

Active and non-active agents: residents' agency in assisted living

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ABSTRACT

Culturally, institutional care has been seen to strip older people of their status as full adult members of society and turn them into 'have-nots' in terms of agency. The substantial emphasis in gerontology of measuring the activity and functional ability of the elderly has unintentionally fostered these stereotypes, as have traditional definitions of agency that emphasise individuals' choices and capacities. The aim of this paper is to discover what kind of opportunities to feel agentic exist for people who have reduced functional abilities and therefore reside in assisted living. In this paper, agency is approached empirically from the viewpoint of Finnish sheltered housing residents. The data were gathered using participant observation and thematic interviews. This study suggests that even people with substantial declines in their functional abilities may feel more or less agentic depending on their functional and material surroundings and the support they receive from the staff, relatives and other residents. The perception that residents' agency in assisted living cannot be reduced to measurable activity has methodological implications for gerontological research on agency. Care providers can utilise our findings in reasserting their residents' quality of life.

KEY WORDS – long-term care, ethnography, agentic space, assisted living facilities, quality of life.

Introduction

At present, gerontological research has privileged activity in particular as the major component of successful ageing (Baltes and Carstensen 1996; Rowe and Kahn 1997) and its different interpretations, such as healthy ageing, productive ageing and active ageing (Nosraty *et al.* 2015). According to Katz (2000), activity has become such a paradigm of wellbeing in old age that questioning it would be considered unprofessional or even heretical. Katz (2000) sees the triumph of activity as deriving from larger societal and ideological

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changes driven by neoliberalism and its anti-welfarist agendas; keeping busy and active has been seen to postpone dependence and the need for help in old age. At the same time, the responsibility for wellbeing in old age is being transferred from the society to choice-making individuals (Jolanki 2009), which is the result of the challenges posed by ageing populations in the Western world (Rozanova 2010).

Katz (2000) maintains that the emphasis on physical activity is partly derived from its applicability in measuring and evaluating age-related phenomena. Meters like activities of daily living (ADLs) were originally created to measure specific physical competencies of maintaining an independent life, but their application has expanded, *e.g.* to determine service requirements and impacts, justify residential location or provide a basis for staffing ratios in care facilities. Katz (2000) suggests that activity is important to the success of care institutions as well. Providing activity programmes is a simple way for professionals to show their resourcefulness and efficiency, and their obedience to official guidelines of care that emphasise activity (*e.g.* Ministry of Social Affairs and Health 2008).

However, questioning the paradigm of activity regarding successful ageing has begun. Critics of successful ageing have even presented it as a technique of regulation that serves to deny older people the legitimate right to bodily dysfunction (Tulle-Winton 1999). The renunciation of bodily dysfunction has been claimed to result in intra-generational ageism (Rozanova 2010) or 'new ageism' (Holstein and Minkler 2003), since older people who do not age successfully become defined as unsuccessful. Critics see activity as too narrow and individual-centred a concept to capture the reality of ageing people (Holstein and Minkler 2003; Katz 2000). Therefore, the concept of agency, which originated in sociology, has lately gained ground in gerontological research (*e.g.* Morgan *et al.* 2006; Wray 2004).

In the sociological tradition, agency relates to the elementary question of the interaction between individuals and structures (Giddens 1984; Ritzer 2000). From the classical, Giddensian point of view, social structures direct individual action, which then feeds back into those structures. Agency deals with activity, but acknowledges the influence of the actor's situation as well. The concept of agency does not easily surrender to strict definitions. Marshall (2005: 59) points out that agency is 'a concept more often invoked than measured', and Emirbayer and Mische (1998: 962) note that 'agency has been associated with selfhood, motivation, will, purposiveness, intentionality, choice, initiative, freedom, and creativity'. Nevertheless, it always seems to involve choice, temporality and structures (Marshall 2005; Sewell 1992). Elder and Johnson's (2003) definition of agency makes this point clearly; agency means that individuals construct

their own lifecourse through the choices they make and the actions they take within the opportunities and constraints of history and social circumstances.

