Colonizing the aged body and the organization of later life

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Abstract

Based on fieldwork in residential homes, arrangements for the care of older people are examined with reference, primarily, to Deetz' (1992) theory of 'corporate colonization'. Extending this theory, it is argued that grouping such people in care homes can result in a form of social segregation, one that reflects the management of the aged body in relation to normative constructions of dependence. Focusing on the experiences of residents, the everyday effects of narratives of decline on disciplining the lives of older people are assessed, with this analysis taking recourse to the work of Foucault (1979). The result is the identification of three related concepts at work in the colonizing process of the aged body: (i) *appropriation of the body* – the physical and social practices involved in placing older people in care homes; (ii) *separation from previous identities* – how a range of new subjectivities are produced in the process of becoming a 'resident'; and (iii) *contesting colonized identities* – the ways in which residents can attempt to challenge normative concepts of managed physical and mental decline. Overall the disciplining of the body is theorized not only as an adjunct to the notion of corporate colonization but also, more generally, as a prominent and powerful organizing principle of later life.

Keywords: Age and ageing; corporate colonization; disciplinary power; organization theory; residential care.

Introduction

'One of the characteristics of colonization is that in order for the colonizers to oppress the people easily they convinced themselves that the colonized have a mere biological life and never an historic existence'. (Freire 1971: 5)

In organization studies, the concept of 'colonization' has frequently been used to describe relations between dominant and dominated societies (Banerjee 2003; Banerjee and Linstead 2001; Boussebaa et al. 2012). Elsewhere attention has focused on the colonizing effects of transferring management concepts and techniques across national boundaries (Frenkel and Shenhav 2003; Muzio and Faulconbridge 2013). Stanley Deetz (1992) however argued that a host of practices combine to create a situation of 'corporately colonized' identities within society, in his case within US organizations. He suggests that corporate interests proliferate and alternatives become almost inconceivable. We develop this line of analysis to theorize the colonization and disciplining of older people's bodies as an adjunct to processes of corporate colonization; that is, theorizing the aged body as both the product of and site for colonization in organizations such as residential care homes.

While Deetz' work has been used to examine the effects of corporate colonization on, for example, employee identity (Brown and Lewis 2011), work and family life (Dempsey and Sanders 2010; Tietze and Musson 2005) and child care (Katz 2004; Medved and Kirby 2005), relatively little attention has been paid to the effects on the lives of retired older people (Burns et al. 2014). This article seeks therefore to develop an analysis of older age and the body through such organizational theorizing (Dale 2001; Hassard et al. 2000; Hindmarsh and Pilnick 2007; Holliday and Hassard 2001). It argues that the organization of care includes processes of corporate colonization whereby the lifeworlds of people living in care homes can become increasingly overshadowed, or even displaced, by corporate cultures where signals, symbols and values are clearly managed. As an organizing principle for residential care provision, we suggest that age converges with such corporate colonization and in the process becomes intensified and accelerated. The analysis explains ultimately how age and ageing become salient organizing principles in the corporate colonization of the body and how this involves the interaction of three concepts; (i) *appropriation of the body* – the physical and social practices involved in placing older

people in care homes; (ii) s*eparation from previous identities* – how new subjectivities are produced in the process of becoming a 'resident'; and (iii) *contesting colonized identities* – the ways in which residents challenge normative concepts of managed physical and mental decline.

The article is developed in three main parts. In Part One we lay out the theoretical grounding for the research. This sees reviews of literatures concerning *inter alia* the concept of corporate colonization, what it means to be old in modern society, and how ageing is increasingly managed and organized. Part Two then describes our formal research investigation into the social organization of care. Here we discuss initially the methodology for the study before outlining the main findings from our interpretive – interview and observation based – investigation of everyday experience in residential care homes. Finally, in Part Three, we discuss the main themes arising from our research in the light of theorising discussed in the first section of our article. In so doing, we offer new theorising on corporate colonization before providing ultimately a set of conclusions from the investigation as a whole.

Part One: Theorizing corporate colonization and age

Corporate colonization

As opposed to studies of physical and economic colonization, Stanley Deetz proposed corporate colonization of the lifeworld to explain the reach of organizational ideologies into public decision making and everyday lives. Basically he argues that consent, manufactured in the workplace, is *reproduced in routine everyday practices, and hidden by the assumption of an open contractual relation* (Deetz 1992: ix). Deetz demonstrated how modern corporations were forming the new site of public decision making with effects extending beyond organizational boundaries and with far reaching effects on home and family life (Deetz 2008).

Drawing on Foucault's notions of disciplinary power, Deetz (1992) showed how corporations have become extremely powerful in colonizing and then controlling the institutions and practices of society, as well as individual lives and identities, through the spread and reinforcement of ideologies (Mitra 2010). Moreover, he argued that corporate power is inherently non-democratic, pervades our everyday experience,

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and is regarded as hegemonically 'normal'. Colonization is sustained by the commercialization of language, vocationalization of education systems and the restructuring of family life around the demands of work (see Dallimore and Mickel 2006; Dempsey and Sanders 2010; Katz 2004). Organizational processes strategically reproduce corporate ideologies by creating spurious consensus and encouraging employees actively to support corporate interests (Brown and Lewis 2011; Casey 1999). The argument is that corporate colonization is remarkably difficult to resist, for it simultaneously anticipates and incorporates attempts at resistance (Learmonth 2009). Control and resistance in fact become mutually constitutive of daily life (Mumby 2005) and people's subjectively construed identities are disciplined and appropriated beyond the organization (Brown and Lewis 2011).

Deetz demonstrates how organizations, while habitually protected from answering to various publics, are ultimately able to colonize perceptions, thoughts and actions in remarkable ways. He describes communicative practices which exemplify discursive closure – preventing consideration of alternative possibilities – and systematic distortion – such as: discrediting arguments as being trivial, refocusing attention from the system to the individual, naturalising decisions that privilege the few over the many, and avoiding sensitive topics which may contradict the preferred corporate view. Inside work places, colonizing managerialisms (Hancock and Tyler 2004) are argued to intervene in the process of subjectivity; or how a sense of identity is constituted and reconstituted (Brown and Lewis 2011; Casey 1999; Hancock and Tyler 2001).

