The Meaning of Activity: Day Care for Persons With Alzheimer Disease

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The purpose of this study was to gain understanding of the meaning of the daily routines and activities at a day-care center for persons with Alzheimer disease, as experienced by the staff. With the use of the qualitative research techniques of participant observation and ethnographic interviewing, data were collected for 4 weeks at a small adult day-care center for persons with mid- to late-stage Alzheimer disease or related disorders. Analysis of the data revealed that the foremost guiding principle for all activities during the day was prevention, that is, to prevent participant behavior that would be harmful to self or to others. Secondary to this overarching guideline, other characteristics of a "good day" versus a "rough day" were also identified. The findings are discussed as they relate to activity program planning and to sources of staff satisfaction in the care of persons with Alzheimer disease.

Adult day-care programs in the United States have evolved during the past decade into an important component of the continuum of long-term care offered to older people. In 1986, the American Occupational Therapy Association (AOTA) published "Roles and Functions of Occupational Therapy in Adult Day Care." In this article, it was stated that "occupational therapy helps the day-care participant to regain and retain meaningful life skills. The potential for continued involvement at home and in the community is enhanced through the use of appropriate, purposeful activity" (AOTA, 1986, p. 818).

Most adult day-care centers serve a population of older people that includes those with physical disabilities and mental frailties (Mace & Rabins, 1984). A smaller number of adult day-care facilities are designed specifically for older people with Alzheimer disease or related dementias (Glenner & Glenner, 1988–1989; Keyes & Szpak, 1983; Panella, Lilliston, Brush, & McDowell, 1984; Rabinowitz, 1986; Sands & Suzuki, 1983). Mace and Rabins (1984) concluded from their survey findings that both specialized and mixed day-care centers can operate successfully. Resources (National Institute on Adult Daycare, 1984; Neustadt, 1985) state that adult day-care programs exist to provide respite for families of disabled elderly people, to restore or rehabilitate the person to his or her highest level of function, to maintain the person's present level of function as long as possible, to provide socialization and meaningful activity, and to serve as an integral part of the community social service network. Further, as Sands and Suzuki (1983) stated, it is assumed in day care that the entire milieu of staff-client and client-client interactions "will be structured in such a way that independence on the part of clients is maximized" (p. 22). With a global impairment such as that imposed by dementia, the general philosophy is somewhat modified to focus on the creation of a milieu that promotes function of the impaired persons at their highest level, whatever that might be (Sands & Suzuki, 1983).

Some researchers believe that activities can be used to enhance the function of clients in adult day care, including clients with Alzheimer disease (Glenner & Glenner, 1988–1989; National Institute on Adult Daycare, 1984; Sands & Suzuki, 1983; Zachary, 1984). These assertions and beliefs are in agreement with the general theoretical framework of occupational therapy regarding the therapeutic use of activities in the promotion of development, the maintenance of health, and the restoration of function (Clark, 1979; Reilly, 1966). Others describe the purpose of activities in dementia care as not so much restorative as preventative (Macdonald, 1985–1986; Mace, 1987; Zgola, 1987). Little, if any, research exists on the actual experience of being a staff person in an adult day-care center for persons with Alzheimer disease or on the meanings that guide the daily activities.

The purpose of the present study was to understand
the experience of being a staff person at a small Alzheimer adult day-care program and the meaning of activity in that setting. Data were collected for 4 weeks with the use of techniques of daily participant observation at the center and ethnographic interviewing of staff. The observations and interviews focused on the structure of the day's activities, the meaning of that structure to the staff, staff-client interactions, and the explicit and implicit guidelines for behaviors and routines throughout the day.

