

Maintaining ordinariness in dementia care

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Abstract Drawing on data from fieldwork in a Norwegian care home for people diagnosed with dementia, the article focuses on how social ordinariness is produced by professional practices and co-operation with residents. Through the lens of ethnomethodological and other pragmatist approaches to ordinariness, social agency and identity, the article uses interviews and observations to explore how residents in a care home were given the opportunity to act as ordinary persons and maintain ordinariness despite their illness. The analysis shows that a social and moral norm of ordinariness was central for how professional care work was performed in the care home. To help residents maintaining ordinariness was an essential part of caring work and to accomplish this, residents were regularly involved in activities they recognised from their everyday lives. This helped them holding on to their identities. The activities were regulated by situational rules that avoided stigmatising behaviour and maintained the residents' dignity.

Keywords: ordinariness, dementia care, social membership, social agency, dignity

Introduction

This article is based on a study of dementia care in an institutional setting, it focuses on maintenance of ordinariness as an essential dimension of dementia care. We have concentrated on how professional practice has helped persons diagnosed with dementia in “doing being ordinary” (Sacks 1995) and we argue that ordinariness is worth highlighting in dementia care because it represents an indispensable social and cultural frame for selfhood and social agency.

Biomedically defined, dementia is a progressive and pathologically degenerative disease of the brain (WHO 1994). Multiple higher cortical functions, such as memory, thinking and language are disturbed. While the disease can be medically diagnosed, at present no cure exists. Social researchers have been critical of the dominance of the biomedical model for the understanding of dementia. Instead they have emphasized interdependence, reciprocity and support of people with dementia as active partners in their own care (Kontos *et al.* 2017). A focus on a metaphysical, cognitive or moral concept of “personhood” has been prominent in recent research (Heron and Wrathall 2018, Higgs and Gilleard 2016a). Other analysts have criticised the concept of “personhood” for being too ambiguous and abstract (Bartlett and O'Connor 2007, Davis 2004, Walsh *et al.* 2019). Instead of “personhood,” Kontos *et al.* (2017) have introduced a political concept of “relational citizenship,” which emphasises the securing of rights for people living with dementia. Before this concept was introduced, however, a comparable citizenship model was criticised for being too ambiguous and abstract, and for ignoring the concept's legal grounding (Behuniak 2010).

We see maintenance of ordinariness as an essential dimension of dementia care and focus on professional practices that support and enable persons diagnosed with dementia to successfully constitute ordinary activities. To the best of our knowledge, ordinariness has not been a central topic in sociological research on dementia care; we are therefore suggesting a theoretical framework that can be used to describe and discuss how caregivers work with people living with dementia to maintain social and behavioural ordinariness.

Our focus on ordinariness in dementia care is informed by other researchers and their emphasis on the importance of organized activities as part of dementia care. Bartlett *et al.* (2017), Gjødsbøl *et al.* (2017), and Heron and Wrathall (2018) argue that people with a life-limiting condition like dementia are suffering and that dementia care should involve residents in organised activities and situations that reduce their social suffering. Likewise, Higgs and Gilleard (2016a) argue that care for people with dementia should “focus on supporting people’s existing capabilities while minimizing the harmful consequences of their incapacities.” Bosco *et al.* (2019) argue for the need for active participation and co-operation in social life, while Taylor (2001) proposes that caregivers might have a political and emancipatory function and temporarily take people living with dementia out of their roles as sufferers.

As a product of practice, social ordinariness is not metaphysical, it is observable and empirically accessible. We have focussed on how ordinariness was enacted and maintained through residents’ participation in regular organised and guided activities in a ward for people diagnosed with dementia. Ordinariness refers to settings, activities and identities that are experienced as common, well-known and unexceptional, as well as to people’s abilities to behave in situationally appropriate manners. The aim of this article is firstly to examine how professional practices establish a frame of ordinariness, secondly, we will show what is needed to maintain ordinariness in an institutional setting.

