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Places like home? Physical, social and psychological aspects in the making of home and other environments in the healthcare of older people

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Abstract: In this paper I consider the ways in which the home and other residential environments are constructed and experienced in the delivery of novel forms of healthcare and rehabilitation for older people in the UK which take place largely outside the walls of the hospital. Drawing on notions such as the ‘therapeutic landscape’ which have been developed in the medical geography literature, I consider critically the discourses of home and homeliness put forward in the academic and policy literature, using testimony about the experiences of those cared for in different settings (including their own homes, residential and nursing homes, sheltered housing and the hospital) given by health professionals to reflect on the various ways in which such places are imagined, constructed and lived. I give particular consideration to (i) psychological and discursive notions of home, (ii) the ways in which social relationships between actors in care provision affect the experience of place, and (iii) the role of health policy in determining the function of place in the provision of care, and the ways in which all these aspects interact to structure the experience of home and other places. The actions and interactions of those involved in the care process ‘make place’ as they take place in the homes of older people and other settings, with power crucial in determining whose social and symbolic constructions of place are dominant. Finally, I consider the ways in which a focus on the microgeography of the home environment itself, alongside that of other contested settings for the healthcare and rehabilitation of older people, can illuminate the role of the physical environment, social relationships, public policy and psychological and symbolic notions in wider questions of neighbourhood, community and identity.

Introduction

Medical geography has in the last 15 years found a new, productive focus alongside its traditional occupations with the distribution of healthcare services and spatial epidemiology. A core concept of the new geography of health, the ‘therapeutic landscape’ was a term coined originally by a reviewer of an early manuscript of Gesler’s (1991) influential text on The Cultural Geography of Health Care. Referring to environments conducive to health, wellbeing and recovery, the notion has been used in relation to a wide array of places, initially particular areas renowned for their restorative qualities (e.g. Gesler, 1993, 1998; Palka, 1999), and recently more abstract ideas of place, such as gardens, green spaces and allotments (Milligan et al., 2004), hospitals (Gesler et al., 2004) and the home (Williams, 2002). By emphasizing the interaction of symbolic and social aspects of place in people’s experiences of it, the therapeutic landscape provides a potentially fruitful means of understanding place as “dynamic, a constantly evolving process,

1 For a general overview of the use of the concept of the therapeutic landscape, see Gesler (2005).
molded by the interplay, the negotiation between, physical, individual, and social factors” (Gesler, 1992: 743), though to date the empirical implications of this theoretical challenge have often been underplayed (Parr, 2003).

In this paper I look at the idea of ‘home’ as a place of recuperation, security and healthiness through the lens of the therapeutic landscape. I trace the ways in which home has been conceptualized both in the academic literature (particularly sociology, social policy and the geography of health) and in British health and social policy, especially in relation to the care and rehabilitation of older people. Then, using empirical data from a recent study of health and social care for older people provided in various settings including the home, I attempt to illustrate some of the ambiguities and tensions in the home and other environments arising from the interaction of physical, symbolic, psychological and social dimensions of place. These, I suggest, challenge the straightforward ideas of home put forward in health policy and in some of the academic literature, and demonstrate the importance of a nuanced theory of place in understanding ‘the home’, taking forward in a critical way the dialectical understanding proposed in the idea of the therapeutic landscape. Finally, I look to outline some of the ways in which this kind of viewpoint may be useful in wider considerations of ‘home’, in relation to the study of neighborhoods, communities and identity.

The home, healthiness and older people

Traditionally, social scientists and policymakers have tended to view the home as the best place for older people in sickness and in health, with living at home equated with independence, happiness and good health. While sociologists and geographers have begun to highlight the difficulties that arise from this equation, however, policymakers in Britain and elsewhere have redoubled efforts to enable and induce older people in particular to live in their own homes, whether for medical, social or financial reasons.