Being old in an aged body

The focus for this research, however, is the colonization of older people's identities. Age is a significant organizing principle in contemporary society (Ainsworth and Hardy 2007; Gullette 2004). Social practices advantage youth and the 'young body' and cast the older body as different and in some respects unnatural (Jones and Higgs 2010). Notions of a natural ageing process depend upon the continuing ability of older people to work and maintain a healthy body. Consequently, old age is often presented as a problem (Hazan 1994); one that is pathologically constrained, as opposed to being a normal part of life (Canguilhem 1991). Discourses about ageing

tend to focus on illness and decline, with concomitant material and ideological consequences being identified for older people (Ainsworth and Hardy 2009; Estes 2001: Gullette 2004; Powell and Biggs 2003). Cultural and political manifestations become apparent as ageing is constructed as an individualized problem to be best managed through enterprising choices (Ainsworth and Hardy 2008; du Gay 1996); such as 'active ageing', 'anti-ageing' and 'ageing well' (Moulaert and Biggs 2013; Biggs et al. 2012; Jones and Higgs 2010).

Signally a 'master narrative of decline' (Trethewey 2001) – characterised by loss of meaningful activity, chronic illness and growing dependency – is activated at the point where older people experience illness (Moulaert and Biggs 2013). At the onset of illness in old age such discourses allow for the separation and segregation of older people as they are presented as an amorphous 'mass of needs bound together by the stigma of age' (Hazan 1994: 21). According to Powell and Biggs (2003: 6), one solution to the problem of 'ageing badly' is 'hiding the unacceptable face of older age in care homes'.

The organization of long term care for people in later life (aged 65 and over) is therefore growing in significance for governments in developed countries. Increasingly family arrangements in modern societies reflect the fact that those in full-time employment lack the resources to care for older relatives at home (Katz 2004; Tietze and Musson 2005). Formal organizations are increasingly important in the provision of residential care, the governance of care practices, and the everyday management of older people. Corporate provision of residential care is a rapidly growing commercial sector (Estes 2001). As corporations expand into the care market they provide capacity to house, cater and assist the older, dependent and fragile person. These corporations form but one small part of the 'medical industrial complex' associated with the care and management of older people's bodies (Estes et al. 2001: 59).

Corporate colonization and the organization of ageing

The body has also been characterised as a site of strategic mediation in the process of corporate colonization – a situation in which 'organizational forms and practices

appropriate and diminish the body' as it is 'trained, manipulated, cajoled, organized and in general disciplined' (Turner 1992: 15 in Hancock and Tyler 2001). Building on earlier studies in healthcare (Learmonth 2009; Levay and Waks 2009), social enterprise (Dempsey and Sanders 2010), law firms (Brown and Lewis 2011) and manufacturing (Mitra 2010), we examine similar strategic mediation in organizations providing residential care to older people. Studies have examined colonization through the body (Hancock and Tyler 2001; 2004) and also the effects of discourses of ageing on identity (Ainsworth and Hardy 2009; Gabriel et al. 2010). It is argued here that the body represents a vehicle for and site of colonization, one that intensifies in older age. Ongoing colonization intervenes in the processes of subjectivity by acting on the body and constructing meanings that limit the ability of residents to embody identities beyond their care needs. While we acknowledge the numerous meanings and definitions imputed (Synnott 1993), we focus on conceptualisations of the body as physical and social phenomena. On the one hand, physical forms of knowledge have constructed the body as a medical and biological object (i.e. body-object). On the other, embodiment can be understood as the bodily expression and performance of human subjectivity – my or your body as I or you experience it. Individuals experience their body as a capacity for doing – a way of living through the acculturated body as changed by customs and social institutions. It is a process through which the body as physical object is actively experienced, produced, sustained and transformed as subject (i.e. body-subject).

In the words of Waskul and van der Riet (2002: 488) 'a person does not "inhabit" a static object body but is subjectively embodied in a fluid, emergent and negotiated process of being. In this process the body, self and social interaction are interrelated to such an extent that distinction between them are not only permeable and shifting but also actively manipulated and configured'. Hence the body and embodiment emerge from each other. It is through the body that we express and present subjectivity to others. Yet through the same activities others also judge our body as an object by means of appearance and performance. The body then is both subject and object.

We use these concepts of the body and embodiment in our analysis to illuminate and elaborate how corporate colonization and its disciplinary techniques can reduce older people to mere physical bodies. We show how processes of colonization act on

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the body and inscribe it with colonised meanings and values. We note, for example, Foucault's assertion that 'the application of all power is on the body' (Foucault 2006:14). The bodies of older people thus form a site for social practice and disciplinary power. In contrast to pastoral power which treats the body as a site for care, disciplinary power strives to make the body more obedient as it becomes more useful, and vice versa, so that an increase in utility is closely linked to an increase in docility (Foucault 1979). Disciplinary power involves regulating the organization of space through the 'art of distributions'. Individuals are separated into particular spaces and within those spaces each area is coded for a particular function in order to make it as useful as possible. According to Foucault (1984: 83) 'the body is the inscribed surface of events'. The constitution of the body in this process rests in the way processes inscribe it; the body becomes the text which is written upon it, from which it is indistinguishable (Brush 1998). We argue that through the process of corporate colonization (and its disciplinary techniques) the bodies of older people very much become body-objects, or surfaces inscribed with a particular construction – the 'aged body'.

We will see therefore how the 'aged body' becomes both the site of colonization and its product. It is through the control of the body that the older person becomes exposed to an accelerated process of corporate colonization; in this case by being removed from their extant lifeworld and disciplined into a new one – residential care. The research focuses on elaborating the disciplinary techniques of corporate colonization to reduce older people to physical bodies. Specifically, we focus on examining how the body as object – a surface – is both constructed and acted upon. In the process, older people act to resist colonization and assert their embodied selves. Within the care home we demonstrate how older peoples' bodies become contested political sites. This involves subjection to, and resistance of, processes that may seek to violate extant lifeworlds and identities. In sum, corporate colonization, through its practices of acting on the body and intervening in processes of subjectivity, has serious implications not only for older people but also for institutional care as a means of organizing later life.