The conceptual framework

The World Health Organization (2012) has promoted normalisation as an important aim for dementia care; normality and normalisation are common topics in research on dementia care and an aim of professional caring work (Bentwich *et al.* 2018, Edvardsson *et al.* 2010, Robbins and Bernat 2017). However, “normal” is an ambiguous term (Canguilhem 1991). In much of the literature about dementia care, the meaning of this term is rarely clarified; it refers instead to a common-sense understanding of individual qualities. Canguilhem (1991: 185) contributed to a clarification of the meaning of the term when used with reference to people living with dementia. He argued that the level of normality of persons with cerebral lesions depends on the environment that they are acting within. “It means nothing to say that a sick man has lost his speech if one does not specify in what typical situation this lack is perceptible” (Canguilhem 1991: 187). This quote indicates that an individual’s ability, or lack of ability, to perform ordinariness must be perceived in connection with situations and activities.

Taylor (1994) has referred to ordinariness in nursing and defined it as pre-reflexive consciousness; however, our concept of ordinariness refers to a product of reflexive and conscious action. A politically defined concept of ordinariness has been connected to citizenship and dementia care (Bartlett 2016, Neveu 2015) and Neveu introduced “ordinariness” as a category with political potential, but also as a category to be used as an analytical lens. As a political category it is irrelevant in the setting of our project; it is more relevant as an analytical lens. Our understanding of ordinariness come from Jerome Bruner and Harvey Sacks who separately argued for the fundamental social, cultural and practical significance of ordinariness in everyday life. Their approaches, informed by pragmatism and forms of interactionism, had less to do with individual cognition and consciousness than with social relations and practices.

According to Bruner (1990), ordinariness is a significant aspect of any culture, and to perform culture-specific ordinariness is essential for being recognized as a person in any culture. Ordinariness is taken for granted. "In every culture (...) we take for granted that people behave in a manner appropriate to the setting in which they find themselves" (Bruner 1990: 48). To enact ordinariness is to follow a cultural rule. Barker (1978) introduced a "situational rule," proposing that people are expected to behave in situationally appropriate manners, whatever their roles. When people for instance go to the post office, they should "behave post-office." According to Bruner, this situational rule holds for verbal as well as for non-verbal actions. He concluded that "when people behave in accordance with Barker's principle of situatedness (...) we do not ask *why*: the ordinary behaviour is simply taken for granted and in need of no further explanation. It is ordinary and experienced as canonical and therefore as self-explanatory" (Bruner 1990: 48).

Harvey Sacks' (1995) concept of ordinariness is implicitly connected to the ethnomethodological concept of "membership knowledge" (Garfinkel and Sacks 1970), which refers to an individual's ability to behave in situationally adequate manners, as a social member, or in Bruner's terms, to follow the situational rule and act ordinarily. To be ordinary is not something you are; similar to Bruner's reasoning, ordinariness is for Sacks a product of adequate or proper situational agency. The ordinary person has, as his or her job and continual and constant occupation to "doing being ordinary" (Sacks 1995: 216). Following Sacks and Bruner, the demand for ordinariness represents a fundamental cultural and social norm and a form of moral authority. To be ordinary, persons have to act according to the principle of situatedness. This may involve the ability to participate in common activities, skilful use of tools and other equipment and embodied skills, such as dancing, singing or other corporeal abilities. Moser (2018) argues with reference to Sacks that persons living with dementia may enact ordinariness when they are allowed to act within frames of phantasies or delusions.

Sacks declared that for "doing being ordinary," you must know what it means to be ordinary in a given situation, and it must be possible for you to do what is needed to be ordinary. Many people living with dementia do not have the memory, understanding or corporeal capacities needed to enact ordinariness. Under these circumstances, other people with the necessary knowledge and skilfulness may guide persons living with dementia to do what is needed to actualise ordinariness, for instance to help a man button his shirt correctly and ordinarily.

Our initial understanding of the role played by ordinariness in dementia care came from our data, but our further analysis is informed by Bruner and Sacks' conception of ordinariness. Ordinariness is produced and reproduced by social practices, often minutely, and in specific, local contexts. Involvement in practices that produce or maintain ordinariness may affirm the social agency and membership of people living with dementia and "redress their biomedical loss and deficit," to quote Bellas *et al.* (2018).