Homes, hospitals and social science

In the social science literature the home has often been constructed as a therapeutic environment in one sense or another. Gurney and Means (1993) refer to the home as a place of ‘ontological security’, deploying the phrase used by Giddens (1991) to relay a sense of calm in the face of the uncertainties and tribulations of modern life. In health geography and medical sociology, the home as a place with restorative qualities is sometimes contrasted to the curative ethos of the hospital: “home … might provide a therapeutic environment, but relatively poor treatment, whereas a hospital might provide good treatment, but a poor environment” (Geores & Gesler, 1999: 100). For older people in particular, institutional environments—the hospital, the hospice, the residential home or day center—are viewed as alienating environments of clinical domination and personal uncertainty (Godkin, 1980; Milligan, 2003; Twigg, 2000).

The complications to this general view, however, are emerging, as researchers focus on the complexities of the attachments of older people to the home (Oldman & Quilgars, 1999; Percival, 2002; Mowl et al., 2000). Percival (2002) finds that older people value their homes for the continuity, self-determination and choice associated with them, but that these attributes are contingent upon the layout of the space and their ability to use it. Oldman and Quilgars (1999) explore the diversity of views about living arrangements among those living at home and in residential and nursing homes, questioning the assumption that home is necessarily the preferred habitat of older people. Increasingly, the social and psychological associations of both the home and institutional environments are recognized as context dependent: abstracted categorizations of ‘home’, ‘hospital’ and other settings need to be grounded in the specific experiences of people through empirical research.

Contemporary geographies of care

At the same time as social scientists have started to identify the ambiguities in the positive notion of home, the provision of care and rehabilitation at home for older people has become ever more central to health and social care policy of governments across much of the world. In the UK, the policy of ‘care in the community’ has placed an emphasis on the long-term care of older people in their own homes wherever possible. Alongside this shift in the setting of care of chronically ill people, the British government, in common with many other states, has attempted to increase the amount of acute care and rehabilitation provided to older people outside the hospital. Technological advances have meant that

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2 For a fuller consideration of some of the themes discussed in this paper, see Martin et al. (2005).
patients can be treated as safely and effectively in non-hospital settings as in the hospital for various conditions, and there is considerable evidence that rehabilitation (physiotherapy, occupational therapy and so on) of older people is most effective when it takes place in their normal living environments. In Britain, concerted efforts to increase the number of older people being given acute and post-acute care outside the hospital have taken the form of a contentious new policy, ‘intermediate care’ (similar approaches to care in other parts of the world include ‘hospitals without walls’ in Australia, ‘transmural care’ in the Netherlands and ‘extra-mural care’ in Canada). With its objectives of preventing ‘unnecessary’ hospital admissions, hastening hospital discharges following treatment and reducing premature entry into long-term residential care, the principal aim of intermediate care is a financial one: to reduce the costs to the health and social care system of the care and rehabilitation of older people, by seeing to their healthcare, social care and therapy needs in settings outside the acute hospital setting: mainly their own homes, but also via temporary care home placements, in sheltered housing, day care and even adapted hospital wards.

Though the root justifications for community care and more recent policies regarding the setting of care of older people are thus undoubtedly financial ones—the transfer of the burden of an ageing population from the state to individuals and families—they also have a more social rationale. Care in the community was also premised on the (as we see above, partially evidenced) notion that older people prefer to live at home; successive consultation and policy documents published by the British government have placed an onus on the ‘promotion of independence’ of older people, through measures aimed at ‘enabling’ them to live at home. Critical social policy academics have highlighted the coercive edge to such efforts. From a governmentality studies perspective, Higgs (1998) notes the way in which positive images of ageing (independence, healthy living at home) accompany the retrenchment of the state in the field of long-term care. More concretely, Oldman and Quigars (1999: 364) analyse the discourse of government policy which constructs even positive choices to cease to live at home as failure:

A report, commissioned by the Department of Health (1994), was titled: The F Factor: Reasons why some people choose residential care. The study aimed to find out more about people on the margins of residential care, those at [sic] ‘at risk’ of giving up their homes. F stood for fear; the question being asked was ‘why do some people manage to remain in the community but others have failed to do so?’ This overlaying of medical, financial and social imperatives, in state policy and in the expectations placed on the individual older person, has contradictory effects on the experience of the home, which I explore in more detail in the empirical section of this paper. On a direct level, several writers have noted how the physical presence of the state’s agents—carers, nurses, occupational therapists—in the home has its own ambivalent effects. As Aronson (2002: 402) puts it, “formal providers’ very presence in the home signals an intrusion of public into private. Home care carries the contradictory potential both to support and undermine what home signifies.” The extension of clinical authority into the home space brings with it power relations a medicalization which may reduce or even reverse the positive associations of home for older people (McGarry, 2003; Milligan, 2000; Twigg, 1997). For Parr (2003: 217), this represents “a curious kind of ‘institutionalization’, actually within [older people’s] own homes.” If we take analyses such as these, which elucidate the ambiguous effects of the intrusion of the state into the homes of older people, alongside more general academic writing on the multifaceted, complex relationships of older people to their homes such as those mentioned in the previous subsection, it is clear that the experience of the home is not something that can be conceptualized purely in physical, symbolic or social terms, nor reduced easily to generalized statements about the ways in which discourses or social relations produce the home space. As Moss and Dyck (1996: 746) put it, environment is embedded in a socially constructed space that acts as a medium of social relations discursively shaping and reshaping both individuals and places. Conceptualizing environment solely in discursive terms, however, does not recognize privileged positions of power nor the ability of individuals to resist processes structuring space.

Theoretical generalizations about the nature of older people’s relationships to home must, therefore, be guarded; empirical efforts to understand that relationship need to focus on the contingencies of particular scenarios, and to be guided by a theoretically nuanced approach able to incorporate various dimensions of place, and understand how these interact.

The therapeutic landscape

The concept of the therapeutic landscape provides a potentially revealing lens through which to view the home in relation to the health and social care of older people. It has its origins in humanistic geography, and the neo-Marxian approach of the new cultural geography (see, e.g., Jackson, 1989), with its emphasis
on the study of culture as the product of the interaction of structure and human agency, rather than some overarching, determining backdrop to human activity. In this outlook, the idea of the ‘landscape’ is broadened to include all sorts of material manifestations of the competing social processes of the time (Cosgrove, 1994). Thus, quoting Pred (1984), Gesler (1992: 743) argues that therapeutic landscapes need to be understood in the same way as the new cultural geography understands place: as a process whereby the reproduction of social and cultural forms, the formation of biographies, and the transformation of nature ceaselessly become one another at the same time that the time-space activities and power relations ceaselessly become one another.

Illustrating the application of these ideas to the geography of health, Gesler (1992: 743) gives the example of a clinical consultation, which is affected by the physical attributes of the room (e.g. temperature, size, color of the walls, arrangement of the furniture), the ideas and intentions of the actors (e.g. illness and treatment beliefs, symptom description and interpretation, concealment of certain facts), and the structural forces underlying the physician-patient relationship (e.g. dominance-resistance, type of medical system, territoriality).

The crucial idea embodied in the therapeutic landscape concept, then, is the dialectical manner in which it understands the interaction of place and events: place produces and is produced by the social interaction, discourses and psychological attributes attached to it. Yet the empirical implications of this understanding of place have to some extent been underplayed or neglected by some of the writers who have made use of the concept, often deploying it only in looking at the histories and therapeutic qualities of particular landscapes. If the concept is to be applied fruitfully to more general, abstract ideas of place (the home, the neighbourhood, the city) rather than solely particular locations and areas, then this dialectical understanding of place is all the more important. Only recently, however, have researchers begun to look at the home as a process, created as much by the acts of those involved in routines of care as by its immanent properties as a place. As Parr (2003: 213) argues, it can hardly be claimed that geographers in this field have as yet fully examined the multiple material and symbolic dimensions to the giving and receiving of care, or thoroughly explicated care as a concept while critically assessed [sic] caring practices, roles, relations and so on.