Part Two: Researching the social organization of care

Methodology

The research which forms the empirical basis of this article is derived from case analysis of a selection of residential homes in England providing care for older people. The terms 'care home' and 'residential care' are used here to cover both nursing and residential care provision. Care homes can be registered to provide residential care, nursing care or a mixture of the two. They are organized to provide rehabilitation, long-term care and/or palliative care.

Eight care homes were selected using purposive sampling to include variation in function (3 residential, 1 nursing, 1 residential and nursing, 3 residential and dementia or physical needs specialists), size (from 10-60 bed facilities) and sector provider type (corporate chains, independent, public and third sector). Inspection reports from the national regulator suggested that three of the homes had a history of relatively 'poor' care quality while five had a history of 'good' care. An interpretive approach was deployed to examine the organization of care in these homes by focusing on events, practices and processes that contributed to everyday experiences in each case. The intention was to build theory from the process of contrasting qualitative data from our various case sites (Eisenhardt and Graebnor 2007).

The study involved a method of participatory organizational research. Following the principles of this approach, the research was designed to provide a 'communicative space' (Kemmis 2001) for organizational analysis: In other words, a space where older people could voice their opinions and also question and reframe issues of relative care quality. In this space, critical discussion was facilitated through providing an opportunity to redefine the organizational context. This was methodologically important as new definitions afforded the opportunity to challenge extant knowledge and practices (Mumby 1988). Specialist ethical approval was required for the study as older people resident in care homes are considered to be potentially vulnerable subjects (National Research Ethics Service 09/H0306/63 Cambridgeshire 3 Research Ethics Committee). The ethical approval subsequently granted allowed for residents to be engaged in three roles: expert advisor to the study, peer researcher, and participant.

The findings reported here are based upon a selection of observations of everyday activities, experiences and practices in the homes, plus evidence from semi-structured interviews with managers, staff and residents[i]. Our research focused on identifying organizational practices associated with institutional care/abuse and developing ethnographic accounts of residents' experiences of care together with employees' experiences of doing care work. In total, 294 hours of observations were completed, with this work taking place during morning, evening and night shifts. Research was carried out on weekdays and at the weekends for a period of six weeks in each home. In addition, 124 semi-structured interviews were carried out: 86 with managers and members of staff and 38 with residents. Of these, 99 were digitally recorded and professionally transcribed. In the process, all research subjects (residents, managers and staff) were given pseudonyms. The interviews typically lasted between 30-60 minutes. Those with managers and staff aimed to understand the home's approach to the provision of care, employees' ability to carry out their work, and issues concerning the standard of service. Interviews with residents explored their experiences of living in a home and the quality of care they received. Formal data collection was complemented by information accrued through informal channels; for example, casual conversations with staff, residents and visitors to the home. In addition, a number of internal documents were consulted, such as the care home's statement of purpose, complaints records, policies and procedures and other publications. For the purposes of this article, however, the focus is primarily on the experiences of residents as derived from face to face interviews, informal conversations and fieldwork observations. Analysis aimed to establish an understanding of the relationships between organizational practices and resident/staff experiences. The nature of these practices and their implications for the organization of later life are explored here.

Findings

> *Well I'm just learning now to be old. It comes hard. Well I would*
> *really love to go back to my bungalow, but I know that's not possible,*
> *so I'm sort of making the best of it and hoping in time I will, you*

> *know, get accustomed to it* [laughs]. *It's so difficult.* (Elsie, a resident
> for 2 months)

From the research interviews it became clear that entry into a residential home commonly followed some form of health setback on behalf of the older person. Residents were often unable to resist entry at that point not only because of the severity or longevity of their illness but also because of consensus between medical staff and family members that the move would be beneficial for all concerned. What was striking was that this transition could often be in response to what, notionally, appeared a provisional health difficulty. Common examples, illustrated below, included brief lapses in cognitive ability, a series of falls, or protracted recovery from an illness. In terms of Deetz' (1992) conception of discursive closure, the master narrative of decline was activated and attention focused upon avoiding potential risk rather than on the chances of recovery (Trethewey 2001). As the primary focus of concern became immediate biological needs the options available to the older person appeared significantly diminished. At times poignant accounts could portray the removal of an individual from society as some form of social necessity. This was notably so when an older person was taken from an established residence or family home and informed that returning was unlikely. This we refer to as 'the appropriation of the body'.

Almost concurrent with such appropriation were a series of 'separations from previous identities'. Examples of this could include the sale of a home, moving neighbourhoods, or the involuntary distribution of personal belongings. In the face of such forces, however, residents could also be resourceful in the ways they found to assert a sense of identity and agency within the home. Examples are offered below of the kinds of challenges made by residents in the process of 'contesting colonized identities' and precipitating what Deetz might term 'systematic distortions' to sustain discursive closure. This three stage process – appropriation, separation, and contestation – forms the conceptual basis for our empirical explanations of colonizing the aged body and the organization of later life

Appropriation of the body. A common theme of accounts of 'becoming a resident' in a care home was that the health of the body came to form the central feature of the

appropriation process.   On the whole, the idea of entering a care home was not perceived as a positive one by those who would experience it first hand. Rather, prospective residents simply reached a point in their lives where there seemed to be no other option available to them. In the face of few suitable alternatives, the move was made, often with the decision being finalised by others on the resident's behalf. The dominant explanation of why admission was necessary centred on immediate concerns with physical or cognitive decline:

> *You see I didn't want to come in of course. I wanted to stay at home but I couldn't. I kept falling down. Well I couldn't walk you see. I couldn't do anything, so it made it difficult, so I had to come in.*
> (Anne, a resident for 18 months)

While a few residents reported that they had been party to the decision to enter a home, the majority found the decision had been made for them, notably while they were in a state of poor physical or mental health. Deetz (1992) argues that such decisions are often 'naturalised', which in the case of residential care sees a focus on decline and failing states of health naturalising the decision to move into a home. What is surprising, however, is that some residents considered such states as temporary:

> *Well I had to come in here because I was looking after my husband who had dementia and in the finish I collapsed. I'd lost three stone in weight. And I had a bit of a gammy leg and I couldn't look after myself. So that's why. And I'd collapsed and then they put him into another care home. And I ended up in here, but half of it I don't remember [such as] being in hospital. I remember collapsing in the bathroom and I don't remember any more for weeks.* (Amy, a resident for 8 months).