Method and analysis

This article is based on data collected from fieldwork carried out in a ward at a Norwegian care home for persons diagnosed with dementia. The data collection period lasted for six weeks. The article builds on video-recordings and field notes from observations, informal conversations with caregivers and residents, and in-depth interviews with three caregivers. The fieldwork lasted for six weeks and was conducted mainly during the daytime, but also on some evening shifts.

The observations were unstructured and took place within the public areas of the ward. The first author had close contact with residents during the fieldwork period and participated in

regular ward activities such as meals, fitness sessions, hiking, dancing and informal conversations. Diaries were kept throughout the fieldwork period. To reduce the negative effects of long-term memory processing (Cicourel 1974), the researcher wrote field notes during or immediately after observing the activities. Whenever possible, the researcher transcribed conversations and other forms of social intercourse in situ, as accurately and comprehensively as possible. Interviews with caregivers were audio recorded, transcribed and analysed with particular focus on: how caregivers described their work and its purposes; how their work was conducted; and how they interacted with and tried to involve residents in regular activities.

Our analytical approach is sociological and represents what Rojek and Turner (2000) have termed “engaged detachment.” We are influenced by social interactionism (Atkinson and Housely 2003), pragmatism, pragmatist realism (Putnam 2016) and phenomenology. We focussed on activities and interactional sequences that took place in the ward. In Atkinson’s words (2015), it was an endeavour, even if imperfect, “to perceive the world in the perspective of the other.” At the same time, the researcher made an effort to keep a relation of “otherness” (Atkinson 2015) to the residents, the caregivers and their activities.

Data were analysed thematically (Rapley 2011). For our use of video-recordings, we followed analytical procedures described by Heath *et al.* (2010). While reading field notes and watching video-recordings, the researcher wrote analytic memos. Data were categorised and certain themes emerged together with evidence of relationships between them. As we became aware of the connection between the organisation of activities, how the activities were described by caregivers, and their guidance of residents, we started to see the relevance of the expression “doing being ordinary” for our analysis of observed activities.

The Norwegian Data Protection Official for Research provided ethical approval for this study in 2013. To satisfy official requirements, informed consent was provided by the head of caring institutions in the municipality and by the care home. A letter describing the project was first sent to the care home and the leader of the ward collected consent from the residents and caregivers. We were not allowed to make the first contact. The employees and residents were thus informed about the research project and the presence and participation of one of the researchers was approved. The residents and caregivers were also informed orally when the researcher attended the ward. This information, as well as the information that it was their right to withdraw from the project without consequences whenever they wanted, and to have all information recorded about them deleted, was repeatedly outlined to the residents and caregivers. Only those who had given consent were video-recorded. The researcher signed the municipality’s confidentiality agreement. In the article, the name of the municipality and the care home, names of residents and caregivers, names of places, and descriptions of certain personal characteristics have been omitted or changed to ensure complete anonymity.

The care home

The ward we collected data from housed 10 residents diagnosed with dementia. During the daytime, three caregivers were present, together with a kitchen assistant. Most caregivers were female authorised nurses or auxiliary nurses. They did traditional care work, such as helping and providing personal care for residents who were unable to manage their personal hygiene or to dress themselves. Most of the time, however, they were involved in what one of the nurses called “milieu therapy,” a version of what Kitwood (1997) called “person-centred care.” It meant including residents in various ordinary activities. The residents were not forced to comply, and similar to what a study of long-term psychiatric patients showed (Pols 2005), residents signalled their appreciation, verbally or non-verbally, in situations that were often co-produced with other residents or caregivers.

The care home is a public health institution and a part of the municipal welfare services in a medium-sized Norwegian town. Most residents were elderly; at the time of our observations, nearly half of the residents was men and the other half was women. On the floor of the ward, the walls of a corridor were decorated with items from earlier times. It had a seating area and enough space to arrange exercise sessions and dancing, and those who did not want to or were unable to take part in physical activities could sit and watch and join in on the conversations and laughter that often followed the physical activities. Each resident had his or her own room, and most rooms were decorated with personal pictures and other private items from the resident's home, such as their own furniture. The ward was made into a setting characterised by material ordinariness for the residents. The care home also had a relatively large sense garden and the residents enjoyed being there. It was also popular to visit a local pub, which had an agreement with the ward. The residents who wanted could go there at certain times and have a drink of whatever they preferred.

