

An Enveloping Shadow?

The Role of the Nursing Home in the Social Imaginary of the Fourth Age

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In this chapter we consider the nursing home as both a site and a symbol that fashions the social imaginary of a fourth age. Before exploring the nursing home's dual role, we will first outline the concept of a social imaginary, as well as how the fourth age can be thought of as such a social imaginary. Bearing in mind this conceptual framework, we go on to address some of the ways in which the nursing home plays out its critical role in conferring meanings onto the fourth age, through its organizational culture, its practices of care, and its own representation in the media. The chapter concludes by considering the extent to which the fourth age needs to be acknowledged as a powerful and coherent social representation of much that is feared about later life and how such representations can be challenged within the nursing home, as well as the cautions that need to be exercised when mounting such challenges. This latter point is important in highlighting the tensions that exist in determining what constitutes "good" care under conditions of compromised agency.

COLLECTIVE REPRESENTATIONS AND SOCIAL IMAGINARIES

Durkheim made the case for distinguishing between what he called "collective" and "individual" representations. While the latter he considered to lie within the domain of psychology – the ways in which an individual person makes conscious sense of his or her world – the former exist outside (exterior to) individual consciousness and hence form part of the domain of sociology. The collective understandings of the world are fashioned and reproduced within society, through social processes that pre-date the individual's emerging self, and will continue to be elaborated within the "social thinking" of society long after the individual has gone. Unlike the sectional interests that have been

seen to typify ideology, collective representations serve collective or common interests – creating the kind of shared understandings of society and the social world that enable successive cohorts to become civic and social beings, integrated into and able to sustain the society into which they are born and which will sustain them as necessarily social beings. Collective representations, in effect, enable society to reproduce itself, by representing itself to itself.

While this way of understanding society through its “collective representations” subsequently lost traction in the social sciences, arguably as interest in thinking and writing about social thought as “ideology” grew, renewed interest in this topic emerged with the work of the social philosopher Cornelius Castoriadis (Thompson). It was particularly in his book *The Imaginary Institution of Society* that Castoriadis developed the concepts of the “social imaginary” and “social imaginary institutions” (*Imaginary*). Social imaginaries, he argued, are what give meaning to society and its institutions and in the process help fashion those institutions and help them function as social institutions (*Imaginary* 146). Where Castoriadis’s ideas differed from those of Durkheim was in his belief that social imaginaries were not merely the symbolic representation of a particular social institution or relationship but rather drew upon a multiplicity (or surplus) of meanings, beyond any singular function or signification. This multiplicity of signifiers arises as much from the inherent capacity of human beings to create meanings “ex nihilo” as it does from the range of symbolic functions that an institution or relationship may at any one time possess (*Imaginary* 343–44, 369). Thus terms like *childhood*, *family*, *patriotism*, *justice* or *education* generate multiple images, elicit multiple narratives, and are embedded within multiple practices that may complement or contradict each other. Such social imaginary institutions are both established and undermined by a surplus of signifiers, whose superfluity is underwritten by what Castoriadis called the “radical imaginary,” that power of imagination and meaning making that distinguishes human beings and human society from other, non-human species (“The Psyche and Society Anew” 203). It is this “subterranean ... flow of the radical imaginary” beneath the established social imaginary institutions that ensures the essential plurality of societies and of social representations (“*Philosophy, Politics, Autonomy*” 153).

THE FOURTH AGE: OLD AGE AS A SOCIAL IMAGINARY

Old age, we suggest, has long functioned as just such a social imaginary – its various sociocultural representations “coexisting, conflictingly” with each other (Castoriadis, “The Psyche and Society Anew” 207). Despite claims for a universal “aversion to age in humans” (Lowenthal 129), there are nevertheless clear differences in the value attached to “old age” at different times and

different places in history (Minois). Medieval images of wise old men with flowing beards bent over their books coexisted with other descriptions of old men whose “shrivelled skin hangs with the hides and flaps with the pelts” (Gilleard 1073). While a similar degree of ambiguity in portraying older men can be observed throughout the pre-modern period (Minois), the portrayal of older women as women has been always less ambiguous and more consistently negative (Minois 229–32). As Maquerelle, in John Marston’s early Jacobean drama *The Malcontent* (1604), complains: for men “[t]he more in years, the more in perfection the[y] grow,” in contrast to women, for whom, once their beauty fades it’s “good night with us” for “[t]here cannot be an uglier thing to see than an old woman” (2.4.57–61).