Many residents actually found the reasons for their admission suspicious, unusual or remarkable as they had scant recollection of the circumstances leading up to entering the home. This moves beyond Deetz, for rather than communication serving to aid colonization, many residents were excluded entirely from the decision-making process. With relative ease their options became fewer and they had little or no ability to resist.

At the immediate point of entry it also became clear that admission to a care home represented a critical move away from an independent and agentic life. This was frequently reflected in moving accounts of the recognition that they would not be allowed to go home at all. The following extended extract illustrates this transition to realising that returning home was no longer an option. In addition, it shows how the closure of the decision, and the process of 'disciplining' (Foucault 1979) the resident to accept their new circumstances, was achieved. In this account, there appears little that the resident could have said that would have allowed her to visit her home again, for the staff had 'instructions':

> *I can't remember much about my first days here at all. I resented being here very much – but that had nothing to do with the place, it was just me. I don't know whether you know,* [but] *I came in under rather peculiar circumstances, so I believe. Apparently I collapsed at home and was found unconscious and taken to hospital. Of course I know nothing about that. I wasn't expected to live and my son was sent for. But I lost my memory. I didn't recognise him at all. And apparently I had a slight stroke as well. And I got over that and I went for a month I think, convalescent, at a very grubby place. It was grubby but funnily enough I enjoyed it there. The thing was, the hospital sent me directly there and I said, 'can't I go home first and collect some clothes to wear?' I was only in a nightdress and a dressing gown. But they said 'no'. So I said 'but I've got nothing to wear'.* [And they replied] *'Oh well, you know, we can't do anything about that, you're not allowed to go home, our instructions are you go straight to this place'. So I turn up there and a very nice person, I think called Mary, sort of said 'well this will be your room'... And I said straight away 'what am I to wear?' I said, 'They wouldn't let me go home'. So she said 'no they have instructions'. I think they thought I was going to run off dressed like this. And she said 'don't worry about it, I'll see to something'. And whether people had donated, or whether people had died I don't know. So she sort of sized me up and said 'hmm, yeah I think we've got your size'. And I looked at it and thought hmm 'M&S and all nice stuff'. And then my*

relatives came to see me and they'd got the keys of the bungalow,
so they were able to bring me my own clothes. (Lilly, a resident for
15 months)

After Deetz (1992), in addition to closure of the decision-making process, this passage illustrates how systematic distortions occur. Attention can be refocused away from the corporate interest and towards consideration for one's family, and specifically the need not to be a burden. One resident, Elizabeth, described the reasons for her being moved to a care home and how, for the sake of not being a burden to her children, she felt it was 'inevitable':

When I first saw people slumped in their chairs I said 'I shan't come
here'. It was a hideous blow [that] *I had to go anywhere. I had had*
some bad falls and I lost the power to write and I was getting my
daughter out of her bed in the night. I would ring her in the night and
she would get up and get in the car and come. It would disturb her
husband. I was so battered about [from the falls] *and my daughter*
would be taking me to the surgery and to the hospital... I could see it
was inevitable [coming into a home] *as I just couldn't cope. It was an*
awful transition from my own home into a care home. I used to order
my own food and do lots of things myself. But I had to get it off my
daughter's back. (Elizabeth, a resident for 9 months)

Not being a burden to relatives, especially when there was a protracted recovery period, was a common concern. In such circumstances it is the older person's body that becomes the focus of disruption for normative family arrangements. As Hilda explained:

I had a stroke and I got over that. I was in hospital for ages. I don't
know how long, but ages. And then the day I was coming out of
hospital I fell and broke my hip. The day I was coming out! I was so
disappointed. I was back in hospital for 4 months. And they couldn't
operate because I've got a bad heart. So it was prolonged, you
know, it wasn't a straight forward thing, it was difficult. And then of
course, then when I got home, when I came out I couldn't walk. I

can't walk since I've done my hip and I'm terribly deaf and I'm nearly blind so I couldn't manage on my own. No. So they got me in here. My sons chose it. They were going round looking for different places. They were at their wits end because they didn't know what to do because they've all got jobs to hold down. Yeah so it's difficult. I was more than ready to be helpful to them, to make it easier for them. Do you know what I mean? (Hilda, a resident for 23 months)

The permanence of the move was often confirmed by the relinquishing of the person's home and other belongings. Residents who owned their homes found that, with little discussion, these could be sold by their children and most of their personal belongings distributed. The funds raised were commonly used to pay for the costs of living in the care home. This underlined the fact that the need for care removed the possibility of other ways of living and of other life opportunities:

One day I was downstairs [in the care home]*; I think I was waiting for the hairdresser. And one of the ladies came over and was talking to me. And I think she wanted to unload and said she'd had to get rid of her home when she came in here. I said, 'well I had to get rid of mine also' and she said, 'yeah, but they got rid of everything'. I said, 'well, I suppose the simple fact is we're not going home anymore – this is your home now isn't it?' And it is isn't it? And she was all tensed up about this and I was saying to her, 'well, we've got to accept the fact that we can't look after ourselves, we have to be looked after, and they're very good here, and you've got a good home here and are well looked after'. And in a while she settled down you know. And that is a fact, we can't go back. I can't. How could I go back home? I couldn't could I? I had a house, three bedrooms, three rooms downstairs. All furnished and very nice. And my daughter said, 'well, I'll have to get rid of your home mum'. I think she gave no end of stuff away because people don't want to buy second-hand stuff do they? And she eventually got the house cleared, handed the keys in. But that was hard. I never said anything to her.* (Eunice, a resident for 6 weeks)

The possibility of considering alternatives or questioning practices remains an essentially private affair (Deetz 1992; Clair 1998). Eunice decided not to challenge her daughter, for any challenge to the decision to move her into a home would become a challenge to the actions of loved ones. In the colonization of the aged body a 'layering' process can be detected whereby the decision to move into a home, and the separation that ensues, becomes refocused as an issue played out in the private realm of the family . The effect is to silence alternatives in the sense that objections are not expressed by the older person to their relatives. Instead, the 'family' mediates the process. Often the sale and distribution of belongings facilitates a rapid and effective separation from historic identity and paves the way for 'learning' how to become a resident.

