Intergenerational Partnerships in Adult Day Centers: Importance of Age-Appropriate Environments and Behaviors

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Purpose: This research identified the potential for infantilization of clients in centers that offer an occasional program of combined adult and child day care. Design and Methods: The study used a comparative ethnographic approach, which analyzed observation and interview data collected from two adult day centers that offered intergenerational activities. Special attention was paid to the environment, behaviors, and clients’ interaction patterns. Results: The adult day center cultures varied widely in age appropriateness, opportunities for autonomy, privacy regulation, choice, and adult interaction, especially as children were introduced into the setting. Infantilization occurred in the intergenerational program when the adults and children were treated as "status equals," and the activities and environments were only child oriented. Older persons perceived a need for an "escape option" if contact with children was overstimulating or age inappropriate. Positive intergenerational experiences involved adults in a mentoring role, voluntary participation, and client-initiated contact with children. Implications: This study explores the influence of intergenerational programming in adult day centers, and bridges the gap between theory and practice with implications for other aging services. Key Words: Infantilization, Aging services, Intergenerational programs

Adult day care services provide psychological benefits and respite for caregivers (Zarit, Stephens, Townsend, & Greene, 1998), as well as community-based social interaction for older persons who may be limited in mobility, health status, or cognitive ability. An innovative trend among centers involves the "intergenerational program" format, which combines adults and children in a common day care setting (Travis & Stremmel, 1999). This study examined social participation through in-depth observation and interview data collected from two adult day centers, each with occasional intergenerational contact. Attention is focused on the behaviors, activities, environments, and interaction patterns among clients in the centers. Results show wide variation in the ability to combine both generations successfully, indicating a special risk associated with this type of program. Client interaction suffered if the speech, environment, and activities were only child oriented. Positive intergenerational contact fostered the maintenance of adult status for clients through choice, age-appropriate treatment, and settings.

Programs that bring children and older adults together have proliferated in communities across the United States. The goals of intergenerational contact are to improve children’s learning, reduce substance abuse, transform ageist attitudes, provide mentoring, decrease isolation, and build generational interdependence (Kuehne, 1999). The trend has spread from school-based programs to nursing homes, residence facilities (Thomas, 1996), and now to adult day centers (Travis & Stremmel, 1999). However, theory development is lacking (Fox & Giles, 1993; VanderVen, 1999), as is evaluative research to determine program success or failure (Ward, 1999).

Infantilization has been identified as the societal treatment of old age as a second childhood, with little or no recognition of a lifetime of experiences that separates aged persons from children. This process commonly occurs in institutions, community services, and adult day centers (Lyman, 1988; Ryan, Bourhis, & Knops, 1991; Whitbourne, Culgin, & Cassidy, 1995). Child-oriented activities are encouraged, as are the use of pet names, age-inappropriate remarks, gestures, and patterns of speaking toward older clients (Hockey & James, 1993; Salari & Rich, 2001). The literature is focused on the verbal communication of infantilization toward older persons, through high-
pitched intonation, simple content, and exaggerated phrasing (Lyman, 1988; Ryan, Hamilton, & See, 1994; Whitbourne et al., 1995). Environmental infantilization in adult day care involves a lack of privacy regulation and autonomy, as well as child-oriented decor and the use of toys (Salari & Rich, 2001). This work points to the risk of infantilization in adult day programs, especially as children are incorporated into the setting.

Theoretical Framework

Kane (2001) recently reported that, for users of aging services, good quality of life is facilitated by a number of individual and environmental factors, including—but not limited to—meaningful activities, dignity, privacy, individuality, autonomy/choice, and the ability to have personal relationships. These issues are important even as individuals lose cognitive and physical functioning. Classic person–environment theory states that environmental processes are central to high-quality interaction, with physical and social environments often having interdependent effects (Altman, 1975; Kahana, 1982; Lawton, 1982, 1985). Environments for older persons struggle between providing security and autonomy simultaneously (Kane, 2001; Parmelee & Lawton, 1990). Autonomy refers to the perception that one is directing his or her own life by making decisions and choices (Kane, 2001). Privacy involves the ability to be alone when desired, together in private with others, and to be in control of information about oneself (Kane, 2001). In addition to maintaining satisfying contacts, it is important to have control over other people's access to us (Altman, 1975), and to achieve limited and protected communication (Westin, 1967). Optimal privacy regulation is maintained as individuals use regulatory mechanisms—including verbal/nonverbal behaviors, territoriality, and manipulation of the environment—to communicate self-identity, and to meet or avoid other people (Altman, 1975). Ultimately, privacy regulation is necessary to exercise autonomy and maintain individuality (Westin, 1967).

