiving home care, a large portion is impaired in some way (Stone 1986). These numbers are likely to increase. Older Americans want to age in place. Services that will allow them to stay at home as they age are becoming popular (Golant 1996).

Adult day care involves community programs that provide services to older persons. They usually run in daytime hours (Montgomery 1992). Adult day care facilities vary in terms of emphasis, but two primary models exist. The first is the health rehabilitative model. It offers medical, nursing, and therapy services. The second type is the social psychological model. This model involves people recovering from illness. These people typically have dementia (Giacalone 2001). Adult day cares are located in a variety of settings. They operate in churches, senior centers, and hospitals (Park 1995). The cost of one full day of care averages less than $40 compared to home care at $40 per hour (Weissert et al. 1989). By the early 1990s, 1,347 adult day cares existed in the United States averaging a daily enrollment of 24 persons (Conrad, Hanrahan, and Hughes 1990).

Respite care involves planned relief. It allows people to drop off family members at a facility. Trained staff members give care for a short time. This provides family caregivers a break from the exhaustion that can occur when taking care of a loved one (Park 1995). Family caregivers often show declines in physical and mental health. This is due to chronic fatigue, isolation, and financial stress. Through respite care services,

caregivers can take time out to pursue personal interests and relaxation (Scharlach and Frenzel 1986).

Assisted living facilities are for non-impaired elders needing help with some activities of daily living. This includes aid with food preparation, bathing, and medications. People in these facilities do not need 24-hour care (Kane and Wilson 1993). They receive meals in a common dining room, have separate lodging, and housekeeping services (Hooyman and Kiyak 1996). Assisted living facilities have a small staff of at least one nurse, a social worker, and a case manager. They contract health care services to external agencies. This keeps costs low (Hooyman and Kiyak 1996). Often, people in these facilities pay with private funds. If someone is not financially secure, or if they need a higher level of supervision, they will likely end up in a nursing home (Kane and Wilson 1993; Giacalone 2001).

The Nursing Home as Long-term Care

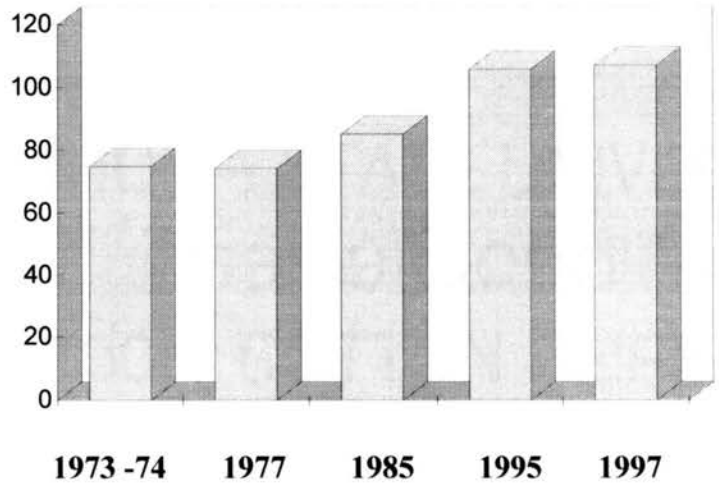
Though a continuum of care exists for the elderly in the United States, nursing homes provide a majority of formal long-term care. They treat patients with chronic illnesses. They provide less intensive care than general hospitals, but they do have staff trained in nursing. Medicare and Medicaid certify nursing homes as eligible for reimbursement based on the type of care provided (Kahana and Brittis 1992).

Through the mid-1980s, levels of care at nursing homes ranged from certified skilled nursing facilities (SNFs) to intermediate care facilities (ICFs). SNFs provided supervision twenty-four hours per day for residents under the care of a registered nurse. Like assisted living facilities, ICFs provided lower levels of care (Sirrocco 1989).

However, the Omnibus Budget Reconciliation Act of 1987, which contained measures for nursing home reform, altered the distinction between SNFs and ICFs. Most agencies now classify all nursing homes as nursing facilities - NFs (Richardson 1990).

The number of nursing homes peaked in 1985, with around 19,100. New ways of care, such as home health care and assisted living, replaced services provided by nursing homes. The number of facilities declined. However, this trend did not last long. Reports indicate that the number of nursing homes is on the rise again. In 1991, there were approximately 15,511 nursing homes. In 1995, there were 16,700, and 17,000 in 1997 (Strahan 1997; Gabrel 2000). Indicating that nursing homes are getting larger, the number of beds per home is also growing. As Figure 1 indicates, the number of beds per facility increased from 75 in the early 1970s to 107 in 1997 (National Center for Health Statistics 1988, 2000).

Figure 1. Growth in Average Number of Beds per Nursing Home



Note: Percentages based on information from the National Center for Health Statistics.

The actual number of residents also increased. In the early 1970s, a little over one million people lived in nursing homes. By 1997, the number was 1,608,700 (National Center for Health Statistics 1988, 2000). In terms of geographic region, Table 1 shows that a larger number of facilities exist in the Midwest and South. The Midwest has 34.2 percent of the nation's nursing homes. The South has 31.8 percent. The Northeast has only 17.3 percent, while the West has 16.8 (Gabrel 2000).

Table 1. Nursing Homes by Region

Region	Number	Percentage
Northeast	2,900	17.3
Midwest	5,800	34.2
South	5,400	31.8
West	2,900	16.8

Note: Based on Table 1 in Gabrel (2000) from the National Center for Health Statistics.

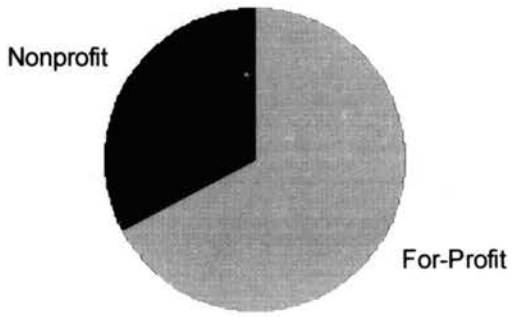
Many people assume that most older people live in nursing homes. The true number of the elderly living in them is around 5 percent (Kemper and Murtaugh 1991). However, this figure is misleading. Nearly 25 percent of people over the age of 65 will spend time in a nursing home, so the likelihood of an older person's admission is high. The number 5 percent is also cross-sectional. It does not take into account movement in and out of nursing homes (Hooyman and Kiyak 1996). The most common reasons for nursing home admission are circulatory disease and cognitive impairment. Cardiovascular problems, such as a stroke and its related effects, comprise 17 percent of

new admissions relating to circulatory disease. The main cognitive problem relating to admission is symptoms of Alzheimer's disease (Sahyoun et al. 2001).

In 1997, the average age of admission for aged residents was 82.6 years. This is an increase from 1985, when the average age of admission for an elderly resident was 81.1 years (Sahyoun et al. 2001). Currently, 51 percent of residents are over the age of 85 (National Center for Health Statistics 2000). In 1985, ninety-three percent of residents were white (National Center for Health Statistics 1991). However, a 1997 survey showed a 4 percent decrease in white nursing home residents (National Center for Health Statistics 2000). In relation to gender, female residents comprise 72 percent of the nursing home population – nearly three women for every man (Giacalone 2001; Sahyoun et al. 2001).

In relation to ownership, in 1986 only ten publicly held nursing home chains existed. These for-profit chains owned and leased 170,000 beds. By 1996, the number of nursing home chains grew considerably. The top ten by themselves accounted for over 290,961 nursing home beds (Giacalone 2001). The largest chain once owned 1,003 facilities. At that time, its homes held 109,000 beds (Forrest, Forrest, and Forrest 1993). As of the year 2000, it had 67,000 employees and sales reports of $116.8 million in revenue (Dun and Bradstreet 2000). As Figure 2 indicates, for-profit nursing homes now comprise 67.1 percent of the market. Nonprofit nursing homes, including government facilities, only account for 32.9 percent of the market (Gabrel 2000).

Figure 2. Nursing Home Ownership



Analysts believe the increased use of for-profit care is creating a "crisis" (Glenn 2000:84). Specifically, paid care is leading to poor care. Cutting corners to increase profits is costing residents. However, it is possible that strict bureaucratic regulations in all facilities promote poor care. With these points in mind, we can turn our attention toward maltreatment in both for-profit and nonprofit nursing homes.

Maltreatment in Nursing Homes

Maltreatment in nursing homes is any "deviation from expected standards for high-quality care" including "physical violence, verbal aggression, and neglect" (Pillemer 1988:228). Concern over this form of organizational deviance has existed since the 1960s (Horton et al. 1994). Tales of nursing home abuse appeared in newspapers and books as nursing homes became prevalent (see Townsend 1971; Mendelson 1974; Vladeck 1980). Government officials sensed the rise in negative sentiments and started a series of investigations.

In 1986, Congress requested that the Institute of Medicine draft a report on the quality of care in nursing homes. The report confirmed academic warnings and print

media stories of problems. A follow-up study conducted by the U.S. General Accounting Office found that over one-third of nursing homes had bad care. In reaction, Congress signed the aforementioned Omnibus Budget Reconciliation Act of 1987. New guidelines enforced by the Health Care Financing Administration (HCFA), currently the Centers for Medicare and Medicaid Services (CMS), required homes to follow strict rules through annual inspections. They also established reforms on the treatment of residents (Mooney and Greenway1996). Since the guidelines, deficiencies recorded by the HCFA declined (Harrington and Carrillo 1999). However, media sources continue to report maltreatment.

Recent headlines highlight the continued trend of maltreatment. They indicate "Nursing Home Deaths Soar" (Amon and Zambito 2001:31), "Elder Care Conditions Shocking" (McCullen 2000:35A), and "Nursing Home Deaths Highlight Staffing Problems" (Neal and Neal 2000:B15). People are now concerned that the abuse of elders in nursing homes constitutes a social threat. Headlines call attention to maltreatment such as "Nursing Home Nurse Accused of Raping Comatose Patient" (Adams 2000:5B), "Worker Charged With Assaulting Alzheimer's Patient" (Rowden 1999:1), and "Aide Charged in Death at Nursing Home" (Warner 1999:B1).

As news of maltreatment in nursing homes emerged in the 1960s, a portion of researchers in sociology and anthropology started studying issues of nursing homes. They often used observation techniques to examine nursing home life (Henderson and Vesperi 1995). Much of it does not focus on abuse and neglect. However, it does reveal interesting themes in relation to nursing home ownership and maltreatment.

Erving Goffman was one the first to discuss nursing homes. Though his mentioning of nursing homes is brief, his idea of a nursing home as a total institution had an impact. Goffman's (1961a) work describes a total institution as a place where people are isolated from the rest of society for a set period. During this isolation, they come under the control of the officials running the institution. Goffman (1961a) presents the self as struggling between life long socialized logic and new institutionalized lines of thought. He indicates that routines of the institutional structure reshape the individual. When entering a total institution, a solid break with past roles and selves occurs and the individual establishes new identities. Regardless, this work indicates that issues relating to maltreatment could be the result of organizational control.

Goffman's work mentioned nursing homes, but Jules Henry's research focused specifically on them. Henry's (1963) work provides a comparative view of life in nursing homes. He studied a government home along with two for-profit facilities. The government nursing home was a community institute. Staff members were efficient and the facility was sanitary. Nonetheless, the relationships between staff and residents were poor. The for-profit nursing homes had the worst characteristics. Henry refers to one for-profit facility as the "vestibule of hell" (1963:407). He explains that staff in the facility treated residents as a mixture between dogs, children, and lunatics.

Gubrium (1975) produced the next significant study. His research concentrates on a nursing home in the Midwest. The facility was a nonprofit church related institution. His work provides information pertaining to organizational dynamics based on lower level and top staff. In addition, it was one of the first works to explicitly indicate that the bureaucratic routines of caring, even in a nonprofit institution, can

impede quality care. Subsequent studies of importance include Laird's (1979) exploration of Golden Mesa. She entered this nursing home at the age of 70. As she adjusted, she recorded her experiences. Her work details the depersonalization that occurs when interacting with staff. Kayser-Jones' (1981) work uses observation techniques to compare a for-profit nursing home in California to a nonprofit institution in Scotland. It archives how the nonprofit home had more regard for residents' personal rights, such as privacy. In the for-profit home she observed dehumanizing situations. She witnessed staff exposing patients' genitals, bathing men and women simultaneously in the same shower room, and creating a situation in which the elderly, due to a lack of help and attention, defecated and urinated on the floor.

As a nurse and anthropologist, Powers (1988) used a network analysis to record the strategies the elderly use in nonprofit nursing homes to construct support systems. O'Brien (1989) studied a nonprofit church facility in the eastern United States. The findings indicate that the institutional orientation toward morality and faith influenced the residents' worldviews. They also show that a religious ideology in the institution influenced cognitive frameworks of the caregivers. O'Brien (1989) indicates that this leads to better care.

Diamond (1992) worked in a nursing home as a nursing assistant. He entered the field without revealing his motives as a researcher. He explains that the administrator would not have hired him otherwise. He asserts that the study "was forced increasingly to become a piece of undercover research" (1992:8). He reveals that for-profit nursing homes are operating under a capitalist mind set. They care little about how residents are treated. They merely view residents as "raw materials" (1992:211). His findings show

that nursing homes operate on a logic of commodity production only concerned with "making gray gold" (1992:5). However, he mentions that balance sheets and bottom lines also hinder care in many nonprofit institutions.

Foner (1994) did reveal her status as a researcher in the examination of a nonprofit state nursing home in New York. Using theories tied to bureaucracies, Foner (1994) contends that demands for efficiency in state facilities impeded quality of care. Specifically, organizational demands to meet regulations create care-giving dilemmas for staff. Often they desire to provide family oriented, compassionate care. However, bureaucratic time constraints and rules enforced by the state force them to focus on merely getting tasks done.

Paterniti (2000) reviewed identity construction in a for-profit nursing home. Her analysis implies that resident narratives have the ability to alter staff perceptions and treatment. She points out that habitual actions by the staff develop into embedded routines. These routines contribute to a common stock of knowledge concerning interaction with residents. Specifically, they dehumanize residents by turning them into objects of work. Paterniti (2000) believes residents fight this process by building personal relationships with staff. They tell staff members personal thoughts and urge them to listen to personal stories so staff will see them as human beings and not just a part of the labor process.

These qualitative studies reveal the levels of social reality existing in nursing homes. Many other studies add to their findings concerning maltreatment (see Stannard 1973; Fontana 1977; Bennett 1980; Howsden 1981; Richard 1986; Savishinsky 1991;

Gubrium 1993; Sass 2000). They all expose the possibility of reexamining second hand sources in order to explore ritualized practices of bureaucracy and maltreatment.

Purpose of the Study

With the dominance of for-profit nursing homes and frequent cases of maltreatment, researchers question the quality of paid care (Pillemer 1988; Glenn 2000). Studies indicate for-profit nursing homes have levels of care that are equal to nonprofit facilities (Holmberg and Anderson 1968; Levey et al. 1973; Winn 1974; Gottesman 1974). Other research shows nonprofit institutions give better care.

Koetting's (1980) work finds that nonprofit nursing homes provide premium care because they are more expensive. They spend more money on caring for residents. It finds for-profit homes are more efficient, but less expensive. To compare the quality of care, Riportella-Muller and Slesinger's (1982) research uses a bank of complaints filed with the Wisconsin Ombudsman Program; a service set up to monitor nursing home maltreatment. Specifically, it matches complaint data with government information on nursing home violations. While the size of the nursing home had an influence, the findings suggest that nonprofit homes receive a lower number of complaints.

Elwell's (1984) research examines nursing homes in New York. In the study, nonprofit homes account for 195 of the institutions examined. For-profit homes account for 298. The findings indicate that government nursing homes spend more money on daily operations. Other nonprofit homes, like those run by religious affiliations, spend a considerable amount on residents, but do not overspend. For-profit homes spend less. Research by Lemke and Moos (1986) examines differences in nursing homes and other types of long-term care. Their findings show nursing homes are less likely to promote

independent living. They found nonprofit facilities exceed for-profit facilities on comfort and quality staff relationships. Lemke and Moos' (1989) later work finds that nonprofit and for-profit facilities have different social climates. They explain that nonprofit facilities are more likely to promote autonomy. They also give residents a greater voice in institutional policy. Moreover, nonprofit facilities provide a sense of community.

Jenkins and Braithwaite's (1993) work shows that deviations from government regulations are more likely in for-profit nursing homes. It examines Australian nursing homes. It shows neglect, the denial of human rights, and maltreatment in most nursing homes. However, for-profit homes have a higher rate of deviance based on a market mindset. The findings indicate that noncompliance emerges from senior management pressure to reach financial goals. They show that without profit as a major motive, nonprofit nursing homes have less pressure to violate regulations. This leads to better care. The findings confirm previous studies indicating the superior nature of nonprofit facilities (see Fottler et al. 1981; Green and Monahan 1981; Elwell 1984; Hawes and Phillips 1986).

Ulsperger and Ulsperger's (2001) research on nursing homes in the southern United States also indicates variety in care. It explores a sample of nursing homes from Arkansas, Oklahoma, Louisiana, and Mississippi using HCFA data. In the study, for-profit homes had more government citations. When examining each state, the analysis revealed differences in overall citations in the states of Arkansas, Oklahoma, and Louisiana. Citations for for-profit and nonprofit homes were not statistically significant in the state of Mississippi; however, the average number of citations was higher.

Though studies indicate the superiority of nonprofit nursing homes, all nursing homes have problems. Strangers care for residents in both for-profit and nonprofit institutions. This creates a situation where staff, with little emotional connection to residents, provide poor care. Complex government regulations bombard for-profit and nonprofit nursing homes as well. This requires caregivers to spend more time on paperwork and less time with residents. In other words, bureaucratic constraints impede social and emotional activities in for-profit and nonprofit facilities (Glenn 2000).

With these points in mind, there are two primary purposes for this study, each relying on a theory of structural ritualization. First, it systematically examines bureaucratic rituals in nursing homes. It explores the levels of bureaucracy in both for-profit and nonprofit facilities that lead to poor care. Second, the study examines maltreatment in nursing homes. Specifically, it considers the influence of rituals in for-profit and nonprofit facilities that lead to resident maltreatment.

Summary

As we start the twenty-first century, the age wave continues. Technology is progressing, and people want to live longer. Mortality rates decline as we push life expectancy to its limits. With the 85 years of age and older group being the fastest growing part of the population, the use of long-term care will continue (Quadagno 1999). Though various types of long-term care exist, cognitive and health problems will still plague the oldest old. This creates an ongoing need for nursing homes and nursing home research (Kahana and Brittis 1992; Giacalone 2001; Ulsperger and Ulsperger 2002).

The escalating use of nursing homes will continue to produce social problems such as maltreatment (Horton et al. 1994; Glenn 2000). Sociological research concerning rituals could shed light on resident abuse and neglect as a form of organizational deviance. Studies do exist that focus on thick descriptions of nursing home life, organizational spending, and the violation of government regulations. However, few of them address resident maltreatment in a systematic manner (Pillemer 1988). Using a theory of structural ritualization to explore interaction in nursing homes will allow us to better understand factors leading to problems in long-term care organizations.

CHAPTER 2

CONCEPTUAL FRAMEWORK

Introduction

This research uses a framework that focuses on rituals. This section reviews work on rituals. It discusses trends in the study of rituals focusing on the theory of structural ritualization. This chapter reviews studies that use a structural ritualization perspective. It also examines concepts relating to ritualization from fields of organizational theory and deviance.

Trends in the Study of Rituals

In the past, sociologists used the term ritual to describe actions expressing sacred or religious meaning (see Durkheim [1912] 1965). Analysts now believe rituals involve secular acts as well (see Goffman 1967; Gusfield and Michalowicz 1984; Etzioni 2000). There is a difference between ritual behavior and ritual action. Ritual behavior has no meaning. Studies on animal behavior use this term when describing repetitive acts with no social meaning. On the other hand, ritual action involves shared social meanings. This term fits with human interaction (Jary and Jary 1991).

Emile Durkheim ([1912] 1965) was one of the first to study ritual action. His work connects rituals to religion. It discusses religious rituals in two ways. First, rituals

represent a system of ideas that shape cognitive frameworks. They provide people with ways to understand the world. Second, rituals are a way of expressing social realities. They represent collective ideas and make social unity possible. Durkheim ([1893] 1933) discusses the punishment of crime as creating social cohesion. However, analysts contend he did not believe public rituals exist. Lukes (1975) argues that Durkheim's work has no indication that secular rituals facilitate social order.

Since Durkheim, secular rituals have been a focus of study. Shils and Young (1953) use a ritual action analysis of the British Coronation. They argue it is a secular ceremony. Shils and Young contend, "The Coronation provided at one time and for practically the entire society such an intensive contact with the sacred that we believe we are justified in interpreting it... as a great act of national communion" (1953:80). Warner's (1959, 1962) research makes a similar argument. It supports the notion that ritual actions exist in secular life. It shows that Memorial Day is a form of collective representation. For Warner, Memorial Day "consists of a system of sacred beliefs and dramatic rituals held by a group of people who when they congregate, represent the whole community" (1959:278). In placing flowers on graves and other acts of remembrance, individuals ritually acknowledge the sacred – the dead. Christmas, Thanksgiving, and the Fourth of July are other events with secular traits characterized by rituals (Warner 1962; also see Etzioni 2000). Work on civil religion relates to secular rituals as well. For example, Bellah (1968) argues that political speeches have themes that relate to religion. These themes, when ritually produced, give legitimacy to the political system. Through this, governments take on sacred characteristics. This generates national solidarity. In addition to these studies, there is a range of research

focusing on secular rituals in different fields (Gusfield and Michalowicz 1984). It includes research on the law and social order, life cycles, and festivals.

With law and social order, the work of Arnold (1935) and Frank (1936) indicates that confirmations of previous decisions in appellate courts are ritual verifications of legal and social order. Garfinkel's (1956) findings show that ritual acts in trials and hearings exist to degrade offenders and promote state authority. Manning's (1977) research shows that the daily activities of the police generate a social myth that they control crime. In actuality, they do little more than react to it.

With the life cycle, Gennep's ([1909] 1960) analysis on rites of passage connects biological processes such as birth, puberty, procreation, aging, and death to rituals (for more examples Nadel 1954). Before a ceremonial rite of passage, social structure is ambiguous. Communal bonds become critically important (Turner 1969). The ritual process creates a smooth transition to new roles. Consider the importance of a retirement party. Speeches, plaques, the serving of a meal, and a traditional toast give a symbolic end to labor force participation (Savishinsky 1995).

Festivals involve large crowds at recurring events. This includes sporting events such as the Olympics. Crowd behavior is what separates these events from life cycle rituals (Gusfield and Michalowicz 1984). In Olympic games studied, MacAloon (1981, 1982) argues unity occurs when symbols have meaning for both individuals and nations. The ritual display of these symbols also creates a sense of familiarity and unity for everyone involved. Grimes' (1976) study on a fiesta in New Mexico shows themes of promoting the benefits of authority. This resulted in a festive, but solemn atmosphere. In a subsequent study on the festivities of a drama group in Toronto, he found a theme of

authority rejection. The celebration provoked outrageous actions contrary to the event in New Mexico (1982).

Studies exist that examine rituals in everyday life. Some examine the daily processes involving consumers and goods (Douglas and Isherwood 1979; Csikszentmihalyi and Rochberg-Halton 1981). Others focus on the symbolism of food (Douglas and Nicod 1974; Douglas 1975). For example, in a study of Hebraic dietary laws, Douglas (1966) explains that a tie exists between food classification and social stratification. Ancient Hebrew people considered foods hard to classify as taboo. The same idea existed for non-Hebrew people. If you could not easily classify a person, they were off limits. In other words, cognitive frameworks supporting social boundaries existed. Rituals relating to food classifications reinforced them. In addition to research on food consumption, Goffman's work is relevant to rituals in everyday life (Gusfield and Michalowicz 1984).

Goffman's (1959) early work provides a perspective that places emphasis on life as drama. It views social life through the lens of a theatrical analogy. In the routines of everyday life, actors attempt to generate favorable impressions of the self to an audience. However, people do not always select the way they present themselves. In some situations, the proper way to act is predetermined. For example, if a child is riding a merry-go-round, the display of childlike joy is acceptable. The same is not true for an adult riding a merry-go-round. In such an instance, actors separate themselves from roles – also known as role distancing. An adult on the ride might show little emotion. This shows that they are on a childish ride, but they are not childish (Goffman 1961b).

Goffman (1967) went on to explain image creation with studies of rituals. Consider his examination of presentational rituals in organizations. These involve unspoken rules on how to deal with interaction. His work in a research hospital for mental patients shows that when members of a ward pass each other, an exchange of salutations takes place. The length depends on the time between the last salutation and estimated time before the next. While sitting at a table, staff members gave a brief smile when eye contact occurred. He explains that "anything less would not have shown proper respect for the state of relatedness that existed among members of the ward" (1967:71). Avoidance rituals in the institution create the opposite effect. These practices occur when staff members interact with patients. He notes that when force-feeding patients, staff members routinely ignored pleas from frightened patients. They stoically drove the food into patients' mouths because their job was to "see that patients are fed" (Goffman 1967:68).

All of these studies focus on a range of behaviors. However, they do not provide a specific approach for analyzing rituals. Knottnerus' (1997) work on structural ritualization fills this void. Using Berger and Luckmann's (1966) notion that most of everyday life is socially constructed, it helps to define the taken-for-granted lives of actors. It uses the concept of ritualization to explain the reproduction and transformation of social structure. The theory focuses on a specific set of factors that previous scholars ignored or only partially discussed.

The Theory of Structural Ritualization

Rituals are a large part of life. They create stability. They provide symbolic meanings that give significance to our actions. The work of various scholars points to the

importance of religious and secular rituals (see for example Durkheim [1912] 1965; Warner 1959, 1962; Goffman 1967; Etzioni 2000). As mentioned, these works do not discuss rituals in terms of a formal theory. Recent works do focus on the importance of routine social interaction (see Giddens 1984; Collins 1987; Kertzer 1988; Sewell 1992). However, they fail to systematically analyze rituals as they relate to the reproduction and transformation of social structure (Knottnerus 1997).

The theory of structural ritualization nullifies this problem. It emphasizes embedded groups. These are groups located in a larger environment. The taken-for-granted practices of people in these groups are similar to patterns of behavior in the larger environment. When routinely performed, their actions acquire symbolic significance. They become part of a cognitive script that dictates behavior. The members of embedded groups do not just copy the practices. They express them in ways that may confirm patterns of behavior in the larger environment (Knottnerus 1997). Consider the elite secondary school system in early nineteenth-century France. Studies show that administrators ritually dealt with male students in a forceful manner. The children resented this. However, the embedded social world of students showed signs of aggressive relations as well. The ritual actions of administrators shaped the relationships between students. Relations between students reinforced the social structure (Van de Poel-Knottnerus and Knottnerus 1992, 1993; Knottnerus and Van de Poel-Knottnerus 1999; Van de Poel-Knottnerus and Knottnerus 2002). Similar findings exist in studies on slave plantation systems (Knottnerus 1999; Knottnerus, Monk, and Jones 1999).

In relation to the theory, the larger environment feeds the embedded group. The ritualized symbolic practices of the embedded group reinforce the larger social structure.

Ritualized symbolic practices (RSPs) are socially standardized actions that are schema-driven. They involve repetitive forms of behavior with symbolic significance (Knottnerus 1997). The term schema refers to a cognitive structure or framework. According to the theory, ritual actions shape an actor's thoughts. This helps structural reproduction take place in specific domains of interaction. A domain of interaction is a "bounded social arena which contains two or more actors" engaged in "face-to-face interaction" (Knottnerus 1997:261). As applied to the theory, this concept allows for the distinction between multiple regions of social activity with different RSPs. Multiple domains of interaction in a specific environment, such as an organization, warrant the use of the term "domain set" (Knottnerus 1997:261). Four factors play an essential role in structural reproduction involving RSPs. They include repetitiveness, salience, homologousness, and resources (Knottnerus 1997).

Repetitiveness entails the "relative frequency with which a RSP is performed" (Knottnerus 1997:262). The repetition of a RSP varies. In a domain of interaction, the presence of a RSP might be rare. In other domains, actors may repeat the RSP often. In certain contexts, RSPs may happen several times a day. Again, consider secondary schools in modern France. Rigid interactions between staff and students transpired hundreds of times a day (Knottnerus and Van de Poel-Knottnerus 1999; Van de Poel-Knottnerus and Knottnerus 2002). Since students witnessed these interactions, the likelihood of social reproduction increased (Knottnerus 1997).

Salience involves the "degree to which a RSP is perceived to be central to an act, action sequence, or bundle of interrelated acts" (Knottnerus 1997:262). This involves the prominence of a specific RSP. For example, in the elite school systems previously

discussed, staff always exercised strict discipline. They stoically required pupils to defer to their commands. In most circumstances, they did not show any form of sympathy. These ritualized, formal ways of behaving were visible in all domains of interaction. They guided actions in academic and nonacademic settings (Knottnerus and Van de Poel-Knottnerus 1999; Van de Poel-Knottnerus and Knottnerus 2002).

Homologousness implies a "degree of perceived similarity among different RSPs" (Knottnerus 1997:263). It is possible that different RSPs exist in a domain of interaction. These actions may display a certain amount of similarity. The greater the correspondence between RSPs, the more likely the reproduction of social structure. In other words, they reinforce each other. This enhances the impact of RSPs. In the French schools discussed, teachers addressed students in a rigid, sarcastic manner. Top staff also dealt with students in a coercive way. Outside of the classroom, staff members were also distant and formal. In addition, the principal, vice principal and other staff subjected students to extensive surveillance (Knottnerus and Van de Poel-Knottnerus 1999; Van de Poel-Knottnerus and Knottnerus 2002). All of these practices were similar in terms of symbolic meaning. They involved hierarchical relationships and social power (Knottnerus 1997).

Resources are "materials needed to engage in RSPs which are available to actors" (Knottnerus 1997:264). The greater the availability of resources, the more likely an actor will engage in a RSP. Resources include nonhuman materials such as money and time (Sell et al. 2000). However, resources also include human traits such as interaction skills, physical strength, and intellectual ability. Teachers ridiculed students to establish their authority in the French schools discussed (Knottnerus and Van de Poel-Knottnerus 1999;

Van de Poel-Knottnerus and Knottnerus 2002). They were able to ridicule students because they had more knowledge and expertise. As such, resources limit the ability to engage in RSPs (Knottnerus 1997). Consider embedded youth groups in the schools discussed. Certain students had a greater cognitive grasp on their environment. Modeling the actions of staff, they dominated other students with physical and verbal coercion. This created arrangements between students similar to the larger social environment (Knottnerus and Van de Poel-Knottnerus 1999; Van de Poel-Knottnerus and Knottnerus 2002).