Separation from previous identities. The process of becoming a permanent resident therefore often involves painful separation from previous forms of identity. The sale of assets and distribution of belongings creates a separation between the person and their historic sense of self. The extract below shows Len talking about his life before entering the home, how he came to be there, and the subsequent separation from his personal possessions:

> *I was right and rich as nine-pence. It was my wife and me together, it was alright, but after she died I couldn't cotton on to it at all. My son he got me this place – well he went round two or three of these places and he said this was as good as any that he'd seen. He went off and that was it. I've gradually come back you know to knowing a little bit anyway. When I came here I couldn't do much, or tell anybody, see – I'd had a heart attack and all my things went from that point… I was out and knew nothing. My son and two daughter-in-laws they've done marvellous, they've been fantastic… I mean I had to pack up. I had a bungalow you see, down the town and they had to pack it all up, pack me car up too. My grand-daughter picked up all me pipes – I used to smoke you see – and she said 'no granddad, no'. And it all went in the bin and that were it.* (Len, a resident for 11 months)

Such separations continue beyond the sale or disposal of personal possessions and are produced through practices that create and manage the aged body and strip away past identities (Brown and Lewis 2011). Such processes focus primarily on the physical body and meeting biological needs. This serves to form new sensory experiences (Dale 2001), disrupt the extant lifeworld of the older person, and ultimately reshape power relations between resident, family and staff. Here the process of colonization deepens, as was evident in the new relationship between Eunice and her family. Similarly Harry described how rapidly new residents could become separated from their previous lives and socialised to new circumstances:

Somebody comes in [and] *they're on their own, they are most of them when they come in. Now they've had no background of going into a thing like this. They're really almost thrown in. Not literally, but the way they have to take them in and deal with everything relating to them on that day. Because unless they get them organized quickly, they're all at sea and they'll be further trouble. Now if they're going to do that, they then think, I think the powers that be think, all we've got to do is to get them settled and then they'll be alright. But that doesn't work. In practice it depends on the individual. After all we're all individuals whether we like it or not.*

Harry went on to describe the relative speed and efficiency with which the process of becoming a resident could be achieved:

But a thing that has always been a headache to me in dealing with this is [that] *if people come in and they're in reasonable health — in other words they can walk in the day they arrive, possibly with help, but nevertheless they're still alive and you know the brain box is still going – I've noticed that in general I would say within a matter of a month or five weeks or so, most of those people are no longer the beings they were. Now that is because of living in this forced community I think. They come in and they've got to do everything they're told.* (Harry, a resident for 22 months)

Rather than accept that his identity was becoming voluntarily aligned with such 'forced' corporate identities (Deetz 1992), Harry constructed his own self as different

from those who would succumb so readily to institutional practices of managed care. Harry is signifying an alternative embodied self – one directed in opposition to organizational practices that attempt to manage collectively the care of the aged body.

Our observations suggested that the position of residents in the corporate space was indeed very carefully managed. Standardised, single room accommodation was normative and organizational rules extended to the use of communal areas. Parts of the home were inaccessible to many residents and their visitors through the use of keypad locks. Consequently limits were placed on the freedom to enter and leave the premises at will. Ella, for example, described how the limitations on access operated, and went on to outline her fears of experiencing a more complete sense of colonization:

> *I think a lot of my problems are that I am disabled in a way. I can't come and go as freely as I would like. I have the code for the door, but those of us who have it we have to keep it secret. We can't give it to the family or anything like that. Getting transport worries me a bit, getting to the dentist and things. I also have frustrations as my mobility is changing but my mind is still the same. I am holding on to my independence so I won't say to my sons I need help and I won't ring the buzzer for help either. When it comes to it, I don't want to be publically fed. I don't want to sit in the dining room, like some of the residents sit now, and be publicly fed by the staff. I am really worried about it but don't want to talk to the staff about it because they say they are too busy to bring people their food to their rooms.* (Ella, a resident for 26 months)

Colonization processes were thus found to involve a separation not only from physical aspects of the lifeworld, but also from agency, autonomy and a bodily sense of self. What was once understood and experienced as a more autonomous way of life came to be defined by organizational systems and practices put in place to manage the aged body. As Mary explained:

> *It's very necessary to have contact with the outside world when you want. You feel a bit hemmed in if you don't have the phone because*

> *I can't go out beyond the gardens unless I have somebody with me*
> *and it's not easy to find anybody. It's all to do with insurance – you*
> *can't do this or that. Some of them go and let themselves in and out,*
> *but on the whole you have to ask somebody to open these gates for*
> *you.* (Mary, a resident for 11 months)

Metaphorically, residents were colonized as they became translated from sentient beings into biological functions that were mediated through spatial arrangements. The location of the aged body in time and space could produce a separation in a person's sense of self and a dislocation from their history. Indeed a sense of personal control of space and associated opportunities for seclusion were often limited:

> *I would like a little more privacy.* [I have] *the shower room and the*
> *rest* [of my room]*, which is where you have your bed and a table*
> *where you can sit at and write,* [but] *that's it.* (Mary)

Although it is common practice for residents' rooms to be advertised as their 'own' space, in everyday reality such ownership is contested and relates to wider issues of control over the body. Notable here is the extent to which bedrooms might permit respite from organizing practices operating more generally in the residence. Tensions emerge as bedrooms are used less as a personal and private space for residents and more like any other in the care home; where older people are spatially organised for staff to carry out care practices. For example, the tools and techniques for such work are often stored in resident's rooms for exactly this purpose; including medical charts, care records, manual hoists and other standardised technologies. It is an organizational logic that can be contested by some residents, such as Jack, who challenged for example a related aspect of colonization, the practice of staff entering his room and touching his belongings without his permission:

> *I went back to my room just now and found Tracey* [senior care
> worker] *in there, touching my things. I call that trespass.* (Jack, a
> resident for 24 months).