Traditional conceptualisations of agency, which emphasise social structures and situationality, capture the multi-dimensionality of human action better than activity, but there remains a serious flaw regarding the agency of people with severe functional disabilities. Giddensian agency presupposes that individuals possess agentic capabilities. As Wray (2004: 24) expresses it, 'dominant Western conceptualisations of agency are often used uncritically; individualistic notions of choice, autonomy, and in/dependence often pervade accounts of agency'. Old age does not necessarily cohere with agency when we consider Gilleard and Higgs' (2010: 122) argument that the combination of publicly failing in self-management and receiving institutional forms of care in Western cultures makes older people lose their frame of reference regarding their individual agency. Eliassen (2015) holds that this stereotyping frequently colours the interaction of health-care personnel with older people.

Morgan *et al.* (2006) emphasise that older people entering assisted living (AL) have probably already encountered constraints on personal agency, either due to prior circumstances resulting in placement or from the AL setting *per se*. Even today, AL facilities are seen to carry some features of Goffman's (1968) total institutions (*e.g.* Pirhonen and Pietilä 2015), thus creating constraints on agency. As organisations, facilities have certain needs of their own (Sherwin and Winsby 2010), and even the physical and functional spaces may influence residents' possibilities to conduct their lives in AL (Golant 2003). Also, since residents' functional abilities are diminished, third parties, including professionals and relatives, often make decisions on behalf of the residents (Schumacher *et al.* 2005). All this makes residents appear to be 'have-nots' in terms of traditionally defined agency.

However, Kontos (2004, 2005), who has studied people with Alzheimer's disease in AL, sees the human body as a fundamental source of selfhood that does not derive its agency from a cognitive form of knowledge. Kontos (2005: 558) argues that 'the body itself is an active, communicative agent, imbued with its own wisdom, intentionality, and purposefulness'. In their report, Morgan *et al.* (2006) showed how AL residents based their agentic feelings on their temporal context, *i.e.* agency was expressed and enforced in relation to the residents' life continuum. Katz (2000) refers to 'anti-activity activities', such as napping and watching television, when problematising traditional classifications of activity in AL settings. This all suggests that both the activity-emphasising approaches and the mainstream classifications of agency seem to be insufficient to capture the agency of residents in AL.

As Golant (2003) remarks, understanding older people's living arrangements and environments is central to any complete understanding of how a current residential setting influences their emotional responses or behaviours, *i.e.* agency. In this paper, our aim was to shed light on factors enabling AL residents to feel agentic in their living surroundings. Based on ethnographical data, we wanted to study what kinds of possibility exist to execute one's agency with remaining physical and cognitive capacities in a care facility for older people.

Design and methods

This paper is based on research that was conducted within an ethnographic research frame. The data were gathered through participant observation and thematic interviews in a sheltered home in southern Finland in 2013–2014. Sheltered housing is a form of housing service for older people that is ideologically located somewhere between institutional and home care. On our research site, people paid rent for their rooms, and they paid separately for their food, medication and care. In addition to the residents' private rooms, there were common spaces to socialise and watch television. Residents furnished their rooms with their own belongings and wore their own clothes in order to achieve an atmosphere that is as homely as possible. Nevertheless, nursing staff were available round the clock, which makes it AL.

At the time of the study, 114 residents lived in eight group homes. Their functional abilities and medical conditions varied considerably. Some suffered from severe cognitive disorders such as Alzheimer's disease, and some lived there due to somatic illnesses such as multiple sclerosis. Some were bedridden, whereas others moved around independently without mobility aids. The majority of the residents were female (70%), and the residents' ages ranged from 60 to over 100 years. Most of the residents suffered from cognitive disorders to some degree.