Rather less emphasis was placed upon the appearance of age during the modern period, as the economies of the state shifted toward paid labour and the ideal was promulgated of the male breadwinner “providing” for the welfare of his or her family (Clark). The progressive institutionalization of the life course that was gradually brought about by the welfare reforms initiated in Bismarck’s Germany in the late nineteenth century and copied throughout Europe and beyond in the early twentieth increasingly segmented the (male) life course into three: a period of childhood, shaped by expectations of education, followed by adulthood, shaped by work, followed by retirement from work and a pensioned old age, shaped by state and/or corporate pension policies (Anderson). More recently, the life course has begun to lose some of this normative structure, with old age ceasing to function as the coherent social category it once was (Gilleard and Higgs, *Contexts*). Changes in the cultural and economic underpinnings of old age have been accompanied by its evident fracturing. Out of the “old” social imaginary of old age has emerged a “new” one, which we have called the social imaginary of the “fourth age” (Gilleard and Higgs, “Aging”; Higgs and Gilleard, *Rethinking*). Though its roots can be traced back to much earlier sociohistorical narratives that distinguished “seniority” from “senility,” a “green” old age from a “decrepit” one, the novelty of the contemporary imaginary has come about from the reimagining of retirement and the emergence of cultural practices and later lifestyles promoting ideals of active, healthy, and/or productive ageing – what we have referred to as the cultures of the third age (Gilleard and Higgs, *Cultures*; “Third”).

DEMENTIA AS SIGN AND SIGNIFIER OF THE FOURTH AGE’S SOCIAL IMAGINARY

As later life is embraced as a period in one’s life celebrating the “consumerist” virtues of choice, autonomy, self-expression, and pleasure, its realization lies equally in practices designed with one eye on warding off all that might

compromise the exercise of such virtues, namely the shadows and the signs of dependency, incapacity, suffering, and being unable to exercise one's choice or express one's voice (Higgs and Gilleard, *Rethinking*). Integral to this social imaginary are narratives of frailty and abjection, of the loss of status and place, of agency and identity, and of the need to be cared for (Higgs and Gilleard, *Personhood*). Dementia, or Alzheimer's disease, provides a powerfully individualized image of what that means. More perhaps than any other condition affecting people in later life, Alzheimer's has come to symbolize all that is most terrifying about old age and to serve as the dominant discursive frame for the fourth age (Alzheimer's Research Trust, "Poll"; Cantegreil-Kallen and Pin; Cutler; Zeng et al.).

This effect is further accentuated by the research community, and by advocacy organizations such as the Alzheimer's Society that seek to "raise awareness" of the condition in order to expand their role and increase their capture of research funding and charitable giving. Between the press releases of the research community and the reports of the charitable sector, what has been described as an "apocalyptic demography" is constructed that overstates the prevalence of the condition and the impact it has upon wider society. One recent press release, for example, claimed that as many as one in three people would develop Alzheimer's disease at some point, in effect making it as common as such established "killers" as cancer or cardiovascular disease (Alzheimer's Research Trust, "One"). While it is difficult to trace such excessive concerns over developing dementia in later life in pre-modern times (Schäfer), and while the fear of poverty dominated public concerns over agedness in more modern times (Thane 2000), the "Alzheimerization" of aging that became evident in the late twentieth century has seen this condition take pole position in representing the fear of old age in the twenty-first (Adelman).

What makes Alzheimer's so emblematic is the sense that the condition (including both Alzheimer's and related disorders) is not just about rendering people forgetful: it represents a malignant forgetfulness that causes people to lose their sense of who they are and what is most important to their sense of self, in effect to lose their grip on, and their place in, the world. It progressively weakens people's connections to society and their access to and use of its "collective representations," as well as their connections to themselves and their "individual representations" of their personal past. While clinical researchers have sought to qualify the nature and extent of such losses, recognizing the large variability among people experiencing these conditions, such empirically based caution seems to have had little public impact. Although media representations of Alzheimer's/dementia have increased greatly since first emerging in the 1980s (Kang et al. 691) they have remained mostly negative, displaying what Peel has called "a largely absent moral economy of hope" regarding those suffering from this condition (897). Almost universally, such representations

emphasize “the catastrophic nature of dementia” and “the horror of the condition” (Peel 890). News of “breakthroughs” in research represent perhaps the only example of a significant “counter-framing” discourse, but these stories must be set against the large number of negative frames that have been adopted, representing dementia as “confiscating a person’s spirit,” appearing like “a thief who steals a person’s life”, “synonymous with being condemned to death” something that can cross the path of any ageing person simply by virtue of their age, while auguring a return to childhood and childishness (van Gorp and Vercruyse).

