

## Articles

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# Constructing Dementia and Dementia Care

## Daily Practices in a Day Care Setting

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- *Summary:* This article explores the ways in which dementia can be constructed and maintained by the actions, and received ideas concerning dementia, of social care staff practising in a local authority day care setting in the UK. The article is set within the context of 'daily practice', the things that we do forming the basis of how things may be (re)defined.
- *Findings:* The study suggests that the physical environment of the day care setting, the routines and activities provided and the practices of care staff indicate three particular ways in which dementia was constructed. These comprised 'holding and homogenizing', 'demarcating and distancing' and 'caring and controlling'. Each depended on individual approach, training and experience and was influenced by 'received' traditional approaches.
- *Applications:* This is important to our understanding of dementia care as we seek to recognise diverse experiences and to consider pluralistic approaches to best practice in dementia care. The study indicates the need for training at a deep and reflective level in which the new culture of person-centred dementia care becomes part of daily practice rather than a distant ideal.

**Keywords** daily practices dementia family practices

## Introduction

The idea of everyday practices is important in formulating notions concerning social actions and relations. This is no less the case in dementia care. The concept of practices as used in this article is taken from the continuing debate originating in family studies that daily familial practices are constitutive of family. These ideas are applicable more generally to the ways in which everyday practices construct and adapt all social entities. In this article, dementia is considered in

terms of its construction by the actions, and applied ideas concerning dementia, of social care staff practising in a local authority day care setting in the UK.

## Practices

The beginnings of a concern with everyday practices lie with Bourdieu's (1977) theory of practice. He attempts to explain how the external world is internalized by individuals and how this is reflected back on the world. These structures, which are constitutive of a particular type of environment, produce what Bourdieu terms *habitus*. Habitus are systems of durable, transposable dispositions which orchestrate the generation and structure of practices, or what we do, at an everyday level. Whilst the individual agent is the producer and reproducer of objective meaning, actions and words are often the product of an unconscious assumption and internalization of external social relations. One of the effects of the habitus is the production, therefore, of a commonsense world endowed with objectivity which is secured by a consensus view of the meaning of certain practices. Bourdieu (1996) applies his ideas to the family. The family as an objective social category is a *structuring structure* – one that helps to create – whilst as a subjective social category it is a *structured structure* – one created by the objective social category. In this sense the objective social category helps to order actions and representations in individual entities, which in turn reflect back and reproduce the objective social category.

Practices may result in a group habitus of expectations associated with particular social entities:

As an acquired system of generative schemes objectively adjusted to the particular conditions in which it is constituted, the habitus engenders all the thoughts, all the perceptions and all the actions consistent with those conditions, and no others. (Bourdieu, 1977: 95)

This articulation of practices can be applied to dementia. The predominant biomedical model of disease and syndrome or even the developing psychosocial approach to dementia may act as an objective social category that structures the meaning of dementia for individuals practising in social and health care settings (Parker, 2003). The received model structures day-to-day care practice and thoughts that explain and justify these actions. These practices – active and cognitive – are then reflected back and reproduce the objective category of dementia found in the biomedical or psychosocial model. Such an understanding may guard against the reification of a particular conceptualization and the homogenization of experiences of dementia, both of which may exclude the individual and his or her own subjective experience.

Whilst Bourdieu's theory of practice accounts for the reproduction of social entities and helps us understand how dementia may be constructed between care services and social care workers, it does not seem to account for the possibilities of change and challenge to existing orders (Morgan, 1999). It does

not, for instance, account for a shift in paradigm in the last two decades of the twentieth century from the biomedical model to a more psychosocial and person-centred approach to dementia.

It is important not to ignore the academic's involvement in the (re)construction of the concepts and practices studied. Smith's (1987) feminist sociological analysis sees practices in a broadly similar way to Bourdieu as ongoing co-ordering of activities that bring the world into being. She adds the important point, however, that the researcher is also part of the world in which these practices take place, and that knowledge gained or created becomes part of that world. The researcher contributes to the production and reproduction of social entities by her/his involvement and study. The exchange between researcher and researched is constitutive of whatever social entities and processes it is articulated to. Therefore, in the case of dementia care it is necessary to keep in mind that the researcher's or observer's practices and questions are in part constitutive of the subject, that is, dementia. The act of observing, choice of site, biography and predilections of the researcher will influence the data gathered, and the analysis and presentation of it. Thus the researcher may also be an important agent in the construction of entities through the examination of daily practices in a given situation. When this understanding is applied to dementia care practices it is clear that asking the questions produces the potential for action or changed action.