Methodology

Setting

The study took place in a small Alzheimer adult day-care center in a midwestern city. At the time of the study, the Alzheimer center was in its second year of operation and was one component of a multicenter adult day-care organization that has been expanding and serving the area for 15 years. The center used in this study was designed specifically to serve people in the midstages to late stages of dementia. The staff consisted of a nurse, a nurse's aide, a social worker, a certified occupational therapy assistant, and a program specialist/site coordinator. As stated in the center's brochure, the program goal is "to maximize the strengths of the person with dementia and to facilitate opportunities for them to express themselves to others, to have pleasurable experiences and to be affirmed in their self worth in a structured, safe, and caring environment."

The center is located on the lower level of a church on the edge of a residential neighborhood. Physical space includes a long entry hallway and a large all-purpose room with adjoining rest rooms and kitchen. An office for the staff is located off the long entry hallway. The all-purpose room has a dining area, a carpeted living room area with large upholstered chairs and sofas, and an activity area around the piano. A bed behind a folding screen is in the back corner of the room.

During the study, from 7 to 14 clients attended the center each day; the total roster consisted of 3 men and 14 women. Each participant had been diagnosed as having Alzheimer disease or another irreversible dementia. Some clients attended the center daily, whereas others attended two or three times a week. Referrals to the center came from a variety of sources, including family members, social workers from other agencies, hospitals, senior centers, and group homes.

From Monday to Friday, the daily schedule on the floor was as follows:

- 8:45 a.m. — The participants arrived; each person was greeted by name, welcomed, and verbally or physically guided to the living room. Everyone sat together in the living room area and talked informally; one or two staff people sat with the group to stimulate conversation.
- 9:30 a.m. — The participants and staff moved to the dining area to sit around the tables for their morning snack (coffee and toast); staff read morning newspaper items aloud and stimulated comments and discussion from the group.

- 10:30 a.m. — Everyone moved back to the living room area and usually did word games or another mentally stimulating activity.
- 11:30 a.m. — Special activities were often initiated, such as singing around the piano, doing arts and crafts, or exercising.
- 12:15 p.m. — Everyone moved to dining area to sit around tables for lunch.
- 1:00 p.m. — Everyone moved back to living room area for quiet time and conversation.
- 1:30 p.m. — Special activities such as exercises, video, and cooking were initiated.
- 2:45 p.m. — Everyone moved to the dining area for their afternoon snack.
- 3:15 p.m. — Rides and buses came.

General staff guidelines were for at least two staff persons to be on the floor at all times — one to lead activities, the other to serve as monitor. The monitor attended to the clients' needs, such as using the bathroom or wandering, thereby enabling the activity leader to continue to focus on the group. During the day, staff also took care of snack preparation and cleanup (sometimes overseeing help from the clients), lunch preparation, laundry, record keeping, and program planning. Breaks were planned for each staff person at specified times during the day.

Data Collection

Data collection at the center took place over a 4-week period in the summer of 1990. As the researcher, I met with the center staff early in the month of July and obtained from each of them a signed consent of participation. Letters of information were sent the clients' guardians or caregivers, explaining the study and seeking signed agreement to my presence at the center for observation. A plan was developed for me to participate as a staff person at the center during mornings for the first week, during afternoons for the second week, and full time for the third week. The fourth week consisted of continued full-time participation as well as interviewing of staff members.

Participant observation is a data-gathering technique whereby the researcher is both observer and participant in the setting (Schatzman & Strauss, 1973). It is used when the researcher wishes to capitalize on two kinds of expertise—in this case, my expertise as a health professional and my expertise as a qualitative researcher. Both roles are fully known to the participants in the study. Participant observation data consisted of handwritten field notes, which were recorded sporadically throughout the daily participant observation time and transcribed at the end of each day.
Ethnographic interviewing (Spradley, 1979) with three staff members—the certified occupational therapy assistant, the nurse’s aide, and the site coordinator—was carried out near the completion of the period of participant observation. This strategy for data collection is in accordance with Smircich’s (1983) statement that “participant observation for significant time periods with interviews conducted after some time in the setting is the favored strategy for data gathering. In this way . . . there is greater likelihood that the questions ultimately asked in an interview will be relevant because they have emerged from interaction in the setting” (p. 171). The open-ended interviews with the three floor staff focused on their views of the daily routine of the center, perceived rationale for the programming, perceptions about group and individual activities, and their sense of what constituted a “good day” versus a “rough day.” The interview content was derived from themes emerging from the daily field notes. (For the purposes of this paper, quotations from the staff members interviewed are attributed to Staff Interview 1, 2, or 3, to maintain anonymity.)