Observations were mainly conducted in one group home, which housed 15 residents, to become familiar with the residents and their characters as well as their interactions and daily routines. Staff were consulted in order to find a home of residents with diverse conditions to contrast the influence of the condition on the residents' agency. The observation lasted for two months and totalled 165 hours, which was regarded as adequate since thematic interviews were to follow. The observation consisted of conversations with the residents, staff and visitors, and participation in recreational activities and tasks permitted for voluntary workers, such as feeding the residents. Observations were made on every day of the week and at all times of the day. Once, the observer spent two consecutive nights at the

home to become as familiar with the surroundings as possible, sleeping in an empty residential room, spending time in the day room and having meals with the residents. Such intensive participant observation enabled us to provide 'thick description' of the research site, as Geertz (1973) puts it. Participant observation also helped us to see the setting from the residents' perspective (*cf.* Diamond 1992; Gubrium 1997). Field notes kept from the observations and the transcriptions were included in the data analysis.

In addition to the observation, ten interviews were conducted with residents between May and September 2014. Since the vast majority of residents suffered from cognitive disorders, we had to find the interviewees among the total 114 residents. We asked the staff to propose ten candidates capable of giving their informed consent and participating in an interview. A team of two head nurses and a practical nurse picked these ten residents (six women and four men), and those selected were all willing and gave their consent. This recruitment strategy involved a potential risk that the staff would nominate residents who felt most positive about the home, but since we did not personally know residents outside the group home we observed, it was a both ethically and practically justified procedure. Also, as we will see in the Results section, interviewees were quite critical about their surroundings. Thematic interviews were conducted in the residents' rooms and included themes such as the residents' previous lifecourse, their perceptions of their current living surroundings and their thoughts about the care they received. Themes were loose to enable data use regarding various research themes in the future. Agency as a concept was not introduced in the interviews, but residents were asked questions about the possibilities of them having control over their daily lives. For example, they were asked if they could move around in the home and go outside on their own initiative, how well did they know their finances or if there were desirable activities available in the home. The interviews were 25–65 minutes in duration and they were transcribed verbatim.

The Ethical Committee of the local Hospital District and the manager of the research site approved our research plan. The research was introduced to the staff in a staff meeting and notices providing information on the research were placed on all the notice boards of the facility. The researcher personally explained the research to everyone on the site the first time he encountered them. In spite of these procedures, not all the residents understood that the research was going on due to their cognitive disorders. However, we found the study ethically justifiable since people with such issues have been granted the right to participate in research aimed at improving their lives or the lives of people in similar situations (Bond and Corner 2001; Finlex 1999).

The data were analysed using directed content analysis (Hsieh and Shannon 2005). In the first phase of analysis, we utilised prior definitions of agency

searching for references to motivation, will, purposiveness, intentionality, choice, initiative, freedom and creativity (*e.g.* Elder and Johnson 2003; Emirbayer and Mische 1998; Wray 2004) to separate data extracts that dealt with the residents' agentic position. Both observational and interview data were involved in the analysis; since two different qualitative data-sets and two researchers were joined together, this enabled triangulation (Thurmond 2001). However, due to our research topic the interview data proved to be more powerful in understanding the nature of the residents' agency. As Jolanki (2009: 215) puts it, agency 'brings forth the human ability to ascribe meaning to objects and events and to act on those meanings'. The residents' meaning-giving was obviously more explicit in their accounts of objects and events. The observational data were nevertheless important as well, since they helped us position the residents' accounts within the frameworks of daily life in AL in order to understand the preconditions of their meaning-giving.

In the second phase of analysis, after separating extracts dealing with agency from the data, we noticed two things. Firstly, the vast majority of our extracts dealt with the residents' competence to do things in the AL setting, their motivation (wishes and feelings) and/or their surroundings in AL. This is not surprising since these three areas are, in some form, the cornerstones of any theory of action and agency. Theories inevitably deal with the abilities and motivations of the actor and the surroundings of the action (*e.g.* Joas 2005). Secondly, some of the extracts dealing with the residents' agency refused to fit in with traditional definitions of agency. Thus, we eventually analysed the residents' agency within three frameworks (competence, motivation, AL surroundings), while acknowledging the exceptions that widened these frameworks.

Results

In the data, the residents' agency appeared in relation to three components: their competence, their motivation, and the opportunities and restrictions produced by the AL surroundings. These components were not separate, but intertwined with each other. We present our findings below, with illuminating extracts from the data. All the names mentioned are pseudonyms. In the extracts, 'R' refers to the researcher.