## Family Discourse

Gubrium and Holstein (1990) use the concept of practices in their examination of family as a process rather than an objective or empirical entity. Much of their work is taken from Gubrium's studies in nursing homes and with people with dementia in which professional language is integrated into coherent descriptions of care and external accountability (Gubrium, 1986, 1993). It is therefore directly relevant to the construction of dementia and dementia care. Their research presents meaning to the experiences of care-giving and in terms of how dementia is constructed. They use the term 'family discourse' to describe how meanings are assigned to actions on behalf of social ties. Family discourses are substantive, in respect of ideas, models and theories, and active in communicating how one intends to look at, understand or respond to what is observed (see also Cheal, 1991). In dementia, the substantive and active delineation of practices can also be applied. Substantive practices relate to the received knowledge, ideas, and models that underpin practice and policies. Procedural approaches taken from the developing performance assessment framework (Department of Health, 1999; Department of Health/NHS Executive, 1999), the outworking of legislation for social and health care in the Care Standards Act 2000, NHS Plan (NHS, 2000), and National Service Framework for Older People (Department of Health, 2001), and models and understandings of dementia – either biomedical or person-centred – inform substantive everyday

practices in dementia care. Active practices emanate from these in terms of assessment, care plans and delivery in the day-to-day actions of individual practitioners.

Family discourse focuses on 'descriptive practices' (Gubrium and Holstein, 1990: 26). These are situationally sensitive and communicate the processes by which social reality is represented. Family, in this sense, is perceived through its signs using a semiotic approach to metaphor and metonymy (see Adams and Bartlett, 2003). A metaphorical denotation of family makes comparisons with other related conditions, situations or relations. An example of this is given in Gubrium and Holstein's use of Bobbie Glaze's association of bereavement and death with Alzheimer's disease. Family metaphors can also serve as a cultural resource available to monitor the self (see Beck, 1986; Giddens, 1991). This is important in social and health care where moves are increasing to monitor the standards of care (Department of Health, 1999; Department of Health/NHS Executive 1999; Care Standards Act 2000). Also, in the development of best practice in dementia care and person-centred approaches (Kitwood, 1997; Benson, 2000), the models received and assimilated can be used to monitor practice and the use of self in dementia care. The 'yardstick' perhaps changes from how long is spent on completing physical tasks to how long one engages socially with a person with dementia (Parker, 2001).

Gubrium and Holstein (1990) also identify a metonymical denotation of family in which a commonly associated feature of family is used to designate family itself. Again, in dementia care denotation of dementia is seen in substantive and active ways. In the attitudes and views expressed, and in considerations of ability and capacity, people with dementia are conceptualized as being child-like in abilities and needs, and practices accordingly can be seen to limit and infantilize when such views are acted upon. Indeed, many people with dementia are defined by risks resulting from incapacity and loss of memory.

## Family and Everyday Practices

It is with Morgan (1996, 1999) that the clearest articulation of practices is given, although, again, he uses the term in respect of family. He challenges the uncritical usage of the term 'family' as potentially rigidifying and normalizing. Popular and policy-oriented accounts of the family often lack the fluidity and diversity observed in society. These accounts produce lists of various elements in which the reader is invited to link entities and identify these entities with the assembly of material collected. The suggestion is made that characteristics of social entities are open to tabulation and quantification. Morgan suggests rather that 'family' should be understood as an adjective or even a verb:

[t]he most common one [definition] is to use 'family' as an adjective rather than as a noun, using the term to refer to sets of practices which deal in some way with ideas of parenthood, kinship and marriage – the expectations and obligations which are associated with those practices. (Morgan, 1996: 11)

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Practices draw upon commonsense, everyday understandings and how these are used reflexively to structure that world. Bernades (1997) adds that they also demarcate from practices not assumed or considered to be part of that site of practice. In terms of dementia and dementia care, it is evident that these understandings have relevance. Dementia is assumed to represent an organic disease entity made manifest by certain behaviours. This becomes the norm against which other practices and articulations fall short. It may be in social and health care that psychosocial approaches based on personhood build an architecture of dementia and dementia care against which other approaches are disregarded or made deviant.