Individuality involves the sense of being known as a person, able to express identity, and able to maintain continuity with the past (Kane, 2001). Goffman (1961) described the effects of the total institution on the sense of identity among inmates. He argued that institutional boundaries, rules, humiliation, and barriers to the outside world led to a loss of identity in a self-mortification process. Adaptation strategies, such as rebellion (taking intransigent line), making the best of the situation (colonization), and imitating staff (conversion), were used by inmates in an attempt to prevent self-mortification. The most common strategy, “situational withdrawal,” involved a drastic decline in interaction with others. Tobin (1991) points to many forces in modern institutions that erode the sense of self, making identity maintenance the most difficult task of residents.

The adult day center is identified here as a partial institution, where clients spend their daytime hours in that setting, with the same clientele, interacting in organized activities, under the same institutional authority, day after day. But, in contrast to the total institution, clients go home to another environment in the evening. Total and partial institutions have a similar potential for negative effects on the identity and sense of self. Clients in adult day centers may be exposed to environments that are not age appropriate, do not allow for privacy regulation, require conformity to institutional rules, and create barriers to the outside world. This process may strip clients of adult status and identity. Adaptation strategies similar to Goffman's have been observed among clients who experience infantilization in partial institutions (Salari & Rich, 2001).

Intergenerational Format for Adult Day Care

Intergenerational programming in the day care setting is considered to be an innovative direction for services that target older persons (Firshein, 1996; Short-DeGraff & Diamond, 1996). The prevalence of intergenerational program models in adult day care was estimated at less than 10% in the early 1990s, but the trend has increased rapidly (Firshein, 1996; Travis, Stremmel, & Duprey, 1993). Previous research on intergenerational day care focused on the benefits of putting adults and children together to: (a) minimize children's negative stereotypes (Dellmann-Jenkins, Lambert, & Fruit, 1991), (b) increase older clients' social interaction with others (Short-DeGraff & Diamond, 1996), and (c) maximize efficiency in dependent care for employee caregivers (Creedon, 1989; Select Committee on Children, Youth, and Families, 1988; Travis et al., 1993; Watts, 1990).

Short-DeGraff and Diamond's (1996) small study followed 10 cognitively impaired older clients over time as their center (located in a small house) was transformed from an exclusively adult day center to an intergenerational program. With the introduction of preschool children, the authors perceived an increase in social interaction and a decrease in “solitary productive behavior” among clients (e.g., knitting, reading). The authors focused on the positive aspects of contact between the two generations, but there were some indications that senior participants occasionally needed to distance themselves from the activity. Some clients exhibited disengaging behaviors to take a break from or avoid the children. The extra noise and activity sometimes led to confusion and “antagonistic encounters” with clients who had cognitive limitations. So, in addition to positive results, negative outcomes of combining generations in one day care center were identified.

Travis and colleagues (1993) described the challenges and rewards of an intergenerational day care program in a university setting. The location was considered optimal for training of staff members from several programs around campus. There were concerns that staff trained in either child or elder care would not be open to the idea of combining the two groups. Planning the activities was challenging, be-
cause child developmental tasks were well known, but older clients had more diverse abilities and needs to be accommodated.

Existing research on the combination of adult and child day care is sparse and nonsystematic (Short-DeGraff & Diamond, 1996). Research evaluating the intergenerational programs usually concludes that they are beneficial to both adults and children. Kuehne (1989) reported mostly positive interactions observed among seven adult day center clients and seven children who met weekly. Most concerns regarding intergenerational programming focus on whether children will develop unhealthy images of older persons, based on clients with cognitive limitations (Travis et al., 1993). Negative effects of this program format on older clients have not been adequately addressed. But, Ryan and colleagues (1994) found evidence of lower satisfaction with intergenerational contact among nursing home residents when young participants directed “baby talk” toward them.

This is the first study to examine the potential for age-inappropriate treatment of clients in day care that includes intergenerational contact. In-depth observations and client interviews were analyzed to bridge the gap between theory and practice by comparing the participation of clients in the programs across two centers. Attention was focused on the behaviors and environments that encouraged client interaction and social ties.