What is needed, then, is further detailed empirical research, in order to understand better how homes and other environments come to be produced and reproduced as more or less therapeutic environments through the various social, physical and symbolic processes related to them. In the following section I consider some of the themes explored above in relation to recent qualitative research which explored the experience of home and other environments during care and rehabilitation with health and social care practitioners, analyzing their testimony from a therapeutic landscape perspective. The aim is to explore the contingencies of the experience of place, and particularly the role of professional power and policy imperatives in structuring the doing, thinking and feeling of home and other environments by those involved in the care process.

Care and rehabilitation in homely settings: the views of practitioners

As described above, the UK, in common with much of the rest of the world, is expanding the role of non-hospital settings in the provision of healthcare to older people, through initiatives such as ‘intermediate care’, with its emphasis on reducing hospital use among older people and building their capacity for independent living. The work described in this section derives from the qualitative component of a multi-method national evaluation of intermediate care, conducted by Birmingham and Leicester Universities between 2002 and 2005, and from the qualitative component of a smaller-scale evaluation of an intermediate care ward in an acute hospital. In the course of these two studies some 92 interviews and focus groups were conducted with various health and social care professionals, managers and practitioners, on various issues around the implementation, benefits and difficulties of intermediate care. Material relevant to the role of place in the care and rehabilitation was then identified and analysed in terms of the therapeutic landscape idea, producing general themes pertinent across respondents and particular themes relevant to individual services and settings. For a more detailed exposition of methods, see Martin et al. (2005). I now turn to consider some of these themes using illustrative quotations from the interviews and focus groups.

The home, homely settings and rehabilitation

In common with some of the academic and policy accounts referred to above, respondents often spoke of the merits of the home environment for older people, contrasting it with the limiting environment of the
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hospital. In hospital, older people quickly became “institutionalized” and “dependent”; at home, on the other hand, “people become themselves” or “naturally take more control.” As one occupational therapist who had worked with older people in a variety of settings put it,

I found when I was working with a small community hospital that for many elderly patients its often their first admission into hospital which is quite traumatic, and you could see how institutionalized they became very quickly and their confidence, their anxiety levels really, of were they ever going to get home, you know, it was unnatural surroundings. So to be able to maintain someone in their own home, how much more benefit is that? Really, really good. If you have the support that’s needed and the care.

Other settings in which intermediate care was provided—care homes, sheltered housing, adapted hospital wards—were commonly described as “homely environments” by respondents who worked in them, to distinguish them from the perceived institutional experience associated with the traditional nursing home or acute hospital ward. One residential home, for example, in which intermediate care was provided to temporary residents was described as “quite a homely environment: it is not home but it is the next step from hospital.” The onus was on making non-home environments as much like home as possible, in terms of the layout of the physical space, the privacy and freedom of the residents, and other positive attributes associated with independent living at home. In the words of an occupational therapist who worked in another residential home providing intermediate care,

we want it to be a home environment, because that’s what people will be doing in their own homes. If they want a cup of tea when they get home they get up and make themselves a hot drink, so here we just try and keep it informal.

For respondents working in patients’ own homes and other environments alike, then, the home environment was often the ‘gold standard’ for care and rehabilitation, which other settings should be judged by and modeled upon. In particular, the associations of the home with independence and autonomy in older people’s living arrangements were often the attributes which workers in other settings tried to emulate. Other popular discourses around the home were also invoked, such as patients’ perceived emotional attachment to their homes.