Dementia can be understood in an active sense. Meaning is given in the practices associated with care given. To some extent this has been undertaken previously by accounts which conceptualize dementia according to behaviours observed. Wandering, anxiety, restlessness and aggression have all been linked to dementia. Daily practices constitutive of dementia care include the responses made to these behaviours in the context in which they occur. This context is itself influenced by normative ideas of the concept of dementia, for instance as a particular disease entity or as an observable set of behaviours displayed under certain conditions.

Morgan (1996) considers O'Neill's three-level model of body politics to explicate his notion of family practices. The familial bio-body focuses on dealing with sickness, health and well-being. The familial productive body concerns work, self-control and exploitation. The libidinal body concerns personality, happiness and fulfilment. Family processes are linked to biology: birth, sexuality, death, ageing. There is often a degree of bodily licence in families. These three ways of viewing the body link to dementia and care across practices that emphasize physical care, that deal with the ageing and dying person, that construct work regimes and everyday practices and that seek to maximize well-being. This emphasis on the importance of the body in constructing daily practices is echoed somewhat by Twigg's (2000) conception of care work as bodywork. The lower status accorded to care work (Jack, 1994), partly as a result of the negative images associated with bodywork, reflects an understanding in respect of dementia as being outside the viable, the normal and the wished for. Daily practices focusing on the body in dementia care may perhaps add to the negative construction of dementia and dementia care.

Morgan (1996) developed further the idea of family practices and suggested that they were not bounded by the usually expected confines of the family. In fact, 'their significance derives from their location in wider systems of meaning' (Morgan, 1996: 190). Family practices, as opposed to *the* family, represent processes that interact with other areas of social enquiry. This avoids the potentially dangerous reification of family in terms of policy constructing normative standards against which others are seen as deviant. This is important to note. Practices constitutive of dementia and dementia care are not bounded by the institutions in which direct care is provided. The gendered nature of the

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workforce (Jack, 1994; Arber and Ginn, 1991), the training and qualifications provided (TOPSS, 2000), the location and status of social care in relation to health care, and the personal biographies of individual care staff are important in (re)producing systems of dementia care.

In general, practices are defined by the social actors involved, but this is not considered the sole criterion of definition. These definitions might not always be available to the observer. For instance, it might not be possible for one person with dementia to communicate their meaning of dementia to another. Practices are concerned with cognitive constructions but also with the significance for those parties involved. They are '... a way of looking at, and describing, practices which might also be described in a variety of other ways' (Morgan, 1996: 199). Practices can, therefore, be described by others involved in an observational or descriptive role.

Morgan (1999) sees that there are three sets of agencies involved in constructing family practices. Firstly, as we have mentioned above, the social actors involved in the social entity themselves make links between activities and general notions of family. These linkages, activities and notions are constantly negotiated and redefined by individual experience and reflection. Secondly, more abstract agencies are involved. These may include professionals, moral and religious agencies, policy makers and the like. Distinctions are made in these pronouncements between family and non-family, between positive and negative, between included and excluded. These professional accounts are influential to individuals and may build a cultural resource which provides meaning for the individual care-practitioner or, indeed, the recipients of that care and their families. There is a reflexive monitoring of one's own routine practices against some standard of normality which becomes reproductive of those standards. The final agency involved in the construction of practices is the observer, as stressed by Smith (1987). Morgan suggests that observers are often ignored in discussions of social construction. It is routinely experienced that the constructions of observers should match and derive from those of the actors whose practices are being described. This is not always the case and observer effects/notions/constructions are important.

The term practices conveys a range of related themes (Morgan, 1999: 17–18):

- A sense of interplay between the perspectives of the social actor, the individual whose actions are being described and accounted for and the perspectives of the observer. The concept of practices emphasizes that there are different perspectives and interpretations.
- A sense of active rather than passive or static. There is a sense of 'doing' which both constitutes and derives from notions of family and proper conduct between family members.
- A focus on the everyday. There is a concern with the routine and trivial as part of how family life is seen.

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- A stress on regularities. Regularities or repeated actions that constitute part of the everyday taken-for-granted worlds.
- A sense of fluidity. Practices are not bounded but flow into other practices that are similar or different.
- An interplay between history and biography. Practices have societal and historical dimensions as well as concern with the everyday and here-and-now.