Findings

We have organized the findings into themes with subheadings that refer to data from interviews with caregivers and from observations of activities in which residents were involved. The way we have organized and presented our findings supports our argument and demonstrates the connection between our empirical data and the central analytical concepts.

'We try to make things normal here'

Early in the fieldwork period, one of the caregivers said, "We try to make things normal here." Caregivers never specified the meaning of the term normal; it represented a form of glossing with an implicit and common-sensical meaning. The indexical term, "here," suggested that the caregiver considered this ward to be different from other institutions for people diagnosed with dementia. Implicitly, other institutions might care less than they did "here" about residents' normal or ordinary behaviour. Another caregiver said:

"Caring culture may mean providing food and drinks and then putting them (the residents) in front of the TV. We do not do that here. We think that life must consist of something more. To go to a café, to walk in the garden, to take a trip to town, to do exercises, to go to concerts (. . . .)."

This utterance contrasted the local practices with possible practices belonging to what the caregiver called "caring culture." This contrast distinguished her ward, as one in which they tried to involve residents in multiple activities, contrary to a caring culture typical of other but unidentified care homes.

It became soon apparent, however, that even in this ward, normality or ordinariness did not always emerge exactly as it usually does in other "more ordinary" settings. Nevertheless, it was the expressed aim of the caregivers to work at recreating normality or ordinariness as far as possible. According to Brannelly *et al.* (2019), achieving an ordinary life is challenging for people living with dementia in a residential setting. In the ward, various activities involving residents were arranged, or residents were asked to complete tasks the caregivers knew they were capable of managing. Inactive residents might become restless or fidgety, and the caregivers would try to encourage them to take part in an activity. They suggested ordinary activities they could do together, such as baking a cake or going for a walk. While residents were never asked to do what they had no capacity for any more, they were encouraged to carry out

tasks they could accomplish, sometimes with support from and co-operation with caregivers. When caregivers tried to realize the local cultural norm, “to make things normal”, they involved residents in activities and situations that gave the residents an opportunity to perform ordinariness.

Activities, social membership and identity

Activities in the ward were meant to be similar to those residents were used to in their earlier ordinary life. Caregivers involved residents in activities that, in the terms of Kitwood and Bredin (1992) and later Higgs and Gilleard (2016b), might display the resident’s personhood or a situated social membership (Garfinkel and Sacks 1970, Gjernes and Måseide 2015, 2019, Gjernes 2017). In other words, they tried to help residents “holding on to [their] identities” (Lindeman 2010).

A caregiver made a general statement about the work needed to help residents to hold on to their individual identities:

“This (work) has much to do with helping them to do something meaningful. Their identities are splintered into a thousand pieces; we must therefore know their histories, and help them to hold on to their past. They become more satisfied when they experience that connection.”

As an example, the caregiver referred to a resident, Ella. Ella and the caregiver shared a background in farming. When Ella became restless or very quiet and withdrawn, the caregiver would start talking to her about women’s life on farms. She talked about a life that had been ordinary for Ella, involving preparation of food, use of various tools and how modern devices have made women’s work on farms easier. These conversations about ordinary life aided Ella in retrieving her memories and experiences. Through conversations, Ella was helped to reflect (also an activity) on her former life and the activities belonging to it. In this way she was helped to hold on to her memory, life history and identity.

A caregiver said they thought it imperative that residents should maintain their ordinary skills as long as possible. Research has shown that individuals in early stages of dementia have expressed the same desire (Menne *et al.* 2002). It was considered important that caregivers should not assist residents too much when completing tasks. Residents should instead be subtly guided in their efforts:

“To spread butter on (residents’) sandwiches (by a caregiver) is taboo here; each resident is supposed to do what he or she is able to, that also refers to dressing themselves and maintaining personal hygiene. They shall be guided. We do a lot of mirroring here; if they do not remember how to sit down on the toilet, we have a short bench in the bathroom on which a caregiver sits down so that the resident can see what the other does and then can do the same”.