Documents were a third source of data. These included intake forms, informational flyers, assessment forms, weekly planning charts, and card files on clients. Thus, by the end of my 4-week stay at the center, my multiple data sources consisted of the field notes, the interview notes, and the center’s documents plus my own experience as a staff person in the setting.

Data Analysis

The data collection approach used in this study is one that allows the themes present in the setting to emerge over time. In sociological terms, the Alzheimer day-care center represents an organization that is a system of shared meanings held together by the social interaction patterns of the members (Smircich, 1983). The analysis of data was an examination of the daily activity at the center as it related to these shared meanings and interactions.

The iterative nature of the data collection (i.e., day after day, incident after incident, multiple sources) facilitated the formulation of key themes and their subsequent verification or contradiction. My own perceptions of meanings were regularly checked against those of the staff, against ongoing overt behaviors of staff and clients, against my own behaviors, and against the interview data. During the analysis of the data, a draft write-up of interpretive findings was circulated to the staff for feedback (Lincoln & Guba, 1986).

Results

Preventing Harm

The foremost guiding principle in the daily operation of the Alzheimer day-care center was to prevent harm, that is, to prevent the clients from engaging in behaviors or activities that might lead to harming themselves or others. Harm might constitute a client’s (a) becoming extremely agitated or fearful, (b) exhibiting behaviors that are embarrassing or undignified to himself or herself, (c) physically striking another client or staff person, or, most dreaded of all, (d) wandering out of the building unattended. The organizational structure and content of the activity program strongly reflected this overriding guideline and, in fact, provided a primary means for operationalizing prevention strategies. The day was structured into blocks of time for a block of people, potentiating the manageability of the clients and hence the prevention of harm.

Additionally, the staff provided activities that offered variety and pleasure, promoted friendship, and were meaningful to the clients. Individualization in the form of personal attention, comfort, and assistance with activities of daily living was an integral part of the activities. The creation and maintenance of a safe place for the participants, however, was the first and foremost mandate, and only after this mandate was met were other considerations addressed. A variety of program strategies were used to ward off trouble and to make the center a safe place for the participants.

Keeping it calm. To help ward off trouble, the general psychological and physical environments of the center were kept calm and low-key: “Here things are kept pretty calm for people” (Staff Interview 2). It was recognized that activities that were mentally and physically varied and stimulating could easily become too varied and too stimulating, thereby setting off a reaction of frustration or agitation that would be injurious to the client and disruptive to everyone. The trick was to find the “fine line between encouraging people yet not having them fail—trying to push the brain somehow but give them an out at the same time.”

Catching trouble early. At the first sign of trouble, the staff tried to catch it before it escalated. This strong sense of catching trouble early, before it got out of hand, led to a full day of continuous vigilance on the part of the staff. In my early notes, I wrote about the staff’s “incredible antennae,” referring to their finely tuned skills at noticing subtle signs of impending trouble. As the participant observer, I felt the strain of this constant vigilance early in the study. On the third day of the data collection, I entered in my notes, “[At] about 11:30 I took a break and went back and sat in the office. I felt a curious sense of RELEASE I think would be the proper word. I think it’s release from vigilance .... There’s a tremendous constraint in the situation—as though if one let up for a minute, the whole thing would fall apart and get out of control.”

In addition to the constraints imposed by constant vigilance, a sense of constraint also emanated from the intimacy of the activity world at the day-care center. On the second day I wrote, “Their world is so small. From
table to living room, from talking to looking at pictures, to eating a snack, going to the bathroom, wondering when their ride is coming, wondering where their family is, wondering where they live. Activities are pretty much the survival activities of life."