Harding and Palfrey (1997) describe how dementia has been socially constructed as a disease entity. This model has dominated the minds of service providers, planners and health and social care (Cheston and Bender, 1999). The work of Kitwood concerning the dialectical interplay of neurological impairment and what he termed 'malignant social psychology' provides a useful model to understand the processes in which dementia becomes known and worked with by the ascriptions associated with it (Kitwood, 1990, 1993, 1997; Davis, 2004). The social constructionist debate has also evolved in respect of the importance of the person and his or her voice in dementia care (Sabat and Harré, 1992; Downs, 1997; Bender and Cheston, 1997; Adams, 2001a, 2001b). Cheston and Bender (1999) progress the model and demonstrate its application to social and health care practice. It is in the context of everyday practices, however, that an understanding of the social construction of dementia is important.

Practices represent a way of conceptualizing the fluidity of social life as a point of departure. Practices allow for a variety of different perspectives and to consider subjects through a variety of different lenses. External practices may reinforce or construct notions of the social entity described. They are associated with wider understandings of the world and, as we have seen, do not necessarily take place in times and spaces that are conventionally designated to do with the entity described. Thus the site of dementia care may not be the only place in which dementia is constructed. In the biographies of workers, and their family experiences, dementia takes on meaning. The role of social care practitioner in his or her family and the family's experience of dementia are important considerations relating to the continued construction of dementia and dementia care in everyday practices.

### The Study

The data for this study are taken from observations of the daily practices of, and interviews with, social care staff working with people with dementia in a local authority day centre in the UK. The study is limited, therefore, in scope and range. A larger study would need to consider practices external to those designated for the purpose of care and examine the language used concerning dementia. However, the everyday social care practices in this day centre provide data that begin to reflect the ways in which dementia and dementia care are



constructed in this particular setting. The study is therefore descriptive rather than representative. The data are analysed by reference to the concept of practices across a range of constructive levels and domains deriving from the data. A process of axial and selective coding was used to make connections between observed practices, perceptions of care and dementia care (see Strauss and Corbin, 1990).

It is the case that representations of practices are organizationally embedded. They are situationally specific and their articulation is embedded in local discursive conventions. Agents are 'constantly interpreting the recognizable features of everyday life, sifting through cultural instructions, articulating available models with everyday experiences to assemble the coherent social realities they inhabit' (Gubrium and Holstein, 1990: 117, 1993). The object of descriptive practice is interpreted and assembled out of experience. Those involved in the site of practice are often assumed to have the most authentic knowledge of the site. This claim to privileged knowledge is used in two ways to warrant the claims of members and to discount outside opinion. Questions of ontology – what the practices are – and epistemology – how we know these practices – are also raised. In day care, this is certainly given evidence in comments about senior care officers and management, change, other groups of staff and sites of practice.

## The Findings

### The Physical Environment and Setting

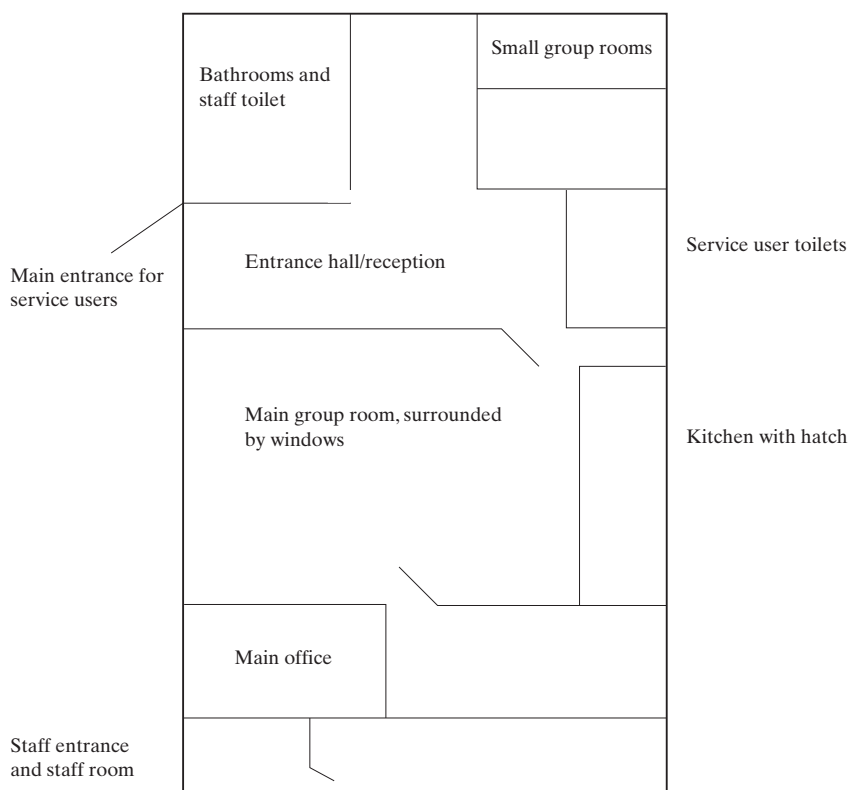
The purpose-built day care centre in which the study was conducted has one large room with a separate staff room at one end by which care staff enter and leave but cannot be seen or overlook activities on-going. There is a serving hatch at one side from which food is served. The main office is situated at the end of the room. The room, people and activities can be observed from this space (see Figure 1).