For subtle guidance, verbal instructions are not always useful. Analogous and embodied information about what to do and how to do it, as exemplified by the use of the short bench in the bathroom, was an effective strategy in maintaining the residents’ ability to do ordinary, everyday things that helped holding on to an identity.

‘We must guide them so that they can do something’

A caregiver emphasized the importance of involving residents in activities and guiding them:

“For me it is important to emphasise the profession (nursing), and why we are here. In relation to culture, one may ask whether we should just provide care and that is it, or should

we do something more, to arrange aromatherapy baths, go to a café, and go out? It is us, the staff, who make the day. The residents have no initiative; we are the ones who must do it. During the process of dementia, one often loses initiative, many (residents) experience a wish to do something, but they only move flower pots or become restless, then we must guide them so that they can do something.”

She referred to the importance of involving residents in common activities they enjoyed. The caregivers provided professional nursing when residents needed it; however, their professionalism should not be restricted to the “bodywork” (Twigg *et al.* 2011) of traditional health care. Professional work should incorporate active involvement of residents in ordinary activities. During interviews and informal conversations, the caregivers explained that when residents were involved in activities, their experience of ordinary involvement was an important precondition for relieving their suffering. Bartlett *et al.* (2017) see relieving of suffering as an important aspect of dementia care, and it plays an important part in maintaining residents’ dignity and quality of life. To succeed with this, it was important to maintain the residents’ experience of ordinary skilfulness and ability to cope.

Residents were regularly involved in situations or activities of various kinds. Some of them were arranged within the ward, while others took place in other settings and contexts. The organised activities were in general not gendered. Both male and female residents were, as a matter of principle, involved in the same kind of activities. The “political potential” (Bartlett 2016) of the spaces or activities we observed could at best be categorised as “micropolitical”; they mostly consisted of collaboration in small groups or face-to-face interactions.

Caregivers used to accompany residents to a neighbouring supermarket for shopping. A caregiver described how they tried to make the residents follow the principle of situatedness and “act supermarket”:

“A person with dementia should be able to go to the supermarket together with a caregiver and be seen by other customers as if she or he were like you or me. We do not want others to look upon them (the residents) as odd. We must subtly guide them to put the groceries into their cart, take it to the till, pay for it and go home.”

The caregiver’s function was to help the resident to act as an ordinary shopper, generate an ordinary social situation and enact ordinariness. Other customers should not see the resident as exceptional or abnormal. If necessary, the caregiver guided the resident “subtly” and helped him or her to act as an ordinary shopper. This form of support has been called “tutoring” or “scaffolding” (Wood *et al.* 1976). In shopping situations, scaffolding was meant to help residents “doing being ordinary” or in Bruner’s terms, to guide the resident in following the situational rule, and thus, preserving the resident’s proper social agency and dignity.

An example mentioned by a caregiver indicated that situations or activities that made a resident’s lack of common skills or capacities noticeable should be avoided:

“You do not take someone who has been a school principal to go bowling together with students from the school where he used to work, to let them watch him and make him experience a situation in which he is not able to master the game and lose face in front of them. You should go for a walk with him instead.”

Residents should not be involved in activities that might threaten their face. Instead, the caregiver should involve residents in activities she knew they could manage like or almost like an ordinary person. If the resident was physically fit, caregivers could, for instance, go for a walk with him or her, and walking is a very ordinary corporeal activity, even if it may require certain body techniques (Mauss 1973).

Meals: making activities ordinary

In this and the sections that follow, we refer not only to interviews with caregivers, but also to observed activities involving residents. Meals represented important and regular activities in the ward, as indicated by a quote from a caregiver:

“The meal is important. We share food there, participate in small talk, and they (the residents) must concentrate fully on eating in a decent manner, so that they do not start eating with their fingers and can thus maintain their dignity. We work a lot to maintain normality.”