Competence: 'I can take care of my diabetes myself'

In this paper, the concept of competence incorporates the personal qualities the residents needed in accomplishing their aspirations, such as their skills and knowledge, and creativity in applying those skills. Being capable

can be seen as a cornerstone of competence, and it was referred to most often in the data excerpts connected with agency. However, living in AL presumes that functional abilities have diminished (*e.g.* Agich 2003; Sherwin and Winsby 2010). Ida spoke openly about her situation.

- R: Yes. So why did you end up in enhanced assisted living?
- Ida: I can't really remember. My son lives in [mentions a town] and he was the one who got me in this place.
- R: Aha, so your son organised this...
- Ida: My son organised it, yes, I couldn't do it myself.
- R: Okay, well, do you know what reasons there were for it, do you have some physical illness or...
- Ida: No, old age.
- R: Just old age?
- Ida: Old age. I couldn't cope any more, and I couldn't manage on my own, so... (Female, aged 94)

In this short extract, Ida expresses four times the restrictions to her agency, all of which were connected to competence. She was not able to tell (she did not remember) why she originally entered the home. Then, she explains that she was not able to arrange the move herself, that she was not able to cope anymore and that she was not able to manage on her own. Ida considered that hampering abilities due to old age was the reason for her to move into a care facility. She did not seek explanations for living in AL in particular diseases or other reasons like the rest of the interviewees did. For example, interviewees reported that they were in AL because they had lost the ability to walk, experienced dizziness or had been incompetent in managing their finances. At the same time, in giving up her own agency, Ida seemed to delegate at least a part of it to her son, who found the home and arranged the move.

Other interviewees also seemed to delegate their agency to family members, friends, the staff and sometimes each other. Residents' children usually managed their finances and brought them the things they needed. Hilda, who spent most of the time in bed, had her closets kept in order by a friend who visited frequently. Timo was not interested in his own medication since he thought that the doctor was qualified enough to make the right decisions for him. Maria used her male neighbour as a messenger when she needed to give the staff feedback on something. In these cases, residents were still agents who employed decisional agency and then delegated executional agency to others.

Delegating one's agency to others voluntarily differs from having one's agency restricted by others. Anita also said that her children had arranged her a place in AL, but against her will. She had to move because her daughter had found her lying unconscious in her apartment. In the following extract, she was asked what the biggest differences were between living in a private home or in a sheltered home.

- Anita: Well, at home I could of course wake up whenever I wanted to, although I can do that here, too. I had to go grocery shopping and cook. That's a difference right there.
- R: Yeah. Do you miss things like that, going to the store or cooking your own meals?
- Anita: (laughs) Why not...
- R: Uh-huh. And do you think you could still do it?
- Anita: Huh?
- R: Could you still do it?
- Anita: Sure, I could still do it. (Female, aged 78)

Anita missed the opportunity to go to the grocery store and cook her own meals and she thought she still could do these tasks. Earlier in the interview, she explicitly stated that her 'children began to say "you can't manage at home on your own". And I could still manage if I was there'. She seemed to consider herself too competent to live in AL and therefore seemed to feel that her agency was restricted by her children.

Ida felt that she had lost her ability to take care of herself, whereas Anita believed she could still manage on her own. Jan, being a 'young' man (60 years old) who lived in AL for somatic reasons, actually seemed to be considerably competent.

- R: And can you eat whenever you want to?
- Jan: They're organised superbly, the meals. I've had diabetes for 17 years and I can manage it myself. I give myself the shots and check the levels myself. That's my equipment there. (Male, aged 60)

Jan's statement can be read as an ultimate expression of competence in the AL surrounding. He was asked about eating arrangements in the home, and as a diabetic he obviously *knew* the importance of nutrition regarding his condition. 'I can take care of my diabetes myself' expresses Jan's agentic competences; he *wanted to* take care of his diabetes himself and he *knew how* to do it and *was able* to do it with the equipment provided by the care system. 'I can take care of my diabetes' could also be interpreted as expressing self-esteem, implying that he *felt* proud to do it, having already done it for 17 years.