The entrance hall is fairly large. Rooms off the entrance hall include lavatories for day care service users en route to the main room. The other corridor contains a small group/meeting room, a kitchen for service users, bathing and physiotherapy areas, and staff lavatories.

The built environment has three particular constructive domains. Primarily, it serves to *hold and homogenize* its service users and the staff who work there. The entrance serves as a conduit, through which service users pass to the main room where they sit, eat and undertake group activities. It also acts to *demarcate and distance* by bounding staff and member space and developing the shared notion of distance between staff and members using the centre. Staff only entered through this entrance when escorting members into the hall. At other times, staff entered at the rear of the building into a staff-only environment.



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Figure 1 **Plan of day centre**

The bounded nature of space created a separation between staff and service users which meant that observation and surveillance was possible and encouraged the notion of control of those deemed to be in need of care. There was also the possibility of senior staff monitoring junior staff activity and work which was noted by care workers and served to demarcate within the staff group itself. This fed into the perceptions of divisions between staff and between staff and service user, allowing staff members to offer care in a standardized way that left out the service users' views and allowed blame for this to be situated outwith those offering the care or those managing it. This was exemplified in comments from care staff indicating that 'they [attendees at the day centre] need us to do everything for them', and by senior care staff stating 'we try to be person-centred but they [junior care staff] just treat them [attendees] like children.'

Interestingly, the physical environment was not commented on by staff. In observations of daily practice it appeared that staff and attendees unconsciously

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used the space to create demarcation by herding activities and, later, at meal-times by bounded activities. The focus was on everyday activities and regularities that constituted a taken-for-granted role (see Morgan, 1996).

The physical layout and use of space did allow the staff group to work together, especially in the mornings when group activities were undertaken. This offered support and opportunities to plan activities, to ensure people were looked after and to create a team approach among staff. Again, elements of demarcation and *care and control* were involved here. The potential for surveillance was emphasized by the physical space and its use. The surveillance was undertaken to ensure that people received care and were monitored and contained. It had a care-giving function in its controlling action.

### Routines and Activities

Staff time was used in a planned way to deliver systematic programmes of day care. This led to a degree of regimentation on arrival for people attending the day centre. They were all greeted by being given a name badge and having a cup of tea, followed by group activities for all service users together, lunch, and smaller group activities in the afternoon. The implicit assumption seemed to be that this constituted appropriate activities for the service user group, who required regularity, an activity-focused day led by staff and undertaken by service users. These actions were constitutive of an overall construction of dementia and dementia care.

However, there were discrepancies in how staff undertook these functions, depending to some extent on the position, training and life experiences of care staff. Senior care staff generally expected a greater level of involvement and capacity from service users and had higher levels of training. Personal or familial experiences of dementia had an impact on junior and senior care staff. Approaches to service users ranged from cajoling all to join in to providing individual activities, where possible, to those who did not wish to join in. At times group activities were dominated by the more confident and competent service users, which detracted from those who were unable to participate as actively. This tended to demarcate those with a greater degree of cognitive ability from those with less.