In terms of spatial autonomy and personal identity the care homes often fashioned thin representations of a resident's historic existences. For example, when moving

into the care home residents were allowed to bring with them a small number of personal belongings, 'to make them feel more at home'. However the types of possessions that could be brought into the home (typically, photographs, ornaments, a radio or small television) were not only limited by the size of the resident's room but also by the fixtures and fittings already in place. Who decided which objects the person kept with them in the care home and what happened to other belongings could represent an issue for negotiation and source of tension.

Elsewhere, life histories of residents – recorded by family or staff members and bound in folders – could act as a personal proxy in pictures and mementoes. The production of such artefacts was often incorporated by residential homes within publicity narratives of providing 'personalised' care of 'clients'. Such simple accounts, however, were rarely read by members of staff. Also, in becoming a resident, separations were often marked by practices that focused on past subjectivities evoked through reminiscence. Two establishments, for example, provided dedicated 'reminiscence rooms' which contained artefacts from the 1930s and 1940s. Other symbols of reminisce, such as regular 'sing-a-longs' of war-time anthems and tunes from yesteryear had a similar separating effect, as the identity of the older person is increasingly focused on socially acceptable signifiers of earlier periods lived through. Despite commendable intentions of evocation, the sense of self so produced is one that is staged and the process of constituting an authentic identity, fully sentient and with continuing citizenship, diminished.

Contesting colonized identities. A sense of determinism, reflected in many of the organizational processes described, can be contrasted however with instances of personal resistance noted in our fieldwork observations. Resistance of the colonization process was evident when older people communicated and asserted an embodied subjectivity and agency. Examples of this included avoiding certain spaces, refusing help from staff, or indicating personal preferences for the care of their bodies. Despite awareness that in the longer term submission to many routine practices was inevitable, some residents were able to contest them in the present. The examples below illuminate how older people made sense of and reacted to the ways in which their bodies were being acted upon in the home.

The lounge area in particular represented an arena in which acts to organize and manage the body were visible. Residents requiring assistance with mobilising, feeding and toileting were often grouped in such communal spaces, which typically had rather regimented seating arrangements.   Some residents would resist being taken to the lounge on the basis that they did not want to watch television during the day, be close to people who did not talk, or be with individuals who sat for long periods asleep, which could be distressing; or as one resident put it, 'deadening'. Three of our interviewees commented thus:

> *I prefer this sitting area upstairs than the lounge downstairs. I am afraid I may start to fall asleep like the rest of them down there. I suppose I am a bit of loner perhaps. I have a lot of fun with the girls and the cleaners, a lot of laughs together. I sit on the balcony and my friends gather there with me.* (Ella)

> *Well I find it dreary to sit there amongst people that go to sleep, so I don't use the lounge. I've met a lot of people outside – just made new friends by walking down the road and I prefer their company. Perhaps because it's a world outside which I, part of me, prefers. Whereas here, well because they sit there and don't perhaps listen to radio or read much, there's no topic of conversation.* (Lilly).

> *I think it is a lovely room but it's not for me. I'll tell you why, I sit there and nearly all of them are asleep and it bores me sick. So I don't use the lounge a lot. I like sitting in the café area* [near the entrance to the home] – *it's better because you see people coming and going and you see the staff and there are different people to talk to.* (Olive, a resident for 15 months)

Here residents are ostensibly resisting integration into processes aimed at managing their bodies. Although in everyday practice the notion of the 'lounge' variously evokes a sense of leisure, freedom and self-expression, in the care home it did not always offer a site for such positive experience. Rather, the opposite could be the case – a lack of independence, choice or free-will: In other words a dearth of the kind of self-directed activity sought by Ella, Lilly and Olive. Avoidance of the lounge enabled some to resist the routine spatial organization of residents' bodies and

demonstrate they had not yet succumbed to the colonization process and its associated disciplinary techniques.

Harry, for example, resisted being reduced to a mere physical presence by distinguishing between his personal sense of self and how his body was being acted upon. Citing an example of the use of care protocols, he explained how he was, on occasion, able to use the inexperience of some staff to his tactical advantage, as in this discussion:

> *Now some girls come in and think that they've got the guide book you see. And the guide book tells them all that they ought to know and they insist on you putting your hand there on the left armchair and the right one there, so that you can hoist yourself up. Now in practice that doesn't work. You think it does and they think it does, but somebody looking from outside says 'so what on earth are you doing that for then, you'll kill them' or something, you know, Now it's very seldom I get a lift in a chair, because I try to do it myself. If I've got to walk from A to B sometimes they sort of think they're being kind to me I think and then they say 'get a chair'. Now if they get a chair then they'll be telling me that it's better to hold the left arm with that hand and the right with this. They have a method which they think is right because it's been issued by some committee. Now I had a girl this morning and she's always done as I've told her up to now because she was new and she hadn't got the experience anyway. And I said to her, you know, I'd say 'well it would be quicker to do that', you know, 'if you put that person on there and then turn the chair round' or whatever it was, and she's taken that well. Now she's got this wretched guide book you see. She thinks that she's right because she's been told officially that this is what they've got to do.*

What is being contested by Harry is the stipulation that generic or standardised procedures be used in the care of individuals, in this case to handle and move residents' bodies. When staff decide to 'get a chair', for example, a sanctioned method stipulating how the body should be moved and placed is initiated and

followed. This practice, with its overriding focus on the physical, serves to metaphorically disembody residents. Harry expresses his preference for moving his *own* body and decries staff intervention in this aspect of his daily living. He rails against normative practice and asserts his desire to move as *he* chooses. In situations where staff are inexperienced with regard to care protocols Harry is able to communicate a degree of subjectivity and agency.