When considering the theory of structural ritualization, it is important to acknowledge rank. Rank involves "the relative standing of a RSP in terms of its dominance" (Knottnerus 1997:266). According to the theory, a RSP has a high rank if repetitiveness, salience, homologousness, and resources are all present. In other words, a RSP ranks high if it is repeated often, visible, similar to other practices, and actors have resources to take part in it. The higher the rank of the RSP, the greater the likelihood that it will be reproduced (Knottnerus 1997). However, the theory of structural ritualization does not only recognize social reproduction. It also acknowledges the possibility of unanticipated consequences resulting from repetitive action (2002a). In addition, it addresses ritual actions in relation to structural transformation. Factors leading to structural reproduction also produce new social structures. This occurs when actors encounter different RSPs in multiple domains of interaction. The more dominant alternative practices are, the more likely they will influence actors. Actors in embedded groups will use elements of alternative practices to construct new cognitive scripts (Knottnerus 1997).

Examinations of Ritualized Symbolic Practices

Various studies provide support for the theory of structural ritualization (Knottnerus 2002a). In addition to the research on French elite schools, research supporting the theory includes studies of slave societies, acculturation for ethnic groups, and social structure in task groups (Knottnerus 1999; Knottnerus et al. 1999; Guan and Knottnerus 1999; Sell et al. 1999; Knottnerus and Berry 2002). Other work on the theory of structural ritualization focuses on strategic ritualization, civility, and disruptions in social order (Knottnerus and LoConto forthcoming; Varner and Knottnerus 2002; Knottnerus 2002b).

In relation to slave societies such as ancient Spartan civilization, ritualized symbolic practices played a large role. The process of rearing male children into adult warriors involved specific rituals. These practices shaped the cognitive frameworks of youth in training. Spartan society emphasized simplicity. It promoted group unity and obedience. It also emphasized aggression and courage. In youth military training, these qualities ranked extremely high. These embedded groups reproduced the social structure of the larger environment. Their training also reinforced the wider social order (Knottnerus and Berry 2002). Similar transmissions existed in U.S. slave plantations. Routine practices conveyed specific meanings. Consider that owners made distinctions between slaves. Some worked in the house while others worked in the fields. Some had high access to owners while others did not. These RSPs influenced the cognitive scripts of slaves. In fact, the status distinctions within a group of slaves modeled status distinctions of the larger environment. Within groups, slaves considered those that

worked in the house or had access to the owner as superior (Knottnerus 1999; Knottnerus et al. 1999).

In terms of ethnic group acculturation, RSPs are critical. Consider the integration of Chinese Americans in the United States. The interaction patterns of older generations contained themes relating to strong kinship ties, hard work, and respect for authority. Things were different for new generations. As their ethnic group merged with American culture, they experienced new patterns. New RSPs stressed qualities like independence. The cognitive framework for new generations shifted because of exposure to alternative RSPs. This smoothed the transition of Chinese Americans into a new culture. It also promoted a bifurcated view of the self for Chinese Americans seeking to hold on to a traditional ethnic identity (Guan and Knottnerus 1999).

In small task groups, RSPs promote the reproduction of social structure. Using the theories of structural ritualization and expectation states, the work of Sell et al. (2000) shows a leader will transform a group based on observed RSPs. Using subjects from a university, the study examined forty-four task groups under three different conditions. A leader for each group arrived fifteen minutes before the other subjects. The leader would then view one of three videos depending on the group assignment. One video was a short introduction to graduate studies at the university. This video did not mention task groups. Both graduate students and faculty discussed graduate programs in the video. The second video, discussed as the high rank video, showed two task groups. One group worked on solutions to a noisy apartment complex. The other had to design a new game people could play. On the second video, a leader used hierarchical rituals. This included standing up, writing on a chalkboard, handing out materials, and disagreeing with others.

The third video, the low rank video, contained the same two groups appearing in the high rank video. However, group leaders used fewer hierarchical RSPs. For example, the leader in the video would speak more than others, but not stand up, write on the chalkboard, or strongly disagree with others.

After the subject assigned to be a group leader in the study watched a video, the subject would join two other people. These three people made up a task group. Their task was to come up with factors that help to explain what makes cartoons funny. As previously mentioned, the researchers studied three different kinds of task groups, one for each video. The results of the study show that leaders in the experimental groups exposed to videos with high ranks of hierarchical RSPs recreated these practices. They took charge by standing, writing on the board so all group members could see, and handing out the materials used in the study. The other group leaders rarely displayed such behaviors. Specifically, in only one instance did a group leader, not in the high rank group, stand. Even when he did, another group member stood as well (Sell et al. 2000).

In terms of strategic ritualization, one study indicates that ritual legitimators, ritual entrepreneurs, and ritual sponsors exist. The study, which focuses on a small Italian-American community in southeastern Oklahoma, indicates ritual legitimators authorize RSPs with a special understanding of a social environment. Ritual entrepreneurs promote RSPs for economic purposes. This includes action linked to the marketing of commodities. Ritual sponsors develop and promote events comprised of RSPs. These events, associated with a particular collective of people, serve to promote social identity, political, and economic issues (Knottnerus and LoConto forthcoming).

With civility, RSPs carry great weight when applied to a game such as golf. Advancing Elias' (1978) concept of the civilizing process, one study shows that RSPs in American golf recreate class divisions (Varner and Knottnerus 2002). Using texts and other forms of data, the research examines golf in America between 1894 and 1920. It demonstrates that social characteristics of civility found in European noble pastimes existed in American golf. Qualities such as self-restraint, practice, courtesy, compliance, and honorable behavior ranked high. These qualities did not just reflect European social traditions. They served to keep those from lower classes from playing the game. Specifically, golf in the early twentieth-century represented a new way to denote status in America. "By recreating social standards and customs that were found in many European noble pastimes, such practices served to distinguish the American upper class from the lower classes" (Varner and Knottnerus 2002:438).

A study concerning institutional deritualization supports the theory (Knottnerus 2002b). It uses accounts from people in concentration and internment camps. The findings show that when disruptions in behavior patterns occur, they affect people in adverse ways. However, even in situations of forced detainment, people reconstitute old RSPs or establish new ones. The study shows that it might be possible to examine this process in relation to other situations of disruption in ritual activity (Knottnerus 2002b). Consider a major health event, such as learning of an HIV infection (see White and Knottnerus 2001). Regardless, Knottnerus (2002a) points out that the study of ritualized practices in formal organizations might be relevant as well.

Organizational Theory, Deviance, and Ritualized Practices

Formal organizations play a large role in contemporary society. Now people are educated and work in them. In relation to nursing homes, people wait to die in them. Sociology helps us to see organizations as a level of analysis (see Perrow 1991). It helps us understand their positive impact on society. Importantly, it helps us understand their negative impact as well (Clegg 1990). This section provides an overview of organizational theory. It discusses concepts relating to new institutionalism and organizational deviance. It argues that the theory of structural ritualization has the potential to supplement these areas due to its systematic focus on social reproduction.

Durkheim ([1895] 1964) sets up the study of organizations with his point that social facts shape individuals. However, Max Weber's work had the largest impact on the development of organizational theory (Clegg 1990). For Weber (1946), historical progress is bound to the use of rationality. Bureaucratic organizations are the only rational way to process large numbers of people in modern societies. In their ideal form, they focus on specialization. Categories of personnel perform tasks. This allows a smooth flow of work. Because tasks are separate, the delegation of power is necessary. This leads to hierarchical relations. Officials in a bureaucracy work based on a contract. These specify that workers must have specific credentials. With the complexity of separate tasks and hierarchical relations, formal rules are crucial to justify legitimate action. With these formal rules, written documents are essential to record and standardize action. Finally, with power based in rules, procedure, and hierarchical position, there is a tendency to be impersonal.

Weber (1946) implies bureaucracies will seep into every form of organizational life. This can have positive consequences. For example, favoritism of ascribed status will decrease. This will promote more equality in society. However, bureaucracies have a negative impact. They create feelings of alienation. Due to formal relations and procedures, bureaucracies view people as one part of a larger machine. In other words, they dehumanize people.

This view has been influential. Scholars in the field of organizational theory modified it over the years. Consider Merton's (1936, 1940) work on organizations and unanticipated consequences. It implies top down pressures for reliability and predictability lead to formality. Formality leads to standardized behavior. Habitual actions leading to unanticipated consequences can emerge. This is due to the complexity of actions in modern organizations. Gouldner's (1954) work focuses on rules. It contends that members of an organization have to interpret rules the same way in order for them to be effective. If the patterns of a bureaucracy do not facilitate shared meanings of rules, conflict results. Not all members of a bureaucracy get along. In other words, things do not always flow smoothly. In a related study, Blau (1955) suggests that organizations are more efficient when workers break rules. Gouldner (1957) explains that aspects of specialization breed problems. Not all people in an organization agree on their role. Therefore, it is possible that the very process of bureaucracy leads to problems.

Blau and Scott (1963) suggest that the characteristics of a bureaucracy do not penetrate every organization in the same way. Some organizations have different goals. These goals might counter efficiency, specialization, and depersonalization. For

example, we can consider religious or fraternal groups that stress unity. In a similar argument, Etzioni (1961) explains that organizations serve different values, and these sometimes run contrary to the purpose of bureaucracy. His concepts of motivational variation are relevant. He argues that three basic types of motive exist in organizations – love, fear, or money. He discusses these motives as normative, coercive, and remunerative bases of power. For example, nuns in a convent might submit to organizational discipline for the love of God. A prisoner in a penitentiary might submit to the discipline of the chain gang fearing the warden. An industrial worker might submit to the discipline of production because of profit goals (for elaboration see Clegg 1990).

Using Durkheim's ([1893] 1933) work, Burns and Stalker (1961) focus on the Scottish electronics industry. They find a distinction between "mechanistic" and "organic" organizations. Mechanistic organizations close off from the external environment. They are stable. They also have characteristics that align with the ideal bureaucracy discussed by Weber. Organic organizations are less formal. They are open to input from the outside. They have traits that do not fit the bureaucratic mold. For example, they do not specialize. In relation to the unsettled electronic industry, Burns and Stalker's (1961) work finds that organic organizations are more effective. With the market changing rapidly, openness allows them to adjust in a more efficient way.

Hage (1965) treats all bureaucratic environments as closed in order to make them units of analysis for testable propositions. His analysis of organizational stratification and job satisfaction shows that the more stratified an organization is the less job satisfaction. Other points generated by his work provide promise. However, many total

institutions can not achieve total independence from outside sources. Viewing a bureaucracy as a self-contained environment is impractical (Clegg 1990).

It is clear that the traits of bureaucracy discussed by Weber do not always stick together. The modified versions of organizational theory show promise. Modified versions focus on specific traits. They do not contend all of them go hand in hand. These modified versions are important because they promote two branches of organizational analysis relevant to the study of RSPs. They involve new institutionalism and organizational deviance.

New institutionalism downplays individual choice. It focuses on social context and its influence on shaping individual choice. It argues that structure in organizations shapes individuals. It specifically considers routines and cognitive scripts when explaining bureaucratic life. As Powell and DiMaggio explain, new institutionalism "locates irrationality in formal structure itself, attributing the diffusion of certain departments and operating procedures to interorganizational influences, conformity, and the persuasiveness of cultural accounts" (1991:13). This is a move away from traditional concepts of organizations. As discussed previously, traditional examinations of bureaucracies emphasize the manifest functions. New institutionalism focuses on bureaucracy as a ceremonial myth. In doing so, it attempts to bring symbolism into organizational analysis.

Meyer and Rowan (1991) imply that the use of organizations is now routine. Bureaucracies no longer take on Weber's ideal form. As such, people take the conception of a bureaucracy for granted. Instead of having the characteristics of a bureaucracy, organizations now spend more time trying to create an image of what a

bureaucracy is supposed to be. In some cases, it is necessary to create the impression of bureaucratic order for organizational survival. For example, when external agencies check an organization to see if it meets certain requirements, they merely concern themselves with written rules and issues concerning credentials. This shifts the goals of the organization. The organization turns its focus to ceremoniously maintaining an appropriate organizational image. In the process, it loses sight of its original purpose. In relation to Goffman's (1959) work, this version of new institutionalism implies organizations seek to maintain a bureaucratic façade in order to retain legitimacy.

Friedland and Alford's (1991) work on new institutionalism focuses on symbols, practices, and contradictions. It argues that institutions are organizational patterns. The patterns have meaning. They are functional and symbolic. Friedland and Alford (1991) contend organizations influence the individual, but the individual actions can also reshape organizations. Without providing a specific account of this process, they propose that "institutional logics" dominate organizations. These logics not only drive goals of the organization; they shape cognitive scripts for organizational actors. Institutions tell us how to order our reality and make sense of the social world. Five logics operate in U.S. organizations. They include themes relating to democracy, the nuclear family, Christian religion, the capitalist market, and the bureaucratic state. The democratic logic focuses on communal participation and state control over human activity. The nuclear family logic concerns unconditional loyalty. The religious logic provides a moral frame of reference based on the supernatural. The capitalist logic focuses on accumulation and modification. The bureaucratic logic emphasizes rationality and regulation. This dispels the traditional view that all organizations operate with an emphasis on bureaucratic traits.

Though Friedland and Alford (1991) acknowledge the bureaucratic logic in contemporary organizations, they also point out that organizations vary when considering other logics. In addition, variations of research point out institutional logics may concern any salient theme relating to accepted behavior in an organization. They do not have to focus on the five core logics previously discussed (Lee and Ermann 1999; Thornton and Ocasio 1999; Vaughan 1999).

In recent years, as with new institutionalism, organizational deviance started to focus less on individual actor models and more on organizational context. In traditional work, analysts linked rule breaking to individual motives. Acts of deviance in organizations related to greed and profit (see for example Sutherland 1940). This changed. In recent work, Coleman (1985) explains that organizational environments encourage deviant behavior. This places less value on rational choice models. The norms inside of an organization may run against social values, but people normalize to routines of acceptable deviance in bureaucratic settings. When this occurs, they no longer see the illegal activity in a negative light.

In a related work, Simon (1985) implies that the fragmentation of organizations leads to deviant activity. He contends that deviance in organizations may simply be a by-product of the organizational environment. Vaughan's (1999) work makes a similar argument. In discussing the "darkside of organizations," it explains that issues such as profit motive may no longer apply. This is because deviance in organizations is often the result of routine nonconformity.

Vaughan (1999) discusses three types of deviance that relate to organizational theory. They include mistakes, misconduct, and disasters. Mistakes occur due to

environmental social divisions. Modern organizations have secrecy between departments, complex relationships, and specific institutional logics that promote deviant behavior. Misconduct occurs due to competition with other organizations and normalization of deviant activity within the organization. It also emphasizes cognitive aspects relating to the prevailing logic of the organization. Disasters occur because of factors relating to multiple regulations. Organizations can drift away from formal goals into an orientation toward practical goals because bureaucratic rules are too intricate. In other words, sometimes it is not practical to follow the rules. In line with Blau (1955), rule breaking can often lead to higher levels of efficiency. Vaughan (1999) also points out that a social psychological factor relating to groupthink leads to disasters (see Janis 1972). Consider these points as they relate to NASA.

Vaughan (1992,1999) indicates that the Challenger space shuttle did not explode in January 1986 because of individual decisions. Using themes from new institutionalism, she explains that a logic of acceptable risk emerged within NASA. It caused the disaster. The O-ring, which seals different points off during ignition, was a problem since the late 1970s at NASA. Administrators regularly let launches occur when O-ring issues were present. Workers normalized O-ring problems and did not act on them. Sometimes, parts of the organization would find O-ring problems and not share the information. This led to catastrophic results. As Webb (1999) implies, the secrecy and culture of production discussed in Vaughan's work indicates that individual actor descriptions of organizational deviance are no longer valid. With this in mind, other studies using routine nonconformity emerged.

Rabe and Ermann (1995) followed up Vaughan's analysis of the Challenger explosion with a review of the tobacco industry. Their work finds that there was a time when the public did not question tobacco use. It was widely accepted. This period, which began in colonial times, was the start of a business that would eventually be the victim of scientific progression. As the 1900s began, people questioned the use of tobacco. According to Rabe and Ermann (1995), studies came out claiming the negative effects. After the emergence of these studies, tobacco companies had to conceal harmful effects to survive. No individual at the top decided to put out a harmful product. People proudly used tobacco for centuries. Regardless, in the face of new technologies, organizations had to defend a once widely accepted product.

A related study by Lee and Ermann (1999) examines the production of the Ford Pinto. Reports did indicate that executives at Ford produced the Pinto knowing it would blow up with a rear end impact. The costs of recalling them outweighed the benefit of profit, so they continued to put them on the market (see Dowie 1977). Lee and Ermann (1999) explain that no cost-benefit analysis occurred. Using Vaughan's (1992,1999) work and new institutionalism literature, Lee and Ermann (1999) indicate that Ford had an institutional logic of acceptable risk. People knew a problem could occur; yet, the issue was acceptable based on normalization within the organization. Ford routinely produced vehicles with design flaws. With those vehicles, no complaints occurred.

Overall, organizational theory has changed greatly. It focused on ideal images of bureaucracy. It questioned the negative impact of bureaucratic domination (for a contemporary example see Ritzer 2000). It then started to focus on specific bureaucratic traits. Recently, the emerging concern has been attempts to generate legitimacy through

ceremonious displays of bureaucratic traits. Both new institutionalism and organizational deviance are focusing on the structure in the organization and its influence on actors.

Since this project will focus on nursing homes as organizations, it is important to acknowledge themes in organizational theory, specifically new institutionalism and organizational deviance, that have similarities with the theory of structural ritualization. They both focus on repetitive behavior in relation to the formation of cognitive frameworks. They both stress the importance of social structure, downplaying rational choice. They both imply routine practices lead to unanticipated consequences. Regardless, the theory of structural ritualization covers several points that the organizational literature does not. It has the potential to complement and add to concepts existing in organizational theory. Several points relate to this argument.

First, as opposed to merely presenting abstract ideas concerning social environments, Knottnerus' (1997) theory of structural ritualization is a formal theory. When applied to an organizational context, its focus on repetitiveness, salience, homologousness, and resources has the capacity to direct attention at specific processes facilitating social reproduction. Second, the concept of ritualized symbolic practices (RSPs) provides a precise tool for the analysis of interaction in organizations. As Troyer and Silver argue, the "theory of structural ritualization, then, offers a systematic explanation of how institutional logics (or RSPs) become mobilized in a collective" (1999:245). Third, the theory of structural ritualization has the ability to be useful in organizational analysis because it deals with domains of interaction. Organizational theory and ideas from organizational deviance do not provide the analytical tools needed to focus on specific situations in which routine behavior influences cognitive thoughts.

With the concept of an interaction domain, the researcher can consider specific points of contact within the organization that promote routine conformity and social reproduction. Finally, the theory of structural ritualization has the ability to focus on embedded groups. Views concerning organizations recognize the importance of specialized groups in bureaucratic environments, but they fail to consider them as levels of analysis in and of themselves. They also neglect to identify the potential of embedded groups in reifying social order.

Summary

Rituals have been a topic of interest for some time. Scholars did focus on rituals and religious practices (Durkheim [1912] 1965). They moved on to recognize the value of studying secular rituals (Warner 1959, 1962; Goffman 1967). As the twentieth-century ended, analysts continued to study routine behaviors. They actively sought to connect micro to macro levels of analysis with their work (see Giddens 1984; Collins 1987; Kertzer 1988; Sewell 1992). However, in line with much of the existing work in organizational theory and organizational deviance, research on rituals only focuses on abstract concepts. Knottnerus' (1997) theory stands apart. It focuses on specific conditions relating to ritual actions. This has relevance for the study of cognitive frameworks, patterns of interaction, and social structure in various environments, including organizations such as nursing homes.

This analysis focuses on the theory of structural ritualization. As previously discussed, the theory is concerned with the taken-for-granted practices of actors in social environments. The theory focuses on the rank of ritualized symbolic practices (RSPs)

considering factors of repetitiveness, salience, homologousness, and resources. The greater degree of repetitiveness of RSPs, salience of RSPs, presence of homologous RSPs, and availability of resources to take part in RSPs, the greater the rank or relative standing of RSPs in a social environment. The greater the rank, the more likely people will repeat RSPs, and similar RSPs will emerge in embedded groups and specific domains of interaction (Knottnerus 1997). This work looks at RSPs with high rank in nursing homes. While considering ownership variation, it considers the influence of RSPs relating to bureaucracy and the maltreatment of residents. The questions guiding this were:

- Do rituals play a role in nursing homes?
- Are the RSPs in for-profit and nonprofit nursing homes different?
- To what extent does bureaucracy dominate social interaction in nursing homes?
- Are bureaucratic RSPs in for-profit and nonprofit nursing homes different?
- To what extent does maltreatment exist in nursing homes?
- Are RSPs of maltreatment in for-profit and nonprofit nursing homes different?
- Do RSPs relating to bureaucracy lead to maltreatment in all types of nursing homes?

To understand the relevance of these questions, it is important to look into the history of nursing homes. A review of the historical development of nursing homes gives insight into issues relating to ownership, bureaucracy, and maltreatment.

CHAPTER 3

THE HISTORY OF NURSING HOMES IN THE UNITED STATES

Introduction

Formal organizations are an important part of society (Perrow 1991). It is not a surprise that they dominate social life. Analysts predicted it years ago. Consider the work of Max Weber ([1921] 1968). It anticipated a rise in the use of bureaucracy. It indicated the critical nature of hierarchical structure, rules, specialization, efficiency, and documentation. Without organizations operating with these traits, social life might be impossible. Therefore, it is no shock that formal long-term care for the elderly emerged. The age wave and the growth of organizations are not the only things that stimulated a rise in the use of nursing homes. This chapter discusses the history of nursing homes addressing the influence of government policy.

The Colonial Era

People view the nursing home industry as an outgrowth of Medicare and Medicaid. Its roots are older and more complex. The industry is actually an extension of colonial life. In colonial times, public policy followed the tradition of English poor laws. Those laws left the care of elderly in the hands of community governments (Hawes and Phillips 1986). For the aged in America, this meant the only form of public support was

institutional. Society left the responsibility of caring for the destitute aged to poor farms (Dunlop 1979; Vladeck 1980; Holstein and Cole 1996). Poor farms, also known as almshouses, were concerned with taking care of the poor, sick, mentally ill, and lawbreakers. The first ones appeared in Boston, Philadelphia, and New York. During certain points, they held as many as 100,000 elderly Americans (Hawes and Phillips 1986).

Many poor farms were actually houses. This generated the use of the term poor house. The community acquired homes and changed them to meet the needs of impoverished occupants. To deter poverty and crime, the conditions in them were intentionally deficient. This created a situation where a community would institutionalize a poor elderly person if the person had little or no family support (Lidz, Fischer, and Arnold 1992; Giacalone 2001). There was no stigma attached to being old, frail, and without resources during the colonial era. Communities with a strong religious basis actually supported the process of aging. Religious organizations would often run poor houses (Giacalone 2001). Administrators operated many of them with a family attitude. The social structure of the facilities was informal, few staff existed, and able-bodied residents participated in minor chores. In relation to Friedland and Alford's (1991) work, care for the aged in this period operated under family and religious logics.

In a Puritan religious context, caring for the destitute only represented an opportunity to fulfill charitable obligations. It made many community members feel better about themselves. There were few attempts to actually improve social conditions (Lidz et al. 1992). This did change.

The Rise of Institutions and The Jacksonian Period

Andrew Jackson became the President of the United States in 1828. He was the first president born into poverty (Wallbank et al. 1992). Many of his policies focused on causes and cures for dependency. Institutions for the destitute increased in numbers and specialized during his tenure. Separate facilities designed to help orphans, criminals, and the aged emerged. As opposed to the family environment of colonial poor farms, new institutions used systematic rules, routines, and discipline (Lidz et al. 1992). This generated the early use of a bureaucratic logic in elder care. Regardless, Jackson's time in office promoted a paradigm shift. It fostered an approach that solutions to dependency exist. Dependency was no longer a sore that religious groups placed a bandage over. It was a secular problem, and it was repairable with the appropriate reforms. There was nothing inherently wrong with dependents. They were like anyone else. They just needed help (Lidz et al. 1992).

Despite the increased use of institutions, problems continued. Dependents lost their new status as equal members of society. People viewed them as responsible for their own difficulties. This included the elderly. People began viewing poor moral habits as the cause of illness and dependency in old age (Lidz et al. 1992). The elderly lost a considerable amount of prestige (Achenbaum 1978). The prevailing ideology was that anyone who lived a life of hard work, faith, and self-discipline could live to a ripe old age. If you had economic, mental, or physical problems in old age, it was your own fault (Cole 1987). In defiance of his intent, Jackson's institutions failed. Public attitudes shifted. People only wanted to isolate the indigent from the rest of society. They no longer favored plans for individual reform. The wealthy did establish quality old-age

homes that provided medical assistance to people with the proper social background. However, a majority of the destitute elderly continued to experience substandard levels of care (Cole 1987; Lidz et al. 1992; Giacalone 2001).

The Push for Pensions in the Early Twentieth Century

An increase in the population occurred in the early twentieth century. The Industrial Revolution placed more people in urban areas. High levels of immigration created an ample amount of conflict between social groups (Vold and Bernard 1986). Society placed more people in institutions. This trend involved a desire to control a select category of immigrants and homeless juveniles. Policy makers promoted this agenda in the name of criminal justice (Bernard 1992; Pfohl 1994). Regardless, many Americans did not want to stigmatize the aged by placing them in institutions. This created a move toward independence with public pensions (Vladeck 1980).

The Fraternal Order of the Eagles was one of the first groups that fought for elderly pensions. They claimed that caring for the aged was a social responsibility. Their efforts led to pensions for the elderly in the states of Pennsylvania, Montana and Nevada by 1923. Other states adopted similar plans (Achenbaum 1978). The California "ham and eggs" group also influenced pension development. The label "ham and eggs" emerged when a speaker addressing campaign workers promised that their group would be as familiar as ham and eggs to California voters (Canterbury 1938; Moore 1939). Their plan proposed weekly payments of $25 to every jobless citizen over the age of 50 (Mitchell 2000). Issues of fraud led to the disintegration of the movement (Putnam 1970; Fischer 1977).

Pension plans came under fire in the 1930s. Consider attacks on Francis Townsend's plan (Mitchell 2000). The Townsend Plan focused on giving $200 per month to those 60 years or older (Holtzman 1963). It gained publicity. A significant event occurred when an Oklahoma congressional representative and a member of the movement debated the merits of the program on national radio. Instead of debating actual issues, the representative attacked the plan. He said it was a moneymaking scheme to drain capital out of the pockets of Americans (Whiteman and Lewis 1936). The debate revealed a lack of credibility in the Townsend Movement. Soon after, it drifted into oblivion (Powell, Branco, and Williamson 1996). The push for pensions failed. However, a new breed of funding for the elderly was on the way. Without intending to, it would ignite the emergence of nursing homes.

Social Security, Old Age Assistance, and the Hill-Burton Act

The federal government gave in to assistance for the elderly with the 1935 Social Security Act. The commitment came in the first title of the act. Politicians labeled the program Old Age Assistance (OAA). The program provided federal payments of no more than $30 to recipients. Recipients had to meet state-defined requirements. States would then match the federal payment (Lidz et al. 1992).

OAA was need-based. Policy makers designed it to provide income to the elderly that did not get full benefits from old age insurance - another part of the Social Security Act. OAA did allow recipients to use funds as they pleased. Because of scandals and criticisms involved in the use of poor farms, regulations prohibited the institutionalized elderly from receiving payments. However, there was not an adequate system set up to check the use of the funds. Politicians did not want the payments to fund the

maintenance of almshouses, but recipients would often use the money for institutional care. As Table 2 indicates, this led to an increase in what we now call nursing homes. In 1939, the National Center for Health Statistics reported only 1,200 facilities with 25,000 beds. Under OAA funding in 1963, 12,800 nursing homes existed with 568,560 beds (Hawes and Phillips 1986).

Table 2. Nursing Home Statistics by Year after Institution of OAA

Year	# of Facilities	# of Beds	% of Change from Prior Report
1939	1,200	25,000	--
1950	9,000	250,000	900
1961	9,900	510,180	104
1963	12,800	568,560	11

Note: Based on Table 1 in (Hawes and Phillips 1986).

An important OAA statute excluded public facilities from receiving payments. Many of these nonprofit facilities relied on charitable contributions (Giacalone 2001). With the economy in a slump relating to the Great Depression, contributions dropped. Private facilities that accepted money from pensioners flourished. People referred to these facilities as "rest" or "convalescent" homes (Vladeck 1980:37). Unemployed nurses or informal partners ran them in their houses. It was often a way of creating extra income. Many people welcomed the use of institutions that cared for an aging population. However, from the start people were discontent with conditions in these facilities. Physical abuse and the abuse of funds leaked to the public. Regardless, few

facilities were available, and high demand existed. Politicians ignored calls for improvements (Lidz et al. 1992).

Soon, for-profit homes dominated. The new flow of income for people in proprietary homes provided extra money to spend on health services. Providing health care was something unemployed nurses running the homes were accustomed to do. However, medical care was a part of elder care largely ignored in the past (Hawes and Phillips 1986). Grant money from OAA continued to feed a for-profit industry through the 1940s. People promoted the notion of applying medical service to care for the aged. The elderly were no longer cared for in informal, family type environments. They were cared for in formal institutions that promoted rules, hierarchical structure, and medical services. Facilities started looking less like homes and more like hospitals. Laws passed to facilitate growth in the hospital industry jointly influenced the nursing home industry (Vladeck 1980; Lidz et al. 1992). We can consider the Hill-Burton Act.

After World War II, hospitals focusing on chronic disease upgraded their services to provide rehabilitative care. They added beds to provide lower-cost care for patients needing acute services (Harrington and Grant 1985). Hospitals did capture a large portion of the emerging long-term care market, but nursing homes also took their share. They were suited for the job since they adopted a medical model (Dunlop 1979). Around this time, the Hill-Burton Act of 1946 passed. The act provided funding for hospital construction. Amendments to the act in 1954 included nonprofit nursing homes. Around this time, amendments to the Social Security Act allowed people to use their OAA money on services provided by nonprofit, public facilities. State, religious, and fraternal organizations started to build nursing homes. On the surface, it appeared nonprofit

homes reaped the most benefits from the Hill-Burton Act and its amendments. This was not the case. The changes in OAA funding and government loans for nursing home construction attracted a plethora of entrepreneurs (Lidz et al. 1992).

For-profit nursing homes were out of the loop when it came to construction funds under the Hill-Burton Act. Regardless, they discovered loans through the Small Business Administration and Federal Housing Act covered their construction costs. The for-profit nursing home sector used the funds to increase bed supplies and build new facilities. A capitalist logic was building in long-term care. OAA funding started going directly to institutions. People receiving the funding were no longer directly involved. With this change, the for-profit nursing home industry began to lobby politicians for OAA funding increases and favorable regulations (Hawes and Phillips 1986). The American Association of Nursing Homes emerged in 1949 as the leading lobby group for for-profit nursing home owners. It merged with the National Association of Registered Nursing homes in 1956 and was renamed the American Nursing Home Administration. The organization is currently the American Health Care Association – AHCA (Williams 1999). Nonprofit nursing homes developed their own group. In 1961, the American Association of Homes for the Aging (AAHA) formed. Both AHCA and AAHA expanded their concerns to include assisted living and home care services (Giacalone 2001).