An entry on the third day read, "Lots of people, lots of watching—everything is close, close, close. Plus everything is intimate—it's tending to people's most intimate needs, it seems."

During the third week, I described feeling smoothed by the attentions and repeated questions of one client and, with great relief and the blessings of the staff, went outside for a vigorous walk. Such a break was indeed a coveted period of release, providing respite from the constant vigilance plus time out to recoup energies and regain equilibrium. Perhaps the most satisfying break was one during which a staff member could get outside, even to just sit for a while. The second most satisfying break was to sit in the office, combining a few restful moments with some desk work. Other lesser levels of break occurred when a staff member shifted from being leader to being monitor, from being on the floor to helping in the kitchen, or from being on the floor to answering the phone.

Keeping people together. Another dominant strategy used to ward off trouble was to try to engage as many participants as possible in group activities. The use of group activities throughout the day acted as a crowd management technique, enabling the staff to keep track of where everyone was and what everyone was doing. A rough morning was described by a staff person as one in which people were pretty scattered... people were everywhere, but by the time we did an exercise thing they were more together again as a group and things were better. ... On a rough day, people are unsettled and on their own agenda. When you can't get people in a group and feeling connected and feeling safe, that can be rough. (Staff Interview 2)

If a group activity was working well, staff sometimes kept it going beyond the usual time, perhaps making the most of a good thing.

The participants were collectively referred to as the group. When a participant left the group temporarily (e.g., to use the bathroom), the first priority was to guide him or her back to the group. As one staff person expressed it, "When they start unraveling, then it's very hard to bring things back together. ... Having everyone involved, not wandering, that means it's going exceptionally well." One or two participants usually chose not to be with the group. Staff accommodated these needs by ensuring that the person was comfortable elsewhere in the room, perhaps providing a magazine, and keeping a watchful eye on the person at all times.

The transition from one group activity to another usually involved a move from one area of the room to another. I came to refer to this as the big move, a phrase used one day by a staff member. Staff did a lot of organiz-
Besides the obvious need to prevent incontinence, other bathrooming concerns included keeping the men out of the women’s rest room and vice versa, making sure a participant was reclothed after using the toilet, offering the appropriate amount of assistance during bathroom use, protecting each participant’s privacy as best as possible, and verbally or physically cuing the participants to and from the bathrooms. Sometimes the signs were quite subtle—a client’s restlessness or leaning forward in a chair—and the staff’s sensitive antennae were used to decipher the need to use the bathroom. As noted in my field notes, sometimes the situation got complicated:

K gets up. [Staff] directs her to the bathroom but she gets confused in a corner. I get up and help K find the bathroom. W. comes along with me and we have to dissuade him from going into the ladies’ room. Then M. goes to the bathroom and [staff] gets up to prevent W. from following her into the bathroom.

The amount of individual attention and time devoted to bathroom use for this small group of people with dementia was an unanticipated finding. One does not find bathrooming described in the literature as part of activity programming.

Booking. The ultimate objective of all of the above management techniques was to prevent the most dreaded happening of all, that is, someone leaving the premises unaccompanied by a staff person, which was referred to as booking.

It’s a horrifying feeling: You don’t know where they are and they don’t know where they are. The worst is knowing the anxiety the person is experiencing. And you find yourself jump in a while, you’re more alert when anybody goes near any exit. (Staff Interview 3)

A modified version of booking sometimes occurred when a participant walked determinedly out the door and was pursued or accompanied by a staff person. This, too, provoked considerable discussion by the staff after the event, contact with the family, and extra watchfulness for days afterwards. An envelope containing $.25 and a slip of paper with the center’s telephone number were kept by each exit for a staff person to grab if they found them—called in to decipher the need to use the bathroom. As noted in my field notes, sometimes the situation got complicated:

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Providing Some Meaningful Purpose

In addition to the use of activities to help ward off trouble, activities served other objectives, including providing some meaningful purpose throughout the day for both participants and staff:

Part of a good day is the feeling that we ran a program and people participated. Yesterday we did a crossword puzzle, took the walks, made a bean salad. It’s important to me [staff] to feel like I’ve done something. (Staff Interview 2)

Special satisfaction for staff was derived from involving participants who were usually reluctant to participate:

For example, the cupcakes the other day—everyone sat at the table, including W., who was reading the recipe. To me, where I can get everybody to do it without losing interest is when I know something is working. . . . So getting someone who’s really ‘hard’ involved tells you you’re doing something right. (Staff Interview 1)

An added source of satisfaction to the staff was present when the activity had been fun:

This morning, I said, it was a good morning—people participated and we had a lot of fun, there was a lot of laughter and joking around. . . . With these people, it’s more simple. To have somebody click in becomes so wonderful when it comes from someone with Alzheimer’s—and to see him enjoy and be happy. (Staff Interview 3)

I vividly remember one day myself when it felt afterwards like an extraordinarily good day. It was a day when several participants played a small joke on one of the staff—they tied the staff member’s shoelaces together while she pretended to be asleep. Everyone enjoyed it immensely, especially when one participant poked the staff member “awake” and said she wanted to go for a walk. The anticipation of the consequences of the tied shoelaces was exquisitely enjoyable, perhaps especially so because the participants were contributing so much to the activity.

In the interviews, staff expressed various purposes to the activity programming, including to provide pleasure, to keep the participants’ minds alert, to promote bonding within the group, to provide physical exercise, and to help maintain the participants’ skills. The need for flexibility was stressed, for example, “With Alzheimer’s you have to constantly evaluate what’s working and not working” (Staff Interview 3). A sense of a difference between morning and afternoon activities was also expressed:

We have to plan more in the afternoon—in the morning you can go more by the seat of your pants. Yesterday, the newspaper fizzled [this refers to the group activity of staff reading newspaper items aloud and stimulating discussion] and we went back to the living room. On the spur of the moment we decided to make get well cards for V. and K., and they really got into it. (Staff Interview 1)

Whether group or individual, the activities were viewed as vehicles for making connections with the participants. During the group activities, staff leaders incorporated as much individualized attention as possible, such as calling people by name, helping them find the correct songbook page, and giving each one positive feedback during the exercises. Even the most mundane activities were viewed as potentially valuable. As one staff member remarked, “Bathrooming [sic] is a wonderful way to get to know people, or even to just walk with people. I think I take every possible moment to make those connections.”

Discussion

Rehabilitation or Prevention

Much of the literature on activities and Alzheimer disease stresses the restorative potential of the activity program. It is asserted that meaningful activity and relationships can help establish a positive self-image and sense of iden-
tity (Glenner & Glenner, 1988-1989; Sands & Suzuki, 1983; Zgola, 1987). Additionally, therapeutic activities can stimulate maximum functioning and positive changes in physical and emotional health (Glenner & Glenner, 1988-1989; Keyes & Szpak, 1983; Sands & Suzuki, 1983). Sensory stimulation and remotion therapy are offered as treatment approaches to use to accomplish improved function (Janssen & Giberson, 1988; Maloney & Daily, 1986). This treatment context of activities may include formalized components of patient assessment and goal setting (Griffin & Matthews, 1986).

Alternatively, the purpose of activities for people with dementia has been described not so much as restorative, but rather, as preventative and enabling. Activities are used to reestablish “a sense of normal functioning...a sense of usefulness, of pleasure, and to reduce the sense of helplessness and futility these people experience” (Mace, 1987, p. 19). The emphasis is on what types of activities will best promote positive experiences rather than on the functional goals of the activities (Macdonald, 1985-1986; Mace, 1987; Williams, 1988-1989; Zgola, 1987). The social interaction and sense of belonging derived from the activities and the safe, structured environment provided for the activities are also important components of the programs (Macdonald, 1985-1986; Panella et al., 1984).