A daily diary is completed whilst most members sit around the white board ... However, I feel the daily diary slot is dominated by the more vocal service users with the least signs of dementia.

Some staff actively encouraged this, suggesting that this allowed those who could join in to get more from the activities and to prevent frustration. There was a degree of disagreement between those constructing the plans for activities and those delivering them, which seemed to be bound up with the routinized expectations of deliverers rather than the fluid potential of planners.

Also, the systematic, planned approach at times excluded members. One woman was left out of smaller group activities because her name had been left

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off the list. She remained unoccupied and mainly unattended until this was noticed. The following quotation from a care officer demonstrates the discrepancies in planning and delivery:

One lady, Flora [not her real name], was left out from the groups, as her name was not written down and assigned to a group activity. I sat and talked with Flora for about five minutes before [another member of staff] came and said she could join their group.

Activities and work within the centre with service users was constrained by the working hours of staff (generally 8.30 am to 4 pm), the timing of the transport bringing service users, and refreshments and meals. The greatest constraint was the transport which collected and returned two groups of people from a wide area of a city, often travelling for over one hour without there being guaranteed times for arrival or departure. This curtailed activities and often led to disquiet. Special needs were not accounted for in this and transport served to herd and homogenize the groups of service users by geography. Needs were assumed to be the same for each member and their families. However, care staff were aware of the problems raised by issues of transport, considering them in the light of their own life settings and perceived expectations, as the following statements from practitioners show:

... transport is abysmal. Those picked up last are generally taken home first. Those picked up first have longer to spend on the bus. I would expect a full day's break.

The transport bus usually takes two runs each day but there is no continuity with the escort – one bus went to pick up someone who had died!

activities didn't begin until 11.40 so people arriving on the first bus just sat waiting for the second bus to arrive... she seemed to be saying she had wasted the morning and resented those coming on the second bus for causing this.

Issues of and difficulties with transport have been noted as a matter of concern by the Social Services Inspectorate report *At Home with Dementia* (SSI/DoH, 1997: 3, 5):

Transport arrangements sometimes undermined the potential value of some services for older people with dementia, most usually because of their failure to respond to the needs of individual users and carers.

SSDs [social services departments] should monitor and review transport arrangements to ensure that they meet the needs of service users as efficiently and effectively as possible.

Meals tended to define the day in a number of ways. Staff tended to service the meals, lay out tables and clear away 'because it's easier like that', and service users seemed to be the passive recipients. This suited many who appreciated the 'hotel' aspect of the experience, but others who wished to help were not actively encouraged to do so. People were treated according to their status as service users rather than their desire to join in or be consulted or, indeed, according to their abilities. This was another distinction creating distance between staff and

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service users and reflected a homogenizing construction that service users were in need of care and control of staff. Staff had lunch in two sittings after service users. Again, this emphasized the cared-for positioning of service users and separated staff from them.

Daily routines and activities were given emphasis at senior care worker level, and planning, designing and implementing activity and group work were considered to be high priorities. However, this created some disillusionment amongst care staff, as demonstrated in the following quotation:

There is no real vision of where (the centre) is going except to provide relief. Daily routine is left to care workers and the different views of seniors. The four-week plans were useful in designing topics . . . not work because care officers wanted to choose their own topics and not everyone has the same skills.

Planning for activities was undertaken in a hierarchical manner by senior care staff who planned weekly activity schedules which were then passed on to care officers to implement. The activities took into account the training needs of care staff, including opportunities for NVQ assessment.<sup>1</sup> Activities were, therefore, consistent with staff development plans and, by default, with contemporary theories concerning positive dementia care and person-centred approaches. Activities included creative methods of communication using word, pictures and objects; reminiscence work; and poetry workshops as well as the more traditional reality orientation quizzes.

In everyday practice, these plans were hampered by staff sickness, leave, perceived low numbers of staff and the contention that senior staff should be responsible for such planning because they are paid more. Senior care staff did not all have the same views. Within the staff teams there was a tension also, as shown by the following statement made by a care officer:

Clients are entertained by attending. When they are not this is because of a lack of time and planning for individuals. There is a great need for more staff and clearer boundaries between workers and officers [A] lot is expected of care officers and abilities are mixed.