Overall, direct payments and construction loans attracted people concerned with profit making and not care taking. Many of the names connected to the for-profit industry during the heyday of OAA funding used shady business practices to generate revenue. Sources indicate many had ties to the Mafia (Mendelson 1974). Regardless,

lobby groups convinced policy makers to pump more money into the industry. National expenditures during this period increased. Estimates indicate they were nearly $33 million in 1940, and increased to $187 million in 1950. By 1965, they were $1.3 billion (Giacalone 2001). In the early stages of nursing home existence, the federal government was only paying 10 percent of expenses. By the 1960s, they paid 22 percent. There were more nursing homes than ever. The U.S. General Accounting Office, considering effects relating to the age wave, proposed that there was still a shortage of nursing home beds (Hawes and Phillips 1986). Changes in policy occurred again. More federal money would go into the long-term care industry.

The Birth of Medicare and Medicaid

The 1960s began with the passage of the Kerr-Mills Act. It replaced OAA with Medical Assistance for the Aged (MAA). It allowed states to control the criteria for government assistance. MAA removed the federal government's responsibility to match state funds. By 1965, MAA money provided support for over half of nursing home residents (Lidz et al. 1992).

The establishment of MAA was important, but the 1965 amendments to the Social Security Act continue to be the most relevant policy concerning elder care. They fostered Medicare and Medicaid (Giacalone 2001). In the years following the passage of the 1965 measures, the industry rapidly expanded – see Table 3.

Table 3. Nursing Home Statistics by Year after Institution of Medicare/Medicaid

Year	# of Facilities	# of Beds	% of Change from Prior Report
1969	14,998	879,091	55
1973	15,737	1,175,865	34
1976	16,426	1,317,909	12
1980	17,737	1,479,000	12

Note: Based on Table 1 in (Hawes and Phillips 1986).

Medicare is the primary source of funding for acute medical care for the aged (Montgomery 1992). For example, if an elderly person falls and breaks a leg, the person might need minor, temporary medical services to recover. Medicare might cover the costs. The original framers of the program designed it to cover hospitals. However, inflated hospital costs made low priced alternatives to hospital care attractive. Later amendments made the use of extended care facilities (ECFs) acceptable. This included nursing homes (Hawes and Phillips 1986). Two primary sections of Medicare exist. Part A pays for inpatient acute care, hospital care, and some skilled nursing and hospice services. Part B pays for physician's fees, some aspects of home care, and medical supplies. Medicare does not cover private items such as televisions, private rooms, or custodial nursing home services (Forrest et al. 1993).

Medicare continues to go a long way in protecting the finances of the aged. Currently, over 99 percent of America's elderly have coverage for acute medical care. That large percentage of coverage exists because of the Medicare program. Regardless, if an aged person enters a nursing facility, the use of Medicare is limited. It is only for

acute care, and only covers up to 100 days of nursing home services. Moreover, an $87 copayment is required for days 21 through 100 (Riekse and Holstege 1996).

Often the elderly do not have the funds to cover those costs. This is partly due to the expensive nature of nursing home care (Montgomery 1992). In 1992, the average cost of spending per year in a nursing home was around $36,000. Depending on geographic region and services needed, the costs can reach $50,000 to $60,000 per year (Riekse and Holstege 1996). Without extra funding, 30 percent of the elderly entering nursing homes are in poverty within three months (Rosen and Wilbur 1992). That impoverishment leads to Medicaid eligibility.

Medicaid is a decentralized program operating between the federal and state level that provides sustained medical services to the impoverished. This includes the old poor. It is the primary funding for nursing homes (Giacalone 2001). As mentioned, Medicare is for acute health services, and does not fund a majority of nursing home costs. Medicare only pays 2 percent of the total dollars spent on nursing home care. Medicaid covers 40 to 60 percent of nursing home expenditures. States determine eligibility. If a nursing home resident's total monthly income is less than the total nursing home cost, 29 states will establish qualification. Thirteen states have a limit of income barely over $1,000 per month. Six states require a maximum income below $1,000 per month. If residents meet requirements, their nursing home expenses are covered. In addition, the resident may receive $30 to $70 per month for personal income through Medicaid (Forrest et al. 1993; Wolfe 1993).

With the passage of Medicare and Medicaid, many people started viewing nursing homes as a substitute for housing. Consider the mentally disabled. During the 1960s, the

deinstitutionalization of mental patients took place. Many of them, if they did not end up homeless, ended up in nursing homes under Medicaid provisions (Dunlop 1979; Vladeck 1980). Again, more people were entering nursing homes, and the government needed to attract providers. To meet demands, they adopted two policies: increased reimbursement rates and decreased concern with regulation (Hawes and Phillips 1986).

Medicare adopted a cost-based reimbursement policy grounded in reported expenditures. There were no ceilings on reimbursement. The government ignored variations between providers. In addition, it provided income to for-profit owners on their net invested equity in a facility. In other words, owners did not have to worry about meeting their mortgage in the first few years of operation. The government would cover it. This allowed facilities a guaranteed profit (Shulman and Galanter 1976; Vladeck 1980).

In terms of regulations, the government did require Medicare and Medicaid funded homes to meet certain requirements to receive funds. States facilitating the program have government workers survey nursing homes making sure they meet minimum requirements. For example, in the early stages of Medicare and Medicaid funding, facilities participating had to provide 24-hour nursing services, have a registered nurse, and rotate the nurse on duty each shift. Requirements also involved areas of medical supervision, pharmacy services, fire safety, diet, and sanitation programs (Giacalone 2001). However, following the Social Security Act of 1965, policy makers estimated that few facilities could meet the minimum standards. Numbers indicate that of the first 6,000 institutions that applied for Medicare and Medicaid funds, only 10 percent were eligible (Lidz et al. 1992). In turn, the government decided to give facilities funds if

they were in substantial compliance, rather than full compliance. When a state survey agency found violations, nursing homes only had to present them with a plan for corrections (Hawes and Phillips). This made it easy for owners seeking profit to cut operating costs. Such a move could lead to increasing levels of infractions, but the only result would involve revising the facility's plan of operation. Through the late 1960s and 1970s, people became increasingly concerned with the quality of care in nursing homes. They seemed specifically concerned with for-profit facilities.

The Emergence of Scandal and Issues of Organizational Variation

Analysts argue that the influence of for-profit nursing homes led to second-rate care (Townsend 1971; Mendelson 1974; Vladeck 1980). Consequently, media sources focused on the industry (Hawes and Phillips 1986). In the 1970s, scandals surrounding financial deceit and political influence took place. The most infamous happened in 1975. The New York courts indicted Vice President Rockefeller. He testified in a televised hearing. His testimony involved illegal activities regarding nursing homes (Hess 1976, 1977). The financial and political abuse was not only occurring in New York. The government scrutinized the industry in other states as well (Vladeck 1980).

Illegal funding and political influence was not the only concern. The experiences of residents came to the forefront. Levels of care fell once entrepreneurs entered the industry and lobbied for soft regulations. They lowered operating costs in the name of monetary gain and residents suffered. During the 1970s, it was not strange to find nursing homes serving green meat, residents drowning in bathtubs, and people lying in their excrement (Vladeck 1980). One investigation, spearheaded by Ralph Nader, used

students from a school in Connecticut. The students took undercover jobs as aides and provided first hand reports of horrors occurring in nursing homes (Townsend 1971). Qualitative studies also showed residents were treated poorly (see Henry 1963; Gubrium 1975). The idea existed that for-profit facilities promote inferior care. A series of research on the difference between for-profit and nonprofit nursing homes emerged.

Holmberg and Anderson (1968) talked to nursing home workers in Minnesota. They went to 118 facilities. Their findings indicate staffing patterns for for-profit and nonprofit nursing homes are similar. However, nonprofit homes have an intense level of medical services, while for-profit homes focus on administrative work. In another study, Gottesman (1974) obtained data on 40 nursing homes. The findings show better psychosocial activities in nonprofit homes. In addition, they indicate nonprofit homes have more staff involvement with residents.

Winn's (1974) work examines a matched sample of 24 proprietary and nonprofit nursing homes in the state of Washington. The study finds that staff members give more attention to residents in the nonprofit homes. A New York study shows that nonprofit facilities spend more on residents per day than for-profits (New York State Moreland Act Commission 1975). Other studies reveal that for-profit homes spend more on property expenses and top staff wages, while nonprofit facilities spend more on food and maintenance. They also imply that families file more complaints against for-profit facilities (Minnesota Senate and House 1976; Virginia Joint Legislative Audit and Review Commission 1978).

Research conducted by Caswell and Cleverley (1978) finds that for-profit nursing homes are more efficient. In addition, they have lower operating costs. However, they

keep costs down by having staff levels below government standards. They also tend to have poor housekeeping, maintenance, medical, and food services (see also Moden 1982). A study by the Ohio Nursing Home Commission (1979) backs this up. It implies that facilities with the most serious violations of government regulations are for-profit (see also California Health Facilities Commission 1982).

Brooks and Hoffman (1978) visited nursing homes in the Cleveland area and found notable differences based on ownership. Their work concludes nonprofit facilities have a more home-like atmosphere. In addition, nonprofit facilities have a higher number of staff members. In terms of social interaction, their research finds nonprofit homes have links to the community and beneficial activities for residents. Vladeck (1980) observed in several nursing homes and found organizational differences as well. His findings imply voluntary facilities are better than proprietary ones. It shows that the worst nursing homes in the industry are for-profit.

Fottler et al. (1981) examined the relationship between profit and measures of resident care. They studied 43 nursing homes in California. The measures included concepts such as nursing staff hours per day and staffing ratios. Using a regression analysis, their findings show that quality increases in nursing homes when profits decrease. Green and Monahan (1981) analyzed information from 24 nursing homes in Phoenix, Arizona. At the time of their study, no state Medicaid program existed. This meant there were no federal regulations or state inspections. They believed the lack of government intervention would make differences between for-profit and nonprofit nursing homes more apparent. Their findings reveal that for-profit institutions give lower

levels of care. The results of the study also indicate for-profit homes with distantly located headquarters provide worse care than locally owned facilities.

Weisbrod and Schlesinger (1983) studied violations of nursing home regulations in Wisconsin. Their project examined 431 facilities. In accordance with the Ohio Nursing Home Commission (1979) study mentioned, the findings reveal that nonprofit nursing homes have fewer complaints filed. They also have fewer violations of regulatory law. Controlling for facility size, the study also indicates nonprofit homes that are not church-owned have more violations than for-profit homes. This calls into question the quality of care in institutions such as government nursing homes. Based on interviews with state officials and visits to over 200 facilities, a study by Hawes and Phillips (1986) concludes nonprofit, church affiliated homes provide better care than for-profit homes. Just as Vladeck (1980) indicated years earlier, they say excellent nonprofit and for-profit homes exist. However, the worst are for-profit.

These studies support findings by other analysts previously discussed (Koetting 1980; Riportella-Muller and Slesinger 1982; Elwell 1984; Lemke and Moose 1986; Jenkins and Braithwaite 1993; Ulsperger and Ulsperger 2001). They show nonprofit facilities offer better activities for residents, have more staff to resident interaction, and spend more money on residents. They also indicate nonprofit homes are likely to have superior housekeeping, food, and maintenance services. Nonprofit facilities have fewer violations against government regulations. In addition, residents and family members file fewer complaints against nonprofit nursing homes. Common sense would lead us to believe these findings would deter growth in the for-profit nursing home sector. However, some analysts contend ownership does not predict quality of care (Holmberg

and Anderson 1968; Winn 1974; Gottesman 1974). Factors of facility size and location might carry more weight (see Hawes and Phillips 1986). While researchers in the 1970s and 1980s debated the superiority of certain types of facilities, costs of care skyrocketed. Another important trend was the rise and dominance of nursing home chains.

Policy Revisions, Nursing Home Chains, and Demands for Reform

As the age wave entered the 1980s, the demand for nursing homes continued. The cost of providing care in nursing homes was high before, but it reached an unprecedented level. Both for-profit and nonprofit homes had trouble keeping pace. The average annual expenditure on one resident went from $5,100 in 1970, to $23,300 in 1985. By 1990, the average was $30,000. Facilities spent more on residents, but poor care still existed. The government took two main steps to address this problem. First, changes in regulations occurred. Second, policy makers modified reimbursements (Giacalone 2001). Each of these steps unintentionally put more power in the hands of for-profit facilities, specifically nursing home chains (Hawes and Phillips 1986).

In relation to federal regulations, the scandals of the 1970s led to major changes. States started to be attentive to the violation of rules. Many went beyond minimum federal standards imposing their own standards. The intention was good; however, the standards put smaller facilities out of business. For example, strict building and fire codes for nursing homes required sprinkler systems (Hawes and Phillips 1986). In Ohio, this requirement shut down 102 facilities in the late 1970s. Nearly 20 percent of those homes had fewer than 12 beds (Ohio Nursing Home Commission 1979). Similar circumstances occurred in other states. Small facilities closed because they could not

logistically meet new requirements. The bureaucratic demands also created a need for specialization within facilities. With requirements for activities, food, rehabilitation, and the preservation of resident records, facilities needed specific departments. Certification for specific workers became a requirement. Nursing home care became complex (Miller and Berry 1979; Johnson and Grant 1985). The bureaucratic logic in long-term care was in full swing. Regardless, the number of nursing home beds in the United States was increasing. Between 1969 and 1980, the number of nursing home beds increased over 73 percent. Yet, facilities with fewer than 50 beds declined by nearly 28 percent (Harrington and Grant 1985).

The reason is simple. Larger for-profit nursing homes, usually part of chains, entered the industry when new regulations emerged. For chains, new regulations were not a problem. They met requirements for new standards as they constructed new, larger facilities. Many of the smaller homes were holdouts from an earlier era. Their facilities began when regulations did not emphasize the physical plant aspect of long-term care or its specialization. Policy makers enacted new regulations in an effort to imply they were cleaning up the industry. However, for-profit homes, the ones with the worst conditions, suffered little (Hawes and Phillips 1986). This changed with the passage of the Omnibus Budget Reconciliation Act of 1987 – OBRA 1987.

Policy makers designed OBRA 1987 to decrease levels of inapt care (Filinson 1995). It continues to have a large impact on facilities. Its provisions remove divisions between a Skilled Nursing Facility (SNF) and an Intermediate Care Facility (ICF). Agencies now typically refer to all nursing homes as nursing facilities (NFs). In addition, nursing homes getting public funding now must meet new, more demanding standards.

They include general issues involving residents' rights and staff requirements (Riekse and Holstege 1996).

Specifically, the new requirements include quality of life issues, regulation of activities, privacy rights, visiting rights, and discharge rights (Riekse and Holstege 1996). In relation to maltreatment, the new guidelines establish the formal right for residents to be free from threats or actual abuse. This includes mental and physical abuse relating to corporal punishment, the use of drugs or physical restraints to control residents, and involuntary isolation (Mooney and Greenway1996). They also make results from state surveys available to family members and residents. This allows them to formally see which areas of care their facility does not adequately provide. Since the new guidelines passed, violations declined. However, analysts imply that the political influence of the for-profit nursing home owners may have a hand in distorting survey results (Harrington and Carrillo 1999).

In terms of modified reimbursement policies, policy makers replaced the flat rate system. Original policies let nursing home owners self report costs and receive full reimbursements. Owners practiced vertical integration to take financial advantage of this situation. They operated satellite services. These businesses would provide food and medical equipment for their own facility. They would overcharge themselves with these services to maximize profits. This gave them more capital allowing them to build more facilities. This was another policy leading to the rise of chain ownership (Hawes and Phillips 1986). However, the 1972 amendments to the Social Security Act did limit this process. They abolished the flat rate system. By 1983, most states switched to a system that put a cap on refund requests. Many now estimate the cost of services before they

provide them. In essence, government money started coming in on the front end of the process (Giacalone 2001). This still played to the advantage of for-profit facilities. Chains that expanded under the old system had the resources to find loopholes in prepay provisions. They hired financial experts that had the ability to manipulate the government's new reimbursement system. The smaller facilities, which were more familiar with the flat rate policy, did not understand the stock-swaps, intercompany loans, and leaseback arrangements that helped the bigger facilities to dominate the industry (Hawes and Phillips 1986). Again, a policy designed to put larger, for-profit facilities on their toes contributed to their growth.

With the industry growing more complex, smaller facilities and chains threw in the towel. An abundance of mergers between nursing home corporations occurred. A majority of activity happened in the late 1970s and early 1980s when the three leading chains increased their control of existing beds. In 1980, they owned 6.4 percent of beds nationwide. By 1982, they owned about 10 percent. Beverly Enterprises, the largest nursing home chain in the country, increased its facilities by 600 percent. Between 1982 and 1983 alone, the 25-30 largest chains increased their control of the total number of beds in the industry by 15 percent (Hawes and Phillips 1986). It appeared profits were increasing and conditions for residents were not better. However, politicians and government agencies were not the only groups trying to improve circumstances in the industry. Efforts by organizations like the National Citizens' Coalition for Nursing Home Reform (NCCNHR) played and continue to play an important role as well.

NCCNHR appeared in 1975 out of a concern to improve nursing home conditions. Over 200 groups and 1,000 individuals have membership (Ulsperger 2002).

Their stated goal is to develop strategies that improve the quality of life for residents. They carry out this task by promoting residents' rights. They also call for minimizing the use of physical and chemical restraints. In relation to fiscal abuse, they advocate liability for all excess spending (NCCNHR 2002). The group fought hard for OBRA 1987. Some analysts even credit its passage to the efforts of NCCNHR (Filinson 1995). On a smaller scale, similar groups exist in a majority of U.S. states. As the age wave continues, groups such as the California Advocates for Nursing Home Reform (CANHR) and Texas Advocates for Nursing Home Reform (TANHR) continue to work for fiduciary responsibility and better nursing home care (Ulsperger 2002).

Summary

Weber ([1921] 1968) predicted the increase of bureaucratic organizations. With nursing homes, this chapter indicates that laws can help facilitate that growth (for more see Coleman 1982). In the colonial period, long-term care for the elderly was informal. People did not use it for profit making. It was a close relative's obligation, or community members provided it. Even poor farms, the earliest form of formal care for the aged, operated with a sense of filial harmony. If a family atmosphere was not present in these facilities, they operated with a religious course of thought (Lidz et al. 1992).

As the use of organizations for the elderly went up, the logic operating in them shifted. Government funds such as OAA, Medicare, and Medicaid opened the door for entrepreneurs. Caring for the aged took on the demeanor of profit maximization. Many financiers opened nursing homes. They cut back on costs, provided substandard services, and generated a lot of revenue. No longer was care for the aged provided with quality of

life in mind. Businesses provided it to make money (Vladeck 1980). Nonprofit homes, operating with family and religious institutional logics, maintained existence. However, it was not long before for-profit homes controlled the industry. Consider recent statistics indicating that the ten largest chains own nearly 300,000 beds and 2,471 facilities. Many of them regularly generate revenues exceeding $1 billion per year (Giacalone 2001).

With the advent of government regulations, nursing homes became very formal. This put a great amount of bureaucratic pressure on for-profit and nonprofit facilities. They had a continued strain to meet specific guidelines relating to the use of government funds. In addition, they had to reckon with new certification provisions for employees. They also had to deal with rules for intake procedures, dietary programs, activities, rehabilitation, and discharge rights (Riekse and Holstege 1996). As a necessity, nursing homes started organizing services with specialized subdivisions. This made it easier to meet the demand of regulations (Miller and Berry 1979; Johnson and Grant 1985).

This historical review indicates that nursing homes operate with different institutional goals. Regardless, a bureaucratic logic now encompasses all of them. Some research shows nonprofit facilities are better. It argues that problems in nursing homes are due to desires to maximize profit. In relation to for-profit homes, people debate that a fundamental conflict exists between the goal of revenue and quality care. However, nonprofit homes still have problems (Hawes and Phillips 1986). This leaves us wondering if certain ritualized symbolic practices create problems in all nursing homes.

CHAPTER 4

METHODOLOGY

Introduction

This project examined bureaucracy and maltreatment in for-profit and nonprofit nursing homes. Other research focuses on nursing homes, however, it does not deal with the abuse of residents in a systematic way (Pillemer 1988). In its first stage, this research used a literary ethnography. The goal was to uncover themes in portions of documents that focused on nursing homes. In its second stage, this work applied these themes to a content analysis.

This chapter starts by reviewing the steps of a literary ethnography. This includes concerns with the scope of sources, interpreting documents, identifying themes, classifying themes, using analytic constructs, and seeking contextual confirmation. It then details the issues involved in a content analysis. This includes a review of problem formation, defining a sample, developing content categories, defining the unit of analysis, and using a system of enumeration. This chapter concludes with a discussion of reliability and validity.

Stage 1: The Literary Ethnography

There is a tradition of using literary records to analyze social realities (see Thomas and Znaniecki 1918; Allport 1942; Dilthey 1962; Geertz 1973; Bogdan and

Taylor 1975; Denzin 1978; Webb et al. 1981; Glassner and Corzine 1982; Lowenthal 1986; White 1986; Griswold 1990, 1992). Whether they use fiction or nonfiction works, scholars define this tradition in different ways. Some call it narrative analysis (Manning and Cullum-Swan 1994). Others call it document analysis or narratology (Bailey 1978; Marshall and Rossman 1995). Analysts in qualitative organizational studies use the term template analysis (King 1998). Regardless, they all claim that the study of literature is a reliable research method. Most work indicates that novels, short stories, articles, plays, biographies, autobiographies, and monographs reflect social life. When researchers correctly use these, their value is great (Van de Poel-Knottnerus and Knottnerus 1994).

The first stage of this research used biographies, autobiographies, and research monographs. It adhered to a document analysis technique known as a literary ethnography (Van de Poel-Knottnerus and Knottnerus 1994; Knottnerus and Van de Poel-Knottnerus 1999; Van de Poel-Knottnerus and Knottnerus 2002). A literary ethnography involves deep reading. Documents should focus on a defined subject. After reading the documents, patterns of experiences will be identifiable. Repeated themes reflect features of the social environment. This is not a quantitative method. The researcher is engaged in an interpretive process. This helps to focus on thick descriptions. These descriptions generate themes that represent a consolidated portrait of actor experiences (Van de Poel-Knottnerus and Knottnerus 1994; Knottnerus and Van de Poel-Knottnerus 1999; Van de Poel-Knottnerus and Knottnerus 2002).

Step 1: Scope of Literary Sources

The first step in conducting a literary ethnography involves determining the scope of sources. The research should obtain documents that focus on the environment under

review. Clear boundaries for inclusion and exclusion of sources should exist. This involves having a specific idea of the topic. The sources should describe the experiences of actors in their social environment (Van de Poel-Knottnerus and Knottnerus 1994). Consider the study of the elite secondary school system mentioned in Chapter 2. The study used literature by authors writing about their experiences. This allowed them to find that ritualized symbolic practices (RSPs) shaped embedded groups and reinforced social structure (Van de Poel-Knottnerus and Knottnerus 2002).

In this research, the scope of literary sources included books, book chapters, chapter sections, and articles that concentrated on nursing home life. The researcher was aware of several sources at the onset of this project. The few known sources were not adequate for a literary ethnography. To find additional sources, it was necessary to consult academicians familiar with literature pertaining to nursing homes. Upon their suggestions, additional sources emerged.

With a core of literature on nursing homes, the researcher thoroughly examined the references of each source for more. Then, the researcher scrutinized the references from those sources for even more. Several searches of library and Internet search engines also led to sources. With an intense search for all literature on nursing home life completed, the researcher ended up with 40 sources appropriate for analysis - see Appendix.

Initially, the researcher identified more than 40 sources. Not all of them were suitable. As indicated, parts of this research concern the examination of RSPs in for-profit and nonprofit nursing homes. In order to compare, it was necessary to know what type of facility the source described. For sources that did not explicitly reveal ownership,

the researcher contacted the author or authors. This proved beneficial in several circumstances. For example, the researcher had a telephone conversation with the author of the book *Nursing Home Life: What It Is and What It Could Be*. He clearly indicated that his book concerns his experiences in a nonprofit government facility (Bennett 2002).

A similar situation emerged through a discussion with one of the co-authors of *Borders of Time: Life in a Nursing Home*. After tracking down the telephone numbers for over 20 Walter Crandalls, the researcher confirmed that text was about a for-profit facility (Crandall 2002). The researcher was not always successful. For example, the researcher was never able to locate the author of the article, "Dying: The Career of the Nursing Home Patient." Though several sources provided intense descriptions of nursing home environments, they were not useful if the researcher did not know the type of facility described.

Step 2: Reading and Interpretation of the Documents

The second step of a literary ethnography is reading the documents. It is also possible that reading portions of the material is suitable depending on the purpose of the study. The reading should be focused. To reach a high level of concentration, you read some or all of the material several times. Because the process involves interpretation, the reader should be familiar with the language in the documents. This includes subtle nuances, informal phrases, and technical jargon. Knowledge of the historical setting is also important (Van de Poel-Knottnerus and Knottnerus 1994; Knottnerus and Van de Poel-Knottnerus 1999; Van de Poel-Knottnerus and Knottnerus 2002).

This research used a literary ethnography as an exploratory tool. At this stage, the researcher only focused on portions of the sources. Specifically, the researcher read one chapter of each book. In addition, the researcher read every article. The content analysis stage of this work involved the systematic review of each page from every document.

Past work experience and volunteer services in long-term care gave a basic understanding of the language used in nursing homes. This helped when reading the documents. In addition, earlier studies conducted by the researcher helped in comprehending nursing home language (Paul and Ulsperger 2001; Ulsperger 2000, 2002; Ulsperger and Ulsperger 2001, 2002). As the reading of the sample progressed, the researcher's base understanding expanded. The historical information reviewed for the development of Chapter 3 also proved beneficial.

Step 3: Identification of Textual Themes

During and following the reading of documents, in the third step, identification of themes is possible. These themes should focus on the experiences and features of the environment under review. The investigator should have an initial recognition of elements that are surfacing in the documents. The focus of themes can be on a variety of things. The author may explain how actors treat each other. This allows for an understanding of interaction patterns.

Again, multiple readings of documents or a portion of them is necessary. As the investigator looks back over the documents, themes unnoticed before might emerge. As the researcher moves between sources, he or she will reread them in a different way because of new themes found. As this goes on, it is possible that elements first found in

only a few documents will appear in several others (Van de Poel-Knottnerus and Knottnerus 2002).

An example of this step involves a study of the world of teachers in the secondary school system of early modern France. Van de Poel-Knottnerus and Knottnerus (1993) read works by various authors. They revealed many features that characterized teachers. For example, authors described teachers having similar social backgrounds. They also described them as hard working. Another theme revolved around alienation from others due to educational background.

In relation to this research, the reading of the sample of documents revealed about 100 themes. Table 4 lists several of them. In some sources, authors described meaningful relationships between residents and staff. Others noted the importance of staff following rules. Many descriptions of maltreatment existed. Authors noted the lack of cleanliness in domains of interaction such as living areas, recreational rooms, and kitchen areas. They also described failure to deliver medicines at appropriate times, physical abuse, verbal aggression, staff ignoring pleas for assistance, and staff stealing.

Table 4. Sample of Initial Themes

routines	charting	faith
privacy issues	dealing with death	prayer
family involvement	lack of maintenance	restraints
bureaucracy	rules	resident abuse
staff abuse	lack of compassion	theft
baby talk	cutting costs	ignoring residents

Step 4: Classification of Thematic Elements

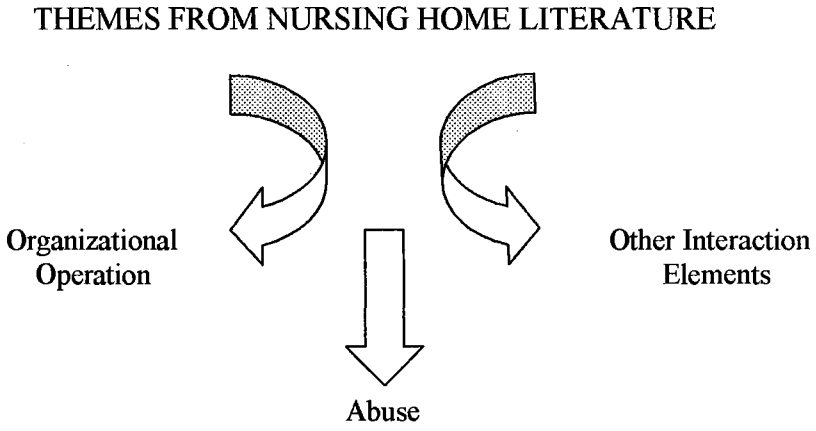
Based on the themes from the third step, the fourth step in a literary ethnography involves a classification system. This indicates certain themes are appearing often. The investigator should still be open to topics that emerge. Regardless, guidelines for classifying themes are desirable. Researchers should look for themes in phrases, sentences, parts of a paragraph, or a whole paragraph. Two issues are important here: the degree that a theme is expressed by different authors and the degree that the theme appears (Knottnerus and Van de Poel-Knottnerus 1999).

A researcher might find repeated comments on relationships. They might give a clear image of how interaction is coordinated. The investigator might define the interaction as random, distant, or brief (Van de Poel-Knottnerus and Knottnerus 1994). Consider the work of Van de Poel-Knottnerus and Knottnerus (1992). It found comments in documents that describe experiences of youth in French schools as abusive, harsh, and threatening.

In this research, the themes located in the third step centered on rules and efficiency. They also focused on personal negligence, bodily harm, and spoken aggression. Some centered on the objectification of residents, faith, prayer, and even theft. As the analysis progressed, it was necessary to classify themes. The researcher developed general categories of organizational operation, abuse, and an open category of other interaction elements – see Figure 3. Again, rereading the material was important so previously developed themes shifted to categories. The researcher kept notes on theme placement. After rereading, the researcher reviewed the notes along with supplemental

materials relating to ownership, bureaucracy, and maltreatment. This eased the transition into the development of analytic constructs.

Figure 3. Classification of Thematic Elements



Step 5: Development of Analytic Constructs

The fifth step requires a set of analytic constructs. This gives a greater degree of structure to the analysis. The constructs should give better understanding to the loose themes generated in previous steps. The constructs should link to theoretical ideas external to the study. This makes for a comprehensive understanding of the subject matter and clarifies why the researcher classified thematic elements a specific way. It also helps to create a composite portrait of the environment under review. Though the focus is sociological, the theoretical link can come from other disciplines. The source of the analytical concepts is secondary to the goal of strengthening your interpretation (Van de Poel-Knottnerus and Knottnerus 2002).

Categories reviewed in this research centered on the operation of nursing homes, abuse, and other interaction elements. To analyze these, ideas developed by others were important. Weber's (1946) work on bureaucracy applies to aspects of organizational operation. Based on the reading and rereading of the sample of documents, it seemed possible that an emphasis on rules and efficiency in nursing homes shapes interaction. It also seemed possible that traits relating to bureaucratic order influence care. Workers seemed more concerned with practices that emphasized efficiency and not quality. With Weber's (1946) aspects of bureaucracy in mind, the researcher applied a formal category of bureaucratization to this study. As such, the research defined bureaucratization as "any aspect of the social environment and its processes that involve the notation of staff separation and hierarchy, rules, documentation, and efficiency."