In this quote, “normality” means to behave according to the situational rule and is connected to a resident’s social agency and dignity. To eat in a decent manner was also considered important for the residents’ experience of the meal as pleasant and ordinary. The meals in the ward were arranged with a significant amount of professional concern and attention. The caregivers wanted the residents to “behave mealtimes,” which meant “doing being ordinary”. Research has shown that persons living with dementia often suffer from malnutrition (Meijers *et al.* 2014, Prince *et al.* 2014), and the ward’s meals served an important nutritional purpose. However, meals consist of more than just eating (Aselage and Amella 2019, Gjernes and Måseide 2019). Pike (1954: 44–45) made a distinction between the “game” and “spectacle” features of human behaviour. The game feature of a meal refers to eating, which is the meal’s core activity, whilst the spectacle feature refers to the aesthetical, social and ceremonial dimensions of the meal, enacted through selection and appetizing presentation of food, social togetherness and behaviour regulated by situational rules. Hence, the spectacle feature enhanced eating and affected the nutritional value of the meal. The core act of eating and the eaters’ ceremonial behaviour made a meal into an ordinary event. In the ward, meals were opportunities for residents to practice ordinariness through social interaction and togetherness, regulated by social and cultural conventions.

If necessary, residents were helped by the caregivers to complete both the game and the spectacle features of the meal. Caregivers were engaged in monitoring and regulating behaviour during meals. This involvement by the caregivers might be seen as use of power in the form of surveillance, paternalism or disciplining. However, in this setting, how power was used and what implications it might have is disputable. Power should be understood as an ambiguous phenomenon with different meanings and functions, as argued by theorists like Behuniak (2010), Elias (1998), Foucault (1976), Måseide (1991), or May (1973). These and other power theorists have argued that subtle use of power may also be understood as relative and seldom one-sided, compassionate and enabling. To define the caregivers’ use of power during the meals merely as coercive would be unjustly simplified. It would have ignored the compassionate and enabling aspect of their involvement with the residents. The quotation from the caregiver suggested that maintaining the ordinariness of the meal, even if it required surveillance and control, was important to maintaining the residents’ ordinariness and dignity. This seemed to be in agreement with both Sacks’ and Bruner’s suggestions about the normative request for ordinariness in everyday life. Goffman (1959: 65) argued that ordinarily people will not simply conduct tasks and express feelings in any idiosyncratic way, they are expected to conduct their tasks and express their feelings in socially and culturally acceptable and ordinary manners. This means to act according to powerful cultural and situational norms. During a meal, the presentation of a self that follows the meal’s cultural and situational norm, even if the presentation is assisted, belongs to the spectacle feature of behaviour; it depicts both the meal and the resident’s presented self as ordinary.

The need to maintain ordinariness was also essential when residents dined outside of the institution, according to another quote from a caregiver:

“If we go to a restaurant to have supper, it must be on a one-to-one basis. If something happens, a caregiver may direct, explain and keep things going, saying things such as ‘now we are here to eat, to look at the view’ etc. Then they are reminded of where they are and what is happening.”

This quote refers implicitly to the relevance of Bruner and Barker’s situational rule. When taken to a restaurant, it was important to behave situationally appropriate or ordinary, and to accomplish this, the residents needed to be accompanied by one caregiver each to give guidance. If not, the situational ordinariness might be disrupted. The restaurant exposed the residents to a particular social context; the food and the setting were different, but it was a context that made stronger normative demands on residents to “doing being ordinary” than in ward meals.

Co-operative activities

We video-recorded a sequence when a resident, Ann, was chopping potatoes together with a caregiver and the researcher. The caregiver had asked her to chop the potatoes into small pieces and put them into a dish (extract 1). For Ann, chopping potatoes was an ordinary activity and she had the embodied skill to do so.