Group activities were set for all service users in the morning and consisted of simple cognitive exercises concerning diary events, names and quizzes, and some gentle physical activity. There was no account taken of those who did not want to join in and, at times, there was a gendered approach to activities which was felt to exclude male service users. This is something recognized as an issue across social care:

SSDs need to consider the extent to which their equal opportunity policies address the gender needs of service users. They should also ensure that service providers have an appropriate mix of staff to deliver gender appropriate care in practice. (SSI/DoH, 1997: 6)

Afternoon activities were planned with specific interests and needs in mind. Smaller groups were organized and some degree of participation in planning

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was possible, although this was mainly led by staff interests. Staff brought a range of perspectives from day care, residential care, NVQ training, wider experiences and family life. These influenced the construction and delivery of day care. Care-giving gave a sense of satisfaction for staff and there was an explicitly stated desire to offer activities determined by service users and to ensure that these were age appropriate. This did not always happen, with service users sometimes receiving the same input regardless. The question of training and competence seemed to demarcate staff.

Groups are designed for the client and matching takes place. But often staff want to be told what to do and not have to think and decide. . . . The care is there but the stimulation needs more support – groups and plans. There is a need for formal training but also for reflecting on experience and recognizing what others do well.

The training and position of staff impacted on practices and beliefs underlying them. Senior care officers were generally undertaking training at a formal level (NVQ) but were reading around the literature to inform practice and had assimilated concepts of well-being and positive communication practice. The managerial responsibilities of staff tended to take senior care staff away from much direct contact with attendees, which was then passed down to junior care staff. These care officers were less likely to be involved in formal training post-induction or, at times, level two NVQ. The views of dementia they brought to the work derived from personal experience in a more explicit way and from embedded constructs from traditional approaches to care work. Amongst those with direct contact responsibility there appeared to be an unquestioning acceptance of the inevitable deterioration and need for active imposed care of people with dementia. One member of staff argued, 'well, it's all right for them [senior care staff] to have these ideas, but they [attendees] need our help; they're just like children whatever you say.' This view seemed to permeate interactions that were of the order of 'doing to' rather than 'doing with'. For example, not only was this the case at mealtimes, but when toileting, members were approached in a way that was sensitive but demonstrative. People were helped physically and walked to the toilet as a matter of course, although senior staff were adamant that individual need should determine these actions.

## Discussion

Understanding and training remained at a superficial level. Whilst training had been undertaken amongst senior care and care staff concerning the development of positive approaches to dementia care and person-centred ways of working (Kitwood and Benson, 1995; Parker and Penhale, 1998; Stokes, 1987a, 1987b, 1987c, 1987d), old habits remained. The person with dementia was seen as impaired, in need, deteriorating – in terms of their weaknesses and illness – rather than as a person. This has great implications for training and development. Indeed, it seems as though there was, at times, a bi-directional assertion

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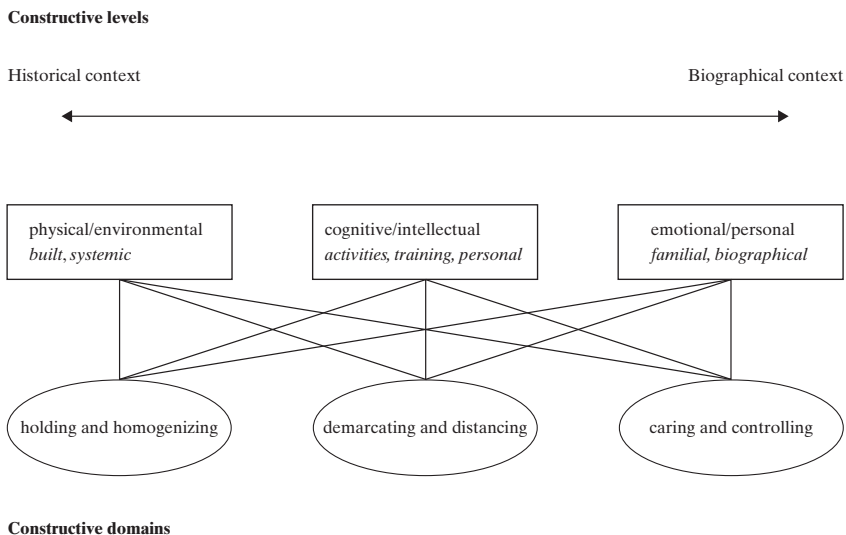
of deviance, with senior care staff assuming greater knowledge and suggesting that care officers should give up their old assumptions, whilst care staff in more junior positions castigated the views of senior staff by stating that their views were idealistic and not grounded in daily realities (see Bernades, 1997). If there was any observer effect on the practices of care staff this indicates further the need for training.