For themes on abuse, it was appropriate to use Pillemer's (1988) definition of nursing home maltreatment. He defines maltreatment as any "deviation from expected standards for high-quality care" including actions such as "physical violence, verbal aggression, and neglect" (Pillemer 1988:228). When applying this definition to the themes interpreted in this research, the researcher defined maltreatment as "any deviation from social, regulatory, or legal standards for interpersonal processes that harm nursing home residents." This included aspects of physical mishandling, emotional neglect, and verbal abuse. Maltreatment relating to physical mishandling involved any act that leads to medical dereliction, personal negligence, environmental negligence, or bodily harm. Emotional neglect involved resident objectification, compassion transgressions, and spiritual negligence. Verbal abuse involved aspects of infantilization, spoken aggression, and ignoring vocal pleas for help.

In this step, the theme of "other interaction elements" transformed into a category of social dynamics not directly related to maltreatment. This involved issues relating to dependency encouragement, privacy violations, property violations, and community contact obstruction. Table 5 provides an overall summation of the final coding scheme devised. The researcher used these in the content analysis stage. In the following pages, this chapter provides definitions for the subdivisions.

Table 5. Analytic Constructs Formulated from the Literary Ethnography

Category	Subdivisions
Bureaucratization	staff separation and hierarchy, rules, documentation, efficiency
Physical Mishandling	medical dereliction, personal negligence, environmental negligence, bodily harm
Emotional Neglect	objectification, compassion transgressions, spiritual negligence
Verbal Abuse	infantilization, spoken aggression, ignoring
Social Dynamics	dependency encouragement, privacy violations, property violations, community contact obstruction

Step 6: Contextual Confirmation

The final step in a literary ethnography is contextual confirmation. Here, the researcher rereads the documents again. This helps the researcher decide if they correctly relate to the final coding scheme. This step involves checking to make sure that the final

idea of the environment under review corresponds with the original narratives (Knottnerus and Van de Poel-Knottnerus 1999).

In this research, the researcher did reread the portions of the sample of documents used. The final categories did fuse with the initially reviewed narratives. The rereading confirmed that the categories and constructs created accurately represented the major themes found through the portions of the documents examined. However, this project remained open to other themes that emerged when reading every page of each document in the content analysis stage. As mentioned, this first stage was only an exploratory tool intended to probe a body of literature. It allowed the researcher to uncover existing patterns for use in the next stage.

Stage 2: The Content Analysis

The second stage of this research used the categories and subdivisions of the coding scheme devised in stage one. This allowed the researcher to methodically review all pages of the documents. Here, the project moved from an exploratory review of documents to a detailed inquiry. This allowed the researcher to stop focusing on broad ideas and look at narrow concepts. This chapter discusses this precise examination as a content analysis.

In a content analysis, investigators study artifacts of social communication. The focus is often on documents (Babbie 1998). However, scholars define a content analysis in different ways. For example, Holsti's work defines it as a quantitative method for "making inferences by systematically and objectively identifying special characteristics of messages" (1968:608). Here, it concerned the examination of manifest content. The

idea is to reduce the communication to a set of categories. The categories represent what the researcher is interested in studying (Berg 1998).

Scholars now argue that a content analysis does not have to be quantitative. It can be qualitative (Singleton and Straits 1999). As with this study, when it avoids attempts to statistically infer causation. In such an analysis, manifest and latent content are of interest (Berg 1998). In other words, a qualitative content analysis is possible when looking for and interpreting emerging themes (Lincoln and Guba 1985). This is similar to the literary ethnography method used in stage one. However, a literary ethnography does not name categories before the analysis starts. A content analysis does. This content analysis relied on the categories defined in the literary ethnography stage.

While discussing issues related to a content analysis, this section discusses the content analysis used in this research. First, it reviews issues related to problem formation. Second, it discusses sample selection. Third, it reviews the process involved in defining content categories. Fourth, it deals with issues involving the development of a unit of analysis. Fifth, it reviews the use of a system of enumeration. It ends with a discussion of integrating the theory of structural ritualization.

Problem Formation

As with most research, a content analysis starts with a research problem. The problem may involve the possibility of studying messages in communication. Researchers use content analyses for a variety of purposes. They use them to study themes in popular songs, religious symbols in hymns, trends in newspaper topics, and even the tone of newspaper editorials (Neuman 1991).

Other applications of this method exist. For example, Sales (1973) studied comic strips. His concern was the presence of protagonists. Through his coding process, he found that comics in the 1920s and the 1930s differed. In the former period, a peaceful time, comic strips downplayed authoritative characters. However, in the ambiguous social environment of the 1930s, they emphasized powerful characters. This included figures such as Dick Tracy and Superman. Seider's work (1974) is a content analysis of public speeches of U.S. corporate executives. He notes that the executives consistently focused on five themes. They varied based on the industry of origin.

Griswold (1981) analyzed a random sample of novels. The novels were from the late nineteenth and early twentieth centuries. She was concerned with how American novels reflected characteristics of the American experience. The work focuses on factors such as gender, age, and social class. There are studies on gender differences in graffiti (Bruner and Kelso 1980). Content analyses of racism in television commercials, wartime propaganda, and suicide notes exist as well (Neuman 1991; Singleton and Straits 1999).

A content analysis is generally useful for three types of research problems. First, it is helpful when the researcher needs to deal with a large volume of text. Second, it is helpful when a researcher needs to study a topic at a great distance. Third, a content analysis can unearth messages in documents that are hard to see with casual observation (Neuman 1991).

In this case, the researcher focused on RSPs in for-profit and nonprofit nursing homes while considering bureaucratization and maltreatment. There is a lot of literature on nursing homes that mention these issues. However, none of it focuses on all of them.

As such, a content analysis is appropriate. All three of the criteria for using a content analysis apply when considering the research problem at hand.

As discussed, the scope of sources in this project is broad. In order to decipher the content of the documents that give thick descriptions of nursing home life, a content analysis appeared necessary. In addition, the topic of resident maltreatment in nursing homes is a precarious subject. To study it from a distance, the examination of secondary documents was ideal. The use of an unobtrusive method such as a content analysis was beneficial. Finally, characteristics of bureaucratization and resident abuse might be hard to fully comprehend with a series of observations. A participant observer might witness a form of abuse and not even realize it or realize it relates to bureaucracy. In addition, the observer might even participate in interaction that unintentionally harms residents. To avoid these dilemmas, it seemed more appropriate to compile records of multiple observations and to develop a composite picture of bureaucratic processes and maltreatment.

Defining the Sample

In the study of communications, as in the study of people, you cannot observe everything. If you wanted to do a content analysis of television violence, it would be impossible to watch everything broadcast. In such a situation, if you were performing a content analysis, you would sample (Babbie 1998). Sampling for a content analysis is similar to sampling in survey research. The primary step involves compiling a sampling frame from which you draw the sample. This can produce bias. You might want to perform a document study of fatalism. You might want to focus on differences among

social classes. Bias might exist if an overabundance of materials representing the upper class is all you have (Bailey 1978). In addition, sampling in a content analysis has similarities with direct observation. In systematic observation the researcher must decide what to code and analyze. When reading documents, a content analysis also involves deciding what to code and analyze (Judd, Smith, and Kidder 1991).

With a content analysis, the investigator can employ a variety of sampling techniques. This includes probability and non-probability sampling (Berg 1998; Babbie 1998). In terms of probability sampling, the researcher might use random or systematic sampling. Random sampling involves applying numbers to documents under review. This involves compiling the sampling frame. You then select documents from the sample list at random. The documents selected are the ones the researcher would give focus. In systematic sampling, you take your sampling frame and develop a sampling interval. In such a case, the researcher would have a standard distance between elements in the frame. For example, the researcher would select every third document (Babbie 1998).

In relation to non-probability sampling in a content analysis, a researcher could use purposive sampling. This is when researchers use their special knowledge about some topic or social setting in selecting the materials. This occurs to ensure that the specific topic a person wants to study is present for the analysis (Berg 1998).

In a survey of delinquent youth, this might involve purposively targeting certain ethnic groups that would not show up with probability sampling. In relation to a content analysis, there may be a limited number of elements, such as documents, to study. In such a case, the researcher would have to use everything he or she is able to find (Berg

1998). As implied in the description of the first stage of this research, the researcher used purposive sampling here.

The researcher was aware of several documents focusing on nursing homes. In order to find additional sources, it was necessary to consult academicians familiar with nursing home literature. Upon their suggestions, additional sources emerged. The researcher found more sources through an examination of references of each existing source. In addition, library and Internet searches led to more. Overall, over 40 appropriate sources emerged. This did not seem like enough to make a sampling frame from, so the researcher decided to purposefully use all of the sources - see Appendix.

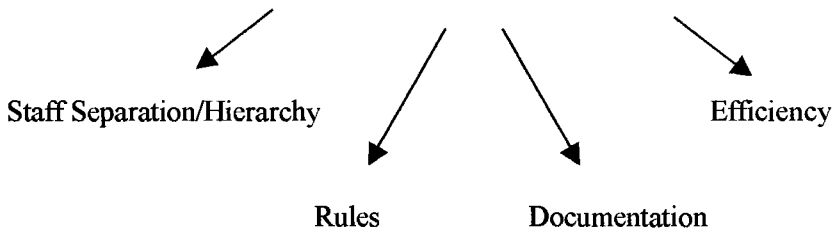
Developing Content Categories

Defining content categories is similar to writing close-ended questions for a survey. However, you do not give questions to respondents. You apply them to documents. You then code them and place them in a category. The investigator should code the document in a clear way. Categories should be exclusive. The overall value of a content analysis depends on two issues. First, the formulation of specific content categories is essential. Second, definitions for placing units into categories are important (Singleton and Straits 1999).

This research used the final categories and subdivisions found in the literary ethnography to decipher the themes in the documents. The first category concerned bureaucratization – see Figure 4. Using Weber's (1946) work as a foundation this research defined bureaucratization as "any aspect of the social environment and its processes that involve the notation of staff separation and hierarchy, rules,

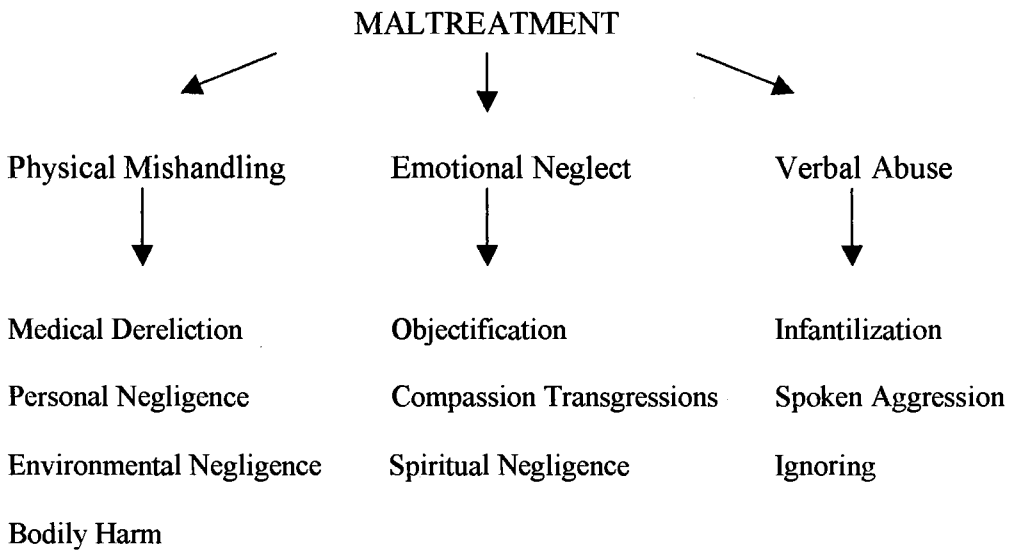
documentation, and efficiency." Staff separation and hierarchy involved dividing lines between any level of staff. In addition, it involved any reference by authors to staff and residents in terms of order of importance. Rules involved any reference to official regulation about the way to do something. This included internal rules of a specific facility. It also included references to government regulations guiding action in nursing homes. Documentation concerned references to recording any aspect of nursing home life in written form. Efficiency involved any demands to behave quickly and effectively.

Figure 4. Illustration of Bureaucracy Category and Its Subdivisions



As mentioned, this work used Pillemer's (1988) definition of nursing home abuse to define maltreatment as "any deviation from social, regulatory, or legal standards for interpersonal processes that harm nursing home residents." This research examined maltreatment in nursing homes with categories relating to physical mishandling, emotional neglect, and verbal abuse. It also examined themes relating to these categories with a specific look at their subdivisions – see Figure 5.

Figure 5. Illustration of Maltreatment Categories and Their Subdivisions



In this research, physical mishandling involved any act that leads to medical dereliction, personal negligence, environmental negligence, or bodily harm. Medical dereliction included the failure to deliver medicine and services that have the capacity to help or heal resident ailments. This included situations in which staff used pharmaceutical drugs, such as Thorazine, for no other reason than to control a patient's behavior. Personal negligence concerned any author references to staff failing to provide sufficient upkeep of tangible features of residents. This included clothing and personal hygiene issues. Environmental negligence included staff members failing to adequately maintain domains of interaction such as living areas, recreational rooms, kitchens, and grounds outside of the facility. This included aspects of cleanliness. The subdivision of bodily harm included physical abuse by staff members directed toward residents. This also included the overuse of physical restraints to control residents.

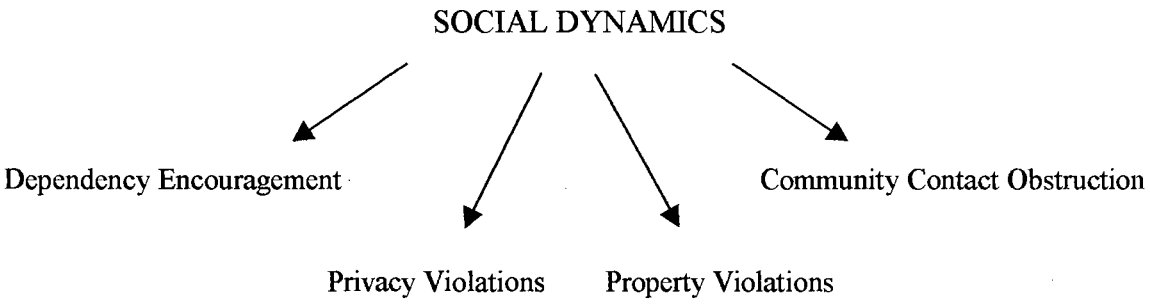
The category of emotional neglect involved resident objectification, compassion transgressions, and spiritual negligence. Objectification involved references to staff members treating residents as impersonal, material items. For example, this included situations where staff members did not refer to a resident by name. It also involved staff members using categories relating to the resident's physical condition when talking about him or her. Compassion transgressions concerned staff failing to exhibit awareness and desires to relieve resident suffering. This included things like staff members not helping residents with personal items when acknowledging their requests, not providing food when residents were hungry, and discussing residents' physical conditions without pity. Spiritual Negligence involved failing to acknowledge and maintain a resident's moral feelings and sacred beliefs.

Verbal abuse involved aspects of infantilization, spoken aggression, and ignoring residents. Infantilization involved condescending staff vocalizations that reduce the status of a resident to that of a young child. Spoken aggression involved author references to the hostile launching of vocal attacks by staff directed against a resident. Ignoring concerned situations described where staff refused to take notice of verbal communication initiated by residents. This included ignoring requests for personal and medical assistance. This is distinct from personal negligence and medical dereliction. With those subdivisions from different categories, staff members acknowledged personal and medical issues but would fail to do anything about them. Here, residents made personal or medical requests and staff did not acknowledge the actual request.

The category of social dynamics involved themes not directly related to maltreatment. However, these themes lead to some negative impact on residents. This

involved dependency encouragement, privacy violations, property violations, and community contact obstruction – see Figure 6. Encouraging dependency involved the lack of staff encouragement for resident self-sufficiency. Privacy violations involved situations where staff members did not acknowledge normally accepted boundaries of personal space. Property violations involved author references to staff members taking a resident's possessions without right or permission. This involved theft and situations where staff moved or removed a resident's possessions without asking. Community contact obstruction concerned staff discouraging or failing to promote resident relationships with actors living outside of the institution.

Figure 6. Illustration of Social Dynamics Category and Its Subdivisions



Defining the Unit of Analysis

In a content analysis, researchers refer to the units of analysis as recording units. The recording unit is the element of the document described by content categories. This could be a single word, symbol, sentence, paragraph, or other grammatical unit. It could also be the entire document. As mentioned, Sales (1973) used character descriptions. Griswold (1981) used character, plot, and entire novels.

Though researchers can code smaller units more reliably then larger ones, smaller units may not be sufficient to extract latent meanings. Numerous small units coded from a large collection of documents may be too much for a researcher to manage (Berg 1998; Singleton and Straits 1999). It is not always possible to put a recording unit in a specific category without considering its context. As such, content analysts consider context units (Holsti 1969). Consider the work of Namenwirth (1969). It describes the editorial orientation of British elite and mass newspapers. He showed that decades ago British elite newspapers, as opposed to mass newspapers, had an overwhelming concern with European affairs and not the Cold War. He indicated that the presence of terms such as Soviet and American indicate concern with the Cold War. When considering context, there is a problem with this technique. The mere presence of such words did not mean that an article took a pro or anti-American position. To take this stance, he had to think about the larger context unit (Singleton and Straits 1999). In this work, the recording units were paragraphs and larger grammatical units. Larger units included portions of book chapters. The research focused on these recording units in relation to themes. In other words, the research involved a focus on themes related to the previously described categories. Larger recording units were necessary due to the focus on descriptions and meanings and not just the appearance of words or phrases.

The context unit involved a focus on different types of nursing homes. As mentioned in previous chapters, an important issue to consider when thinking about maltreatment is organizational variation. Researchers argue that ownership influences the form of supervision provided in long-term care facilities. There are studies that indicate for-profit nursing homes have levels of care that are equal, if not superior to

nonprofit facilities (Holmberg and Anderson 1968; Gottesman 1974; Winn 1974). Some believe that nonprofit facilities offer the best services (Fottler, Smith and James 1981; Elwell 1984; Lee 1984). Following in this research tradition, this project looked at the differences between for-profit and nonprofit nursing homes. It separated the documents under review into two groups. The first involved documents in the study that focused on for-profit nursing homes – see Table 6. Of the 40 sources in the sample, 20 described for-profit facilities. The sources included books, book chapters, chapter sections, and articles that concentrate on nursing home life

Table 6. Sources Focusing on For-profit Nursing Homes

Document	Author
"Rosemont"	J. Henry
"The Tower Nursing Home"	J. Henry
"Old Folks and Dirty Work"	C. Stannard
The Last Frontier	A. Fontana
"Ripping off the Elderly"	A. Fontana
Limbo	C. Laird
Old, Alone, and Neglected	J. Kayser-Jones
"Nursing Home Housekeepers"	J.N. Henderson
Work and the Helpless Self	J. Howsden
"The Reluctant Consumer"	M. Vesperi
It's OK Mom	J. Retsinas
Borders of Time	Crandall and Crandall
Making Gray Gold	T. Diamond
Speaking of Life	J. Gubrium
"The Culture of Care in a Nursing Home"	J.N. Henderson
"Life at Lake Home: An Ethnographic..."	C. Wellin
A Nursing Home and Its Organizational Climate	B. Farmer
Television in the Nursing Home: A Case Study	W. Hajjar
Maudie: A Positive Nursing Home Experience	R. Metz
"The Micropolitics of Identity in Adverse Circumstance"	D. Paterniti

The second group involved documents focused on nonprofit nursing homes – see Table 7. Of the 40 sources in the sample, 20 described interaction in nonprofit facilities. Again, the sources here included books, book chapters, chapter sections, and articles.

Table 7. Sources Focusing on Nonprofit Nursing Homes

Document	Author
"Muni San"	J. Henry
Living and Dying at Murray Manor	J.F. Gubrium
"The Internal Order of a Home for the Jewish Elderly"	Watson and Maxwell
Nursing Home Life	C. Bennett
"Goffman Revisited: Relatives v. Administrators..."	M. Richard
Harvest Moon	S. Tisdale
Uneasy Endings	R. Shield
"Social Networks, Social Support, and Elderly Institutions"	B. Powers
"Self Perceived Health of Elderly Institutionalized People"	B. Powers
Anatomy of a Nursing Home	M. O'Brien
The Ends of Time	J. Savishinsky
The Erosion of Autonomy in Long-term Care	Lidz, Fischer, and Arnold
The Caregiving Dilemma	N. Foner
"In and Out of Bounds"	J. Savishinsky
"Ethics in the Nursing Home"	R. Shield
"The Head Nurse as a Key Informant"	McLean and Perkinson
"Relatives as Trouble"	N. Foner
"From the Inside Out"	B. Powers
"The Hidden Injuries of Bureaucracy"	N. Foner
"Emotional Labor as Cultural Performance"	J. Sass

Using a System of Enumeration

Even a qualitative content analysis can use frequencies. A researcher can use them to describe findings. In such a case, it is necessary to define a system of enumeration. This involves at least a simple quantification of the information. Careful measurement is important. After all, the researcher is turning general communication into precise elements of inquiry (Neuman 1991). Systems of enumeration involve time-space measures, appearance, frequency, and intensity (Singleton and Straits 1999).

Time-space measures involve attention given to a topic. Early content analysts of newspapers measured the inches of the columns covering topics. Studies of television content measure issues such as the number of seconds, minutes, or hours shows give to

topics. Appearance, also known as direction, involves confirming the presence of a category in a recording unit. It focuses on the position that it appears to take (Singleton and Straits 1999). For example, Sales (1973) classified characters in comic strips as powerful or not. Griswold (1981) measured issues such as whether main characters were male or female.

Frequency is the most common system of enumeration. It involves keeping track of the times a category occurs (Singleton and Straits 1999). For example, in an analysis of Democratic and Republican Party platforms, Weber (1990) calculated the proportion of words in a category of wealth. This involved counting the presence of words such as capital, inflation, and unemployment. Intensity focuses on the values and attitudes present in an analysis of documents. For example, instead of focusing on the number of times money appears in a document, a researcher would focus on the author's passion in discussing the issue of money (Singleton and Straits 1999).

This research used frequency and intensity as systems of enumeration. It counted the number of times themes related to categories of bureaucracy, physical mishandling, emotional neglect, verbal abuse, and social dynamics appeared. It examined subdivisions in those categories in a numerical manner. The research did not use these numbers for statistical inference. It only used them for descriptive purposes. As mentioned, this content analysis was open to emerging themes. Each category has an open subdivision of "other" for themes not initially discovered.

This research focused on intensity using sample text from documents. The use of frequencies implies that all elements categorized carry equal weight. However, this is not always the case in a content analysis. It is possible that the content of a theme in one

situation may emphasize an issue to a higher degree when compared to another. In these situations, this research used excerpts to highlight the power behind comments in certain recording units.

The Link to the Theory of Structural Ritualization

The current project focused on the theory of structural ritualization. The theory is concerned with the taken-for-granted practices of actors in specific environments. It looks at ritualized symbolic practices (RSPs). These are schema-driven actions involving repetitive behavior with symbolic significance (Knottnerus 1997).

This work focused on RSPs fitting into content categories. This included repetitive acts with symbolic significance relating to bureaucratization and maltreatment. As discussed in Chapter 2, four factors play a role in the theory. They concern the influence of RSPs in reproducing social structure. The four factors are repetitiveness, salience, homologousness, and resources (Knottnerus 1997).

Repetitiveness entails the "relative frequency with which a RSP is performed" (Knottnerus 1997:262). This project measured repetitiveness by counting the actual times specified RSPs occurred in the documents. Salience involves the "degree to which a RSP is perceived to be central to an act, action sequence, or bundle of interrelated acts" (Knottnerus 1997:262). This involves the prominence of a RSP. This aspect of the theory tied into the examination of intensity when looking at themes.

Homologousness implies a "degree of perceived similarity among different RSPs" (Knottnerus 1997:263). Resources are "materials needed to engage in RSPs which are available to actors" (Knottnerus 1997:264). This project focused on both homologousness and resources by interpreting and citing sample text. Again, this

research measured RSPs based on a division between documents that focused on for-profit and nonprofit nursing homes.

The greater degree of repetitiveness of RSPs, salience of RSPs, presence of homologous RSPs, and availability of resources to take part in RSPs, the greater the rank or relative standing of RSPs. The greater the rank, the more likely similar RSPs will emerge with actors in embedded groups and domains of interaction (Knottnerus 1997). Again, this work is looking for RSPs with high rank in nursing homes that facilitate bureaucratization and maltreatment. High rank RSPs are synonymous to concepts discussed by theorists in organizational theory as institutional logics. Overall, this project argues that high ranked RSPs relating to bureaucratization and maltreatment permeate domains of interaction in nursing homes leading to substandard levels of resident care. Again, the research questions that drove this study were:

- What roles do rituals play in nursing homes?
- Are the RSPs in for-profit and nonprofit nursing homes different?
- To what extent does bureaucracy dominate social interaction in nursing homes?
- Are bureaucratic RSPs in for-profit and nonprofit nursing homes different?
- To what extent does maltreatment exist in nursing homes?
- Are RSPs of maltreatment in for-profit and nonprofit nursing homes different?
- Do RSPs relating to bureaucracy lead to maltreatment in all types of nursing homes?

Summary

People have been using literary records in research for years (Berman 1994). With the examination of them, a literary ethnography is advantageous. It gives order to

the study of documents. It provides systematic steps for studying documents. It also allows you to develop a familiarity with a topic before entering a more intense stage of research. This is especially true when documents can give you insight into the issue under review. Even when using it as an exploratory tool, its steps increase the trustworthiness of research (Van de Poel-Knottnerus and Knottnerus 1994; Knottnerus and Van de Poel-Knottnerus 1999; Van de Poel-Knottnerus and Knottnerus 2002).

In terms of a content analysis, advantages also exist. A content analysis is an unobtrusive method. The researcher does not need to interview anyone. No one fills out lengthy questionnaires. No one has to enter the high-pressure environment of a laboratory. Performing a content analysis is cost effective as well (Berg 1998). Despite this, when using the methods present in this study, the researcher had to consider validity and reliability.

A content analysis generally has high validity. This is the case because it reviews documents that provide first-hand accounts. This type of validity is face validity. However, face validity is low if authors wrote documents with a biased opinion. In other words, biased authors do not provide objective descriptions of social environments. In relation to an issue such as criterion validity, the use of many sources can alleviate this problem. This is especially true when a majority of the documents show similar themes (Bailey 1978).

A lag between when the author wrote the document and when he or she observed might decrease the face validity. The survival rate of a document is also important to consider. It is possible that older documents that outlive others provide a hyperbolic version of the case under review. This might relate to their popularity. In addition,

historical circumstances influencing the content of documents from different times might produce an inconsistent picture (Bailey 1978; Berg 1998). As in the case of this study, the documents used come from a wide time range – see Appendix. They start in the 1960s and continue until recent years. With this in mind, it might be fruitful to extend this analysis at another point to consider variations of bureaucratization and maltreatment in different periods.

A content analysis is concerned with two types of reliability. They are instrument and analyst reliability. The former involves comparing documents at one or more points in time. It is often low because of selective survival of documents. The latter involves checking the work of two researchers from the same period. It can be high when several documents from the same time are available. Regardless, the main reliability issue in a content analysis concerns defining categories (Bailey 1978).

As mentioned, some definitions of a content analysis claim objectivity. This implies a lack of subjectivity in performing a content analysis. However, a researcher must construct categories and decide on issues such as recording units, context units, and systems of enumeration. All of these decisions call for subjective decisions by the researcher (Bailey 1978). The absence of standard categories is often the case in content analysis procedures. It is possible that a demand for original research helps to promote this trend (Holsti 1969). Regardless, this does not mean researchers should not use content analysis methods. The researcher should compare advantages and disadvantages of performing a content analysis to other methods. As with this project, when it is appropriate to study a sensitive topic such as maltreatment through available documents, a content analysis is suitable (Berg 1998).

CHAPTER 5

DESCRIPTION AND DISCUSSION OF THE FINDINGS

Introduction

This analysis focused on rituals in nursing homes using the theory of structural ritualization. The theory defines rituals in terms of ritualized symbolic practices (RSPs). These are schema-driven standardized actions. They involve repetitive behavior with symbolic significance (Knottnerus 1997). The term schema refers to a cognitive framework. The theory focuses on the rank of RSPs considering factors of repetitiveness, salience, homologousness, and resources. Repetitiveness is the "relative frequency with which a RSP is performed" (Knottnerus 1997:262). Salience is the "degree to which a RSP is perceived to be central to an act, action sequence, or bundle of interrelated acts" (Knottnerus 1997:262). Homologousness implies a "degree of perceived similarity among different RSPs" (Knottnerus 1997:263). Resources are "materials needed to engage in RSPs which are available to actors" (Knottnerus 1997:264). The greater degree of repetitiveness, salience, homologous, and availability of resources, the greater the rank of RSPs. The greater rank, the more likely actors engage in and reproduce RSPs (Knottnerus 1997). This work looked at RSPs in nursing homes. The study considered the influence of them on bureaucracy and maltreatment. It focused on RSPs in categories

of bureaucratization, physical mishandling, emotional neglect, verbal abuse, and other social dynamics.

Bureaucratization

This section focuses on bureaucracy and RSPs in nursing homes. Following Weber's (1946) work, this study defined bureaucracy as "any aspect of the social environment and its processes that involve the notation of staff separation and hierarchy, rules, documentation, and efficiency." This section discusses four subdivisions based on this definition. It also explores themes in an "other" subdivision. Table 8 shows 2,076 references to bureaucracy existed.

Table 8. Frequencies for Bureaucracy Category

Subdivision	Number	Percentage
Staff Separation and Hierarchy	716	34.5
Rules	522	25.1
Documentation	490	23.6
Efficiency	241	11.6
Other	107	5.2
Total	2076	100.0

The sources referenced staff separation and hierarchy 716 times making 34.5 percent of bureaucracy references. They referenced rules 522 times making 25.1 percent and documentation 490 times making 23.6 percent. They referenced efficiency 241

times. This made 11.6 percent. Finally, the "other" subdivision had 107 references making only 5.2 percent of the references to bureaucracy.

Staff Separation and Hierarchy

Staff separation and hierarchy involved dividing lines between any level of staff. It also involved any reference by authors to staff and residents in terms of order of importance. Table 9 shows 716 references to staff separation and hierarchy appeared. Of those, 297 references to staff separation and hierarchy appeared in for-profit sources. This comprised 41.5 percent of the references to this subdivision. In terms of nonprofit sources, 419 references appeared. This made 58.5 percent of the references.