Given such media coverage, it is hardly surprising that much of what is nowadays considered most fearful about old age is this prospect of developing Alzheimer’s/dementia. While old age once threatened – and frequently realised – a loss of power and status, whether framed in terms of declining physical attractiveness or prowess or in terms of reduced earning power, such losses pale into insignificance when set against the widespread fear of losing not just one’s status but also one’s mind. For most of the nineteenth and much of the first half of the twentieth century, for most people, old age was a time of poverty (Thane). The image of the nineteenth-century alms-house (in the United States) and the workhouse (in Europe) symbolized that threat; once entered, these institutions were hard to escape from. However, after their introduction, old-age pensions served as a lifeline for the “aged and impotent,” ensuring that most could now avoid this fate. During the period of the postwar welfare state, the majority of these institutions of impoverishment were replaced, in many cases by more sociable, less intimidating residential-care homes or by long-stay hostels or hospitals where significant numbers of the more infirm older people ended their lives. While some combination of infirmity, limited income, and a serious lack of social capital (in the sense of weak or absent family networks) still served as the immediate cause of older people’s “institutionalization,” the majority of ill, infirm, and poor pensioners managed to remain at home, their suffering invisible to the health and welfare services and the wider public alike (Williams et al.; Williamson et al.). Dementia, though evidently present, was just a part of that greater silence, that marginalization of age and infirmity which, when discovered, led primarily to calls from researchers in the field for the state to expand its health and welfare services in and to the community rather than turning back to the earlier solution of building more institutions.

Following the first “crisis” of the postwar welfare state, during the 1970s, there was some expansion of “community care,” in the sense of an expansion of health and welfare services provided to people living at home. At the same time, the emergence of the “cholinergic hypothesis” research paradigm saw “senile dementia” upgraded, first becoming “Senile Dementia of the Alzheimer’s Type” (SDAT; see, e.g., Reisberg et al., Summers et al.) and then quickly being rebranded as “Alzheimer’s disease and related disorders” (ADRD; see,

e.g., Egger et al.). A stirring of public interest in the problem of dementia became discernible as a new discourse emerged framing dementia as a public health problem – a “rising tide” that sooner or later would need to be addressed (Arie and Jolley; Health Advisory Service). Subsequently, funding began for research into the problem of “caregiver burden,” effectively extending interest in dementia as a problem not just for individual older people but also for their families, including their adult, working-age children. By the mid-1980s, novel drug trials were being initiated of various potential “anti-dementia” medications (Chatellier and Lacomblez; Egger et al.; Summers et al.). Since these invariably enlisted the support of carers to complement the clinician’s assessments, with ratings based on the person’s “behavioural functioning” or general “dependency,” these two developments proceeded with a kind of synergy, as carers’ and researchers’ reports of dramatic improvements in patients’ mental functioning began making headline news (see, e.g., Nelson; “Drug”; “New”).

The combination of disease-modifying treatments, new “intermediate,” semi-institutional settings for care, and enhanced “community-care management” were trialled with the hope that some combination of care and treatment might “prevent” institutionalization. By the time the twentieth century was reaching its end, the prospect of drugs to treat dementia, community-care services to keep people with dementia at home, and a range of “psychosocial” interventions that promised to preserve the personhood of people with dementia (Bourgeois et al.; Mittelman et al.) had the cumulative effect of making institutionalization – that is, entry into a nursing home or other residential care – even more a mark of failure than it had been before. Set against these bright lights of hope, the shadows in the background were darkening.

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This optimism was retained for a short time into the twenty-first century. It was soon becoming clear that these solutions were nowhere near as credible as they had once seemed. Day care and respite services were cut back, anti-dementia drug trials petered out, and psychosocial interventions were increasingly targeted toward people who were not “aging in place” but dementing in nursing homes (AD 2000 Collaborative Group; Cabrera et al.; Cooper et al.; Schneider et al.). Trends in long-term care (LTC), in developed economies at least, indicated that community services were being increasingly stretched to meet the needs of older people to age in place. As the threshold for receiving help rose, nursing homes were having to deal with a growing intensity of need among their residents (Meijer et al.; Gori et al.; Ranci and Pavolini). Confusion, incontinence, and immobility exemplified the chronic conditions affecting an

increasing majority of nursing-home residents, as the nursing home became the endpoint when the drugs had failed, the day centres were no longer able to support the families, and no other sources of respite were left beyond that of the institution (van den Brink et al.).