In order to understand some of the ways in which dementia and dementia care were constructed in this setting a number of levels of practice and construction were identified from the observations made and interviews undertaken. These concerned the physical environment, a cognitive and intellectual level and an emotional/personal level. At each level of practice and construction, a number of constructive domains were noted. These overlapped across levels and included 'holding and homogenizing', 'demarcating and distancing' and 'care-giving and control'. These domains of practice illustrated how dementia was understood, as a disease affecting others who will need care and control, and how dementia care was done. This was similar to Morgan's (1996) view of family as an adjective or verb as opposed to static noun. The context in which these practices and constructions were made was also important. Dementia was seen to be constructed on these three interacting levels, which were in turn influenced by the context of social care history, change and the individual experiences of the care staff. The experiences of care staff are not bounded solely by history. Their individual knowledge, experience, training and interpretation are important in the co-construction of day care and dementia within that context. This model of construction is shown in Figure 2. It is also possible that the historical context of social care provides a rationale for purpose-built centres that reflect the 'holding' and 'distancing' functions that do not fit comfortably with contemporary constructions of care but still inform many of the everyday practices observed.

Daily practices recreate dementia and dementia care because of their regularized nature and specific function as a centre for dementia care. The activities and attitudes promoted are associated with the condition. This is clear in respect of the care-giving, regulated aspects of the centre and in the planning and implementation of activities. However, these constructions are not fixed but are open to change and development by interaction, interpreting difference and challenge. The overall importance of daily practices lies in the potential for planning services, training staff and ensuring that an ethic of social care is promoted. The generalizing and homogenizing principles of social care evident in this particular study are potentially exclusive of individuals and their worth. By making transparent the practices and meanings derived from them, it helps to identify training needs and aspects of practice for change, and highlights the importance of ethical approaches to practice.

It is important to remember that the construction and reconstruction of practices is multi-directional and influence at each level can produce effects at other levels (Bourdieu, 1996). Policies, procedures and working methods

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Figure 2 **Constructing dementia in the day care setting**

influence practice but, also, the expectations and daily routines of each practice site reflect back on to policy makers. It is especially important to attend to the personal biographies of staff to provide a supportive environment that encourages reflection on practice and the development of approaches that take cognisance of the individual needs of the person with dementia (Kitwood, 1997). In this study, biographies appeared to be used in two ways. Firstly, there was a historical use in which care staff used personal and familial experiences to affect their views of how care should be delivered: a projection of what one would want for one's own relatives or oneself, which often related to caring and controlling approaches to practice. Secondly, there was a more contemporaneous use of personal development and training. Unfortunately, at times this development seemed to be concerned with a 'professionalizing' tendency that demarcated and distanced staff from service users. What seemed to be lacking was a reflexive and future-oriented developmental approach. This, again, suggests that training is needed, not only in understanding the concepts of person-centred care, but also in the implementation of a new culture. However, to suggest that this was the result of individual care staff experiences alone would exclude the significance of structural and organizational aspects of care delivery. The given nature of day care did not seem to be questioned and this had an impact on the approaches to individual practice. Traditional models of dementia seemed to become embedded when a personal experience of dementia confirmed to the individual that a caring and controlling approach to service users was necessary. This tended to homogenize individuals' constructions of dementia and impact upon their practice.



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The ways in which we approach, engage with and talk about people conveys a sense of how we interpret their situations. This informs our practices and the practices of others, and becomes embedded as part of the assumptive world when dealing with people. As moves are made more widely to improve and enhance dementia care, it is important that practices demonstrate the new culture of care, not only the worlds spoken about it. We may be able to achieve this cultural shift more readily if we accept that we construct our practices in our interactions with others and that those practices can be fluid and lead to development and change. If we take as our starting point respect for individual staff members in social care and their biography alongside respect for service users and their carers, this new culture may become more of a reality.

**Note**

1. National Vocational Qualifications (NVQs) form an important continuum of formally recognized training designed to up-skill the social care workforce.

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