In the present study, the staff at the Alzheimer day-care center focused on the preventative and enabling activities in their programming. Strategies for warding off trouble were employed to prevent harm. Staff derived satisfaction from providing activity meaningful for the moment (“Yesterday, we did a jigsaw puzzle, took the walks, made a bean salad” [Staff Interview 2]).

However, staff members were also aware of the rehabilitative view of activities and care of persons with Alzheimer disease. For some, this awareness seemed to temper the satisfactions received from their work. One staff member stated that she often felt lost, explaining that she wondered if she was using her professional skills in her work:

Sometimes I go home and have no idea what I've done all day. In [other settings] you get something concrete, measurable stuff with people, but here it gets kind of foggy. So I hang onto my philosophy that I'm helping people maintain their abilities through everything we do.

In previous research on the meaning of practice in occupational therapy (Hasselkus & Dickie, 1990), a major source of satisfaction in practice to therapists was the sense of making a difference. Students entered occupational therapy because they wanted to help others (DePoy & Merrill, 1988). Therapists continue to find helping others and making a difference to be a primary source of satisfaction. It is probable that when one works with people who have Alzheimer disease, one finds that satisfaction derived from making a difference is less readily obtainable. Another possibility is that the difference that one is able to make takes an alternate form, that is, it is more a difference of the moment (e.g., “To have someone click in.” “Getting someone who's really ‘hard’ involved,” catching trouble early). Additionally, in caring for persons with Alzheimer disease, one's sense of satisfaction from helping others may stem as much or more from helping family members as from helping the clients themselves. All three of the staff members interviewed in the present study named respite for families as a primary purpose of the center. “In just talking to M. [a client’s daughter], it made me feel good, she was so appreciative that we were taking such an interest in her mother” (Staff Interview 3). The ability to keep people out of nursing homes as long as possible was a corollary belief.

The staff may attempt to incorporate rehabilitative program components due to what are perceived to be expectations of others (e.g., the sponsoring agency, the regulatory guidelines). For example, the bulk of the time in the weekly staff meetings was spent discussing the status and problems of individual participants. This process included regularly scheduled, lengthy functional assessments on each participant, with level of independence scored in 21 areas of function (e.g., eating, toileting, attention span, judgment). Given the reality of the day-care center's activities, with the focus on meaningful group activities and warding off trouble, the amount of time spent in staff meetings determining individual needs and functional status was disproportionately high. I was unclear as to what programming purpose the functional assessment served in this setting. Perhaps it is understandable that one staff member commented, “I hate these. These take up so much time.”

The purposes of functional assessments in the care of persons with Alzheimer disease need to be examined and clarified for practitioners. It seems appropriate that functional assessments be used to monitor the progression of the disease and to establish realistic staff expectations for performance by the participants. It seems less appropriate and unrealistic to try to use assessment data to determine individual rehabilitative needs or to set short- and long-term treatment goals. Our training can be used to help all staff support functional capabilities and offer appropriate levels of assistance. General guidelines for each participant can be formulated (e.g., a particular client may not need her food cut up; another may be able to handle the toileting alone). We must also remember, however, that capabilities fluctuate from day to day, and in the end, continuous vigilance must still be maintained to prevent trouble.

These findings suggest to me that the rehabilitative model of activities in the care of persons with Alzheimer disease is inappropriate and misleading. Staff frustrations may develop if they come to their work expecting to be able to bring about restorative differences. The overriding emphasis must be on meeting the client's basic needs of food, shelter, and safety. As Zgola (1987) stated, “A calm,
predictable and accepting environment can provide the sense of security that enables a client to make full use of his [sic] abilities’ (p. 28). It is the safety and security itself that enables the person with dementia to function to the best of his or her abilities. Activity programming in dementia care may provide the key means for the creation of that safe and predictable environment, which may be its primary and most important contribution.