These abstract ideas of home were the ones to which respondents alluded in general terms when attempting to describe what was good or beneficial about the settings in which intermediate care was provided. When they spoke in more specific terms, however, the complications to such generalizations about ‘the home’, ‘homeliness’ and ‘institutions’ began to emerge, along with the role of various social dynamics in reproducing place. When interviewees referred to concrete examples, it became apparent that the home was not always a space of independence and self-determination. In some cases, the home could act as a limiting environment, detrimental to the convalescence and reintegration with normal life that practitioners were trying to promote among their patients after sometimes long periods in hospital:

Somebody who’s been in hospital for six weeks, just think, six weeks they’ve never made themselves a cup of tea, they haven’t done themselves a sandwich, a cooked meal or anything, and when they come home its like rocket science to them, you know, they’ve been away from the home for so long it doesn’t feel like their home. I mean I’ve had that said to me, “It doesn’t feel like my home any more, I don’t know where anything is.”

On the same basis, a respondent who provided intermediate care in a residential home pointed out the benefits for patients of a stay in another institution following a hospital admission rather than being discharged straight home:

A lot of them would have gone home and sat and given up, whereas at least having come through intermediate care, … they’ve got the confidence to go and do something else: for a lot of them it’s the confidence of getting back outside the front door and going back to church and other things like that, which they can do from here.

In contrast to the equation of home with and independent, active old age, then, in practice homes could just as easily act to restrict older people in their everyday lives. What was needed, according to some respondents, was rehabilitation outside the domestic space: as one nurse who provided intermediate care in a rehabilitation ward in a hospital suggested,

some people are immobilized and they’re confident in their own little world at home, but bring them out of their world … and taking them not only here in the hospital but taking them just outside in the garden or round the grounds of the hospital, where you’ve got the fresh air on your skin, you’ve got steps down, you’ve got slopes up, you’ve got uneven pavements, that’s what they’re frightened of often, of going to the post office or going to the shops themselves.

As these respondents pointed out, then, the home was not an unambiguously positive place for their
patients, even in terms of qualities such as independence and autonomy which are tied so closely to the idea of the home by social policy. And as we see in the next section, the social dynamics of the home, hospital and other settings further complicate the picture.

**Social interaction and the home**

Alongside the positive aspects of non-home settings identified above, another common theme was the communal benefits of rehabilitation and care in collective environments such as the care home and day center. For those who lived alone or with very frail, dependent spouses, the social rehabilitation offered by such places was, according to many respondents, crucial to the return to functional independence:

A lot of clients are living alone and they make friends here and communicate with each other and have overall a positive and quite social experience here. … For them it is vital social contact on here so alongside the motor function and mechanical improvement that we hope to gain, one of the things I value about this ward is that we have a kind of socio-emotional input as well.

Some claimed that the communal environment itself could assist in the physical and occupational therapy process:

The group activities, you will suddenly see that one of them is using what has been an affected hand really well because they are not actually thinking about it but they are joining in, copying and it is the social bit. You can say, “I have watched you and you have been doing that for 10 minutes,” or they have been tapping their feet to music. Had you said, “I would like you to tap your foot,” they would not do it, or it would be laboured, struggle, “Oh I cannot do this any more.” Get them in a social atmosphere, make it part of an activity, with a beat of music, and before you know it they are away.

These respondents describe the limits of the home as a site for rehabilitation, of the discourse of the home as a site of independence and autonomy, and of the association of home with an active and happy social existence. Indeed, some respondents recalled how many of their patients had described their surprise at the pleasantness of communal living, with some even electing to move into sheltered housing or care homes following their experience. For older people who lived alone in particular, then, the home could be a place of isolation and inactivity. As a therapeutic landscape, then, ‘the home’ is not something that can be reduced to straightforward physical, social or symbolic characteristics, or even a fixed combination of these. What we see here is the interaction of these features in the particular context of a rehabilitation process which renders places more or less therapeutic.