Table 9. Frequency of References to Staff Separation and Hierarchy

Context Unit	Number	Percentage
For-profit	297	41.5
Nonprofit	419	58.5
Overall	716	100.0

This subdivision was salient in for-profit and nonprofit sources. Discussions involved work duties. In one for-profit facility, residents looked forward to coffee. The activity director served it. Residents confined to their rooms wanted aides to bring it to them. The aides would not. They felt it was the activity director's responsibility (Kayser-Jones 1981). In another for-profit home, strict lines existed with work domains. Administrators had luxurious air-conditioned offices. Diamond explains he would see administrators get off the elevator coming to the floor and make a "sudden leap from 70

degrees to over 90" (1992:49). On the division between nursing staff he explains, "There were numerous distinctions among the ranks of the nursing staff: different training and income, different racial, ethnic, and age groups" (Diamond 1992:156). Similar points existed in nonprofit sources. In one source Shield describes, "Several implicit hierarchies - medical, administrative, nursing, and social service – operate within the bureaucracy..." (1988:93).

Rules

The subdivision of rules involved any reference to official regulation about the way to do something. This included internal rules of a facility. It also included references to government regulations. As shown in Table 10, 522 references to rules appeared in the sources. Foner indicates it appears nursing homes are under a "tyranny" of rules and regulations (1995a:231). This was true for for-profit and nonprofit sources. However, Table 10 shows more references in nonprofit sources. In for-profit facilities, 202 references appeared making up 38.7 percent. For nonprofit facilities, 320 references to rules appeared. This made up 61.3 percent. In reference to RSPs and rank, rules were a prominent force in nursing homes. However, in this study they had a larger role shaping ritual action in nonprofit facilities.

Table 10. Frequency of References to Rules

Context Unit	Number	Percentage
For-profit	202	38.7
Nonprofit	320	61.3
Overall	522	100.0

In relation to salience and rules in for-profit facilities, Fontana points out "rules above compassion" dominate in nursing homes (1978:130). In this study, formal rules regulated what many would consider routine. There were rules for everything from feeding to personal care. Laws even required staff to help residents bathe. One resident told Howsden (1981), "I feel so strangled here. So many rules and regulations that don't make any sense" (1981:144). In the sources, the salience rules existed in nonprofit descriptions as well. Michael Fisher, an 82-year-old resident in a nonprofit facility, did not like all of the "rules and regulations" (O'Brien 1989:83). Foner (1994:68) explains:

> ... resentments ran especially high because, in an effort to upgrade the facility, the new administrator was tightening enforcement of existing rules and adding new ones. A seemingly endless onslaught of new rules affected even the smallest details of work life. One day aides could wear jewelry to work; the next, after a memo went out, only watches, engagement and wedding rings, and small earrings were allowed.

In this study, facilities emphasized informal rules. In one for-profit home, an aide commented on a staff member violating an informal rule. The staff member scalded a senile resident with hot bath water. Implying the scalding was intentional, the aide said the person should have known that "crazy patients are not punished for cursing aides" (Stannard 1973:338). In this study, for-profit sources had more references to rules, but repetitiveness and salience appeared high in both for-profit and nonprofit sources. This indicated the high rank of rules. This chapter addresses points related to homologousness and resources in a later section.

Documentation

Documentation concerned references to recording any aspect of nursing home life in written form. This included activities of paperwork fulfilling legal requirements based

on government regulation. In the sources, 490 references to this subdivision appeared. As shown in Table 11, the references in for-profit and nonprofit sources had similar repetition patterns. In for-profit sources, 243 references appeared making up 49.6 percent. In nonprofit sources, 247 appeared. This comprised 50.4 percent of the references.

Table 11. Frequency of References to Documentation

Context Unit	Number	Percentage
For-profit	243	49.6
Nonprofit	247	50.4
Overall	490	100.0

Documentation was salient in for-profit and nonprofit sources. One for-profit administrator commented "there is so much of it there is little time left to do anything else" (Farmer 1996:20). Someone explained later that "An abundance of tedious paperwork and documentation is the norm and not the exception" (Farmer 1996:97). Documents consumed nursing staff. They shaped the way nurses thought, spoke, and provided care. Diamond (1992:160) explains:

> Staff continually cursed at being overwhelmed with paperwork. Denny once waved his hand at the whole row of binders containing these records. "Oh, they're just a formality," he said. They were a formality with force – made of forms, and forming the contours of the job, both in doing the prescribed work and in certifying that it had been done. Sometimes they formed the way we spoke. A nursing assistant once approached a charge nurse who had been at the home for two months and was crying out loudly in her room. "Is there anything I can do for her?" asked the nursing assistant. "Oh," said the nurse, immersed in the medications checklist, "don't worry about it, it's nothing

physical, just emotional."

As Howsden explains, "written documentation provides a medical rationale" for dealing with patients (1981:89). The RSP of writing things down shaped the way staff members viewed the people. Diamond explains that a nurse made it clear that documentation was a primary objective. The nurse pointed to a sign over his head reading "If It's Not Charted, It Didn't Happen" (1992:131).

Documentation shaped actions in nonprofit church facilities. One account from Gubrium (1975:144) explains:

> Top staff expects floor staff to chart clientele systematically... Charting is fairly well routinized on the floors... Whenever a patient or resident has an accident such as falling or fainting, an incident report is written. One of the floor nurses may be asked to complete the report if she is considered to be well acquainted with the person involved and the circumstances under which the accident occurred. The report contains a variety of questions. In addition to name and room number, the person filling out the report is asked for the location of the incident, an account of any property involved, the names of witnesses, a description of the incident, and the patient's or resident's 'condition before it occurred.

Efficiency

Efficiency involved any demands to behave quickly and effectively. As shown in Table 12, 241 references to RSPs of efficiency appeared. The sources repeated themes of efficiency less than any other subdivision of bureaucracy. Regardless, 116 references to efficiency appeared in the for-profit sources. This made up 48.1 percent of references. In nonprofit sources, 125 references appeared. This made 51.9 percent. With these numbers, it seemed that the emphasis on efficiency was similar in for-profit and nonprofit sources.

Table 12. Frequency of References to Efficiency

Context Unit	Number	Percentage
For-profit	116	48.1
Nonprofit	125	51.9
Overall	241	100.0

In terms of salience, for-profit and nonprofit facilities emphasized efficiency. Large amounts of staff stress existed due to the "pressure of time" (Diamond 1992:79). In terms of a for-profit facility, Fontana (1978:130) explains:

> There was usually a minimal number of aides on the ward, and in order to meet administrative demands the aides would accomplish their daily assignments as quickly as possible... The patient was scrubbed, washed, turned over, rinsed – and the aides were ready for the next patient. Feeding the patients followed the same course. In the rushed meal hour, food was shoved down open mouths or splattered on closed mouths as the aides carried on without missing a beat. The aides broke the rules concerning good care, but it mattered little to them since the goal of efficiency was seemingly more important.

In the sources, similar accounts existed for nonprofit facilities. A good worker was not a worker that cared for residents, but one that executed tasks quickly. Foner (1994:60) explains:

> Ms. James was typically the first nursing aide in the day room at lunchtime getting residents ready to eat. She was a fast worker. She finished her "bed and body" work early and was punctilious about getting her paper work done neatly and on time... Ms. James' attitude toward dressing, bathing, and feeding patients was much the same as her attitude toward her other chores. She was determined to get them all done quickly, whether patients liked it or not. Residents in her view had no choice but to take prescribed medicines, eat so they would not lose weight or be forced to go on tube feeding, or "do a BM" so they would not get impacted. She

> had no tolerance for patients' resistance, which slowed her down... In fact, Ms. James was proud that she could get patients to eat and "do a BM" so they would not get impacted. I overheard her explain, indeed justify, her approach to one of the therapists: "Schmidt eats for me, but if anyone hears me they're gonna get me for patient abuse..."

In describing Ms. James, Foner (1994:60) states that she explained:

> I say "You eat" and I'm a big woman and I have a loud voice... Now Bernice Grossman, one day I was feeding her, saying eat, if you don't eat, I'm gonna...

Other

As mentioned, this analysis was open to emerging themes. Each category had an open subdivision. This was for themes not discovered in the early phases. In the category of bureaucracy, a common theme emerged on meetings. This involved staff members and/or family assembling. Table 13 shows the number of references. The sources referenced meetings 107 times. In for-profit sources, 38 appeared making up 35.5 percent of references. In nonprofit sources, 69 appeared. This made up 64.5 percent.

Table 13. Frequency of References to Meetings

Context Unit	Number	Percentage
For-profit	38	35.5
Nonprofit	69	64.5
Overall	107	100.0

In terms of validity, the researcher should note that this subdivision, as with the "other" subdivisions in later categories, emerged after the reading of sources. After the theme emerged, the researcher did not go back and reread every source for meeting references.

Meetings were salient in the nonprofit sources though examples for meetings existed in for-profit sources as well. One type that showed up on a consistent basis was a staff meeting. These involved drafting a resident care plan. Savishinsky (1991:42) explains:

> Upon admission to the home, a new resident was discussed at Thursday Review. This was a regular staff meeting at which "care plans" were developed and periodically reviewed for each person living in the institution. The plan specified, for example, which treatment modalities a resident would be getting, such as PT (physical therapy), OT (occupational therapy), or ST (speech therapy); it indicated what foods and medications were to be administered; and it identified treatment goals which, if achieved, would allow a person to leave the facility for either a lower level of care or her own home. The latter details constituted a "discharge plan."

In the sources, another type of meeting involved in-services. These were meetings that administration required staff, such as aides, to attend for continuing education. Foner (1994:72-73) explains disruption they create:

> During my research, aides had to attend an average of three or four in-service sessions a month, each lasting about half an hour. Five of the "in-services" given annually - on fire safety, needs of the elderly, patients' rights, body mechanics and infection control are mandated by New York State. Others, on such topics as rehabilitation nursing, behavioral problems, and accidents and incidents, were designed by the nursing home to review and bring up to date the nursing aides' job skills and to teach them more about patients' special problems. Aides, administrators felt, needed re-training in even the most elementary tasks as well as instruction when added responsibilities such as filling out a new form, were introduced. Aides did not like in-services. In their

> view, the session taught things they already knew and did every day, interfered with getting their work done, and were boring. In-services run by outside experts were, in fact, generally uninteresting and unrelated to the needs of workers and residents. A sales representative for an infectious waste disposal company, for example, showed slides as he read, in a monotone, from company-prepared material that extolled the virtues of his firm... One aide told me that in-services were the most difficult aspect of her job. "When you have too many meetings in a day, they take you from your direct work and take your time away from the patient and slow you up." In fact, conscientious and caring aides were often the most vocal in their resentment of in-services, for they wanted to spend their time doing a good job for their residents.

Synopsis

The sources repeated many references to bureaucratic RSPs. Most references were to staff separation and hierarchy. Fewer for-profit references in this category existed. However, for-profit and nonprofit sources discussed the importance of staff separation and hierarchy in terms of salience. Specifically, staff members in all sources felt a sense of separation based on factors of duties, training, income, race, ethnicity, and age. This separation had a social psychological effect on individuals working in nursing homes. Specifically, staff members tended to perform a duty only if it was specifically their responsibility (see Bennett 1980). We can consider the example of an aide refusing to get a resident coffee. As Stannard (1973) contends, these separations lead to resident maltreatment. With a high degree of separation between staff members, different levels of the organization developed their own norms. For example, employees at lower levels of the organization accepted abuse. They saw it as appropriate punishment if a resident disrupted their work routine. New aides that socialized with other aides learned to neutralize abuse if residents violated institutional rituals of staff work (for more on this

process see Sutherland 1939; Sykes and Matza 1957). Stannard (1973) explains that top staff members sometimes see the abuse as deviant. However, cohesion for aides created by staff separation led aides to cover up abuse because it was carried out by one of their own. Not only did they normalize the behavior; they covered it up from superiors. This implied that staff separation in for-profit and nonprofit nursing homes facilitated maltreatment.

Many references to rules also existed in the sources. Again, more of the references were from nonprofit sources. However, RSPs concerning rules were salient in for-profit and nonprofit sources. Many of the actions of formal rules involved requirements brought on by government regulation. However, informal rules existed for things like resident care. As mentioned, accounts from the sources suggested that the abuse of certain residents may be legitimate depending on whether the person is senile or not. Like staff separation, these informal rules unintentionally promoted maltreatment.

In terms of documentation and efficiency, fewer references existed. With these two subdivisions, similarity existed between for-profit and nonprofit sources on factors of repetitiveness and salience. In relation to documentation, paperwork even controlled church operated facilities. This created a situation where staff members stopped thinking they worked with people. Documentation of what many would consider routine behavior ritualistically turned residents into objects of work. For example, when residents had bowel movements, aides recorded it in a "defecation book" (Gubrium 1975:138). A personal act turned into a quantitative measurement. Aides counted human excrement like factory workers count the number of parts falling from a conveyer belt. With humans and their behavior turned into objects of documentation, impersonalization and

maltreatment were more likely. Moreover, the emphasis on efficiency did not help. As mentioned, the goal of the organization and its actors was to get duties done as quickly as possible. Both for-profit and nonprofit accounts indicated that it did not matter how a job was done as long as it was done, and was done fast. Consider feeding. Aides fed residents as quickly as possible. It did not matter if the food went in a mouth or on a lap, as long as staff fed residents fast.

In addition to these points, meetings unintentionally led to poor care. In line with the new institutionalism perspective discussed in Chapter 2 (see Meyer and Rowan 1991), nursing homes value meetings. Meetings may not even have relevance to the organization. However, modern organizations think they have to act like organizations. Meetings are a part of this. In this study, this ceremonial legitimation of organizations had negative consequences. Foner (1994:73) explains with an aide's account:

> Say you have a patient who you put on the toilet every day at 2:00. They're confused when you get back from the in-service and say, "Where were you?" They get depressed when time passes on and I don't come. Now with an hour lost, I got to rush through my work. And, when I rush, I don't have the confidence that I do my job and have the time to take care. And when you rushing a patient, you're in a problem.

Repeated references to staff separation and hierarchy, rules, and meetings indicated bureaucratic RSPs drive nonprofit facilities. However, salience existed for bureaucracy in the study in for-profit and nonprofit sources. This indicated repetitiveness and salience provided evidence of bureaucratic RSPs having a high rank in all types of nursing homes. As mentioned, for-profit facilities may promote poor quality of care with profit motives. However, any nursing home unintentionally promotes poor care if a

bureaucratic logic supporting staff separation, rules, documentation, efficiency, and meetings dictates its interaction patterns.

Physical Mishandling

The physical mishandling category involved references to medical dereliction, personal negligence, environmental negligence, and bodily harm. As shown in Table 14, 541 acts of abuse involving physical mishandling appeared in the sources.

Table 14. Frequencies for Physical Mishandling Category

Category	Number	Percentage
Medical Dereliction	119	22.0
Personal Negligence	111	20.5
Environmental Negligence	99	18.3
Bodily Harm	97	17.9
Other	115	21.3
Total	541	100.0

The most references were to medical dereliction. In the sources, 119 references to it appeared making up 22 percent in this category. References to personal negligence appeared 111 times making up 20.5 percent. Environmental negligence appeared 99 times making up 18.3 percent and bodily harm 97 times comprising 17.9 percent. The open subdivision had 115 references making 21.3 percent.

Medical Dereliction

Medical dereliction included the failure to deliver medicine and services that have the capacity to help or heal resident ailments. This included the use of pharmaceutical drugs, such as Thorazine, for no other reason than to control a patient's behavior. In these situations, residents did not need medication. Staff still used it in order to keep annoying patients from disrupting work. Table 15 shows that 119 references to medical dereliction appeared in the sources. In for-profit sources, 78 appeared making up 65.5 percent of the references. In nonprofit sources, 41 references appeared making 34.5 percent.

Table 15. Frequency of References to Medical Dereliction

Context Unit	Number	Percentage
For-profit	78	65.5
Nonprofit	41	34.5
Overall	119	100.0

For-profit sources revealed the salience of medical dereliction. References indicated that doctors working for the organization failed to provide medical care. Kayser-Jones (1981:76) explains:

> The nurse in charge of Unit B said that on some occasions when she had suggested glasses or a hearing aide for a patient, the doctor had rejected this suggestion with, "Oh well, she's old anyhow." Mr. Franklin, a patient, said, "There are too many patients here whom the doctors have rejected or turned away."

In relation to nursing staff, Kayser-Jones (1981:77) notes:

> ... at Pacific Manor the lack of medical care and concern for

> medical needs was frequently a subject for discussion both with patients and the nursing staff. Inattention to patients' needs at Pacific Manor causes anxiety, stress, and fear among patients...

The lack of medical attention in for-profit facilities revolved around monetary issues. Residents, not having money of their own, shared their grievance with staff members. Diamond reports that he would tell residents that "it costs a lot to take care of sick people these days" (1992:151). However, the money in the facility he worked at was not spending the money on the medical needs of residents. He notes that aides would often bring medical supplies from home. One of the better aides complained one day, "Damn... I forgot to bring those Epsom salts. Now Violet is not going to be able to soak her foot" (Diamond 1992:151).

Regardless, staff members sometimes overmedicated. As mentioned, they overmedicated residents that caused disruptions to the workday. Fontana (1978:128) explains that staff label resident behavior deviant even when medications to control them cause the initial problem:

> The center exhibited many forms of deviance, which were perpetrated by individual members of the organization but were really done for and normalized in the name of the organization. The goal of the center, a typical one in this respect, was to provide a smooth-running schedule and flow of work, minimizing disturbances and avoiding trouble. What constituted disturbances and trouble was defined by the staff. Hence many deviant acts perpetrated by patients on other patients or by staff members were handled to minimize their hindrance to the running of the organization. Often these acts were normalized in order to avoid stopping the center's smoothly flowing machine. Therefore if Maria, a wiry old patient, fell heavily to the ground after having been pumped full of Thorazine, the incident was dismissed as the result of an obfuscated mind and deteriorated body.

This practice is not limited to for-profit facilities. Gubrium (1975:148) explains:

> Early in the day shift, it is not unusual for various aides on the floor to pass the nurses' station and ask, "Did Max get his shot today?" or "I hope you remembered to give Emma her Thorazine. I have a lot of work to do, you know." When the nurses forget to sedate such patients, concerned aides repeatedly remind them of it early in their shifts. Nurses usually oblige them if they claim to be busy, "just to get her [an aide] off my back so we can all get our work done." When they do not, aides may threaten to do nothing until their request is granted... As one floor nurse stated to several aides just before leaving for her break, "Well, I guess I can take my break now. Everyone's sedated."

Gubrium (1975:148-49) explains that the power to label residents as deviant lies in the hands of staff members. They often abuse this power:

> Patients and residents do not necessarily enter the Manor with physician's orders for tranquilizers. However, when aides define them as "troublemakers," they get tranquilizers shortly after. Tranquilizers are mostly prescribed "PRN," which means that they may be administered as needed at the discretion of the floor nurses. In practice, however, the discretion involved is that of the aide, who asks for, or reminds a floor nurse of "her need" for, a sedative. From start to finish, the prescription and administration of tranquilizers is controlled indirectly by aides.

In this study, the numbers indicated that medical dereliction was more prevalent in for-profit facilities. However, examples from the sources showed that nonprofit facilities carried out the nonuse and abuse of medications as well. We can conclude staff members from both types of facilities ritually overused medications to control residents labeled as problems.

Personal Negligence

Personal negligence concerned any author references to staff failing to provide sufficient upkeep of tangible features of residents. This included clothing and personal hygiene. Table 16 shows that the sources repeated references to personal negligence 111

times. In for-profit sources, 76 references appeared making up 68.5 percent of references. In nonprofit sources, 35 references appeared making 31.5 percent. As with medical dereliction, the for-profit sources had more counts of personal negligence. In fact, the number for references to personal negligence from for-profit sources double the number from the nonprofit sources.

Table 16. Frequency of References to Personal Negligence

Context Unit	Number	Percentage
For-profit	76	68.5
Nonprofit	35	31.5
Overall	111	100.0

Issues involving personal negligence seemed less salient in the sources compared to medical dereliction. Regardless, similar themes existed. In for-profit sources, accounts showed that busy aides would often fail to properly clean or clothe residents. Laird (1979:99) elaborates:

> Florence had a daffodil-yellow dress which didn't entirely satisfy her. One day she said, "I believe I'll give this to Annie. The color will be becoming to her." No sooner than done, and a few days later Annie wore it. But to our disappointment, the aide had put it on her backwards.

It would be easy to assume that putting on a dress backwards would be a mistake and not intentional personal negligence. However, this is not the case. Kayser-Jones (1981:46) explains:

> ... many residents at Pacific Manor do not have personal clothing, and what is provided for them is ill-fitting, un-pressed, and inappropriate. The available clothing (contributed by charitable organizations or left behind by previous patients) is

> stuffed in large cardboard boxes; no attempt is made to keep it neat or pressed. When someone needs a shirt or dress, attendants pull out whatever they can find; if the appropriate piece of attire is not available, a substitute is made. Mrs. White, an attractive 78-year-old woman who normally sat in a wheelchair clad in a sweater and slip, had to wear a bathrobe tied backwards around her waist to simulate a skirt when the therapist came to help her walk. To lack underclothes or to have clothes put on backwards is also dehumanizing for the elderly. Robes often are put on this way, staff informed me, to decrease the amount of work involved in changing an incontinent patient and to decrease the amount of laundry. If robes are put on backwards and not tucked under, they are not soiled when patients are incontinent.

In reference to personal negligence, Gubrium (1975) explains that staff members make the lack of hygienic care routine. They turn actions other people find repugnant into something normal. In this study, nonprofit sources pointed out personal negligence can even be a punishment if a resident upsets a staff member. Shield states that "... staff retribution can result when residents are too demanding. In subtle and not so subtle ways, staff members neglect or delay doing things" (1988:159). In this study, personal negligence, in similar ways to the bureaucratic RSPs, sped up the process of care. However, it also dehumanized residents and facilitated more maltreatment.

Environmental Negligence

Environmental negligence included staff members failing to adequately maintain domains of interaction such as living areas, recreational rooms, kitchens, and grounds outside of the facility. This included aspects of cleanliness. As Table 17 indicates, 99 references to this subdivision appeared. Many came from for-profit sources. They had 74 making 74.7 percent of the references in this subdivision. There were 25 from the nonprofit sources. This made 25.3 percent.

Table 17. Frequency of References to Environmental Negligence

Context Unit	Number	Percentage
For-profit	74	74.7
Nonprofit	25	25.3
Overall	99	100.0

Environmental negligence was salient in the for-profit, but not nonprofit sources. In the for-profit sources, the theme of environmental negligence was intense. Gubrium (1993:170) explains with an account from a former nursing home surveyor turned resident:

> I think that cleanliness is a problem. I think here roaches are a problem. We are having a roach war here, okay? They are trying to kill the roaches. I myself am not a roach person. I don't like them. I used to write out nursing homes for roaches all over. And this place has probably got as good roaches as I have ever run into... I mean, I was sitting with Harry [another resident] last night talking and one of them walks up the back of my dresser. I do not keep loose food in my room, okay? An experienced surveyor knows this. We have got a really, truly serious, bad roach problem.

No examples pertaining to environmental negligence and pests existed in the nonprofit sources. Though environmental negligence references showed up less and were not as intense for nonprofit sources, examples did exist. They involved situations where staff did not clean messes in resident rooms. Henry (1963:404) explains:

> Mr. Unger sat in his wheelchair by the foot of his bed. He was dressed and wore a black corduroy cap. He was holding a urinal in his lap like a spitoon, and the neck of it was bloody... Next to him sat Mr. Butler, dressed, in a chair... A bedpan with dried feces sat uncovered in front of Mr. Butler's bedside table on the floor.

In for-profit and nonprofit facilities, this type of neglect left residents feeling nonhuman. Henry (1963:405) states that it communicates to residents that "they all have become junk" not worthy of well kept surroundings (Henry 1963:405).

Bodily Harm

The subdivision of bodily harm included physical abuse by staff members directed toward residents. This also included the overuse of physical restraints to control residents. Table 18 shows that 97 references to this subdivision appeared. Again, for-profit references out numbered the nonprofit references. In for-profit sources, 70 appeared making 72.2 percent. Nonprofit sources had 27 for 27.8 percent.

Table 18. Frequency of References to Bodily Harm

Context Unit	Number	Percentage
For-profit	70	72.2
Nonprofit	27	27.8
Overall	97	100.0

Regardless of repetitiveness, the theme of bodily harm was salient in for-profit and nonprofit sources. Stannard (1973) suggests staff in for-profit facilities give scalding hot baths to residents as a form of punishment when they create problems. Other for-profit sources suggested that staff tied residents up with restraints when they disrupted schedules. Paterniti (2000:106) provides one account:

> Out of frustration and a perceived need to keep Scott restrained, aides frequently tied a square knot in the nylon vest restraint that secured Scott in a reclining Gerry chair. Some even remarked,

> "If you're a mechanic, let's see you get yourself out of this one!" On one occasion, an aide locked Scott, tied to a chair, in the janitors' closet. The aide entertained himself by keeping records of how long it took Scott to work his way out of the restraints and to the door of the closet. Ironically, additional work to this staff member's schedule, generated under his own control, seemed to present no obstacle to his work timetable.

Henry (1963) sees restraint use as a form of psychological terrorism. Residents know the discomfort and pain created when tied down. The threat of restraint use is a deterrent for what the staff members see as deviant behavior – any act disrupting the routines of the institution. Diamond (1992) links this to bureaucratic and profit issues. Specifically, he notes goals of cost cutting. Diamond (1992:182) provides this account:

> Mary Ryan, like many others, spent all day in the day room, secured to her chair with a restraining vest. "How'y doin' today, Mary?" I once asked in passing. She answered the question with a question. "Why do I have to sit here with this thing on?" I responded automatically with the trained answer, "That's so you won't fall. You know that." "Oh, get away from me," she reacted with disgust. "I don't trust anybody in white anymore." Stunned by her rejection, and not completely confident of my own answer, I passed the question on to Beulah Feders, the LPN in charge. "Beulah, why does she have to wear that thing all the time?" Beulah accompanied her quick comeback with a chuckle. "That's so they don't have to hire any more of you."

Regardless of profit, nonprofit sources had accounts of this subdivision as well. Tisdale's conversation with a staff member explains one worker's opinion on bodily harm, "Some are kind, some are cruel... They kick me, I kick them" (1987:109). This revealed a dynamic of reciprocity in terms of abuse. However, not all staff members had the same perspective of bodily harm. It is possible for a person that encounters residents in a different domain of interaction to disagree with the use of bodily harm. Shield (1988:76) explains the attitude of one physical therapist working in a nonprofit facility:

> She is telling me about the time one of the residents came to physical therapy and had a bruise that, to the physical therapist, looked suspicious. She was sticking her neck out, she knew, by reporting it, but she decided to act. She phoned the charge nurse on the resident's floor and reported it. She also wrote it up. Though she knew she was inviting employee resentment and anger by her actions, she felt it was important to be a resident's advocate and agent for change in this way. She was letting employees on the floor know she was not going to avoid difficult issues and help cover things up.

The actions of the physical therapist were rare in the literature. As mentioned in this study, low level staff members of nursing homes normalized maltreatment. However, the physical therapist was in a unique position. The physical therapist was not administrative staff, but not floor staff either. Stannard (1973) explains that in nursing homes administrative staff members seldom see abusive behavior on the part of lower level staff. Moreover, they are far removed from resident interaction. They, like the lower staff, develop a culture of accounts to deal with repetitive cases of abuse. As with lower staff, this allows them to normalize maltreatment with specific vocabularies of motive (for more see Mills 1940). In the case of this physical therapist, Stannard's (1973) work indicates she lacked successful socialization to the organization's culture. However, her attitude indicated that people use different RSPs when dealing with residents in specific locations. Shield (1988) explains the physical therapy room, as a domain of interaction, is a unique place within the nursing home. It has a different atmosphere. When residents are there they joke, smile, laugh, and flirt with one another.

Other

This analysis was open to emerging themes. Each category had an open subdivision of "other." In the case of physical mishandling, common themes emerged

concerning limited supplies and inappropriate architecture. Upon reviewing these themes, it appeared they were not applicable as ritualized practices. However, they did hinder good care. As such, this analysis dealt with them in terms of RSPs. Table 19 indicates 115 references fit into the "other" subdivision. For-profit sources had 83 references making 72.2 percent of the references. Nonprofit sources had 32 references making 27.8 percent.

Table 19. Frequency of References to Physical Mishandling "Other" Subdivision

Context Unit	Number	Percentage
For-profit	83	72.2
Nonprofit	32	27.8
Overall	115	100.0

In terms of the validity, the researcher should again note that themes in this "other" subdivision emerged after the reading of several sources. The researcher did not go back and reread every source for "other" references.

References to limited supplies only appeared in for-profit sources. The cost cutting mentality may explain this phenomenon. References to inappropriate architecture did appear, but did not appear salient, in the for-profit or nonprofit sources. However, examples did exist. Bennett (1980:65-6) explains:

> A four-foot passageway at the foot of the beds is unreasonably small. It does not allow patients to go by one another without some risk... a patient ambulating in this passageway tripped over another's foot, fell down, and fractured his hip.

Staff abuse did not always cause bodily harm. Residents did things to hurt themselves. However, the inappropriate architecture did not help. O'Brien (1989:216) explains:

> Many Bethany Manor residents described both falls and the fear of falling. Mrs. Cavanaugh, a five-year resident, reminisced, "I have had 14 falls since I have been here. The first day I was here I went downstairs to breakfast in the main dining room and I used the walker. After breakfast I came back to the elevator, and before I could get on, the door closed on me and knocked me down in the elevator. I didn't break anything but I skinned all my side."

Overall, inappropriate architecture is not a theme we can discuss as a RSP. However, in this study, it did influence the way people moved around in nursing homes. It created a situation where simple tasks like getting out of bed or going to another floor of the building were hard to do. These everyday tasks were even dangerous to the physical condition of residents. This sent a symbolic message to them that their physical needs were not important.

Synopsis

In this study, for-profit sources had more references to physical mishandling. This showed that for-profit institutions had more RSPs that led to resident physical abuse. However, salience of themes in this category existed for most of the subdivisions in for-profit and nonprofit sources.

In terms of medical dereliction, doctors often failed to provide medical care to residents when they needed it. Staff members in the facility also failed to provide adequate care in certain situations. In the for-profit homes, this failure involved issues connected to money. Some facilities simply did not purchase medical products. Aides

often brought what they needed from home. For-profit and nonprofit staff members regularly overused medications. This occurred when staff members wanted to control residents that kept them from efficiently carrying out work. As a symbolic ritual of power, aides tied residents down, even when they did not need it, in order to get them out of the way. Moreover, staff members labeled residents deviant if they got in the way in order to justify restraint use.

In terms of personal negligence, the sources indicated that busy aides failed to clean residents properly. They even intentionally failed to dress them properly because improper dress sped up the fulfillment of work duties. Aides in nonprofit facilities neglected the personal care of residents to punish them if they were too demanding. In terms of environmental negligence, cleanliness was an issue as well. For-profit sources had accounts explaining pest control issues. Nonprofit sources had accounts describing the failure to adequately clean rooms. This sent a symbolic message to residents that they were not worthy of good care.

In terms of bodily harm, references to explicit physical abuse existed in for-profit and nonprofit sources. Staff members justified the physical abuse of residents with an eye for an eye mentality. They claimed residents abused them, so they got revenge. Aides and nurses gave scalding hot baths, unnecessarily restrained, and even locked up residents to get them out of the way or punish them for getting in the way. These punishments were for performing acts that disrupted the flow of the workday. Nonetheless, the for-profit sources indicated that restraint use was also an effective means of cost control. A small staff could easily handle many residents if they tied them down.