In the new millennium, dementia and the nursing home have become indissoluble entities, the latter the institutional location where the former reaches its ultimate form. They serve as the collective representation of the fourth age, signifiers of the failure to age well, to age mindfully, and to sustain the practices of self-care. Within the nursing home, the daily round can seem a continual challenge to hold at bay, for as long and as much as possible, the ultimate abjections of the fourth age. It is a challenge not confined to maintaining what has been called the “personhood” of the residents suffering from dementia and related disorders; it is equally a challenge for staff to maintain their own personhood in the face of constant threats to their own moral identity as carers. Care workers who face the daily task of doing the dirty work of care must do so without succumbing to its potentially contaminating influences – contaminating their bodies, their feelings, and their sensibilities (Sandvoll et al.). It is this dual process of resisting the penetration of the social imaginary of the fourth age into the lives and experiences of those who live and those who work in the nursing home that is addressed in the final section of this chapter.

RESISTANCE AND RESIGNATION IN THE FACE OF THE FOURTH AGE

In the twenty-first century, developing dementia is one of the most powerful predictors of who will and who will not enter a nursing home (Houttekier et al.; Luppá et al.). It is also one of the few conditions that would induce the majority of adults to at least contemplate moving in future into a nursing home (Werner and Segel-Karpas). The nursing home, more than any other social institution, realizes the social imaginary of the fourth age within contemporary society. As with dementia, “the popular press focuses on nursing homes as contemporary ‘gulags,’ sites of increasing use of chemical restraints, places of abuse and violence, and locations of tragedies that reveal high levels of neglect” (Chivers 134–35), casting what Gubrium and Holstein have termed “an interpretive shadow on meaning” over the frail bodies and failing minds of its residents (521). Yet nursing homes remain on the periphery of society’s vision, as much as the alms-house or the workhouse were over a century ago. They are brought into the public gaze, it seems, only when a scandal breaks out or a company collapses (Lloyd et al.). Although nursing homes are a real presence in the lives of many more people than just the staff and the residents (because of the involvement of families – both as occasional or regular visitors, and as proxy clients looking into the acceptability of a home for their relative, partner or

friend), the public's experience and understanding of the nursing home seem to arise more from media news stories portraying these institutions in a frankly negative or less often neutral light (Miller et al.).

It is a curious paradox that while abuse, indignity, and scandal provide the main focus of media attention on the nursing home, these darker aspects of care feature least prominently in what could be called the "professional literature on care work." Ever since Everett Hughes introduced the term "dirty work" to refer to the degrading, undignified or immoral aspects of work performed by various occupational groups, it has become common to refer to certain occupations, including that of the nursing-home care worker, as pervasively dirty, because of workers' continual contact with physical, moral, or socially tainted "dirt" (Ashforth and Kreiner, "How"; "Dirty"). What helps define dirty work is its capacity to taint – and hence to marginalize and render abject those who perform such tasks. Given these threats to dirty workers' self-regard, it has been argued that in response there is a greater likelihood that "a strong occupational or workgroup culture will emerge to counter that threat" (Ashforth and Kreiner, "How" 431). One consequence is that the more troubling aspects of the work tend to be excluded from discussion, and instead the work is reframed as a "morally valuable" service, recalibrated as "a necessity shield" or retold through "rites of initiation" as a marker of emotional moral or physical strength (Ashforth and Kreiner, "Dirty").

In the process, the hurt, indignity, and suffering of both residents and workers may be minimized and the emotional damage denied, repressed, or reattributed to the residents' neglect by their families. Tensions between staff and family are not uncommon, as the guilt experienced by family members who feel they have failed to look after their relative long enough or well enough is displaced onto the perceived failings of the staff in carrying out their duties, who in turn resent the (c)overt hostility of relatives (Bauer). Complaints may arise that staff neglect residents (such as losing items of their relatives' clothing), that they do not give residents enough time (to eat, to get dressed or to find their way to the toilet), or that they are inattentive to their needs (responding slowly or not at all to calls for help, or failing to prevent episodes of incontinence). In turn, staff may feel simmering resentment toward these criticisms, secretly harbouring the belief that the relatives are the ones who have failed or "given up" too easily on their dependent while having little understanding of the pressure that they, the staff, are under looking after so many mentally and physically frail residents (Abrahamson et al.).