A similar understanding is helpful in considering the interaction between place and the relationships between patients, informal carers and staff. A number of respondents illustrated how providing for patients in less institutional settings made the relationship less hierarchical and more ‘patient-centered’: “if you can work with people in those environments it is a lot easier, and they are more co-operative, they don’t see you as an authoritarian figure, they see you as a friend that they can work with.” Others, though, found that the more formal relationship to be found in institutional settings was more productive in terms of the rehabilitative objective of intermediate care. In the more informal setting of the home, alternative symbols of the clinical relationship provided a substitute, as one rehabilitation assistant explained:

Before I wore uniform, I went in for a chat and had a nice cup of tea with them as opposed to physio, who would go in uniform and they would be up and doing everything. So OK, that is it, back in uniform. Completely different. It just sets the boundaries.

The symbolic attributes of place, then, could have an important impact on the behaviour and interactions between patients and practitioners. The presence of patients’ family members, often informal carers of long standing, could complicate matters, introducing an extra social dimension and power relation into the setting—particularly in the home:

You can’t say, “Excuse me, can you leave the room while I do this?” because you are in their home. Particularly elderly couples, the dialogue between husband and wife has not been good for 30 years.

You go in to perhaps change things in their environment. If you have an irritable partner the other side of the room giving negative feedback to the person you are working with, it is difficult.

The relationship between individuals and their carers, then, could work to render the home environment a stifling one, quite inappropriate to rehabilitation, whether through carers’ overbearing love or their fear of the burden created by the return home of their relative.

**The structuring role of policy**

A common theme from the testimony of interviewees was the companionship, routine and attention afforded to patients by the intermediate care process, both in their homes and in institutional settings. For the interviewees, though, these qualities were tinged with ambiguity. Patients could become, in the
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words of respondents, too “attached” to the social contact entailed by the visits of rehabilitation assistants in their homes, for example, or to the camaraderie of the residential home, day center or even the hospital ward:

Once they’ve built up this wonderful rapport with the carers and everything, they don’t want you to go, that’s the down side of it, you know, that they’ve got used to the carers coming in and this is rather lovely and this is nice.

The transition between being on the ward and going home seems to get extended and extended, and it’s something we just haven’t struck a balance on yet. People come and yes, it’s a nice environment, it’s nice staff and all the rest of it. Consequently you’ve got to start prising them out. … It’s human nature. If you give somebody all this kindness and comfort they’re not going to want to go, but we haven’t found the happy medium yet as to when that point should be forced.

The ‘intrusion’ of the health professional into the home of the older person, then, or the older person’s stay in the ‘institutionalizing’, ‘alien’ environment of the residential home or hospital ward, could actually in some circumstances provide exactly that social input that is supposedly intrinsically to the ‘independence’ and ‘autonomy’ of living at home.

But what we see in the above quotations, and in the earlier material about the relationship between patients, staff and family members, also reflects conflicts over the nature and purpose of an intervention like intermediate care. And here, the crucial role of social policy, and its effects on the relationship between staff and patients, and on the experience of place, begins to emerge. The social aspects of intermediate care, apparently so valued by many patients according to the practitioners we interviewed, were only available as long as they did not conflict with the core aim of the policy—improving physical function with a view to restoring independent living in the community—for example by fostering ‘dependency’ on the social life of the residential home. The following excerpt from an interview with the joint managers of a care home is illustrative:

It’s very much like being at home, it’s really a practice run within a very supportive goal-set environment really. We’ve stayed away from the social activities and groups for things, we did it for a long, long time. … When we were still doing quite a lot of it and every day was structured, people were going home and not coping because the structure of their day had gone, they were lonelier and they weren’t feeling good about themselves, and then everything else was becoming more difficult. … It’s not a busy, dynamic unit: as I said, we tried busy-dynamic and it worked while they were here but it backfired.