Sometimes the residents supported their competence and thus their agency by aids or other devices, just like the rest of us. Jan was notably modern in this sense:

- Jan: Yup. And then I spend time with that (points to a laptop).
R: You've got an internet connection on it, haven't you?
Jan: I have. I read national newspapers, there are plenty of those. I can even read all the local papers online, even if it's a small town.
R: Yes.
Jan: And then I surf the net for all kinds of things. Recently I've checked the prices for a 40-inch Samsung television. I've got a small TV, a 23-inch one, and I'm going to get rid of that, sell it to someone and then buy that 40-inch Samsung. (Male, aged 60)

Jan's ability to use a laptop and internet seemingly supported his agency. He kept up to date by reading online newspapers and used the internet to obtain information, for example, about buying a new television.

The residents used wheelchairs and walkers to move around, and they had cell phones to keep in touch with people outside the AL setting. Usually, the devices were appreciated simply as aids, but sometimes they enabled deeper agentic feelings, as in the case of Ida.

- Ida: And I can go to the bathroom, that's a big deal.
R: You can go on your own?
Ida: I can go on my own, and then I've got this walker, I can use it to go to the bathroom. (Female, aged 94)

Ida stressed the importance of getting to the bathroom independently, and a walker made her agency possible in this case. The connection between the device and agency was even more significant for Hilda. In the following extract, the researcher interviewed Hilda, who sat in a wheelchair in her room.

But then I came to [mentions the hospital ward she was in before AL] and the first time two nurses, pretty strong, strong-looking ones, tried to get me into a wheelchair, and my legs went all ... one crossed under the other. Then they said we'd all been close to taking a tumble. So that's when they said this isn't going to work, off to the bed with you. And after that it's been bed rest for me. I like to sit there, too (points to the bed). I don't lie down unless I'm sleeping. (Hilda, female, aged 86)

Hilda's account begins with a description of her diminishing functional abilities. She 'lost her legs' due to a progressive illness, after which other people decided she should stay in bed in future, which inevitably affected her chances to feel agentic. However, in this case, the bed itself has given

Hilda a chance to hang on to her agency. Her bed was motorised and she could operate it with a remote control device. She could lift the top part of the bed as a backrest and sit comfortably. The bed enabled her to feel that she was actively sitting instead of passively lying down: ‘I don’t lie down unless I’m sleeping’ expresses that Hilda has her ways of feeling agentic even when she is in bed and cannot get out of it on her own.

Motivation: ‘I refused to take that medicine’

The second widely referred to component of agency in our data was the residents’ own motivation, which manifested itself in their talk about their wishes and feelings. On many occasions, motivation seemed to act as a starting point for agency. Juho gave an apt example:

- Juho: Yes. If I want to go outside, I have to let them know.
 R: Yes.
 Juho: And I’ve got the code to the door. (Male, aged 82)

Juho said that if he wants to go out, he first has to inform the staff about his wish. In the home, the external door was always locked, and it could be opened with a five-number code. This system was designed to prevent cognitively impaired people from wandering off on their own. Juho stated that he had the code, meaning that he knew how to open the door and that he was capable of doing so. In this case, acting would result from motivation in line with traditional teleological theories of action. Sometimes, however, it seemed that the residents’ situation influenced or even generated their motivation, as in the case with Ida.

I don’t really move around. I get dizzy, so I’m a bit timid about going anywhere. But I quite like it here. I’m one of those people, I don’t care much for company. (Ida, female, aged 94)

Ida’s diminished functional abilities (dizziness) resulted in feeling insecure, which motivated her to stay in her room. She compensated for this by stating that she felt comfortable about staying in her room and explained this by adding that she did not long for company that much. Ida also reported during the interview that she would have liked a dog as a companion, but she was no longer able to take care of one. Maria said that she would like to exercise outdoors more often, but that it was not possible because of her diminishing functional abilities. However, the interviewees reassessed their situation in terms of coping with changes in their functional abilities. Hilda, for example, had switched from knitting to completing cryptic cross-words due to aching wrists, and Jan had switched from walking outdoors to

sitting on a bench due to shortness of breath. Coping with age-related changes certainly supported the residents' opportunities to feel agentic.