Extract 1

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|----|-------------|--|
| 1. | Ann: | Where? |
| 2. | Caregiver: | Here (points to a dish) |
| 3. | Ann: | What am I to do with this? |
| 4. | Caregiver: | Put them into the dish. |
| 5. | | Here (points to the dish again) |
| 6. | | (The researcher tilts the dish toward Ann so that she can see the pieces of potatoes that are already in there and asks her to put the pieces into the dish) |
| 7. | Ann: | Is it in there I should put them? |
| 8. | Researcher: | Yes, put the potato pieces there (points to the potato pieces in the dish) |
| 9. | | (Ann puts the chopped potato into the dish, a bit hesitant, as if she is uncertain if this is correct) |
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While Ann had the ability to chop potatoes, her initial remark, “where?”, meaning where to put the chopped potatoes (line 1, Extract 1), indicated that she did not understand what to do with the chopped potatoes; she needed guidance. Even if the caregiver told Ann to put the potatoes into a dish, Ann was uncertain about what to do with the potatoes she had finished chopping (line 3). The caregiver repeated that she should put them into a dish and she showed Ann the dish (lines 4–5). To assist, the researcher tilted the dish so Ann could see that it contained chopped potatoes, she asked Ann to put the rest of the chopped potatoes in there. Ann was still uncertain and asked if it was into this particular dish that she should put the chopped potatoes (line 7). The researcher confirmed this, and a bit hesitantly, Ann put the potatoes she had chopped into the dish. The tilting of the dish that made the chopped potatoes visible, an analogous and corporeal form of scaffolding that was more concrete than talking and pointing, made Ann able to complete her job. Ann had the embodied skill to peel and chop potatoes, but she did not understand the more abstract, or not body-centred, part of the job concerning where to put the chopped potatoes. She had to be instructed step-by-step, by the caregiver and the researcher to act situationally adequate. In this way, a team co-operated to do an ordinary job and the resident was collaboratively made part of this working team.

Embodies skills and ordinariness

We video-recorded a situation when residents exhibited ordinariness through display of embodied skills. A caregiver was seated at a table together with Sam, a resident with verbal and cognitive incapacities. A pile of flannels from the laundry was on the table in front of them. The caregiver asked if Sam would fold the flannels. Sam immediately started to fold; he worked independently, carefully and correctly. He folded each of the flannels two times and tried to make the corners sharp. He stretched and shook them if they were wrinkled. When folded, he systematically placed the flannels into piles. His skilfulness indicated that this was ordinary work for Sam. Another resident, Peter, joined Sam at the table; he had a cup of coffee and when asked by the caregiver if he would help folding, he answered yes. He took one of the flannels from the table, wiped his face with it, took a sip of coffee, and started talking to some other residents before he left the table. The caregiver did not react to this. Peter talked with other residents, sipped coffee and wiped his face with a flannel before he left; all of these are ordinary acts. The meaning of our activities depends on how they are framed (Goffman 1974), and folding flannels makes an individual ordinary within a flannel-folding frame. But within other frames, Peter's acts were also ordinary.

A female resident, Helga, then entered the room and the caregiver asked her if she would help out with the folding. Helga answered yes and started to fold. To her, folding was also an embodied skill. While Sam worked independently and systematically, Helga, however, acted as if she were more uncertain, not about the folding, but about what to do with the folded flannels. She started to make a pile of flannels, like Sam did; but she suddenly seemed unable to remember where to put a flannel. She asked Sam where she should put it and Sam answered, "oh yes" and laughed a bit. "Oh yes" Helga responded and continued, "well, well, then I'll just put it here like this." She put the flannel on her pile with a laugh and continued folding. Helga showed embodied skills, but she did not remember where to put the flannels she had folded, even if she had started doing it correctly. Helga obviously wanted to do her job ordinarily and asked Sam to help her, and he answered, "oh yes" with a laugh. His response was incomplete, but it served to direct Helga's further action. Helga was hardly directed by the content of what Sam said, but his act of responding was in a restricted sense adequate and meant something to her, and she noticed what he did with the flannels. She also completed an incomplete interactional sequence and made it into an ordinary adjacency pair structure (Schegloff and Sacks 1973). In this case, a resident aided another resident in acting ordinarily and ordinariness became a product of their co-operation.