Respondents explained how they tried to make it clear to patients from the start that their intervention would only be a temporary one, to avoid disappointment when the inevitable withdrawal of the service came. The majority of patients seemed happy to accept these ground rules for the provision, and many were happy to return to independent living in their own homes at the end of it. Conflict emerged when patients or carers had different priorities to those of the service and its employees. Incongruences such as these in the goals of different actors in the rehabilitation process illustrate again some of the ambiguity and contingency inherent in the therapeutic landscape concept as applied to notions like the home. Clearly the concrete experience of place cannot be reduced to immutable qualities of ‘the home’ or ‘the institution’, and the utility of the therapeutic landscape perspective must be in its dialectical approach, which insists on seeing place and process as inextricably linked, co-producing, and thus specific to the combination of physical, social, psychological, discursive and other factors as they play out in particular places.

Discussion and conclusion

In the research described above, a focus on the microgeography of the home and other environments in which intermediate care is provided through the lens of the therapeutic landscape permitted a closer understanding of how various factors contributed to the experience of places of the older people living in them. While in some circumstances the emotional significance and the physical familiarity of the home setting were seen as most conducive to patients’ psychological and functional rehabilitation, at other times it was escaping the four confining walls of the home or enjoying the conviviality of the residential home or day center which benefited older people. What emerges is the centrality of social and symbolic context in determining the therapeutic qualities of these different settings of care, and particularly the importance of the sometimes conflicting goals of the actors involved. The role of conflict and power, and the diversity of symbolisms held by these environments for different individuals, calls into question the reification of particular landscapes, such as the home, as necessarily ‘therapeutic’, as is often the case in
policy discourse, and occasionally academic assumptions too. Recent expositions of, for example, the home as a simultaneously liberating and confining place (Mowl et al., 2000), or the nursing home as a potentially integrated element of local community life (Rowles et al., 1996), or the limitations of attempts based on abstract ideas of the home to make institutions more ‘homely’ (Hart et al., 2005), offer important reminders of the fact that social and symbolic generalizations about place must be questioned through grounded empirical research.

Policy, power and place

Particularly important in the experience of place in this study was the structuring role of intermediate care policy and the work of practitioners to put its aims into practice. The overwhelming emphasis of intermediate care on functional and social independence among older people follows the pattern set by community care and associated policies from the late 1980s onwards. While independent living may well be what many older people aspire to, it sets a very narrow definition of what constitutes ‘success’ and ‘failure’. As Aronson (2002: 400) puts it in relation to the similar Canadian policy context, ‘dependence’ is demonized and the interdependencies inherent in human experience obscured. … This individualizing ethos is compounded for older people by a dominant imagery of successful or positive ageing that enjoins them to age actively and self-sufficiently.

Consequently, the emotional or ‘psychosocial’ aspects of the home are rendered marginal in healthcare interventions, or even annulled by an extension of medical norms into the home environment (Allen, 2001; McGarry, 2003; Milligan, 2003; Twigg, 1997). In the process, as we have seen, holistic, non-medical notions of patient wellbeing and the values of the home environment become sidelined, as the mantra of functional independence dictates the ultimate aims and means of the intervention.

The state’s idea of the purpose of intermediate care, and of the place of the home and of homely environments in achieving that purpose, was not, though, something which went uncontested by the older people described by interviewees. Higgs’ (1998) Foucaultian perspective on the parallel roles of, on the one hand, discourses of ‘independence’ and ‘living at home’ as positive states to be aspired to, and on the other, more direct, coercive measures to prevent ‘dependency’, through the closure of long-term care facilities and the transfer of the financial and social burden of care onto individuals and families, is an interesting one in this context. Taking seriously Foucault’s (1991) description of liberal governmentality, as a distributed governmental rationality which affects free subjects through discursive and non-discursive practices pursued by both state and non-state actors, we can view intermediate care as just this kind of mix of coercion, persuasion and free will. The discourse of the home becomes one conduit of this governmentality, as a place imbued with various strong connotations; then people’s homes become places in which power and resistance are played out as older people, carers and practitioners seek to define their proper roles, relationships and the future living arrangements of the patients. Ultimately the health service had the power to withdraw provision; indeed, official policy documents delimiting the nature and purpose of intermediate care indicate that intermediate care interventions should normally be limited to six weeks, on the basis that this is the kind of time frame necessary for rehabilitation and convalescence following (or instead of) an episode of acute care in hospital (Department of Health, 2001). Some of the respondents said that they had found this six-week limit a useful tool in justifying their ‘exit strategy’ to their patients. In other cases, though, and despite this structuring influence of central policy and the efforts of practitioners to abide by it, compromises were reached between older people, carers and health and social care practitioners. In all of these negotiations and struggles, the nature of home and other environments was defined and produced not by a single power or discourse, but by the actions of the various free actors involved.