Thus the abjection and the failure that shape the social imaginary of the fourth age within the nursing home envelop not just the residents but relatives and staff as well, leaving each group of stakeholders depressed, demoralized, and dissatisfied. The moral imperative to care that is shared by all concerned is continually confronted by residents who often do not wish to be cared for –

whether because they are angered or agitated by the unwanted intrusion it involves, or because they fail to recognize the identity or intentions of those doing the caring (Hoeffler et al.). It is one thing to help those who either recognize their helplessness (such as people with severe physical disabilities) or whose have no prior experience of autonomy or independence (such as infants or people with developmental disabilities), where the moral imperative of caregiving is realized through mutuality and (asymmetric) reciprocity; it is another when neither mutuality nor reciprocity can be realized. While it would be a gross exaggeration to confine examples of the latter to people with dementia, it is still the case that most examples of “conflicted caregiving” are linked to this condition, making care of older people with dementia the setting for further abjection and ignominy (Higgs and Gilleard, “Frailty”).

CARE AND ITS UNINTENDED CONSEQUENCES

It would be misrepresenting the nursing home if it were seen as little other than a site of mutual abjection, and it would be misrepresenting nursing-home staff if they were seen as engaging in little more than reframing their experience and practices in ways to safeguard their self-esteem in the face of doing a dirty and demoralizing job. There are many examples of staff and residents forming open, caring relationships characterized by mutual feelings of attachment (Costigan; Wilson et al.). For many staff, the dominant frame for their work is that of “family” (Dodson and Zinavage). But even when care is given within such a framework, there exists the possibility that caregiving itself undermines the autonomy and compromises the identity of the resident, while staff who are less engaged with the residents may paradoxically strengthen the collective agency of the residents by causing them to come to each other’s aid (Ryvicker). These and many other contradictions of care are embedded within the organizational culture of the nursing home. Work done to resist the prospect of a social death and protect residents against the shadows of a fourth age may risk demanding too much or alternatively infantilizing them (Gilleard and Higgs, “Social”). A too intense focus on delivering comprehensive physical care may minimise the indignities of pain and suffering, while quietly nursing residents into a kind of social death. Offers of aid and assistance to keep residents “dignified” (like bathing, showering, and toileting) may elicit only aggression as such aid is perceived as intrusive, unwanted, and threatening to an already vulnerable person (Gates et al.).

The nursing home itself produces multiple meanings by which both staff and residents can be represented. It may be represented through a number of different frames, ranging from a “home from home” to a biomedical “skilled nursing” facility through to a necessary institution to prevent the abjection of

extreme agedness from leaking into the public sphere (Nakrem). Foucauldian narratives can be employed to represent the nursing home as part of modern-day “bio-politics,” controlling the unruly bodies of the uncivilized old (Hyde et al.), but such seemingly radical perspectives leave unaddressed what most families want for their frail, aged relatives: a safe and dignified life as free from suffering as possible. Creating a setting where that is possible necessarily sets in motion practices and procedures that involve an asymmetrical set of relationships between carers and those being cared for. This asymmetry is a function of both relational and representational power, operating at the level of what Foucault has called the agonisms of freedom, as much as through systems of governance. What this amounts to is staff who both are more able to look after the residents than the residents themselves and also have more power to represent and enact the “reality of care” than do the residents (more so in those “units” where most residents suffer from dementia and related mental infirmities). While it could be argued that the nursing home itself – the institutional matrix determined by the commissioning authority and the provider organization – operates its own separate systems of power, through its regimes of corporate governance, regulating the conduct of staff and residents alike, this overarching regulatory structure may add to, as much as it ensures against, enveloping the residents within the shadows of a fourth-age imaginary.