Discussion and conclusion

The residents were diagnosed with dementia. In the ward, this diagnosis was not an identity marker and the caregivers' work consisted of offering a form of "moral treatment," which meant to help the persons diagnosed with dementia "doing being ordinary," and through this, to temporarily emancipate residents from their pathological identity (Taylor 2001) and take them out of their role as sufferers (Bartlett *et al.* 2017, Heron and Wrathall 2018). Goffman (1959, 1974) made a distinction relevant for our analysis between an individual's "character" and "social role." This distinction refers to human beings as simultaneously physical and social beings. Signs indicating dementia are usually behavioural and expressive, but to be diagnosed with "dementia" indicates a biomedical condition. In Goffman's terms a dementia diagnosis refers to a person's corporeal character. This character, which cannot be deliberately changed, has the potential of becoming an individual's master status. The afflicted individual or any health profession has limited or no medical control over this corporeal condition and cannot

get rid of it. A social role, on the contrary, can be attributed, changed and made relevant for the social occasion or activity, identity and standing for an individual diagnosed with dementia. Ascription of a social role that replaces the master status that might follow from a dementia diagnosis, may have an emancipatory function for the afflicted person. Within the context of the observed ward, persons diagnosed with dementia were not treated as individuals with a prominent somatic or mental character. They were attributed other social roles and identities, and through organised efforts to maintain ordinariness, they were given the opportunity and helped to hold on to their identities and to act as social selves. When considered necessary, the caregivers recognized and responded to signs of an individual's neuropathological character, but in many situations, they deliberately ignored it and strived to make a resident's neuropathological character in Sacks' terms "unseeable."

Boyle (2014) has asked for a more expansive concept of agency in social science theory, informed by the experiences of cognitively disabled people. Our focus on the enactment of ordinariness by people living with dementia may contribute to such an expansion; it takes the focus away from agency as product of individual cognitive and physical capacities or impairments and integrates social agency in environments and ordinary interpersonal and collaborative practices. Referring to our findings and in accordance with Bruner's formulation (1990), social agency means to behave in manners appropriate to the setting, but as we have shown, to behave this way may require guidance and collaboration. A quote from Goffman (1967), "Not then men and their moments. Rather moments and their men," indicates our understanding of concepts like "person," "social agency" and "social membership."

To be ordinary is something one does as a social agent, and the ordinary person does it constantly and continuously (Sacks 1995). However, it was impossible to make residents act constantly and continuously in ways that made them ordinary, and it was not always considered desirable. It was, however, a constant and almost continuous ambition among the caregivers to help residents to act as ordinary participants in regular, organised and common activities. They organised situations and activities that allowed the residents, often with some help, to act in accordance with Barker's principle of situatedness. It is important to organise situations and activities that residents have the capacity to be involved in, if necessary through scaffolding; it is in the context of situations and by participation in activities that social agency and membership emerge, also for the residents.

According to Sacks, the work that enables the ordinary person to become ordinary requires analytical, intellectual and emotional energy. People living with dementia often lack such capacities. To maintain ordinariness for them, someone else must provide or stimulate the remaining skills and energy needed to do so. To provide that energy, to stimulate skills and activities, to guide the residents' accomplishment of organized activities, and to help them to act according to situational rules were central elements of the caregivers' professional job. By doing this, they provided persons living with dementia with social agency and membership and assisted them in "doing being ordinary."

This article has shown that a social and moral norm of ordinariness was central for how professional care work was performed in the ward where our study was conducted. Social and behavioural ordinariness is not an individual attribute isolated from the individual's social context or surroundings. For the residents, the actions and activities that produced ordinariness, social agency and dignity needed material affordances, social contexts, situations and relations, and often subtle scaffolding or direct guidance, most often from caregivers.

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Trude Gjernes: Conceptualization (equal); Data curation (lead); Formal analysis (equal); Funding acquisition (lead); Investigation (equal); Methodology (equal); Project administration (lead); Resources (equal); Software (equal); Supervision (equal); Validation (equal); Visualization (equal); Writing-original draft (supporting); Writing-review & editing (equal). **Per Måseide:** Conceptualization (equal); Data curation (supporting); Formal analysis (equal); Funding acquisition (supporting); Investigation (equal); Methodology (equal); Project administration (supporting); Resources (equal); Software (equal); Supervision (equal); Validation (equal); Visualization (equal); Writing-original draft (lead); Writing-review & editing (equal).

Data Availability

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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