In contrast, residents can actively seek out staff to care for their bodies in line with official guidelines in situations where this can be agreeable. Rather than routines and standardised practices reducing residents to a mere physical presence, this can see them express agency in negotiating such protocols in order to meet their own self-defined needs and preferences. As Audrey explained:

> *I get up about six because I like to have a shower before I get dressed. And I used to have a shower in the evening but now I do need a little bit of help with getting into bed, or at least I pretend I do* [laughs]. *I could do it myself and I have but it's very nice to be done. And if you're going to be done then you've got to be available at a reasonable time.* (Audrey, a resident for 9 years)

Overall, however, care was organized in terms of a standard routine. It was common practice, for example, for residents to have a weekly bath with the assistance of a care worker. The activity was timetabled and a resident's 'bath-time' was usually performed by the same care worker on the same day. However one resident, Jack, appeared to resist the bathing care routinely planned for him. Specifically he refused to be bathed by the particular member of staff assigned to carry out the task. Jack requested instead that an ex-member of staff bathe him under a private arrangement. The care home manager however refused to allow this. As our observational field notes describe:

> *Jack was sitting at one of the tables in the café area having breakfast when I arrived this morning. He prefers to eat alone* [not in the dining room] *and his wish is catered for by staff at the home. We say hello and I ask him if he is alright. He says 'I am in trouble'. He nods for me to join him at his table and I sit in the chair opposite. I ask him 'what is the matter?' He says 'I won't have my bath'. I ask*

'why, is something wrong?' He says he didn't know the person who was to give him a bath this morning and as such that he's 'refusing to have one'. After a few moments he says 'I have a right to don't I? If I don't like the person, why would I want that person to bath me? I have the right to say no don't I?' He then looks me in the eye – I comment 'yes, I think you do have a choice, I'm sure'. He goes on to say 'I have very few rights left; I want to hold on to what rights I have'.

The implication here is that Jack does not have a genuine say in how his body will be managed and experienced. Rather he is reduced to a mere physical body that potentially can be washed by any member of staff the care home chooses. Personal objections to such practice, however, can invoke what appear to be, at face value, systematic distortions on the part of management (Dale 2001; Deetz 1992). A resident contesting routine norms and procedures, for example, can be constructed by managers and staff as problematic, or 'different'. Shortly after this conversation, the care home manager drew upon the habitual 'master narrative' (Trethewey 2001) to suggest that Jack's health was 'declining' and that this was 'making him grumpy'. What could be viewed as a seemingly valid request is thus reframed as an anomalous one – a problem relating to age-related pathology (Canguilhem 1991). The manager's construction of Jack's resistance being caused by 'decline' diminishes his objections while simultaneously elevating the normalcy of organizational practice. When normalcy is maintained, the colonization process can come to be understood as 'natural' (Deetz 1992). During the remainder of the research period, however, Jack continued to refuse to take his 'bath time', choosing instead to shower, without assistance, in his en-suite washroom.

So while in many ways the everyday experience of residents seems to reflect the progressive, inevitable and unmediated colonization of old age, this was not an absolute or complete process. Older people were frequently able to challenge, manipulate, subvert or avoid institutional routines and practices. On the part of some residents this served to express embodied subjectivity and retain a degree of agency in the face of appropriation, co-option and ultimately colonization.

Part Three: Discussion

On the basis of this research it is argued that care homes represent sites of organizing where processes of bodily colonization develop and intensify. Specifically, three related concepts in the realization of such colonization have been identified: (i) appropriation of the aged body, (ii) separation from previous identities and (iii) contesting of colonized identities. It is our contention that the disciplining of the body operates not only as an accessory to corporate colonization but also as a potent organizing factor of later life.

Within residential homes, managers and staff organize care through practices that can monitor, control and distribute older people's bodies (Martin 2002). Through systems of management and organization, the physical bodies of older people are frequently acted upon as if they were passive objects. Care home staff and managers possess a range of discretions as far as residents are concerned; for example, to discuss their personal affairs, touch or handle them, and permit or deny them access to various spaces (Martin 2002). These disciplinary powers serve progressively to reduce older people to the status of physical bodies – humans conceptualised as though they lacked agency and identity.

As noted, this progression towards a fuller colonization of older people's identities begins with 'appropriation'. Colonization centres on the body and at the moment of biological difficulty an older person is at risk of being appropriated. Families are co-opted and the 'master narrative of decline' (Trethewey 2001) is set in motion. It becomes clear how readily older people are excluded from the decision making process. What undergirds such exclusion is the view of the older person as perceived through the lens of the biological body and its need for care. This renders the person primarily physical – an object of care; a surface that can be freely acted upon and inscribed (Dale 2001). Ultimately it is the treatment of older people as physical objects that facilitates forms of narrative distortion and ultimately discursive closure. It is though practices of physical and intellectual separation that the exclusion process of colonization is realised. The use of the master narrative of decline accelerates the process and so produces the aged body, resident in a care home, who becomes not only precluded from making a social contribution but also deprived increasingly of personal control (Dale 2001; Foucault 1979).

In addition, the *corporate* colonization of this particular lifeworld underpins a subject's desire not to be a burden to family, whose members must not be diverted from their 'productive' lives. Opportunities to question or challenge decisions are relegated to the 'private' sphere, as the family comes to mediate the bureaucratised process of placing a relative in residential care. This marks a subtle shift of the older person from an active to a passive being – from an autonomous subject to one possessed of a need to sustain dependent relationships with family. As the new subjectivity of the 'resident' is produced, an 'inner colonization' (Deetz 1992:42) works insidiously on intra-family relationships. This sees potential areas of dispute between resident and family remain unvoiced and unchallenged. Residents can become separated from their assets and possessions, making remote any chance of them leaving a care home. The dominant narrative of bodily decline not only supplants any potential evidence of residents' improved abilities but also precludes alternative narratives such as recovery (Estes 2001). Residents can be cajoled and consoled by family with the idea that returning home might one day be an option, but realistically they are being progressively disciplined to accept their new circumstances and ultimate fate.