Paradoxes of care abound within the interstices of power that permeate the nursing home. Since the residents mostly lack power to resist the institutional systems of governance of the nursing home (and arguably have entered the nursing home precisely for that reason), their agency is likely to be exercised more in the daily agonisms of freedom that constitute the interactions between staff and residents, and between the residents themselves. While the former are marked by the asymmetry of power noted above, the latter are least affected by such asymmetries. Does that mean that here at least, in resident-to-resident interactions, lie the best chances for sustaining one’s agency, representing one’s identity, and establishing one’s place in the social world? Perhaps not. Perhaps such possibilities become less realizable because most residents have lost their power to form, maintain, and adapt their social relationships to others, especially others who share the same weakness. While the aged poor in the Victorian workhouses were able to and did write letters of complaint about the conditions in the wards or the infirmary, few residents of today’s nursing homes have the means to do so – not because of poverty, not because of a lack of education, not even because of a lack of social capital, but because of their own mental infirmity: their inability to represent themselves in and to the social.

CONCLUSIONS

The nursing home has long been portrayed in a negative light, as an oppressive institution, prone to scandalous practices and serving as an antechamber to the grave. As the residents of these institutions have become more prone to physical and mental infirmity, and as the care offered by these institutions has intensified, the power of staff and residents has consequently become weaker in resisting these institutions' "interpretive power" to confer upon old age the imaginary of a fourth age. The direct experience of life within the nursing home remains confined to a small group of people: the residents, who are increasingly mentally and physically frail, and the staff, who are increasingly drawn from the poorer and more marginal groups within the workforce. Consequently, the nursing home's collective representation relies heavily upon reports in the media. Since media attention is strongly influenced by issues of newsworthiness, it is hardly surprising that abuse, scandal, and poor standards of care dominate the framing of the nursing home. It is in this sense that we have argued in this chapter that the nursing home acts as a potent signifier of the fourth age and what it represents: society's greatest fears of old age.

Resistance to that imaginary is difficult to mount and even more difficult to sustain, not least because it is mediated through the frames of the news media, rather than constrained within the everyday practices of the staff or its visitors. Further, the densification of disability that has taken place over the last two decades means that the residents are less and less able to position themselves as dissatisfied customers or discontented citizens – in the way that the aged residents of the old workhouses or alms-houses once were. Who can provide the "counter-frames" against such representations, and how? Arguably, the research community, rather than serving such a function, only adds to it by critiquing standards of care, particularly by identifying care practices as contributing to, rather than preventing, a malignant social psychology that makes the residents more demented than they would otherwise be. While such critiques are no doubt motivated by the desire to "do something," to improve the quality of life of the residents – in short to defend them from being engulfed by the shadows of the fourth age – the evidence of their success in so doing remains limited at the very least (Beerens et al.; Olsen et al.).

Caught by what we have called "the moral imperative of care" (Higgs and Gilleard, *Personhood*), it can seem that staff working in the care sector are assailed on all sides by a morally ambiguous task, namely to treat the people they care for in ways that depend upon a narrative that their daily experience either confounds or frankly contradicts. Work that is carried out itself under a shadow – the shadow of "dirty work" – requires care workers to manage their own feelings of disgust and indignity while maintaining a semblance of their own and their residents' sense of worth and dignity. The general lack of signs

of moral worth assigned to their work and to their place of work (demonstrated, in pre-modern times, by the religious nature of their calling and their place of work) goes back to the poor laws. While early-twentieth-century reforms saw hospitals and hospital nursing rise in standing as nursing became professionalized and increasingly allied with medicine, the workhouses and alms-houses – and now nursing homes – are staffed predominantly by non-professionalized hourly-paid labour: the legacy of the pauper nurse and the workhouse maid.

To achieve change, to strengthen the capacity of staff and residents to resist the shadows of the fourth age, requires more resources to combat the devaluing of the work, the marginalization of the workplace, and the spectacular nature of the care environment, where visitors are encouraged as much as to observe as to share in the quality of care. More specific responses can be suggested, from the creation of university-affiliated nursing homes to the development of shared citizenship in the running and shared ownership in the management of the nursing home itself, with government or local-authority incentivization of such collective systems by staff, relatives, and those residents most able and willing to contribute. Achieving any kind of cultural change in nursing homes is difficult (Shier et al.). The Green House model¹ represents a definite step toward implementing this agenda, for example, although even this has proved difficult to implement consistently (Zimmerman et al.). So long as the nursing home remains both a symbol and a structure that realizes the social imaginary of the fourth age, it will continue to be the site where the struggle to resist that imaginary is most acute and most challenging. Rather than hiding from the uncomfortable contradictions of later life by segregating a space for the fourth age within the nursing home, the opening out of this struggle is important, even if – or most likely because – its resolution is so hard to realize.

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1 | For a description of Bill Thomas's Eden-Greenhouse model, see Brune.

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