Sometimes the interviewees expressed their wishes explicitly, such as 'I refused to take that medicine', 'I denied the night nurse permission to enter my room', 'I don't want to wear make-up', and so on. Wishes were expressed explicitly, especially when they referred to things people did not want. Positive wishes were, however, intertwined with talk about restrictions set by circumstances. It seems that not wanting something did not demand explanations, but wanting something seemed to call for an account regarding how the speaker would be able to meet his or her expectations. The following extract is typical in this sense.

R: What expectations do you have for the future now that you've moved in here and lived here for three months?

Juho: Well, I'd of course want to take a short trip abroad at some point. I need an assistant, though, and I can't afford to pay for two people. (Male, aged 82)

Juho stated earlier in the interview that he had travelled abroad a lot with his wife. He still dreamed of taking a trip somewhere, but he admitted the restrictions set by his situation (the need for an attendant and limited finances). This seems to be a kind of accountability for agentic feelings. Residents who had obviously entered the home because of functional problems seemed to reflect constantly on their chances of feeling agentic.

AL surroundings: 'So to say, I prefer men'

The third frequently referred-to component of agency was its entanglement with the surroundings, that is, AL. Like any other surrounding, AL both encourages agency by providing opportunities and discourages agency by setting limitations. Putting the terms 'agency' and 'AL' into the same sentence easily directs our thinking towards restrictions of agency. There were references to restrictions in our data, too. In the following extract, Johanna compared her private home and the sheltered home.

R: That's great. If you think of home as a concept, do you have some kind of idea of what home consists of? What kinds of things make a home?

Johanna: It's the living itself. The things that you do. You don't do them here. There's no cooking or baking here. (Female, aged 85)

Here we have an explicit example of how the AL setting in itself may restrict people's agency. Johanna states that domestic work makes a home. Like Anita earlier, Johanna missed the opportunity to cook for herself.

The official, public business model of the sheltered home we studied explicitly states that residents could take part in the daily chores and household duties, but the kitchen was *de facto* off limits to them for hygiene reasons. Juho said that he sometimes helped other residents, although the staff had tried to prevent him from doing so by appealing to safety regulations. Another female resident once wondered why there were no duties available for her in the home. Providers of sheltered housing in Finland tend to emphasise that sheltered housing units are not institutions but homes. These findings imply that the practice does not yet meet expectations.

Timo, being a relatively young man (73 years old) surrounded with older women, gave a straightforward account regarding how the AL surroundings affected his agency. He was asked if he took part in recreational activities at the home.

Like hell I'm going to go there with those old hags, they're a hundred years old, and I have nothing to talk to them about and nothing in common with them, so I just feel like a damn crank around them. (Timo, male, aged 73)

Timo felt that he had nothing in common with the other residents. Enjoying recreational activities with them would have made him feel awkward, so he decided to stay in his room alone, although he said in the interview that he sometimes missed company. On the one hand, Timo's agency was restricted because of the limitations set by his social surroundings, on the other hand, he executed his agency by isolating himself from the others.

The AL setting was also found to support the residents' agency. For Maria, the setting gave her the opportunity to choose her company.

Maria: So I pick out the ones that somehow suit me.

R: Right, so you can choose your company here.

Maria: Yes. Yes, that's right. And, so to say, I prefer men. (Female, aged 82)

Maria preferred the company of men, and living in a group home of 15 residents made this possible. People were happy to have their own rooms (part of the business model of sheltered housing) and to take part in recreational activities provided by the home. They also appreciated the staff's help which supported their own agency. It is worthwhile noting that for some people, AL was indeed an expansion of their agency compared to a private home, highlighting the core idea of AL. As Ida put it earlier, 'I was not able to cope anymore' (at home).