Finally, inappropriate architecture was an important issue. Spatial conditions of nursing homes influenced patterns of resident behavior. The influence was often negative. Inappropriate architecture led to bodily harm. With frequencies and salience high in this subdivision, there is little question RSPs of maltreatment from this category ranked high in terms of structural ritualization. RSPs that supported physical abuse shaped the cognitive frameworks of staff members. Staff members accepted and repeated physical mishandling. Later, this work will discuss how residents internalized these RSPs and reproduced them.

Emotional Neglect

The category of emotional neglect involved resident objectification, compassion transgressions, and spiritual negligence. As shown in Table 20, 362 acts involving maltreatment and emotional neglect appeared in the sources.

Table 20. Frequencies for Emotional Neglect Category

Category	Number	Percentage
Objectification	167	46.1
Compassion Transgressions	112	31.0
Spiritual Negligence	42	11.6
Other	41	11.3
Total	362	100.0

Objectification appeared the most. In the sources, 167 references to it made 46.1 percent of this category. References to compassion transgressions appeared 112 times

making 31 percent. Spiritual negligence appeared 42 times. This made 11.6 percent. The open subdivision had 41 references making up the final 11.3 percent.

Objectification

Objectification involved references to staff members treating residents as impersonal, material items. For example, this involved situations where staff members did not refer to a resident by name. It also involved staff members using categories relating to the resident's physical condition when talking about him or her. Table 21 shows 167 references to this subdivision. In the for-profit sources, 120 appeared making 71.9 percent of the objectification references. Nonprofit sources had 47 making 28.1 percent.

Table 21. Frequency of References to Objectification

Context Unit	Number	Percentage
For-profit	120	71.9
Nonprofit	47	28.1
Overall	167	100.0

A large number of references in this subdivision came from for-profit sources. In terms of salience, for-profit and nonprofit sources had several intense examples. Paterniti (2000) explains resident objectification through classification:

> Residents at Merimore Chronic Care Center came to the institution because they could not, of their own volition, meet the physical or psychological requirements necessary for daily living... At Merimore, staff members recognized each resident to have deficiencies in activities of daily living, and according to resident deficiencies, the staff structured their work routine.

> In this routine, the human patient constituted the product of work, and residents, defined by their deficiencies, became a particular type of labor.

Retsinas (1986:80) elaborates with a discussion of identity loss:

> Whatever the route, however, the individual becomes a "resident," and that identity overshadows, even eclipses, any prior identity. In nursing homes people are identified by disability, by nursing needs, by room number, perhaps even by physician. Mrs. Smith becomes "the self care patient on Unit 3," or "the woman with MS," or "one of Dr. Jones' patients." Mr. Morgan becomes the "terminal case in Room 26."

In this work, top staff members also viewed residents as objects. In relation to a for-profit facility Diamond (1992:176) explains:

> On the day the head nurse finished speaking about efficiency she stood waiting for the elevator. I happened to be passing her en route to Alice McGraw, who sang Irish lullabies to the delight of several who worked there. Since I had not been at this home long, the nurse paused to ask, "How are things going for you up here?" "Oh, not bad," I responded with a slight chuckle, nodding toward Alice, anticipating lullaby time. "I kinda like a lot of the people." As the elevator doors opened and she backed in, she nodded in apparent agreement with me. "Yes," she said, as the doors closed between us, "they're a good team. Very professional." The maintenance supervisor's reference to how they should look and the head nurses assumption that by "people" I meant staff served as examples of a certain attitude that dominated the settings. Those living there were the receivers of service, more acted upon than actors, whose ability to act was reduced not only by their own incapacities but by administrative definitions.

This sort of ritualized objectification took place in nonprofit facilities as well. Consider Shield's (1988:97) account of a Jewish nonprofit home:

> Activities are scheduled according to plans administered within the institution. Residents are generally treated alike though a competing philosophy of care insists that residents are unique individuals. Nonperson treatment... is a standard of resident care at Franklin.

Edgley (1970) explains, to situate a person as a social object is to put the person in a category with other objects. These categories are potentially meaningful. They say something about the way other actors in an environment view people. In this study, this type of categorizing took place at both the top and bottom levels of nursing homes. It occurred in for-profit and nonprofit facilities. This indicated that objectification may simply be a consequence of total institutions regardless of ownership.

As mental patients are brought into the asylum and defined by their mental problem, the elderly are brought into nursing homes and defined by the problem that brought them to the facility (for elaboration see Goffman 1961a). Their identity is spoiled. In essence, they are social deviants being isolated. They bear the mark of their status with their appearance, but also by their inability to care for themselves (for elaboration see Goffman 1963). However, once they enter the nursing home they do attempt to fight off objectification. Paterniti (2000) explains that residents have their own rituals they use to fight off staff labels. In this study, residents used narratives to create personal identities. They made efforts to constantly talk to staff. They did not just talk about anything. They told staff members stories about their lives. They gave them information on personal likes and dislikes. They tried to find common interests with staff members to establish alternative interaction frames. It is important to understand that residents did not sit by idle as others labeled them and acted on those labels. They resisted RSPs leading to objectification. However, with both top and lower staff constantly engaging in conversations that framed residents in terms of work tasks, they fought an uphill battle.

Compassion Transgressions

Compassion transgressions concerned staff failing to exhibit awareness and desires to relieve resident suffering. This included things like staff members not helping residents with personal items when acknowledging their requests, not providing food when residents were hungry, and discussing residents' physical conditions without pity. Table 22 indicates the sources referenced to this subdivision 112 times. In for-profit sources, 83 references appeared making up 74.1 percent of this subdivision. In nonprofit sources, 29 appeared comprising 25.9 percent.

Table 22. Frequency of References to Compassion Transgressions

Context Unit	Number	Percentage
For-profit	83	74.1
Nonprofit	29	25.9
Overall	112	100.0

For-profit sources referenced compassion transgressions the most. In terms of salience, no source represented this subdivision in an intense manner. However, descriptive examples existed. Kayser-Jones (1981:49) notes:

> Ninety-nine-year-old Mr. White, a bachelor, is alone in the world. His only visitor is a woman who has been appointed by the court to be his guardian. "pull up a chair and sit down," he immediately suggested as I entered the room... As I started to offer him a glass of water, I found the pitcher empty. I filled it with ice water and gave him some. "Thank you, that was wonderful," he said... "One boy used to come and give me water, but nobody comes any more. They are all so cruel to me. I asked a nurse for a towel to clean my glasses and she handed me a wet one. I said, this towel is wet and she said it's good enough for you... Some of the boys who mop the floor are nice to

> me, but the nurses don't talk to me. They walk by the door, but nobody stops to talk with me..."

This work pointed out earlier that staff members punished aides that disrupted their workday. Some even, in a lack of compassion, remarked to each other wishing problematic residents would die. Vesperi (1983:236) gives an account from a for-profit facility:

> Staff members wish wholeheartedly for the death of incontinent or otherwise troublesome residents. My fear that a woman left sleeping with her face buried in a pillow might suffocate was met with the straightforward reply: "What difference does it make? That much less for us to do."

Shield (1988:112) provides an account of requests for haircuts and false teeth:

> As the daughter leaves, Louise immediately blurts, "It's going to be impossible to bring that lady down to get her hair done; I don't know how we're ever going to do it." Bernice says, "She was lucid? I could barely understand her." A few other staff members share anecdotes about how difficult she is to manage and how she hollers. A social worker says that a long time ago she was a dental assistant and she knows about the process of making impressions for false teeth. It's involved, takes time, causes discomfort, and after the teeth are made and in, they hurt. She is convinced that this woman [the resident requesting the teeth] would never wear her new teeth.

In this subdivision, many references to compassion transgressions existed, yet this subdivision did not seem salient in the sources. However, it did have examples in the sources that showed a lack of compassion and pity for residents. When ritualistically carried out, these compassion transgressions supported emotional neglect.

Spiritual Negligence

Spiritual Negligence involved failing to acknowledge and maintain a resident's moral feelings and sacred beliefs. As O'Brien (1989) explains, it is important to

understand that spirituality may or may not be associated with the participation in and practice of religions. Spirituality also concerns nonmaterial forces. In turn, this subdivision included a failure to acknowledge resident grief after death. Table 23 shows that the sources repeated references to this subdivision 42 times. For-profit sources had 19 references making up 45.2 percent of this subdivision. Nonprofit sources had 23 sources making up 54.8 percent.

Table 23. Frequency of References to Spiritual Negligence

Context Unit	Number	Percentage
For-profit	19	45.2
Nonprofit	23	54.8
Overall	42	100.0

Nonprofit sources, especially the religious ones, indicated spiritual support. O'Brien (1989:47) explains:

> Many of the Manor residents discussed their religious beliefs. Miss Teresa Kearney, 90, spoke about the importance of religion and spirituality in her life now and commented, "My belief [in God] means everything to me. It is so lovely to have the chapel in this building. We don't have to go outside in any weather. We have Mass in the chapel. During Lent now we have the Rosary and then we have Benediction. So the day goes along very well. I have an awful lot to be thankful for." Another long-term resident, Mrs. Riddley, observed, "The hereafter is pleasant to think about. I have been brought up a Christian, and my belief is a great support to me now." Mrs. Cavanaugh asserted that her practice of religion was a great comfort now, noting, "I don't like to sound preachy, but the ability to have that chapel and to go to Mass after you have worked in the world for 70 years like I did, or 50 years - yes, I worked 52 years and didn't have time, except to rush to Mass on Sunday, then you appreciate that chapel."

Ironically, frequencies indicated nonprofit nursing homes were also more likely to show spiritual neglect. Regardless, for-profit and nonprofit sources had salient themes of spiritual negligence. Howsden (1981:61) gives an account of a nurse's attitude concerning spiritual rituals in a for-profit home:

> Is that minister still preaching? It's sure getting close to medication time and people should be getting back to their rooms.

An aide replies:

> This happened last week, too. They are such a long winded bunch. I don't think the patients like it that long either. Maybe someone should mention to them that their service lasts too long.

The nurse exclaims:

> Well, if he doesn't break it up pretty soon I'm going to have a few words to say to him. These people don't need that much religion.

Here, staff members disregarded the importance of spiritual needs. Ritualized discussions downplaying the importance of religion shaped the way staff members thought of care. In general, thinking someone does not need religion leads to emotional neglect because it takes away the spiritual side of life. Regardless, in this study, it was not shocking that for-profit nursing homes did not support spiritual aspects of life. It was a surprise that nonprofit homes did not. In this work, many nonprofit staff members neglected bereavement support. Concerning a nonprofit Jewish facility Shield (1988:70) explains:

> When a resident is about to die, most staff members seem to withdraw. Ironically, as social and emotional supports form staff dwindle, medical props and life-prolonging interventions are fortified... When the death finally occurs, the room is closed, the physician is called so the body may be "pronounced," the next of kin is notified, the personal effects are picked up, and the body is

> taken to the funeral home. Staff time is occupied with sanitation and paperwork following the death... Meanwhile, the news of the death travels quickly and stealthily among residents, though there is little or no staff disclosure of them. Officially, silence reigns. During my field work there was no memorial services, there was no notice on the bulletin boards in the hallways; there was no place to mention the event in the resident newsletter, and there was no kaddish (the Jewish prayer for the dead).

Savishinsky (1991:210) explains that following a passing, nursing homes act as if the person never lived:

> You see them one week and then, within a few days, someone new has moved into their room. It's almost like they did not exist. Just within that week, all traces of them have disappeared: their clothes, their pictures, their name outside the door.

In this subdivision, few references to emotional neglect existed. This indicated a low repetitiveness of RSPs of spiritual negligence. Nonprofit sources did have slightly more references, yet the number of references in for-profit sources was similar. The rank of spiritual negligence seemed high considering salience. For-profit sources implied spiritual negligence ties into a logic that runs contrary to religious support. There was not enough evidence amassed to determine whether motives relating to profit lead to spiritual negligence. Nonprofit sources showed that religious logics did influence and support RSPs related to spiritual needs. At the same time, they did not display support for residents when another passed. Even in religious facilities, staff members ignored the passing of residents and had no ceremonies to acknowledge death. These facilities left living residents without emotional closure.

Other

The "other" subdivision included references to staff ridiculing residents. This included situations where staff openly made fun of residents. Table 24 indicates 41

references to this subdivision. For-profit sources had 26 comprising 63.4 percent of this subdivision. Nonprofit sources had 15 making up 36.6 percent.

Table 24. Frequency of References to Emotional Neglect "Other" Subdivision

Context Unit	Number	Percentage
For-profit	26	63.4
Nonprofit	15	36.6
Overall	41	100.0

In terms of repetitiveness, for-profit references outweighed nonprofit references in the sources. Several accounts indicated the salience of this subdivision. For-profit and nonprofit sources had examples. They concerned issues such as incontinence and sexuality. Kayser-Jones (1981:47) recalls the humor a nurse found in a resident's inability to control urination and her reaction as an onlooker:

> Another patient, Mr. Thomas, always sat in a particular location in the hallway. One evening I saw him struggling to get out of his wheelchair. Sensing he needed a urinal, I called the nurse. "Oh, that's all right," she assured me. "Don't worry about him; he has two spots right here in the hallway where he urinates every day." The expression on my face was one of shock and disbelief as I watched the man publicly urinate on the carpet in the hallway. "What's the matter," laughed the nurse, "is it too much for you?"

In terms of deviance, urinating in public is a violation of cultural norms in the United States. Kayser-Jones (1981) explains that when staff members accept this deviant activity in the nursing home milieu it degrades and dehumanizes residents. In this study, staff members attempted to normalize this deviant behavior for residents, but distance themselves from it by making fun of it (for more on role distancing see Goffman 1961b).

This created an even larger emotional gap between those caring and those being cared for. This work should note, however, that not all residents normalize public urination. Vesperi (1983:230) explains that the humiliation experienced from incontinence drove one resident over the edge:

> Like many other residents at Martindale, Daren found his frustration turning gradually to self-hatred and self-destructiveness... He was obviously embarrassed by the evidence of his spotted pants, and tried to conceal this as much as possible. Still unsatisfied, he tied a string tightly around his penis in a last desperate attempt to prevent further accidents. It is not known how long he continued this painful practice, but by the time it was discovered he was suffering intensely and had caused himself irreparable physical damage.

The interesting point on this resident's actions involves the transformation from something many consider routine into something symbolic. Most people consider urination a routine part of the day. In addition, most people do it in private and do not make it a public issue. However, in this study, nursing home staff members let it occur in public places, often when they were too busy to help a resident urinate in private. Moreover, they sometimes joked about the inability of residents in controlling their own bodily functions adding to the stigma of incontinence.

In terms of sex and humiliation, Fontana (1978:128) discusses his observations of resident behavior and staff reactions in a for-profit facility:

> Nobody must have told big John that his fly was open showing hints of physical delight to whomever was willing to watch. Nurses aides laughed at him...

In relation to the same resident, Fontana (1978:129) notes:

> ... big John was persistent and somehow convinced Thelma, another patient, to perform fellatio on him. They were caught in the act and quickly separated, amidst laughter. Thelma couldn't speak as a result of an operation, thus no one asked or even

> considered that perhaps she might have been an unwilling partner.

Shield (1988) explains that staff members in the nonprofit nursing home she observed in denied resident sexuality. Staff treated sexual behavior, such as masturbation or resident comments about the opposite sex, as amusing. Shield (1988:198) notes:

> Mr. Bernstein is somewhat senile, and several of the orderlies on his floor have discovered that he has a vivid interest in talking about the females that he sees. They egg him on, asking him what he thinks about this one and that one. He is specific in his appraisal of the attributes of those women he admires and of those he does not, and the orderlies listen, and giggle, and ask, "What about this one? How about her?"

Synopsis

With repetitiveness and salience, the rank of RSPs in the emotional neglect category was high. In terms of objectification, the highest number of references for any subdivision existed in this category. Moreover, RSPs in this subdivision were salient for both for-profit and nonprofit sources. In this study, it seemed that objectification was part of the interaction pattern in nursing homes. Residents entered these institutions, staff members stigmatized them, labeled them, and then they viewed them as objects of labor. As this work will discuss later, this form of emotional neglect ties in heavily with themes related to bureaucratization. In terms of compassion transgressions, more references existed in for-profit sources. The references that existed did not imply intensity. However, several indicated staff members were void of pity when it came to residents. This led to a severe lack of emotional support.

In terms of spiritual negligence, similar frequencies existed in for-profit and nonprofit sources. For many people, it would not be shocking that for-profits have RSPs

that downplay spirituality. However, it is interesting that nonprofit nursing homes, even ones operated by religious groups, do not support spirituality. The points related to bereavement are interesting. In this study, both for-profit and nonprofit facilities failed to acknowledge the death of residents. They did not even let the room stay empty for long after a death. Staff members ritualistically moved one resident in right after another. With statements from a volunteer, Savishinsky (1991:210) shows us that this indicates that even nonprofit facilities have financial issues tied to emotional neglect:

> I know, as an economist, that the economics are against it, but they should leave their [the dead resident's] room empty for a while, or do something like that, to show that there is an emptiness where they once were.

As with RSPs related to objectification, this sent the message that residents were disposable, almost nonhuman. In this work, ridiculing residents did the same thing. It even led residents to commit acts of self-mutilation to fight off the stigma of humiliation. Making fun of residents' sexual desires and actions made them feel less than human.

In the sources, frequencies indicated emotional neglect occurred less often than physical. However, there were many references to this category. Those references indicated the salience of RSPs concerning emotional neglect. With this, the rank of RSPs of emotional maltreatment appeared high. We can conclude RSPs that supported emotional neglect shaped the cognitive frameworks of staff members in nursing homes. These RSPs of improper emotional treatment were accepted and repeated. At a later point, this work discusses how even residents in this study internalized and reproduced these RSPs.

Verbal Abuse

The category of verbal abuse included themes related to RSPs of infantilization, spoken aggression, and ignoring. Table 25 shows the sources referenced verbal abuse 328 times.

Table 25. Frequencies for Verbal Abuse Category

Category	Number	Percentage
Infantilization	144	43.9
Spoken Aggression	96	29.3
Ignoring	86	26.2
Other	2	0.6
Total	328	100.0

The sources referenced infantilization the most. Specifically, 144 references to it appeared. This comprised 43.9 percent of references in this category. Spoken aggression references appeared 96 times making 29.3 percent. Eighty-six counts of ignoring existed. This comprised 26.2 percent of references. The researcher only placed two references in the "other" subdivision.

Infantilization

Infantilization involved condescending staff vocalizations that reduce the status of a resident to that of a young child. Though this subdivision primarily involved verbal abuse, the researcher also included a few other actions involving staff treating residents like children. Later, it would be beneficial to focus on this subdivision making a verbal

and nonverbal distinction. Regardless, Table 26 shows the sources referenced this subdivision 144 times. For-profit sources had 85 references making 59 percent of this subdivision. Nonprofit sources had 69 making 41 percent.

Table 26. Frequency of References to Infantilization

Context Unit	Number	Percentage
For-profit	85	59.0
Nonprofit	59	41.0
Overall	144	100.0

In terms of salience, for-profit and nonprofit sources showed the intensity of this subdivision. Kayser-Jones (1981:39) explains:

> At Pacific Manor there were innumerable incidents of staff treating the residents like children. Authoritarian scoldings of the aged by staff were common. For example, one day a nurse aide walked into the lounge and, seeing a puddle of water on the floor, asked loudly, "Who wet the floor?" Pointing her finger at one woman, she inquired in an accusing voice, "Did you wet the floor?" Very embarrassed at being singled out as the culprit, the patient replied, "Why, no it wasn't me." Staff frequently command patients in a parental voice: "Shut up," "Stay in your chair!"; "Go to your place for lunch"; "I want you to go in and put on a dress, now get dressed!" and "Sit down, Grace." Such commands are often accompanied by gestures, such as pointing a finger at the aged person, forcibly taking him by the arm, or "leading' him to a chair."

This work should point out that staff members do not always intend to be malicious with their comments. From his work in a for-profit facility, Diamond (1992:138) points out:

> In this instance she was using the term "baby" to ridicule the

> rule, which many residents made fun of as well, that bibs had to be tied on to each resident for each meal. "Baby" was often used, and in more than one way. In some contexts it was used to create fictive family roles. Dorothy Tomason put her arm around Joanne Macon when she cried. "C'mere, my baby, now what's the trouble..." "Baby" was also used more broadly as a designation of the impersonal, referring to infants who were incompetent and unaware. "Oh, you work up there on the baby floor," observed a first-floor nursing assistant. Another advised, "Oh, don't worry about these people; when they get old they all start acting just like babies."

From his work in a nonprofit facility, Savishinsky (1991:75) points out that there was an "infantilizing habit of addressing residents with unearned terms of endearment: 'honey,' 'love,' 'sweetie,' and 'dear' were patronizing to the ear..." As with staff actions of objectification, residents do not just stand. In this study, when spoken to in a childlike manner, residents resisted. Diamond (1992:138) points out that the use of terms like "baby" often create conflict between staff members and residents:

> Bedridden Frances Wasserman protested, "Just cause I have to lay here in this gown doesn't mean I'm a baby." The same protests came up at meal time in the same tone, in part, because of bibs but also for the reason expressed by Mrs. Herman, who was blind. "You know, I was a field nurse, too. I'm no baby just because someone has to help me eat."

Regardless of resistance, in this study, other RSPs in nursing homes influenced infantilization. Kayser-Jones (1981) points out one for-profit home, allegedly cutting corners, only showed movies donated from a kids daycare. Metz (1999) explains another for-profit facility always had Santa Clause come in to hand out presents to residents on Christmas.

As indicated in this work, the sources implied that staff members did not always intentionally treat residents as infants. It is possible that staff members were trying to negotiate their relationship with residents. In doing so, they used cognitive frameworks

that guide other relationships where they are caregivers. Diamond (1992) points out, often these are parent-child relationships. In terms of literature on new institutionalism, staff members in this study used a family logic in an institutional setting (Friedland and Alford 1991). As an unintended consequence, residents interpreted the use of this cognitive framework as degrading. However, staff members did sometimes talk to residents as children with ill will in mind.

Spoken Aggression

Spoken aggression involved author references to the hostile launching of vocal attacks by staff directed against a resident. Table 27 shows 96 references in the sources. For-profit sources had 45 making 46.9 percent of the references. Nonprofit sources had 51 for 53.1 percent.

Table 27. Frequency of References to Spoken Aggression

Context Unit	Number	Percentage
For-profit	45	46.9
Nonprofit	51	53.1
Overall	96	100.0

Table 27 indicates, the number of references to spoken aggression was similar in for-profit and nonprofit sources. References to this subdivision ranked high in terms of frequency, but were not salient.

Some of the sources indicated that staff use spoken aggression to deter residents from bothering staff. Howsden (1981:76) explains:

> A typical encounter includes a complaint of a headache, stomach ache or another patient who has caused them distress. The patient is not ignored, but merely put off with the typical response, "Oh, go sit down and you will feel better," or "You and ____ go find something to do like feeding the cat," or "Go help Mrs. C. with her chair." The tactic is one of diversion which if unsuccessful is followed by threats, such as "If you don't leave me alone, I'll send you to your room."

In this study, sometimes upper staff members favored floor staff that used spoken aggression. They believed it helped to speed along work tasks. In one source, upper staff members praised a nurse that humiliated and verbally assaulted patients. Her verbal attacks made residents do what administrative staff thought they should. Foner (1994:61) explains:

> When the woman complained that she could not eat because her foot hurt, Ms. James screamed, "Shut up you and eat you. Eat. You think I have all day for you." And she turned to another woman, "You're such a nasty pig. You hear me, drink..." When a resident Ms. James had put on the toilet complained, she barked, "Sit there. Just sit. I don't care what hurts, just sit there. Sit down, don't bother me about being ready." As the LPN passed, Ms. James loudly commented so that the residents could hear: "Two dingbats I got here. One has shit coming out of her ass and the other one says her back hurts..." Ms. James humiliated and verbally abused patients out in the open: in front of nurses, administrators, doctors, and visitors. Yet she received the best evaluation on the floor and had privileges denied other aides.

In this subdivision, parity between references existed with for-profit and nonprofit sources. The sources did not have many references indicating the intensity of RSPs of spoken aggression. However, existing examples did show that staff members used spoken aggression to threaten residents. It helped to keep residents from disrupting work tasks. Staff members also vocalized threats in a way that supported the infantilization. Top staff even rewarded lower staff members that used spoken aggression.

Ignoring

Ignoring concerned situations described where staff refused to take notice of verbal communication initiated by residents (for more on this process see Goffman 1967). This included ignoring requests for personal and medical assistance. In this study, this was distinct from personal negligence and medical dereliction. With those subdivisions from different categories, staff members acknowledged personal and medical issues but failed to do anything about them. Here, residents made personal or medical requests and staff did not acknowledge them. Table 28 indicates 86 references to ignoring. For-profit sources had 37 making up 43 percent of this subdivision. Nonprofit had 49 making 57 percent.

Table 28. Frequency of References to Ignoring

Context Unit	Number	Percentage
For-profit	37	43.0
Nonprofit	49	57.0
Overall	86	100.0

The number of references to this subdivision was greater in the nonprofit sources. In terms of salience, many intense examples of ignoring existed in for-profit and nonprofit sources. Paterniti (2000:106) explains:

> Staff meet residents, whom they identify as disruptive or incompetent, at the convenience of their own work schedule. By doing so, they sometimes avoid residents whom they believe will reduce control over the work shift. This formula for interaction, however, may have detrimental consequences for "difficult" residents. Hazel Kleweski – a 325-pound, bed-bound resident in her early sixties – often had trouble with her meals, pushing her

> nurse's call button to alert staff of her digestive complications. Because Hazel rang her call button at each meal, her call light often went unanswered by staff who were trying to assist resident "feeders" during the institutionally designated mealtime.

As one for-profit resident told Gubrium, "You ask them to do something and they ignore you like dirty shit" (1993:144). In the nonprofit sources, residents suffered the same fate. From earlier work in a nonprofit nursing home, Gubrium (1975) explains that residents have various resources to influence work patterns of lower staff. They can be uncooperative or complain. Nurses and aides on the floor know the residents that are uncooperative or complain the most. They see a lack of cooperation or complaining as disruptions of their work routine. In this study, to punish these residents, nurses and aides ignored them. Ignoring these residents sent the symbolic message to others that they should not disrupt organizational tasks or they would receive poor care. Consequently, residents complied with staff members work routines fearing the stigma of being a troublemaker. As mentioned in another section, resident care suffered when staff members labeled them as troublemakers.

Vaughan (1999) explains that routine practices in organizations can have unintended consequences. When performing a task, it frequently becomes second nature. You then accept the risk involved in disregarding dangers of the task. If the result runs contrary to the organization's formal goals, organizational deviance occurs. In this work, this dynamic applied to the RSP of ignoring. Ignoring a resident's plea for help was risky. It had horrifying results. Paterniti (2000:106) explains:

> This afternoon, I talked with a staff member over lunch about

> some of the residents at Merimore who had died during my days off. Jessica said, "It was during lunch, ya know, when we're reeeaal busy. As usual, we were still passing trays, and Hazel put on her [nurse call] light. Naturally, Michele [Hazel's usual aide] just ignored it." Jessica noted with a certain matter-of-factness: anyone who had any knowledge of Hazel, her deficiencies, and the work routine would have, of course, followed the same course of action. She continued, "When Michele went in [to Hazel's room] to pick up Hazel's tray, she [Hazel] didn't respond. She wasn't breathing (the aide swallowed). Hazel was dead..."

Other

In the open subdivision, only two references that did not fit into the other subdivisions appeared. They concerned making loud noises in the halls when residents were trying to sleep (see Tisdale 1987). With so few references, a table for frequencies to examine repetitiveness and a discussion of salience is not of concern.

Synopsis

In terms of repetitiveness and rank, few references to the verbal abuse category existed in the sources compared to physical mishandling or emotional neglect. However, the qualitative comments discussed show that this category had much relevance in relation to maltreatment.

This study indicated that the sources mentioned infantilization the most. From those references, more came from for-profit sources. It is possible that RSPs tied to infantilization relate to cost cutting measures. For example, one source indicated that instead of buying movies for residents to watch, one home used movies donated by a local daycare. Yet, vocal patterns cited in for-profit and nonprofit sources revealed that staff members in most institutions talked to residents as if they were children. This might

have been the result of defining relationships with cognitive frameworks used in family relationships.

With spoken aggression, similar frequencies existed in for-profit and nonprofit sources. However, there were not many examples in the sources indicating the salience of this subdivision. The examples that did exist revealed that staff members used threats to get residents to comply with the institutional order. These threats sent a symbolic message that organizational tasks were the primary concern, not the resident. Administrators even rewarded lower staff members that used spoken aggression. Ironically, the least referenced subdivision, ignoring, was the most disturbing. Here more references existed in the for-profit sources. However, the references indicated that in this work, ignoring was a salient RSP in for-profit and nonprofit facilities. Staff members made a ritual practice out of ignoring residents that disrupted work schedules. In doing so, they avoided situations they should not have. From Vaughan's (1999) perspective, organizational deviance occurred. Staff members sacrificed the original goal of the organization - to care for its residents. The completion of organizational tasks became a primary focus. In turn, unanticipated consequences, even death, occurred.

Social Dynamics

The category of social dynamics involved themes not directly related to maltreatment. These themes did lead to some negative impact on residents. This involved encouraging dependency, privacy violations, property violations, and community contact obstructions. Table 29 shows the sources referenced this category 609 times.

Table 29. Frequencies for Social Dynamics Category

Category	Number	Percentage
Dependency Encouragement	214	35.1
Privacy Violations	184	30.2
Property Violations	75	12.3
Community Contact Obstruction	61	10.1
Other	75	12.3
Total	609	100.0

In this category, 214 references to dependency encouragement existed. This comprised 35.1 percent of the references. The sources referenced privacy violations 184 times making 30.2 percent, and property violations 75 times at 12.3 percent. References to community contact obstruction appeared 61 times making 10.1 percent. The "other" category had 75 references. This made 12.3 percent of the category.

Dependency Encouragement

The subdivision of dependency encouragement involved the lack of staff encouragement for resident self-sufficiency. Table 30 indicates the sources referenced situations where staff discouraged resident autonomy 214 times. For-profit sources had 150 references. This made 70 percent of references to this subdivision. Nonprofit sources had 64 for 30 percent.

Table 30. Frequency of References to Dependency Encouragement

Context Unit	Number	Percentage
For-profit	150	70.0
Nonprofit	64	30.0
Overall	214	100.0

For-profit sources had more references to staff encouraging dependency. Retsinas (1986:38) explains the salience of this subdivision in the for-profit facility she calls "The Nursing Home":

> In the world outside the nursing home, the individual routinely made an array of personal decisions, some major (where to live, whom to live with, how to spend money), some minor (what to eat, when to bathe, when to rise for breakfast). A nursing home resident makes fewer decisions. The resident need not decide when to eat, what to eat, whom to eat with, when to bathe, what to do, where to sleep, where to go, when to see the doctor, what holidays to celebrate, how to celebrate them. Nursing homes, however, vary in the autonomy allowed to individuals... The Nursing Home allows little autonomy. Even though mealtime is the major social event, residents do not choose menus. Dietary staff interview new residents to learn their preferences and dislikes, but after that initial interview the dietary staff will set the residents' menus. Menus vary, but the staff determine the variations. Nor can patients choose mealtimes. The patient who rises early will need to wait for breakfast to be served, and the patient who sleeps late must forego breakfast.