Microgeography, the experience of place and larger spatial scales

The analysis presented above, and the focus of the therapeutic landscape approach, may hold some useful lessons for studies of the experience of home on the wider spatial scales of the neighborhood, community or city in social and cultural geography. Of course, that the meaning of place is contingent and unfixed is a given in social and cultural geography, probably much more so than in the new geography of health, with its comparatively nascent focus on place which emerged only in the 1990s. Certainly, the insidious dimension of dominant discourses of place has been identified and analyzed to a much fuller extent by cultural geographers, to the point where some have criticized a tendency towards an overriding focus on the landscapes of the powerful at the expense of considering the alternative place meanings held by less powerful groups (e.g. Rose, 1994). The tendency of much urban geography, for example, and particularly that focusing on the post-Fordist city of gentrification and globalization, has been to construct a narrative...
of capitalist hegemony, where resistance to dominant discourses of place is ultimately doomed, as the material and symbolic might of the powerful holds sway. In this reading, alternative ideas of place are aestheticized; politics and difference are appropriated and commodified as they are reduced to ‘lifestyle gloss’ in the selling of places (e.g. Smith, 1992; Zukin, 1991; for a slightly lengthier account of this literature, see Martin, 2005). Relatively few papers have attempted to look at the alternative understandings of place that may exist alongside dominant representations (e.g. Massey, 1995), and few of these are based on empirical research gathering firsthand the meanings of place held by the people who live there (though see e.g. Blokland, 2001; Martin, 2005; May, 1996). Even in this literature, the focus is more on the nature of the meanings of place rather than the detail of the social processes which give rise to these meanings: the thinking and feeling of place, more than the doing. The aim of the analysis described above was to look at exactly how the experience of place was molded by the particular combinations of physical, symbolic and social factors to be found in the microgeographies of the home, the care home and the hospital: more extensive research on this dialectic of micro-level processes on larger geographical scales may be a beneficial path for future research. Clearly, the study of the interplay of physical, symbolic and social dimensions, and of the sway of power, is something much more difficult to put into empirical practice on the level of the neighborhood than on the level of the individual home, hospital ward or day center. Nevertheless, the contingency of the experience of place on the particular outcomes of micro-level processes (e.g. whose ideas on the aims of rehabilitation and the benefits of independent living at home were dominant in a particular case) in this research suggests that there is a lot to be gained from efforts to study these on wider spatial levels: in the neighborhood, the community, the district.

Alongside this, the research detailed above also suggests the importance of the smaller spatial landscape in the experience of place. Those studying the experience of home at the level of the neighborhood may also do well to consider the experience of home at the level of the home. For the group considered in this work, the feelings and practices associated with home itself were crucial in the wider relationship with neighborhood and community (see also Fincher, 1998), as the home became for some a place of confinement, limitation and loneliness, and for others a platform from which wider interaction with the locality could give rise to social integration and personal fulfillment (cf. Mowl et al., 2000; Rowles et al., 1996). In particular, then, studies which consider the differential connotations of the city, community or neighborhood for different social groups (as defined by sex, age, ethnicity, class or something else) may do well to pay some attention to the microgeography of the home, and the struggles and compromises located therein.

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