**Control Versus Overcontrol**

In this Alzheimer day-care center, the basic philosophy of ensuring that the center be a safe place for the clients meant exercising constant staff control of the day’s occupations and the clients’ involvement. The sense of the ceaseless need to prevent unnecessary anxiety and agitation resulted in continual, intense surveillance by the staff. “When someone gets up, I always assume that they need something, and we need to check in to see if we can help. If we didn’t, I think for some of them, they would be lost” (Staff Interview 2).

Staff recognized the potential for overcontrol in such a situation:

I notice where sometimes we help too much... That’s a real easy trap to get into where it’s easier and quicker to do it for them, so we have to remind ourselves to give them the time to do it themselves. (Staff Interview 2)

Sometimes I battle with this, that we are trying to keep people down... It’s prevention... Anxiety is such a thing with this disease. So it’s a fine line between that and control. (Staff Interview 2)

Issues of control were brought up at the staff meetings and other program planning meetings between staff members. Staff members did not always agree with each other’s approaches to situations that involved control issues.

The staff’s focus on the prevention of harm in this Alzheimer day-care center is similar to that found previously in family caregivers in the community (Hasselkus, 1991). In the family caregiving data, the “prevention of falling, getting bedsores, choking on food, getting an infection, being constipated, having to go to a nursing home—these were the guiding maxims of care” (Hasselkus, 1991, p. 210). Also evident in the family data was a theme of tension between the ethical principles of beneficence and autonomy. The family caregivers, too, often employed strategies of control, thereby overriding autonomy in order to uphold beneficence. In the family caregiving study, I postulated that the primary focus on risks and prevention of harm was present largely during the early phases of caregiving. In contrast, the focus on the prevention of harm in the present study was clearly ongoing. The use of activities as a means of control and management of the behaviors of persons with dementia requires further research for a better understanding of the ethical issues of beneficence and autonomy.

We need to examine our values and the reality of our practice in Alzheimer care and to bring about a match between our values and practice so that the satisfactions derived from working with persons with Alzheimer disease may be better realized. If we accept the suggestion that a philosophy of rehabilitation does not fit well with Alzheimer care, then we need to clarify for ourselves just how our training does contribute to the quality of care for persons with dementia. Further, what are the rewards for occupational therapists and other trained personnel in working in Alzheimer care? If satisfaction comes from a sense that things are under control, how is this reconciled with our basic belief in autonomy and independence? If satisfaction comes from knowing that our clients are busy and happy, how is this reconciled with our belief that we are uniquely trained to improve clients’ function?

This qualitative study of the experience of being a staff person at a day-care center for persons with Alzheimer disease revealed several key themes of care. The overarching theme of prevention of harm provided the most powerful guidelines for the routines of the day. Success in this preventative mandate involved other themes, such as (a) trying to get as many people as possible to take part in the group activities; (b) trying to always be informed about where everyone is and what everyone is doing; (c) keeping everything calm and low-key, and (d) maintaining constant vigilance to catch trouble before it escalates. Other activity goals, such as providing an enriched environment, promoting friendships, and attending to individual needs and interests, were also recognized as important, but only if the primary mandate of safety was also met. Judgments about whether or not it had been a good day or a rough day were based on these criteria.

The findings suggest that the nature of Alzheimer disease or related disorders, at least in the midstages to late stages, does not lend itself to activity programming that is rehabilitative in scope or emphasis. Instead, the prevention of harm, provision of family respite, and enabling of participation in activities that are meaningful in the present moment are the major sources of staff satisfaction. Sources of satisfaction to staff trained in the care of persons with Alzheimer disease must be further identified. Additionally, the use of activities to control and manage group behaviors requires further research regarding ethical issues of autonomy and beneficence in the care of persons with dementia.

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References


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