**History and Purpose of the Study**

The two centers described in this research are part of a larger comparative study that examined a total of five social model adult day centers. The original aim of the study was to observe the characteristics of centers that facilitated client social interaction and friendship formation. Once observations were underway in the first center (in the northeast), it became clear that older persons were often being treated age inappropriately. We then examined all four existing adult day centers in one western metropolitan area. Although it varied widely, all five centers had evidence of infantilization, which involved some combination of baby talk, reprimands, child-oriented decor, nonprivate bathrooms, lack of choice, children’s activities, and the use of toys. Client social interaction patterns suffered if the center lacked privacy, choice, and/or autonomy. Participants in specific centers had very little of their own time, were discouraged from conversing, and were repeatedly stripped of adult status. Client interviews revealed knowledge of, and resentment toward, age-inappropriate activities and environments.

This study is focused on two of the centers studied in the west that each had an intergenerational program format. By comparison, it became clear that certain social and environmental considerations were required to mix two generations in one setting, without subjecting the elderly clients to infantilization. A holistic approach is used to describe the social culture of each center and the dynamics of intergenerational programs, with attention focused on age-appropriateness and client participation levels. A conceptual model is introduced to illustrate the proposed pathways to client social participation versus withdrawal in this setting.

**Research Process and Methods**

This study represents a comparative ethnography of two adult day centers with occasional intergenerational programming. Ward (1999) points to the importance of examining intergenerational contacts with the ethnographic approach, because (a) the locations include naturalistic settings and their contexts, (b) the focus is on the insider’s perspective, (c) the researcher is personally involved in the study, and (d) both the informally and formally stated agendas are of interest. Ethnographic studies describe in detail those shared systems of knowledge and cultural rules that guide behaviors in cross-generation settings (Ward, 1999). The lack of ethnographic research in this area is criticized (Kuehne & Collins, 1997; Ward, 1999), because existing studies do not describe in-depth, complex interaction patterns and cultural rules that guide multigeneration contact.

This research involved extensive observations of the two centers (Centers B and E) located in a western metropolitan area. Clients in “social model” adult day centers vary in their cognitive functioning, with a few requiring some assistance and others who do not need much help, but come as an alternative to staying home. The clients in both centers studied were comparable with regard to their number, health, and cognitive abilities. Center B was observed for 60 hours and Center E for 40 hours. The number of intergenerational program observations was 11 and 13, respectively. In each center, trained research assistants typically observed at least 2 hours at a time, produced field notes, illustrated diagrams, discussed findings at weekly meetings, and were evaluated closely by the primary investigator. The field notes included a description of center entrée; nonverbal and verbal communications; a map of the environment; descriptions of décor, activities, reactions, and other options (e.g., outdoor areas, private conversations, solitary pursuits); and the perceived well-being of participants.

In addition to observations, seven client interviews were conducted in each center. A purposive sample of interviewees was chosen based on observations and the judgment of the researcher. Selected informants could be either outgoing or introverted, in an attempt to include both active and passive participants. Clients were chosen only if they had been attending for a while, provided written informed consent, their families consented, and they were functionally able to hold a conversation. The family consent requirement was the greatest constraint on client selection, with some families refusing participation. Interviews were conducted in a private area of the center, audiotaped, and transcribed immediately after completion. The interview structure was guided, with open-ended
responses. Questions asked respondent’s opinion of the center, reason for coming, how they got there, alternative options, perceptions of choice, compatibility with clients/staff, could they name a client friend, were their conversations “in depth” or “small talk,” personal interests, and a brief adult history. None were asked specifically about intergenerational contact or age appropriateness, but a few respondents brought these subjects up themselves. The interviewees seemed to appreciate the opportunity to discuss their preferences and interests.

Extensive field notes and interview transcripts were produced by the research team and discussed at weekly meetings. The primary researcher supervised data collection and determined aspects of center descriptions that warranted clarification. Researchers were trained to be as unobtrusive as possible, and client or staff attention was discouraged by lacking acknowledgments. Notes were taken on the scene for detailed recollection and to indicate “busy work,” so researchers could avoid making eye contact, performing tasks, or participating in center activities.