In this work, for-profit homes encouraged dependency, but nonprofit homes did as well. Bennett (1980:58) explains:

> Traditional nursing home environments are very incarcerating. They restrict freedom in a variety of ways. Patients may be permitted to move about at will, but there are few places for them to go. My usual routine was to roam the corridor or move back and forth between my room and the single lounge in my ward. When one is situated on an upper floor as I was, without ready access to the outside and without unrestricted use of the elevator,

> there is no sense of being free... Because staff is busy, patients do not ask for "favored" treatment. Although one could say that this particular freedom deprivation is, in part, a self-administered one, it is really induced by the nature of the environment and the systems deployed.

This research should note that not all patients have resources to act autonomously. Organizational rules that keep demented residents safe seem legitimate. You want a staff member to keep a cognitively impaired resident from making financial, food, and personal care decisions. However, to punish other individuals in the nursing home by encouraging dependency for all residents is not fair (Lidz et al. 1992). This work elaborates on resident resources later.

Privacy Violations

Privacy violations involved situations where staff members did not acknowledge normally accepted boundaries of personal space. Gubrium (1975) explains that in nursing homes, lines blur when distinguishing public from private places. The sources indicated that privacy is secondary if staff need to do work. As such, privacy violations in this work included situations such as staff casually walking in on residents using the toilet just to give medications. It also included situations such as staff leaving residents naked and exposed to others. Table 31 indicates the sources repeated references for this subdivision 184 times. For-profit sources had 114 references making 62 percent of references to privacy violations. Nonprofit sources had 70 references for 38 percent.

Table 31. Frequency of References to Privacy Violations

Context Unit	Number	Percentage
For-profit	114	62.0
Nonprofit	70	38.0
Overall	184	100.0

In terms of repetitiveness, privacy violations occurred more in for-profit sources. Several examples in the sources indicated the intensity of this theme in for-profit facilities. Kayser-Jones (1981) explains that many of the privacy violations in the facility she observed concerned bathing. Staff members would regularly expose patients' genitals and bathe men and women simultaneously. Again, the goal in bathing many patients together relates to the aforementioned issue of bureaucratic efficiency. She claims these practices did not occur in a nonprofit facility she studied. As with letting residents urinate in public, ritualistically leaving residents' genitals exposed promotes dehumanization. Fontana (1977:164) gives another example:

> The aide came into the room without knocking and left the door opened behind her. Mrs. Leister was fully dressed, but she was lying on the bed awaiting her doctor's visit. The aide, taking no notice of either of us, began making the bed around Mrs. Leister. The doctor walked in and nodded good morning to the aide. He had no way of knowing who I was since he had never met me before, thus I was a stranger of the opposite sex of the patient he was examining; nevertheless, he casually unbuttoned Mrs. Leister's blouse while asking her about her health and began listing with a stethoscope to her heart. He left after a few minutes, and the nurse resumed making the bed...

Privacy violations involving resident rooms as a domain of interaction were salient in for-profit and nonprofit sources. In one for-profit source, Howsden (1981:73) gives a resident account:

> The other day this lady walked right into my room and over to the bathroom. I asked her just what she thought she was doing. She told me that if she thought it was any of my business she would tell me.

In reference to Goffman's (1959) work, this blurred line between public and private keeps residents from having a backstage to call their own. Howsden (1981:73) explains that doors to residents' rooms in the facility she observed did not have locks. When a closed door existed, staff would rarely knock. Yet, another deviation from a social expectation people would have outside the walls of a nursing home. However, in this study, many of the privacy problems resulted because rooms held multiple people. In relation to a nonprofit facility, Bennett (1980:89) explains:

> ... conversations which take place within them are seldom private. Visitors cannot talk without being overheard and are denied intimate family-patient interaction and communication... To overcome this kind of a predicament, family members are often seen pushing their relatives down the corridors, or sitting with them in obscure places because they have a need to be removed from others and be free to talk in private. The total inconvenience of all this makes one question the merit of the nursing home standards which sponsor multi-bed rooms.

The lack of privacy when relatives visit possibly discourages family members from coming to the institution. As Gubrium (1975) points out, routine visitors are a resource that lowers maltreatment. In this work, if residents had close relatives from outside the facility constantly checking on them, staff members were less likely to take advantage of those residents.

Property Violations

Property violations involved author references to staff members taking a resident's possessions without right or permission. This involved theft and situations

where staff moved or removed a resident's possessions without asking. Table 32 shows that the sources repeated references to this subdivision 75 times. For-profit sources had 58 references making 77.3 percent of the references. Nonprofit sources had 17 making 22.7 percent.

Table 32. Frequency of References to Property Violations

Context Unit	Number	Percentage
For-profit	58	77.3
Nonprofit	17	22.7
Overall	75	100.0

In terms of frequency, there were more references to for-profit sources than nonprofit sources. The thick descriptions showed the salience of property violations in for-profit sources. Though examples for property violations existed in the nonprofit sources, none of them had intensity. In terms of one for-profit facility, Kayser-Jones (1981:51) states:

> ... at Pacific Manor theft of personal possessions is an overt type of victimization; the theft of patients' food, clothing, money, jewelry, and other personal belongings is common. As mentioned earlier, many patients do not like the institutional diet and try to supplement it with food from friends and relatives. But because of theft, it is nearly impossible for them to keep food in their possession. If they place perishable goods in the refrigerator, invariably they are taken by the staff.

Kayser-Jones (1981) attributes the high level of theft in for-profit facilities to financial issues. She contends that the owners pay the lower staff so little, they force staff to take the belongings of residents out of necessity. She also indicates that rational choice models linked to deviant behavior are at play. Kayser-Jones (1981) argues that,

due to the high level of staff separation in nursing homes, the administration distance themselves from residents and their problems. Therefore, they do not see theft as an issue (for more on this process see Coleman 1985). With no action taken by the administration, the benefits of stealing from residents outweigh the costs. Regardless, in this study, the people from upper levels of the organization stole from residents as well. Fontana (1978:130) explains:

> Administration of patients' money provided another way to rip them off. Of course money was administered "for the good of the patients," who were mentally incompetent to handle their own finances. At least that was the account provided by the administrator when I asked why old Jim was always begging for dimes while hovering around the coin-operated soft drink machine. This seemed strange since I knew Medicaid provided each patient with $25 a month for small personal expenses. What I did know was that Jim never saw that money...

Fontana (1978:130) goes on:

> Since most patients were the wards of the government in one fashion or another, when they died there were no relatives claiming their few possessions. This led to another rip-off. Medicaid allotted $15 a month as a clothing allowance for the patients. But, perhaps believing the old myth that old age is a second childhood, the staff handed down old clothing to patients, the clothing of those who no longer needed them in their eternal rest. And the clothing allowance? All I know is that is wasn't handed down along with the old clothing.

Community Contact Obstruction

In this study, community contact obstruction concerned staff discouraging or failing to promote resident relationships with actors living outside of the institution. In this study, with community contact obstruction, you had situations where residents had not left the nursing home for nearly a decade (see Kayser-Jones 1981). The sources

referenced this subdivision 61 times. For-profit sources had 35 references making 57.4 percent of this subdivision. Nonprofit sources had 26 making 42.6 percent.

Table 33. Frequency of References to Community Contact Obstruction

Context Unit	Number	Percentage
For-profit	35	57.4
Nonprofit	26	42.6
Overall	61	100.0

In terms of repetitiveness, for-profit sources had more references. However, the references indicated that RSPs relating to this subdivision were salient in for-profit and nonprofit sources. In this work, many of the sources indicated nursing homes did not supply resources to keep residents up to date with the outside world. For example, facilities did not make telephones freely available, provide televisions, or even clocks to keep track of time (see Bennett 1980; Kayser-Jones 1981; Hajjar 1998). Many of the references indicated that staff discouraged visiting the community and having visitors. In reference to a for-profit facility, Retsinas explains, "Organizational outings – trips to a local park, a summer theater, or a historic village – are infrequent" (1986:35). In terms of visitors from outside, Farmer (1996) explains staff members often show signs of being hesitant for state inspectors to enter facilities. Issues concerning staff discouragement of resident visits were most interesting. Staff members believed that resident visitors disrupted work. From her work in a nonprofit home, Foner (1994:113) explains:

> A couple of aides even mentioned patients' families as the biggest problem they had in doing their job. A major reason for this is that patients' relatives are thought to be too demanding.

> "They feel," said one worker, "you never doing enough." Or as another put it, "Some of them don't want the mother home, but when they come to the nursing home, they want her perfect. But when you have ten patients, you cannot give them that kind of care." A common complaint about regular visitors is that they think their relative is the only patient. "I can't stand that woman," said Ms. James, referring to a resident's daughter. "She comes round saying, you have to reposition my mother NOW. I was busy with someone else."

Foner (1994:112) also explains:

> ... I found that nursing aides tended to be annoyed, occasionally deeply angry, with them. The general view is that actively involved relatives are another source of pressure on the job. It is not that family members are thought to be infringing on tasks that aides claim as their own. Indeed, aides generally take for granted assistance that family members offer. Aides have come to expect that certain regulars will do specific jobs, like helping with meals, and they build such assistance into their schedules. When these relatives do not show up, aides are irritated since now their routines are upset and they have what they perceive to be added work.

Other

Table 34 shows that the "other" subdivision in this category had 75 references. These included issues of intentional isolation of residents and forced socialization. For-profit sources repeated references to this subdivision 42 times making 56 percent of the "other" references. Nonprofit sources had 33 for 44 percent.

Table 34. Frequency of References to Social Dynamics "Other" Subdivision

Context Unit	Number	Percentage
For-profit	42	56.0
Nonprofit	33	44.0
Overall	75	100.0

In terms of isolation, one for-profit source noted that staff isolate residents with severe health problems. Howsden (1981:103-04) explains isolation of residents that require help with eating:

> These patients who need assistance with eating but demand independence are especially troublesome for the staff. They become frustrated because the patients take up more work time than is necessary... Being a "feeder" has several interpersonal consequences that tend toward the negative side... "feeders" are always hustled off to their rooms to eat alone, segregated from the normal meal routine.

In this study, isolation occurred if residents caused disruptions through interactions with others. Even when residents were with family members, if they got into arguments that hindered the flow of the organization, staff members isolated them. Using information from a nonprofit facility, Lidz et al. (1992) explain:

> Staff also frequently complained about the effect of inter-patient conflicts on the institutional order. When patients fought, either physically or verbally, an effort was usually made to isolate them from one another. The fact that the fighting parties were spouses or old friends did not change staff's response.

With this research, it was clear that RSPs concerning isolation represented another pattern of interaction used for control. Ironically, forced socialization, the opposite of isolation was another. In relation to a nonprofit home, Powers (1988a) argues that residents having many outside visitors do not feel the need for extra socialization. Some would just like to be alone. With a resident's opinion, O'Brien (1989:158) explains:

> One third floor resident who said when I asked her age, "I'm around 300 years old" (later she said that she had been born in 1902), and admitted that she found being forced to interact with other home residents very hard. She stated, "I am what you call a loner because I am not companionable with very many people. There are not many people that I want to talk to."

In this work, if this type of attitude worked against the goals of staff members, in order to control the residents behavior and keep others from acting in a similar fashion, staff labeled and stereotyped the resident. Shield (1988:139) provides an example from a nonprofit facility:

> As a staff member said: "Mrs. Grosz stays in her room most of the day and seems angry when asked to join us at activities. Most of the other residents are staying away from her as well. We think it would be helpful if she could be persuaded to come to activities, but at least right now, she really doesn't want to. She's mean to everyone."

Synopsis

Many references to this category existed in the sources. These themes were not direct examples of maltreatment, but they often represented RSPs that led to negative consequences for residents. The largest subdivision, dependency encouragement, represented actions that discouraged autonomy. In terms of repetitiveness and rank, more references existed in for-profit sources. However, this theme appeared salient in for-profit and nonprofit sources. Rules and regulations of nursing homes helped to encourage dependency. In this project, dependency encouragement was an unanticipated product of the social environment. As Bennett explains, it is created "by the nature of the environment" (1980:58). It is also interesting that the encouragement of dependency related to the subdivision of infantilization discussed earlier.

In relation to privacy violations, more references existed in for-profit sources. However, RSPs relating to privacy violations were salient in for-profit and nonprofit sources. Specifically, privacy was an issue in domains of interaction such as residents' rooms. If staff needed to complete specific tasks, the privacy of residents was secondary.

In relation to property violations, repetitiveness and salience were higher in for-profit sources. Upper level staff members in for-profit nursing homes supported the illegal collection of resident finances while bottom level staff members normalized the theft of resident property. Finally, RSPs of isolation and forced socialization represented yet another means of institutional control over residents that disrupted nursing home tasks.

Supplementary Conditions of Structural Ritualization

This research focused on two main conditions of structural ritualization – repetitiveness and salience. For a complete analysis of RSPs in nursing homes, it is necessary to discuss other conditions. Other conditions related to the rank of RSPs include homologousness and resources. A discussion of domains of interaction is also appropriate. Homologousness implies a "degree of perceived similarity among different RSPs" (Knottnerus 1997:263). Resources are "materials needed to engage in RSPs which are available to actors" (Knottnerus 1997:264). A domain of interaction is a "bounded social arena which contains two or more actors" engaged in "face-to-face interaction" (Knottnerus 1997:261). Domains of interaction are where RSPs take place. This project focused on homologousness, resources, and domains of interaction by interpreting themes in the sources.

Homologousness

This work suggested differences in for-profit and nonprofit sources. For example, for-profit sources mentioned themes relating to material gain. These themes tied into

maltreatment. Consider the theme of property violations. For-profit sources showed that multiple levels of the organization normalized the illegal possession of financial and material resources. Nonprofit sources did not. On the contrary, some nonprofit sources, especially those operated by religious organizations, had RSPs that generated spiritual support for residents. However, bureaucratic RSPs dominated both for-profit and nonprofit sources. In fact, those RSPs often had direct links to RSPs of maltreatment. This indicated homologousness. In other words, a degree of similarity between patterns of interaction involving bureaucracy and maltreatment existed.

In relation to hierarchy, this work pointed out that workers in nursing homes had a high degree of separation. This bureaucratic feature often led to, or supported, poor care. In one facility, residents wanted coffee in the mornings. Though the activity director served it in the lounge, those confined to their rooms could not get it. They wanted aides on their floor to bring it to them. The aides would not do it because they felt it was the activity director's responsibility. In another example discussed, one source indicated that the theft of property by aides was not an issue for top staff because they do not deal directly with aides or residents. In other words, the problem did not have a direct influence on them, so they did not think it was an issue of maltreatment worth addressing (for more on each example see Kayser-Jones 1981).

In relation to rules, Fontana points out that rules take precedent over compassion in nursing homes (1978:130). In this study, they prohibited self-bathing (see Howsden 1981; Shield 1988). They prohibited carpeting on floors, which led to falls (see Crandall and Crandall 1990). In addition, they even restricted government reimbursements for the upkeep of personal items such as eyeglasses and false teeth. They took away autonomy

by restricting what residents could eat (see Diamond 1992). RSPs of documentation also related to RSPs of maltreatment. Paperwork not only monopolized time that floor staff spent caring for residents; it objectified residents. Top staff members told lower staff to get to know residents better by reading their charts. Yet, those charts gave no personal information on residents. They kept track of actions most people consider routine. For example, if a resident had a bowel movement, staff members recorded it in a defecation book (Gubrium 1975; Howsden 1981). In general, when staff objectify residents, they see them as less than human. Certainly, it is easier to hit or yell at an object than a person.

Finally, RSPs of efficiency and maltreatment were relevant. As Foner explains, in the nursing home "efficiency is key" (Foner 1994:67). In this study, this was not a good thing for residents. In the name of efficiency, staff members compromised decent relationships with residents. Staff members yelled at and physically manipulated residents to get tasks related to work finished faster. They intentionally neglected the personal appearance of residents because it sped up work processes. They treated residents as infants making them wear diapers. This occurred even when residents could control their bladders and bowels. They restrained residents unnecessarily to control disruptions of work. They even entered otherwise private domains of interaction when they had work duties to perform (see Gubrium 1975; Diamond 1992; Lidz et al. 1992; Foner 1994).

With RSPs concerning bureaucracy and maltreatment connected, similarities between patterns of interaction existed. In fact, RSPs related to bureaucracy seem to lead to maltreatment. Those aspects of maltreatment pertained to everything from personal

negligence to physical abuse. In Merton's (1936, 1940) terms, the result of high levels of bureaucratic RSPs in nursing homes led to unanticipated consequences. In terms of Vaughan's work (1992, 1999) we can discuss these consequences as organizational deviance. This is especially true in the case of this research since organizational processes directly harmed people.

Resources

Resources are "materials needed to engage in RSPs which are available to actors" (Knottnerus 1997:264). In terms of the theory, two types of resources exist – nonhuman and human. Nonhuman resources include materials such as money and time. Human resources include traits such as interaction skills, physical strength, and intellectual ability (Knottnerus 1997; Sell et al. 2000). The original discussion of resources concerning the theory revolves around the necessity of resources to engage in RSPs. However, this research showed how a lack of resources allowed others to continue the reproduction of RSPs.

The sources used indicated nursing home residents have a lack of nonhuman resources. Using points related to exchange theory, Shield (1988) explains that residents have little control over social and economic resources (for more on exchange theory see Blau 1964; Down 1975; Homans 1974). She explains that the only thing residents have to exchange with staff members is compliance. Kayser-Jones (1981:113) provides an example of the powerlessness residents feel:

> ... since they have few resources with which to reciprocate, they are forced to comply with the wishes of the staff. Mrs. Lundgren, for example, is dependent on the staff for bathing. She objects to being placed in the shower room with male patients. "I don't

> know how the men feel," she averred, "but I find it disgusting! But what can I do?"

In social life, with little or nothing to exchange, dependency increases and the value of the person declines. In terms of maltreatment, examples in the sources showed that aides took advantage of this situation. Residents sometimes used the only resources they had left to get things they wanted. Fontana (1978:129) explains:

> Or take the time when Wanda, an aide in her mid-fifties, took a fancy to George. George was a patient... He was a tall, good looking black man. Unfortunately, his penchant for drinking had aged him prematurely, and his mental state made him appear to be drunk all of the time. Thus there was no noticeable change in his behavior when Wanda began to supply him with bottles of after shave lotion in exchange for sexual favors.

A lack of nonhuman resources does not necessarily help residents to participate in RSPs. However, it does facilitate the dependency of residents. In other words, a lack of nonhuman resources actually helps in the creation and reproduction of maltreatment. As the next chapter discusses, some residents in this study did have enough resources to reproduce RSPs of bureaucracy and maltreatment. With that in mind, we can discuss the importance of human resources.

Using the theory of structural ritualization as a foundation, this work showed two distinct kinds of human resources: individual and social. Individual resources included those originally discussed by Knottnerus (1997) such as interaction skills, physical strength, and intellectual ability. Social resources, not discussed in the original theory, included relationships to actors outside of the organization. In terms of individual resources, this research should note that many people in nursing homes have physical or cognitive impairments (Shield 1988). This hinders exposure to RSPs. With that in mind, their lack of human resources, as with nonhuman resources, actually helps to promote

RSPs of maltreatment. For example, Henry (1963) implies that staff members treat blind residents worse than they treat others. Gubrium (1975) explains that residents with mental problems are more likely to have their privacy violated. On the other hand, in this study social resources helped to lower exposure to RSPs of maltreatment. For example, when family members visited and frequently discussed their loved one with the staff, prestige emerged. Staff changed their perceptions of residents. Staff members saw residents with visitors as people with connections to the outside. In addition, they saw them as people who had advocates that visited and checked on their treatment. In turn, staff were less likely to mistreat residents with social resources (see Gubrium 1975; Powers 1988; Shield 1988).

Domains of Interaction

A domain of interaction is a "bounded social arena which contains two or more actors" engaged in "face-to-face interaction" (Knottnerus 1997:261). Domains of interaction are where RSPs take place. This concept allows for the distinction between multiple regions of social activity with different types of RSPs. Multiple domains of interaction in a specific environment, such as an organization, warrant the use of the term "domain set" (Knottnerus 1997:261). This research used new terminology to deal with domains that supported organizational RSPs. It referred to them as "conducive domains." It referred to domains of interaction that worked against accepted RSPs as "contrastive domains."

In this research, several domains of interaction supported the maltreatment of residents. As a domain set, these conducive domains included resident rooms,

bathrooms, shower rooms, and dining areas. RSPs of maltreatment occurred often in resident rooms. Specifically, we can consider privacy. Though staff members often violated the privacy of residents in their rooms, the sources showed these areas also provided private locations where aides could abuse residents without others watching. Connected to this domain was the resident bathroom. This was a prime location for what Lidz et al. call "violations of bodily privacy" (1992:149). A related area was the shower room where multiple residents were bathed in front of each other as well as punished with a variation in water temperature (see Stannard 1973; Kayser-Jones 1981). The dining room as a domain of interaction was relevant in a different way. It was a public place where maltreatment took place. Primarily eating was an issue when staff members forced residents to consume food. However, infantilization occurred in this area as well. As with resident rooms, staff members talked to residents as if they were children in these areas. In certain facilities, staff members also did things like assign resident seats (see Kayser-Jones 1981; Lidz et al. 1992; Foner 1994).

Regardless of conducive domains, several contrastive domains existed in nursing homes. As a domain set, these contrastive domains included worship rooms, physical therapy quarters, and areas involving resident/housekeeper interaction. In certain nonprofit sources, especially ones focusing on nursing homes operated by religious groups, special areas were set aside for religious services. These areas were the place many RSPs that contradicted bureaucracy and maltreatment took place. O'Brien (1989:169) explains:

> Directly off of the lobby was Bethany Manor's chapel, which was a communal place considered very important to many residents. In fact, a primary reason why many Catholic residents chose to come to the Manor was the fact that the home had a

chapel providing daily Mass and other Catholic services.

O'Brien (1989) explains that this contrastive domain significantly influences the cognitive frameworks of people in the institution. Another contrastive domain that provided more alternative RSPs was the physical therapy area. This area seemed to be a safe haven for residents in both for-profit and nonprofit facilities (see Laird 1979; O'Brien 1989; Savishinsky 1991). Shield (1988:77) explains the social dynamics of physical therapy:

> In the physical therapy room residents have the opportunity to be themselves at the same time that they assert their commonality. The ease with which they talk with each other and with the physical therapy staff about their pasts as well as about what is currently happening in their lives confers a special aura to the room and the hard work that goes on within it. Physical therapy is frustrating, painful, and arduous; results can take a long time to materialize. Residents make strides, sometimes only to relapse. But residents who come to physical therapy are encouraged to continue work against the pain and the odds of failure, and they often have astonishing results.

The contrastive nature of this domain probably related to residents being able to discuss their pasts freely. They had the opportunity to openly speak, build, and maintain a sense of self. It also gave them goals to meet. These were all things that separated them from other objects in the nursing home and made them seem more human. Shield explains that one physical therapist contended that she was on the residents' side, acted on their behalf, and made it a point to "not betray their confidences" (1988:76). Interestingly, the sources showed a similar relationship existed with housekeepers. They often provided informal therapy for residents. Henderson (1981:302) provides a resident account that explains how this is possible:

> Well, all the nurse's aides don't have the time [to visit] 'cause [basic care] is more important. Now, Jane [housekeeper,

> pseudonym], she can come in here and clean that wash basin and talk all at the same time. And the nurse's aide, if I am sick they come in to give me some attention, why they got their mind on what they are doing... they don't know what time that intercom is going to say go to so-and-so room or a certain wing. Jane, she knows that she is going to clean this wing up before going over to that east wing.

Henderson (1981:303) presents another resident account that explains:

> She [i.e., housekeeper] just comes in and cleans up and... she's not in a big hurry. And we talk and visit some... When [nurse's aides] come in, well, whatever they come to do, why they will talk but they do just what they've got to do and then they just go on.

When goals of efficiency do not drive workers in nursing homes, they have the time to build personal relationships with residents. As Henderson (1981) explains, the informal psychosocial role provided by staff like housekeepers is an overlooked benefit in nursing home environments. In relation to this research, the relationships between housekeepers and staff provided alternative interaction patterns that fought off RSPs, such as objectification, that led to maltreatment.

Summary

The sources repeated many references to bureaucratic RSPs. The references indicated the salience, or intensity, of many RSPs in nursing homes. RSPs of maltreatment were repetitive and salient as well. The sources also showed homologousness between various RSPs of bureaucracy and maltreatment. Staff members and residents had resources to internalize, but also block RSPs. With these conditions in mind, the RSPs that concerned bureaucracy and maltreatment ranked high in terms of the theory of structural ritualization. In this study, this allowed the reproduction of social

structure facilitating bureaucratic and abusive patterns of interaction. Not only was this the case for staff members, but for residents as well. The final chapter explores this point in more detail. Regardless, here it is necessary to summarize the findings for each category and subdivision.

In several subdivisions, RSPs related to bureaucracy appeared salient. The most references were to staff separation and hierarchy. Fewer for-profit references existed. However, in terms of salience, for-profit and nonprofit sources discussed the importance of staff separation and hierarchy. Specifically, staff members in all of the sources felt a sense of separation based on factors concerning duties, training, income, race, ethnicity, and age. This separation had a social psychological effect on individuals working in nursing homes. Specifically, staff members tended to only perform a duty if it was specifically their responsibility (see Bennett 1980). With such a high degree of separation, staff members at different levels of the organization sometimes developed their own norms for dealing with residents. Nursing home employees at lower levels of the hierarchy sometimes accepted abuse. They saw it as appropriate punishment if a resident disrupted their work routines. New aides that socialized with other aides learned to neutralize resident abuse as acceptable behavior if residents violated the institutional rituals of staff work. Not only did they neutralize the behavior as normal; they covered it up. This indicated that high levels of staff separation in for-profit and nonprofit nursing homes facilitated the maltreatment of residents.

The sources repeated references to rules in the sources as well. The nonprofit sources repeated references more. However, RSPs concerning rules were salient in for-profit and nonprofit sources. Many of the actions concerning formal rules involved

requirements brought on by government regulation. However, the references to rules also indicated that informal norms exist for things like resident care. Like staff separation, these informal rules unintentionally promoted maltreatment in for-profit and nonprofit facilities.

In terms of documentation and efficiency, the sources repeated fewer references. With these two subdivisions similarity existed between for-profit and nonprofit sources on factors of repetitiveness and salience. In relation to documentation, paperwork even controlled church operated facilities. This created a situation where staff members pulled away from thinking they were working with people. Instead, documentation of what many would consider routine behavior ritualistically turned residents into objects of work. A personal act turned into a quantitative measurement. With humans and their behavior turned into objects of documentation, impersonalization and maltreatment seemed more likely. The bureaucratic emphasis on efficiency did not help. In relation to efficiency, the same idea applied. The goal of the organization was not to provide quality care, but to get a job done quickly. For-profit and nonprofit nursing homes had accounts indicating that it does not matter how a job gets done as long as it gets done, and gets done fast.

Frequent references to bureaucracy showed that nonprofit facilities were more driven by bureaucratic RSPs. However, salience indicated the intensity of all bureaucratic themes in for-profit and nonprofit sources. Coupled with the issues of homologousness previously discussed, this showed that measures of repetitiveness and salience provided evidence of bureaucratic RSPs having a high rank in all types of nursing homes. As mentioned, for-profit facilities might promote poor quality of care

with profit motives. However, any nursing home might unintentionally promote poor quality of care if a bureaucratic logic dominates it.

In terms of RSPs related to the category of physical mishandling, frequencies of themes showed that for-profit sources repeated more references to this category of maltreatment. This indicated that for-profit institutions have more RSPs that led to physical mishandling. However, issues on the salience of themes in this category existed for most of the subdivisions in all sources.

In terms of medical dereliction, it appeared that doctors working with facilities often failed to provide medical care to residents when they needed it. Accounts also showed that staff members in the facility failed to provide adequate care in certain situations. In the for-profit sources, this failure to deliver medical care involved issues connected to money. Accounts indicated that some of the facilities simply would not purchase certain medical products. In turn, aides would bring products from home to help heal their residents. However, for-profit and nonprofit sources implied that staff members regularly overused medications in certain situations. Primarily this occurred when staff members wanted to control residents that kept them from efficiently carrying out their daily work routines. Staff members labeled residents deviant if they got in the way. This often justified the overuse of physical restraints.

In terms of personal negligence, the sources indicated that busy aides failed to clean residents properly. They even intentionally failed to dress them properly at times because improper dress sped up the fulfillment of their daily duties. In addition, even aides in nonprofit facilities neglected the personal care of residents. They did so to punish them if they were too demanding. In terms of environmental negligence,

cleanliness is an issue as well. For-profit sources had accounts explaining pest control issues. Nonprofit sources had accounts describing the failure to adequately clean rooms and food carts. As mentioned, this sent a symbolic message to residents that they were not worth adequately taking care of by members of society.

In terms of bodily harm, references to explicit physical abuse existed in for-profit and nonprofit sources. Some of the sources implied that staff members justified the physical abuse of residents with an eye for an eye mentality. They claimed residents sometimes abused them, so they got revenge. The sources also pointed out that aides or nurses gave scalding hot baths, unnecessarily restrained, or even locked up residents to punish them. These punishments were for performing acts that disrupted the flow of the workday. The for-profit sources indicated that restraint use was also an effective means of cost control. Residents were more easily dealt with by a few aides on staff if they were tied down and easier to manage. With the repetition and salience of themes of physical mishandling, RSPs for the physical mishandling category rank high. In turn, RSPs that support physical abuse shaped the cognitive frameworks of staff members. RSPs of physical mishandling were accepted and repeated. However, as discussed, the domain of interaction was a factor to consider.

With repetitiveness and salience in mind, the rank of RSPs in the emotional neglect category was high. In terms of objectification, we saw the highest number of references for any subdivision in this category. Moreover, RSPs in this subdivision were salient for both for-profit and nonprofit sources. It appeared that objectification was part of the interaction patterns in sources. Residents entered nursing homes, staff members stigmatized them, labeled them, and then viewed them as objects of labor. In terms of

compassion transgressions, more references existed in for-profit sources. The references that did exist did not imply intensity in regards to salience. However, several examples did exist that indicated staff members were void of resident pity. This led to interaction patterns void of emotional support. In terms of spiritual negligence, similar frequencies existed in for-profit and nonprofit sources. For many people, it would not be shocking that for-profits had RSPs that downplayed spirituality. However, it is interesting that nonprofit nursing homes, even ones operated by religious groups, did not support spirituality. In the sources, for-profit and nonprofit facilities failed to acknowledge the death of residents. As with RSPs related to objectification, this sent the message that residents were disposable products of the social environment. Overall, repeated themes indicated emotional neglect occurred less often than physical. However, there were many references to this category in the sources. Those references indicated the salience of RSPs of emotional neglect. As with issues of physical mishandling in terms of structural ritualization, the rank of these RSPs appeared high. In turn, RSPs that supported emotional neglect shaped the cognitive frameworks of staff members. RSPs of improper emotional treatment were accepted and repeated. However, again the domain of interaction was important to consider.