During such acculturation, processes of disciplinary power on the body (Foucault 1979) serve to regulate progressively the organization of key aspects of the subject's lifeworld. Examples include issues of *space* – through providing private areas for staff but not residents, locking doors and gates, etc.; *time* – through use of timetables, routines and shift patterns, etc.; and *behaviour* – through collective feeding, weekly bathing, communal sing-a-longs, etc. Thus the activities of the body are disciplined and age as an organizing principle both intensifies and accelerates colonization. Disciplinary power underscores the discursive production of the 'resident' as a physical entity and an object of control. Separation from historic identity and the construction of the 'resident' are achieved through a range of physical, social and discursive practices. In terms of personal history, residents are allowed to retain a limited set of belongings, but this only serves to reinforce a normative 'residential' identity.

Accounts of how newcomers to a home became 'no longer the beings they were' emphasise how rapidly subjects come to terms with their new circumstances. This process includes a series of practices akin to those outlined by Deetz (1992) and

which are deployed similarly in the colonization of employee identities. Residents might be referred to as 'customers' or 'clients' within the care home industry, but realistically they are never able to achieve such an identity, not least because of a lack of any genuine consumer power or choice (Estes et al. 2001). Colonization intervenes in the process of such subjectivity; that is, in the constitution and reconstitution of the resident's sense of self (Brown and Lewis 2011; Williams and Bendelow 1998). As the identity of the older person as a 'customer' of the care home is never realised, the relationship of the resident to the care organization is produced in terms of a passive 'recipient' – a docile body.

The intersection of logics of 'aging well' and 'rule-bound organizing' in care homes also produces a duty to pursue or maintain levels of activity and control on the part of older people. During fieldwork a finely calibrated performance of care was regularly encountered whereby staff organized the distribution and control of older people's bodies as they were washed, dressed, fed and toileted and then placed in various spaces (Martin 2002). These actions served to reduce people increasingly to biological identities and separate them from their historic, let alone continuing, social or self identities (Friere 1971). Whereas Deetz in his study of corporate colonization described how employees' arguments can be discredited as trivial, similar discursive practices related to residential colonization can see attempts at independence, autonomy or choice downplayed as unsafe or unsuitable.

Nevertheless, some residents in our study could find means of contesting elements of colonization and its disciplinary techniques. In their various acts of resistance residents were often able to achieve small but personally important expressions of subjectivity and autonomy. Examples of embodied resistance included refusing to be 'put' in the lounge, not going to bed when requested, and persuading staff to provide care in ways preferred by the subject (Dale 2001; Williams and Bendelow 1998). Such acts offered consolation to residents at the same time as they came to feel the inevitability of the loss of agency. However, contestations such as these – reflecting various struggles for respect, fairness and a sense of a future – only delayed the onset of commodified and colonized forms of being (Deetz 2008). In fact the evidence from our research suggests that the colonization process was far more totalizing than that described by Deetz (2008).

Our paper also emphasises the need to sustain a sense of 'mature subjectivity' (Moulaert and Biggs 2013) even when older people become ill and/or reside in care homes. This involves what Friere (1971) termed being 'fully human' – the opposite of colonization as explained earlier in this discussion. Deetz himself argued for a spirit of 'balanced responsiveness' in order to counter the colonization processes described. For older people it is the body which forms the main site of such strategic mediation (Hancock and Tyler 2001; Holliday and Hassard 2001), with associated effects on the accomplishment of individuality as well as sustaining citizenship. It can be argued, however, that as older people are increasingly grouped together and segregated in residential care homes – and such organizations progressively appropriate the body and personal agency – the possibilities for developing a mature subjectivity are diminished. Care homes offer just one model for organizing age relations, albeit one that fits well with modern forms of economy (for alternatives see Hazan, 1994). The colonization of aged care operates both inside the residential facility – with demands for operational efficiency and the optimizing of resources – and outside – with the pressures of full-time working and the normalizing of social arrangements such the nuclear family. Generations of families no longer cohabit and those in full-time work are unable to care for older relatives at home. The entry of older people into care homes and the practices within them are thus increasingly influenced by the organization of social and economic relations outside such facilities. In our research, this was reflected in individual residents perceiving no viable alternatives to their permanent residency in care homes which in turn limited their capacity to resist.

Finally, in examining the experiences of older people in residential care it becomes clear that the body represents the central locus for organizing and disciplining (Foucault 1979). Control of the body becomes a powerful management principle and entry into a care home engenders its progressive colonization. In the care home, dominant narratives of progress – associated with opportunities for work, activity and productivity – become replaced with those of decline, deterioration and descent (Gullette 2004). After Freire (1971), it is argued that grouping older people into residential care facilities accelerates and intensifies the colonization process as it engenders separation from historic identities and a focus on biological function.

Conclusion

Entry to, and life within, residential care homes seems to exemplify cultural manifestations of ageism and colonization in meeting the needs of modern corporate economies. By examining arrangements for care largely through Deetz' (1992) lens of corporate colonization, we have argued that grouping older people in residential homes facilitates the collective management, monitoring and control of such individuals' bodies. Also, our theorizing of colonization has exemplified how such processes promote a naturalising effect in which older people are integrated tacitly into a system for realising economic efficiency. Polarising the meta-narratives of human productivity and bodily decline serves to sustain processes of colonization for older people and reinforce the rational-economic discourse that makes 'going into a home' inevitable. Colonization of the aged body involves a process of 'becoming' – one that separates older people from their historic existence and propels them towards a new homogenized identity. Here the focus of care is upon generic processes to manage physical dependence. We argue that there are three primary forces at work here: the physical and social practices involved in placing older people in care homes (or the 'appropriation of the body'); the production of new subjectivities in the process of becoming a resident (or the 'separation from previous identities'); and how colonization may be deferred through residents challenging normative concepts of managed physical and mental decline (or 'contesting colonized identities'). The interaction of these factors realises the notion of the aged body within wider processes and practices of corporate colonization. Ultimately, the colonization of the aged body becomes a powerful principle that operates in conjunction with the organization of social, political and economic relations in society as a whole.

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