The only quantitative aspect of the study identified activities observed with a distinct beginning and ending. It was then determined whether these activities were infantilizing or age appropriate. We classified reprimands, client use of toys, coloring with crayons, child-oriented stories, baby talk toward adults, labels such as good boy/girl, and childish nicknames as infantilizing. Conservative judgment was used so that activities with an occasional “Sweetie” or “Honey” nickname were not considered infantilized, unless used pervasively. In most age-inappropriate activities identified, there were several infantilizing characteristics observed. Instances that occurred between activities were often numerous, but were not counted in the tally reported here.

Qualitative data analysis is important to gerontological research to gain perspective about the intimate interactions and culture that exist in an institutional setting (Gubrium, 1992; Henderson & Vesperi, 1995; Ward, 1999). Successful use of grounded theory requires data generation and analysis in an “ongoing reiterative process,” which provides integrative linkages that become obvious as the collection of data and interpretation draw on one another (Hendricks, 1996). Intensive interpretations of field notes and transcripts allow for the emergence of a theoretical model to organize these data into a more clearly communicated work.

**Observations of Two Centers with Intergenerational Day Care Programs**

**Adult Day Center B**

**Study Description.**—Our observations of Center B spanned 60 total hours. Originally, we observed 59 unigenerational activities over 40 hours in 1996 and returned to observe an additional 35 activities over approximately 20 hours in 2000–2001, after intergenerational interactions were added. The adult/child contact was just once (and later twice) per week in this center; so, we purposefully scheduled 11 observations to correspond with these programs (the children attended nine). Unigenerational activities were also observed during 11 of the 20 hours to note similarities and differences with our earlier center observations. It was determined that the director, center philosophy, environment, activities, staff, and clientele were similar to those observed earlier. Seven client interviews were conducted in conjunction with the more recent observations. The center requirement for family consent constrained the sample, because some families refused and others were not accessible.

**Environment.**—Adult Day Center B’s environment was originally designed and built for this purpose. Decor was adult oriented and similar to a country club setting, with living room and dining room decor. The spacious main activity room had a cathedral ceiling and a fireplace. Chairs were arranged with an outer row along two walls and an inner three-sided square of chairs (the fourth side was open at the fireplace where the staff conducted activities). In addition to the main rooms, clients had the option of being outdoors in a gated garden, a sunroom, or congregating near the entrance of the center. Bathrooms were private, and staff members were discrete when assisting, if needed. A quilted wall hanging in the front foyer displayed the intergenerational philosophy, with a child’s hand inside an adult hand, with the name of the center sewn onto it.

**Clients.**—There were approximately 35–40 clients in attendance at a time in Center B. The ratio of men to women was about 1:3. The official roster was about 60 persons long, but fewer attend regularly. Not all of the clients were elderly adults. Approximately seven were younger adults who were brain injured or mentally retarded. Several of the brain injured adults were taken by van to swim during one of the intergenerational programs. Five frail elderly clients were confined to wheelchairs, and some others often sat in recliners. A few of the elderly clients suffered from mild to moderate Alzheimer’s disease. The majority of the clients were functional, could carry on a regular conversation, and could participate in activities. Some were quite active and got up to move around the room with various programs and exercises. The number of sleeping clients varied by the activity, but two slept often.

**Behavior/Activities.**—The majority of the activities in Center B were unigenerational, only involving adults. Most of those were adult level, including visits from community professionals, trivia games, walks, exercises, and van trips. On rare occasions, an activity or behavior seemed to be child oriented (e.g., a Teddy Bear’s Picnic), but the vast majority were age appropriate. Activities were deemed infantilizing at a rate of 24% in the first 40 hours of observation and 20% in the 20 hours from 2000 to 2001. Clients were given...
the option of participating in activities, and their wishes for nonparticipation were respected. Client sleeping was permitted without interruption. Strong friendships among clients were common, and many opportunities for private conversations existed. All interviewees in Center B perceived a choice in activities. For example:

Interviewer: When you are here, do you have a choice of activities or do you have to do what everyone else is doing?
Mr. P: No, no, we have a choice.
Interviewer: Do you ever feel bored with the activities in the center?
Mr. P: No, 'cause if I do I can read.