In terms of repetitiveness and rank, fewer references to verbal abuse existed in the sources than for RSPs of physical mishandling or emotional neglect. However, the accounts in the sources indicated this category had relevance to maltreatment. This study indicated that the sources repeated references to infantilization the most. From those references, more came from for-profit sources. The sources showed that it is possible that RSPs of infantilization related to cost cutting. However, vocal patterns in both for-

profit and nonprofit sources revealed that staff members in most cases talked to residents as if they were children. This may be the result of attempting to define relationships based on cognitive frameworks used in family relationships. With spoken aggression, similar frequencies existed in for-profit and nonprofit sources. However, there were not many examples in the sources indicating the salience of RSPs. The existing examples revealed that staff members used threats to get residents to comply with the institutional order. Threats sent a symbolic message that organizational tasks were the primary concern. Moreover, sources showed that some administrators even rewarded staff members that used spoken aggression. The least referenced subdivision, ignoring, was the most disturbing. Here the for-profit sources repeated the theme of ignoring more. However, the references indicated that ignoring was a salient RSP in for-profit and nonprofit facilities. Staff members ignored residents that disrupted work schedules with constant failure to comply and tendencies to complain. They made it a routine practice to ignore residents. We can consider this a form of organizational deviance. When staff ignored residents, they sacrificed the goal of the organization – to care for its residents. The completion of organizational tasks became a primary focus. In turn, unanticipated consequences, even death, occurred.

Many references to social dynamics related to maltreatment existed. In the largest subdivision, dependency encouragement, many references existed in for-profit sources. However, this theme was salient in for-profit and nonprofit sources. The study indicated that the rules and regulations of nursing homes helped to encourage dependency. In other words, dependency may be yet another unanticipated product of the nursing home milieu. In relation to privacy violations and repetitiveness, more references existed in for-profit

sources. However, RSPs of privacy violations were salient in both for-profit and nonprofit sources. Specifically, privacy was an issue in domains of interaction such as residents' rooms. It appeared if staff needed to complete specific tasks, the privacy of residents was secondary. In relation to property violations, the rank of RSPs based on repetitiveness and salience was higher in for-profit sources. Importantly, the sources indicated that top staff members in for-profit homes supported the illegal collection of resident finances while bottom level staff members normalized the theft of resident property.

This research showed that nursing homes have many rituals. Though many of these rituals did not support the well being of residents, they did support poor quality of care. Specifically, RSPs of bureaucracy and maltreatment were frequent and intense in nursing home environments. These high-ranking RSPs shared characteristics reinforcing themes of bureaucratization and resident abuse. In some nonprofit facilities, especially those based on a religious logic, we saw RSPs that were beneficial to residents. In others, especially for-profits, we saw RSPs that normalized deviant behavior such as property violations. However, all appeared to have domains of interaction supporting RSPs that influenced maltreatment. Nonetheless, some nursing homes had domains of interaction that provided contrastive RSPs. These RSPs fought off RSPs influencing maltreatment. Regardless, the high rank of RSPs of bureaucratization appeared to have a large influence on the cognitive frameworks of actors. As this study pointed out, this facilitated maltreatment in all types of nursing homes regardless of ownership.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

Introduction

The age wave is pushing into the twenty-first century. Now, more than ever, Americans need long-term care (Giacalone 2001). Important issues when thinking about placing a relative in a nursing home revolve around quality of care. With so many people in organizations that care for the old, we need to know how organizations affect them. We also need to know how organizations affect people providing care. We need to examine organizational differences and similarities. In order to do that, we need to focus on rituals. In relation to this point, this research looked for several things.

First, it sought to determine if rituals play a role in nursing homes. The findings suggest that they do. Repetitive actions are an important part of nursing home life. In nursing homes, acts many people consider routine take on symbolic significance. For residents, this includes everything from eating to defecating. If they need help with these things, it symbolizes dependence. When staff members perform routine work tasks, there are symbolic messages in their actions as well. The messages let residents know they are objects of work, and staff members have the power to control their actions.

Second, this research wanted to determine if ritualized symbolic practices (RSPs) differ in for-profit and nonprofit nursing homes. The findings suggest that distinctions exist. People in for-profit homes engage in RSPs that emphasize cost cutting. These

measures can lead to maltreatment. On the other hand, certain nonprofit facilities encourage spirituality. Regardless, for-profit and nonprofit nursing homes face budgetary constraints. Workers in both types of facilities have a concern over operating costs. In addition, for-profit and nonprofit facilities, even ones operated by religious organizations, downplay the importance of issues like resident bereavement. They neglect emotion. Overall, differences in RSPs of for-profit and nonprofit nursing homes are present. However, many similarities also exist.

Third, this research sought to determine the extent that bureaucracy dominates social interaction in nursing homes. The findings clearly indicate RSPs of bureaucracy tyrannize nursing homes. Fourth, this work attempted to look for differences in levels of bureaucracy in for-profit and nonprofit nursing homes. Measures of repetitiveness and salience imply RSPs of staff separation and rules have a high rank in nonprofit facilities. RSPs of documentation and efficiency rank high in all types of nursing homes despite organizational variation.

Fifth, this project sought to determine levels of maltreatment in nursing homes. The findings show that RSPs of maltreatment involving physical mishandling are prominent. Specifically, issues of medial dereliction, personal negligence, environmental negligence, and bodily harm are common. The findings also show that RSPs of emotional neglect rank high. Acts of objectification, compassion transgression, and spiritual negligence are wide reaching. Similarly, RSPs of verbal abuse, such as infantilization, spoken aggression, and ignoring are eminent. From this, it is apparent that these RSPs, in addition to other social dynamics, play a large part in shaping the thoughts of employees caring for residents. Unfortunately, with a presence in multiple

domains of interaction, the repetitiveness and salience of these RSPs also promote maltreatment.

Sixth, this research tried to see if maltreatment in for-profit and nonprofit nursing homes is different. Based on this study, for physical mishandling such as medical dereliction, there appears to be a link to financial gain. For-profit facilities cut back on medical supplies to save money. In addition, they cut back on staff for the same reason. This creates a situation where workers overuse medications and even physical restraints to manage multiple residents. For other issues, such as property violations, a desire for material gain promotes the acceptance of maltreatment. Specifically, administrative personnel in for-profit facilities normalize illegally obtaining finances. Lower level staff members normalize taking resident property without permission. Regardless of these points, other RSPs of maltreatment discussed in this study are widely accepted in both for-profit and nonprofit nursing homes.

Finally, this research sought to determine if bureaucracy leads to maltreatment in all nursing homes. In for-profit and nonprofit nursing homes, hierarchical arrangements place workers into distinct groups. Separated from other staff, those groups normalize deviant behavior and generate vocabularies of motive to justify it. With strict rules and regulations guiding behavior, paperwork takes precedence over care. In both for-profit and nonprofit nursing homes, it becomes more important to document that a task is complete than to be concerned with the way it was performed. Administrative staff praise workers that focus on efficiency. Here, praise comes to workers that shove food down residents throats, put several residents in showers together, and leave them naked when changing their clothes in an assembly line manner. Most for-profit and nonprofit

nursing homes are large organizations. They both accept government reimbursements to care for the aged. They both operate under government guidelines when receiving this funding. By nature, they are both extremely bureaucratic. Unfortunately, as this study explains, residents in both fall victim to bureaucracy's unanticipated consequences.

With RSPs of bureaucracy and maltreatment ranking high, the theory of structural ritualization leads us to believe embedded groups in nursing homes reproduce social structure (Knottnerus 1997). This chapter addresses this issue. In addition, it provides an assessment of non-organizational factors that influence maltreatment. It also discusses strategic ritualization in nursing homes adding several concepts to the theory of structural ritualization. Finally, it provides recommendations to alleviate maltreatment in nursing homes.

Focusing on the Reproduction of Social Structure

The theory of structural ritualization emphasizes embedded groups. These are groups located in a larger environment. The taken-for-granted practices of people in these groups are similar to patterns of behavior in the larger environment. When routinely performed, their actions acquire symbolic significance. They become part of a cognitive script that dictates behavior. The members of embedded groups do not just copy the practices. They express them in ways that may confirm patterns of behavior in the larger environment (Knottnerus 1997). In relation to this research, we can focus on residents as an embedded group. RSPs of bureaucracy and maltreatment rank high in nursing homes. With this in mind, residents with the appropriate cognitive resources reproduce these RSPs.

Accounts in the sources show residents internalize and reproduce bureaucracy. We can consider separation and hierarchy in terms of senility. Gubrium (1975:30) explains:

> ... residents – sometimes alone and sometimes in a group – are quite aggressive in pressuring the activity director to "keep the ones with no marbles" off the premises in their presence. Some residents threatened to boycott planned events if segregation is not maintained.

This type of activity not only repeats staff separation patterns, it reinforces RSPs of objectification. It also creates heightened levels of isolation. Residents know staff members stigmatize dependent, senile people. Independent, cognitively aware residents do not want staff to stigmatize them. Consequently, they disassociate themselves from others. Fontana explains when this happens the resident "only has one group left with which to interact: himself" (1977:167).

Another example of structural reproduction and bureaucracy involves meetings. Often, rules do not allow residents to even attend their own care plan meetings. This does not stop them from having meetings of their own. Many long-term care facilities have resident councils. These councils meet on a regular basis to discuss facility issues. However, these councils have little power. The separation of residents into cliques keeps councils from concurring on issues. Without a collective voice, they can do little to change their living conditions. In relation to a resident council in a nonprofit facility, O'Brien indicates that one resident told her "nobody could ever agree on things" (1989:181). Regardless of this reproduction of bureaucracy, accounts in the sources also show residents internalize and reproduce maltreatment. Here we will consider bodily harm and infantilization.

In terms of bodily harm, residents attack and abuse each other. Fontana (1977) explains that residents physically assault other residents. However, residents also strike out against staff. Foner (1994:37) notes:

> "Despite help from two aides, Ms. Rios, a Dominican aide, was badly scratched one morning – she sustained a bleeding and swollen patch on her arm – by a resident who thrashed and scratched in the bath. The nurse finally requested that the doctor order a sedative for this resident..."

Foner also explains that staff members know certain residents "do not know what they are doing," but others "have their senses and are nasty" (1994:36).

Supporting RSPs of infantilization, residents refer to each other as children. In this study, an author describes a situation where a social worker praised a recovering resident. A nearby resident smirked and commented, "What a baby you are" (Shield 1988:170). O'Brien (1989:191) elaborates with a resident's account:

> When, on the other hand, a bright and alert but perhaps physically disabled resident is treated like a child, he or she might begin to respond in that fashion. As one 78-year-old widower put it, "You know, you come in here – you've given up your home and your things, buried most of your family and friends, and you just need a place for a little peace at the end of your life. But just because you can't get around doesn't mean your brain has gone soft! Sometimes they treat you like the 'elevator doesn't go all the way to the top floor,' so you figure, what the hell, if I'm going to be treated like a two-year-old, I might as well act like it..."

Other cases involving the reproduction of maltreatment involve verbal abuse, ignoring, privacy violations, and theft (see Fontana 1977, 1978; Laird 1979; Howsden 1981; Shield 1988; Diamond 1992; Foner 1994).

Non-Organizational Factors

Hage (1965) treats all bureaucratic environments as closed in order to make them units of analysis for testable propositions. However, many total institutions can not achieve total independence from outside sources. Viewing a bureaucracy as a self-contained environment is impractical (Clegg 1990). As such, this research should note that certain non-organizational factors influence poor treatment in nursing homes. We will consider factors such as cultural perceptions, class factors, and race issues.

With cultural perceptions, we can consider overall attitudes toward the aged. Savishinsky (1991) argues that cultural attitudes about the elderly affect the way staff members view the elderly. People do not just stigmatize the elderly when they enter institutions. People stigmatize them before they enter a nursing home's doors. In other words, some staff members probably have a negative image of the aged before the organization exposes them to RSPs that promote maltreatment (for more see Dinkel 1944; Tuckman and Lorge 1953; Drake 1957; McTavish 1972; Ulsperger 2001).

With class factors, Stannard (1973) indicates many staff members, specifically floor staff, come from a lower class background. He believes these workers have the greatest contact with residents and that leads to an increase in maltreatment. Specifically, these workers lack the education to deal with resident actions in a sophisticated manner. Instead of acknowledging residents' special needs and knowing how to work around them, their first reaction in dealing with resident problems is to lash out. Based on a lower class mentality, Stannard (1973) believes floor staff members see this forceful and aggressive means of resolving conflicts as legitimate.

With race, Gottesman (1974) explains that nonprofit facilities provide better care. However, he also contends homogeneity with residents and staff creates better care. He notes that in one nursing home that had primarily black residents, black staff, and a black owner the motivation for quality care was high. In sources in this study, racial conflict was a theme. Applied to a facility where all of the aides were black, Foner (1994:45) explains:

> Racial differences magnify the opposition with patients. Minority aides, who suffer racial discrimination and prejudice outside of work on account of their skin color, have to cater to needs of and swallow abuse from the patients, almost all of whom are white. "When the patient calls you nigger, you can't say anything, have to be deaf," a Jamaican aide told me.

The findings of this study imply there are times when disgruntled aides get retribution. Regardless, Kayser-Jones (1981) believes racial and ethnic differences are not an issue when facilities have responsible leadership (for more see Diamond 1992; Gubrium 1993).

New Perspectives on Strategic Ritualization

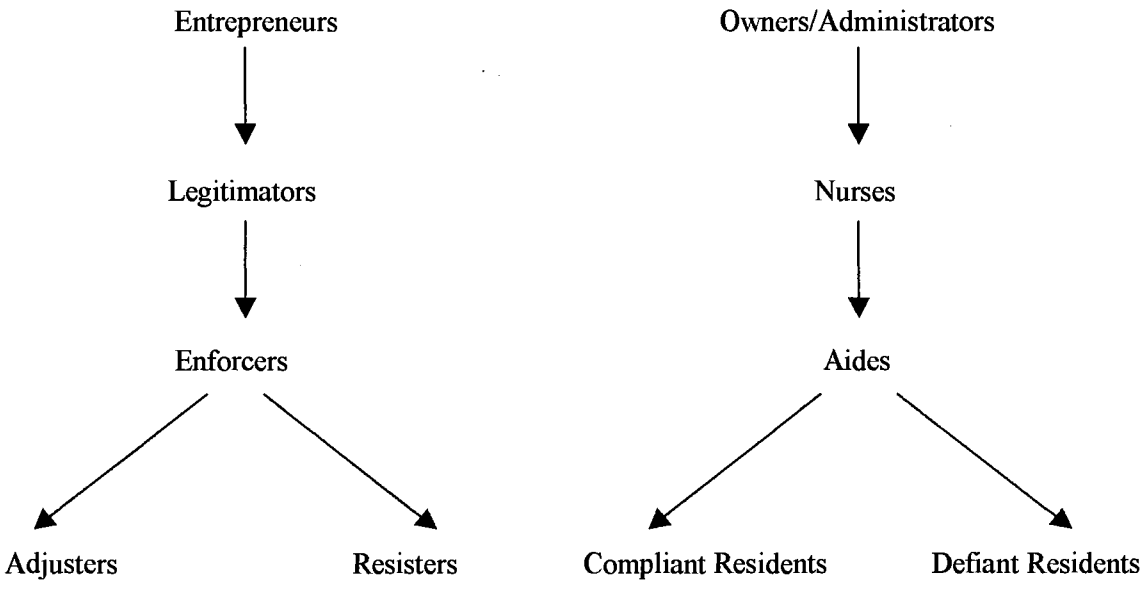
Recent work in the theory of structural ritualization focuses on strategic ritualization. One study indicates ritual sponsors, entrepreneurs, and legitimators exist. Ritual sponsors develop events. These events promote, for example, social identity. Ritual entrepreneurs advance RSPs for economic purposes. Ritual legitimators authorize RSPs with a special understanding of a social environment (Knottnerus and LoConto forthcoming). These concepts apply to patterns of interaction in this study.

First, and of least concern here, ritual sponsors exist in nursing homes. We can consider staff members such as activity directors. These individuals sponsor events, such

as games, with the intent of building a sense of community. More relevant to this research are ritual entrepreneurs and legitimators. Ritual entrepreneurs include owners and administrators. For example, facilities concern themselves with bureaucratic issues. Owners and top staff members set the tone of the organization by emphasizing themes such as bureaucracy (see Jenkins and Braithwaite 1993). Ritual legitimators, nurse supervisors, internalize and emphasize these themes. They have an advanced understanding of how actions encourage goals of owners and administrators. They emphasize these actions when socializing with subordinates.

Based on the findings of this research, additional steps in strategic ritualization exist – see Figure 7. These additional steps are specific to organizational processes but may apply to other social environments. They concern what other research calls ritual enforcers (see Knottnerus, Van Delinder, and Wolynetz 2002). They also involve what this research calls "ritual adjusters," "ritual resisters," and "ritual dissent."

Figure 7. Strategic Ritualization in Nursing Homes



After legitimators shape the interaction patterns of subordinates, RSPs continue to influence interaction. Ritual enforcers, in this case nursing aides, must meet demands imposed by entrepreneurs and legitimators. They have an enormous amount of formal and informal pressure to promote specific RSPs. In nursing homes, this concerns getting residents to comply with the institutional order.

Ritual adjusters are compliant individuals in organizations. They accept, internalize, and reproduce RSPs. When they comply with organizational goals, staff members view them in a positive light. Situations involving ritual resisters are different. Ritual resisters reject RSPs in organizations. In relation to this study, consider residents that fight RSPs leading to, for example, objectification. They use personal narratives that involve strategic communication with staff members that provide alternative perspectives of residents (see Paterniti 2000). However, these narratives do not always work. Under the influence of RSPs with a high ranking, goals relating to bureaucracy dominate care. In turn, ritual enforcers become frustrated with ritual resisters. In the face of organizational demands, this frustration may breed problems.

In nursing homes, staff label, stigmatize, and even isolate resisters. However, residents still act out to hold onto a sense of self. In nursing homes, this involves the use of bodily functions. Things most people consider routine, urinating and defecating, have symbolic meaning. Residents intentionally perform bodily functions to show their resentment of RSPs imposed on them. We can view these symbolic protests as "ritual dissent." For example, in some cases staff members fail to realize incontinence is intentional. Residents urinate on themselves to put ritual enforcers, people that sometimes abuse their power, in their place. Vesperi (1983:233) explains:

> "Its most immediate effect is a significant workload increase for unpopular employees Yet staff anger does not stem entirely from the work increase, or from the knowledge that they are being manipulated by residents. More significantly, incontinence provides a powerful symbolic negation of the aide's professional self-image... Such incidents often lead to expression of bitter resentment over the nature of the work required. Incontinence serves as the most frequent catalyst for job reassessment, after which staff members are left severely demoralized and convinced that they are engaged in a futile, thankless enterprise."

Rejecting food is another form of ritual dissent used to reject nursing home order. Vesperi explains that sometimes to "accept food would imply acquiescence to institutional authority" (1983:234). In turn, residents often intentionally go hungry because not eating is one of their last indications of individual decision making.

Recommendations: The Prospects for Structural Transformation

This study indicates rituals have a negative impact on residents. Rituals, however, do not always have negative outcomes. They have the ability to empower individuals and build a sense of community. In addition to structural reproduction, the theory of structural ritualization makes note of structural transformation. When actors encounter different RSPs, social structure can change. The more dominant alternative practices are, the more likely they will influence actors. Actors in embedded groups will use elements of alternative practices to construct new cognitive scripts (Knottnerus 1997). It seems possible to encourage new RSPs in nursing homes to improve social conditions. With this point made and the findings of this research in mind, the following general recommendations might be of importance:

- *Downplay bureaucracy*: The industry should work with policy makers to either cut back on, or revise regulations. Sometimes it might be beneficial to accept health risks involved in promoting quality of life. This involves emphasizing the emotional side of care and not the bureaucratic. Strictly enforced rules that promote dependency for medical reasons should not be emphasized. Staff should be rewarded for building personal relationships with residents and not for task efficiency. In addition, even state guidelines that generate bureaucratic demands should include measures concerned with emotional care. They should still concern themselves with documenting if staff members deliver care. However, they should also be concerned with how they deliver it.

- *Revise staff policy*: Pay lower level employees more. This might lessen the pressure to supplement their resources through property violations. Moreover, provide them with extra funds if they do extra things that encourage emotional support. In other words, provide them with incentives to meet emotional needs. Also, create measures for top staff to communicate with residents. Make it a requirement that they spend portions of the workday visiting with residents. This will fight the promotion of objectification and generate an alternative logic in the facility.

- *Acknowledge spirituality and death*: Nursing homes should not overlook the importance of spirituality. In this study, even nonprofit religious facilities did not do a good enough job in acknowledging the spiritual side of care. Moreover, they should acknowledge the death of residents. They should have RSPs that support the grieving process letting residents know their lives are important although they live in institutions. For example, memorial services or at least death announcements would provide symbolic closure to the loss of someone in the organization.

- *Embrace resident narratives*: With residents willing to share life histories, make it a point to record their stories. These could be the foundation for a personal narrative section in their chart. It would also be possible to have an organizational newsletter relaying the information. In addition, facilities could contact a local newspaper and have a column discussing the life of a resident on a weekly basis. This would not only downplay residents as objects of work, but also familiarize the community with people in their institutions – both factors operating against maltreatment.

- *Promote empathy*: Help staff members understand the lives of residents. This will build a sense of empathy and promote quality relationships. As mentioned, documentation concerning residents should include life histories. The organization should emphasize personal information just as much as information on medical conditions. In other words, staff members should realize getting to know residents involves more than just reviewing notes on their physical condition presented in a chart. In addition, it might be beneficial to have all staff members, as part of their training go through simulation exercises. For example, aides could spend an afternoon in a mock resident room. They could be tied down to the bed, fed meals, dressed in inappropriate clothing, and ignored. This would give them some indication of what it feels like to be dependent.

- *Support autonomy*. Abandon rules that restrict residents from performing tasks for themselves. Again, this might involve accepting certain health risks for the benefit of quality of life. Regardless, let residents bathe on their own and sometimes choose their own food. Let them go to their own "plan of care" conferences so they have a say in how their lives are structured. Let them help with duties in the facility so they feel like they are not just being taken care of, but caring for others as well. In addition, let them have access to their own charts.

- *Utilize communication tools*: Specifically, nursing homes should acknowledge the importance of devices like television. Nursing homes do not typically provide televisions to residents. Usually, it is the responsibility of family members to buy them. Facilities should provide at least a small set to any resident that wants one. This might include multiple sets if there are several residents in one room. A set of headphones for each resident would be necessary. This would not only benefit hearing impaired residents, but also encourage independent decision making through channel selection. In other words, residents will not have to stare at a television watching another person's program of choice. Moreover, having a set in each room would provide residents with open access to information concerning the community, country, and world at large. In recreation areas, wide screen televisions should exist. The screen should be large enough for people with vision problems. The facility could show movies that residents request, not just ones donated from, for example, local day cares. It would even be possible to show certain movies and have group discussions about them afterwards. This would be intellectually stimulating, but also promote a sense of community among residents (for more on this see Hajjar 1998).

- *Address the architecture*: This study shows that architecture in nursing homes influences RSPs. Specifically, it promotes bodily harm. Restructuring architecture in existing homes would be difficult. However, it is feasible to address it in the construction of new facilities.

- *Empower residents*. Residents lack resources. Caring for them provides little in terms of exchange. They should be able to provide input into employee evaluations at every level of the organization. This will create a sense of balance for staff/resident relations. It will motivate staff members to provide better care if residents can be involved in decisions such as whether a staff member deserves, for example, a raise or promotion. In addition, residents should be allowed to tip staff members or give them material rewards for good service.

Alternative RSPs can improve nursing homes. However, with both for-profit and nonprofit nursing homes dominated by bureaucratic RSPs that lead to maltreatment, it will be difficult. As Savishinsky explains with a quote from an aide, "Even the most sensitive institution is still, in the end, an institution" (1991:150).

Directions for Future Research

The findings of this project add insight to other research. Since they focus on nursing homes, they have a clear link to research in gerontology and studies of long-term care. Specifically, they provide a better understanding of how nursing homes operate. However, they also contribute to other areas. This section provides a brief discussion of these areas and gives directions for future research.

First, we can consider organizational theory, specifically new institutionalism. It downplays individual choice. It focuses on social context. It argues that in organizations taken-for-granted cognitive scripts, rules, and classifications influence actors and their thoughts (see Powell and DiMaggio 1991). As Troyer and Silver (1999) explain, and this research shows, the theory of structural ritualization corresponds to this. However, it provides a systematic explanation of how cognitive frameworks form in organizations.

Second, we can consider recent studies in organizational deviance. They also reject individual choice. They emphasize organizational norms. As this research shows, the norms inside an organization may run against social values. Through repetition, people normalize deviance in organizational settings. Once they normalize it, they easily carry out acts that would appall people external to the organization (see Coleman 1985; Vaughan 1999). The findings of this research show that RSPs with high rank play a part in this process.

Finally, the findings add to studies on rituals. Specifically, we can consider the theory of structural ritualization. In addition to the research on French elite schools, research supporting the theory includes studies of slave societies, ethnic groups, and task groups (Knottnerus 1999; Knottnerus et al. 1999; Guan and Knottnerus 1999; Sell et al.

1999; Knottnerus and Berry 2002). Others focus on strategic ritualization, civility, and disruptions in social order (Knottnerus and LoConto forthcoming; Varner and Knottnerus 2002; Knottnerus 2002b). However, none focus on RSPs in organizational settings such as nursing homes. This project fills this void. Most importantly, it provides a link between the theory and the aforementioned literature on organizational analysis.

In terms of future research, it would be interesting to analyze RSPs in nursing homes with different research methods. This project relies heavily on accounts detailing the experiences of lower level staff. Focus group research examining workers from each level of the organization would allow a researcher to better delineate RSPs in the staff hierarchy. It would also provide a researcher a more explicit understanding of RSPs at multiple levels that reinforce organizational structure. Regardless, future research should attempt to explore levels of bureaucratization in other forms of long-term care. It is possible that alternatives to nursing homes, such as adult day care, assisted living, and home health care, have RSPs that lead to maltreatment. It is even possible that the RSPs of adults caring for their aged relatives in home environments lead to abuse.

Albert (1990) points out, caring for aged loved ones can disrupt household organization. This can lead to the resentment of dependent elders in the household setting. Moreover, to adapt to disruptions, caregivers in household settings create ways to make caregiving easier. They objectify and infantilize dependent loved ones in order to speed up caregiving. As with care in nursing homes, Albert (1990) explains that routines become more important than the person needing care. An analysis of this process would build on the findings of this project and add to existing literature focusing on the broader field of elder abuse.

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Appendix: Literary Ethnography and Content Analysis Sources

Source	Author	Year
"Rosemont"	J. Henry	1963
"The Tower Nursing Home"	J. Henry	1963
"Muni San"	J. Henry	1963
"Old Folks and Dirty Work"	C. Stannard	1973
Living and Dying at Murray Manor	J. Gubrium	1975
"The Internal Order of a Home for the Jewish Elderly"	Watson/Maxwell	1977
The Last Frontier	A. Fontana	1977
"Ripping off the Elderly"	A. Fontana	1978
Limbo	C. Laird	1979
Nursing Home Life	C. Bennett	1980
Old, Alone, and Neglected	J. Kayser-Jones	1981
"Nursing Home Housekeepers"	J. Henderson	1981
Work and the Helpless Self	J. Howsden	1981
"The Reluctant Consumer"	M. Vesperi	1983
"Goffman Revisited: Relatives v. Administrators..."	M. Richard	1986
It's OK Mom	J. Retsinas	1986
Harvest Moon	S. Tisdale	1987
Uneasy Endings	R. Shield	1988
"Social Networks, Social Support, and Elderly Institutions"	B. Powers	1988
"Self Perceived Health of Elderly Institutionalized People"	B. Powers	1988
Anatomy of a Nursing Home	M. O'Brien	1989
Borders of Time	Crandall/Crandall	1990
The Ends of Time	J. Savishinsky	1991
The Erosion of Autonomy in Long-term Care	Lidz/Fischer/Arnold	1992
Making Gray Gold	T. Diamond	1992
Speaking of Life	J. Gubrium	1993
The Caregiving Dilemma	N. Foner	1994
"In and Out of Bounds"	J. Savishinsky	1995
"Ethics in the Nursing Home"	R. Shield	1995
"The Head Nurse as a Key Informant"	McLean/Perkinson	1995
"Relatives as Trouble"	N. Foner	1995
"From the Inside Out"	B. Powers	1995
"The Culture of Care in a Nursing Home"	J. Henderson	1995
"The Hidden Injuries of Bureaucracy"	N. Foner	1995
"Life at Lake Home"	C. Wellin	1996
A Nursing Home and Its Organizational Climate	B. Farmer	1996
Television in the Nursing Home: A Case Study	W. Hajjar	1998
Maudie: A Positive Nursing Home Experience	R. Metz	1999
"The Micropolitics of Identity in Adverse Circumstance"	D. Paterniti	2000
"Emotional Labor as Cultural Performance"	J. Sass	2000

VITA 2

Jason S. Ulsperger

Candidate for the Degree of

Doctor of Philosophy

Thesis: ASSESSING ORGANIZATIONAL VARIATION IN LONG-TERM CARE: A STRUCTURAL RITUALIZATION ANALYSIS OF MALTREATMENT IN FOR-PROFIT AND NONPROFIT NURSING HOMES

Major Field: Sociology

Biographical:

Personal Data: Born in Jacksonville, Arkansas, August 13, 1975. The son of Harold W. Ulsperger and Mary K. Printup. Two brothers, Chris W. Ulsperger and Tyler Jackson. Two sisters, Sarah E. Jackson and Elizabeth Ulsperger. On January 9, 1999, married Kristen Kloss.

Education: Graduated from Beebe High School, Beebe, Arkansas in May 1993; received Associate of Arts degree in Liberal Arts from Arkansas State University – Beebe in July 1995. Obtained Bachelor of Science degree in Political Science from the University of Central Arkansas in December 1997 and Master of Arts degree in Sociology from Arkansas State University in May 1999. Completed the requirements for the Doctor of Philosophy degree with a major in Sociology at Oklahoma State University in May 2003.

Experience: Raised in Beebe, Arkansas; employed as a machine operator and parts inspector at Kloss Machine Company, 1994-1997. Employed as an intervention specialist at North Arkansas Human Services in 1998. Employed by Oklahoma State University, Department of Sociology as a graduate teaching assistant, 1999-present.

Professional Memberships: Southwest Sociological Association, Mid-South Sociological Association, American Sociological Association, American Society of Criminology, Southwest Society on Aging.