As Giddens (1984) points out, social structures affect individuals and *vice versa*. In AL, this means that residents have to cope with the setting, but they shape it as well. Hilda reflected on her interaction with other residents.

But then, little by little ... The other residents wouldn't say anything to anyone. I just went on and asked questions and now I've got four people at the table that I can talk to. And who talk to me, and listen, and answer questions. (Hilda, female, aged 86)

Hilda was a very social person. At first, she was rather annoyed since the other residents would not hold conversations during meals. She decided to change the situation and kept talking to others until they started to respond. Hilda made her social surroundings more social herself.

AL constitutes very specific and compact physical, social, functional and cultural surroundings, which have been suggested to possess features of Goffman's (1968) total institutions (*e.g.* Pirhonen and Pietilä 2015). Nevertheless, based on our findings, the residents are not only passive receivers of care but also active agents utilising opportunities and affecting the AL surroundings.

Discussion

The ethnographic research frame applied in this study sets limitations regarding the generalisation of our results. We studied only one AL facility, and there are numerous forms of care – ranging from geriatric hospitals to sheltered housing – which are provided by various bodies, such as municipalities, private enterprises and foundations. However, the purpose of this ethnographic study was to widen our understanding of the agency of people with declining functional abilities. While our findings cannot be generalised in a practical sense, we believe we have revealed some of the universal features of older people's agency in AL, and thus our findings can be generalised theoretically. We trust that our findings on residents' competence and motivation as well as influences of their surroundings can be utilised to develop both policies and practices for AL regarding the enhancement of the residents' agency.

Residents' competences employed their skills, knowledge and abilities. Competence manifested itself in residents' accounts of managing in their living environment. The residents' functional abilities varied significantly, expressing the heterogeneity of older people in AL, just as described earlier regarding older people in general (Degnen 2007; Featherstone and Hepworth 1989). People highlighted what they still were able to do, in line with previous research (King *et al.* 2012). Our interviewees also reaffirmed Kaufman's (1986) finding that older people tend to avoid feeling old and frail by dealing separately with specific problems and disabilities, which may add to their feeling of still being agentic. As we saw in the results, interviewees (except for Ida) reported that they were residing in AL due to specific reasons.

Despite the differences in functional abilities, residents had their own ways of feeling agentic. The delegation of agency describes how the older people in our data voluntarily gave a part of their agency to other people, for example, when they were not interested in their medication, trusted that a doctor knows better or let a relative take care of their finances (*cf.* Young *et al.* 2003). Allowing someone to do something on one's behalf is agentic since to allow is still to be in charge of things. In our case, residents sometimes delegated execution of an action to other people while the decisional agency remained untouched. George Agich's (2003) differentiation between independence and autonomy is enlightening here. Agich (2003) holds that it is independent to make and execute decisions on one's own, but it is autonomous to make decisions and then get help in executing those. However, according to Sherwin and Winsby (2010), residents' autonomy may be lessened by several reasons like other people's (such as relatives') interests and residents' fear that disobedience may result in abandonment. It seems that allowing someone else to decide may sometimes actually result from constraints set by the situation.

Agentic feelings were also supported by aids. However, supporting agency with aids differs from delegating one's agency to other people in one significant sense. One does not allow an aid to act on one's behalf; rather, the aid extends one's own agency. Using a pill dispenser is an appropriate example. Allowing someone to fill one's pill dispenser delegates agency partly to the filler, but using a filled dispenser supports one's own agency, since it furthers one's own coping with the situation. In our data, residents delegated their agency to other people and supported their own agency with aids and other devices, creating categories of delegated and supported agency. Young *et al.* (2003) discussed shared agency when they described how older people semantically shared their agency with medical personnel or medical devices in their talk (*e.g.* the machine does my breathing). A hi-tech device, such as a ventilator, can be semantically comprehended as an 'other' to whom agency may be delegated. Social and other interactive robots in future welfare services will inevitably have interesting impacts on human agency.

The AL environment provided both opportunities and restrictions on the execution of agency, and it had more in-depth implications for agency, too. In terms of the relation between the residents' motivations and their surroundings, we found Joas' (2005) theory of non-teleological action highly plausible. Joas' basic theory is that the situation (affordances and constraints) is constitutive of action. Traditional teleological approaches to action emphasise the motivation of an actor, but Joas suggests that it is the situation that counts. As traditionally understood, residents in AL would first set their goals (motivation) and then move towards them with the means available (competence) in the situation (surrounding). The

will (motivation) finds a way (competence and surrounding). Joas suggests that the reverse is true. Applying his theory in AL, the residents' reflective response to the situation decides which actions would be appropriate: a way (competence and surrounding) creates the will (motivation).

Our interviewees adjusted their motivations and thus their actions on the basis of their competences and their situation in AL, the situation encompassing both affordances (such as aids) and constraints (such as staff being sometimes too busy). This is in line with SOC (selection, optimisation, compensation) theory, according to which older people use coping strategies to deal with age-related changes in their functional abilities in later life (Freund and Baltes 1998). Both Joas' (2005) theory and SOC theory highlight the situatedness of action, but there is one fundamental difference. SOC focuses on *adjusting* on the basis of one's situation, but Joas' theory is concerned with *creating* on the basis of one's situation. Perhaps we could say that activities may be adjusted to one's situation, but agency is created in one's situation. Regarding the bed case, Hilda did not just adjust her activities on the basis of her diminishing functional abilities (having multiple sclerosis), but created her agency in her situation.

The three components of agency – competence, motivation and surroundings – were not separate but intermingled with each other, providing people with *agentic space*. We suggest that agentic space is something that traditional sociological or 'Giddensian' individual–structure interaction cannot account for (*cf.* Honkasalo, Ketokivi and Leppo 2014). For example, Hilda found her agentic space when sitting on her bed instead of lying down. Her agentic space was constructed from her competence (ability to use her mechanical bed), motivation (preferred sitting during the day) and the surroundings (AL provided her with the bed). Agentic space is the situational affordance of enabling people to feel agentic. It is not visible as such: when Hilda was sitting on her bed, she felt agentic even though her agency was not visible to the eye.

A substantial part of the data used in this study was gathered in interviews with people capable of reflecting upon their situation. It may appear that we have nothing to say about the agency of people with dementia, even though the majority of people living in AL suffer with it. However, our study has methodological implications regarding research on the agency of people with dementia as well. If we accept Joas' (2005) idea that motivation does not lead our action but derives from the situation, people with dementia may be recognised as possessors of agency, and their agency may be studied and affirmed. People with dementia could be seen as a living argument supporting Joas' non-teleological approach to action. However, a specific study on the agency of people with dementia, as well as the methods to capture it, remains work for the future. One plausible approach

to the agency of people with dementia could be joining Joas' (2005) ideas with Kontos' (2004, 2005) work on embodied selfhood. Kontos urges researchers to abandon the Cartesian dualism of mind and body in which the mind leads and the body follows. Embracing the notion that the person is his or her body, its gestures, movements and habits, would provide a new insight and direction for the future investigation of the agency of people with dementia (Kontos 2004, 2005).

Conclusion

How we conceptualise agency has important methodological implications for gerontological research. Research could benefit from widening the concept of agency from 'doing' to also include 'being'. In addition to structured and standardised meters and checklists regarding older people's physical competence and their capacity to manage independently, a more philosophical understanding of agency is required. There is a need for ethnographical research on agentic spaces (including competence, motivation and the surroundings) of older people in different surroundings to widen our understanding of what we should be looking for in our quest for human agency in general and the agency of AL residents in particular.

Our data suggest that sometimes agency is more like a feeling, a state of mind or an affordance of the situation. Based on the analysis of our ethnographic fieldwork in a sheltered home, we claim that even people with substantial declines in their functional abilities may feel more or less agentic depending on their functional and material surroundings, and the support they receive from the staff, relatives and other residents. Adjusting the delivery of long-term care to acknowledge the invisible aspects of human agency would undoubtedly result in better quality of life in AL facilities.

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