**Intergenerational Program.**—Staff L, a visiting movement therapist with an MSW, facilitated the more established intergenerational program in Center B, which included the entire clientele. The program was conducted on Thursdays for 1 hour, with the children attending for 30 minutes. The second program, facilitated by visiting musician Staff M, was newly established and intended for a smaller set of the clientele. On Tuesdays, Staff M chose eight clients to interact with children in the sunroom for a 30-minute music session. In each program, 3–9 preschool children age 3–5 years were introduced, accompanied by their teacher who assisted. The children came from a child day care center on the same gated grounds. The two centers shared a common outdoor area with a playground. Clients could walk around it on a track or see the children playing from inside.

We observed six intergenerational program sessions facilitated by Staff L. She treated clients age appropriately at all times, and provided extraordinary choices for participation. During the program, clients sat on the couches and chairs in the center of the main activity room with a few on the periphery, along the walls. Several of those seated along the edge moved in to participate more centrally when Staff L visited. As she arrived, she greeted each client individually, bending toward them and exchanging conversation with each one. Staff L engaged each client in personal dialogue, which was more in-depth than the normative surface level conversation observed between staff and clients. She began with 30 minutes of stretching, conversation, exercise, and singing with only the adult clients present. Close attention was paid to personal stories and accomplishments.

- **Staff L:** What music would you like to hear? Shine on Harvest Moon? Yellow Rose of Texas? Speaking of roses, whose are these? (She lifts up a vase with orange roses in them.)
- **Staff L:** Flowers from J’s garden!
- **Staff L:** (Walks over to Mr. J with the roses and discusses how beautiful they are. Then she moves around to each client, showing the roses.)

On another occasion, she began to talk about the history of the tango during the Great Depression. After describing some trivia about it, she asked if anyone else had a story on this topic.

Ms. D: My family was doing the Tango, so I got into it. (She does a few steps, Staff L joins her, others clap.)
Ms. D: My father was Argentinian.
**Staff L:** (Incorporates Ms. D’s description.) What dances do you like? Ms. D likes the Tango.

In another visit, Ms. N’s dance history was discussed.

- **Staff L:** Ms. N, I would like to go dancing with you! Where did you dance?
- **Ms. N:** Bars.
- **Staff L:** Ms. N used to compete.
- **Ms. N:** I have two trophies. (They discuss the dance she preferred.)

**Staff L:** Anyone else like dancing? Mr. C had his own band.

Staff L encouraged extraordinary client choice. She asked what music they wished to hear, songs they would like to sing, and which exercises they wanted to do. Individual variation was noticed during exercises, and the entire group was encouraged to follow one client’s lead. Clients regularly chose the program format and music through their actions and requests. During the group exercises and stretching, Staff L prepared the clients by discussing the plan for bringing the children in at 11:30. When the children came in, they sat in the center of the square of couches and chairs. Here is a typical example: The children entered and one child ran to Staff L and hugged her. They then formed a train and waved to the clapping children as they marched past. Next, clients were paired with a child to play with “scruffies,” where they tossed them back and forth. Some adults teased the children by hiding the scruffies. Staff L also paired them to move brightly colored 3-foot square scarves to music. She instructed the children to crawl under the scarves to “go goodnight” while “Good Night Irene” music played. The adults counted to three and chanted “wake up children!” On one occasion, two of the children covered a male client with a scarf. Ms. D tried to cover a child with the scarf, but the child covered her instead and they both laughed. One girl wrapped herself in the scarf like a wedding veil and moved around to each client.

In another observation, Staff L asked if everyone would like to use maracas. The whole group seemed in favor of the activity, and one child shouted, “I like the maracas!” She put on some Tex-Mex music, and the children passed out colorful maracas to each adult. Staff L encouraged dancing and exercises. She then told the children “go say hello to someone!” One little girl spontaneously went around the room to each client and gently tapped her maraca onto theirs. The clients seemed quite happy to be greeted individually. The children collected the maracas, and Staff L praised one girl who had a whole armful. The majority of clients were heavily engaged in the activities from their chairs, but several stood up and participated in the center of the room.

Clients seemed to really enjoy interacting with Staff L and the children. In the end of Staff L’s intergenerational program, the children and clients were asked to describe their favorite exercise. As the chil-
The clients were obviously aware of the basic nature of the questions directed at them and used sarcasm as a response. They were very cognitively aware, and some, like Mr. D, were highly educated, former professionals. Center B’s philosophy encouraged client choice in activities, and the option to leave was exercised by Mr. D on several occasions during Staff M’s program. At the first gathering, Mr. D sang with a strong voice and seemed to enjoy the children. Another time, as they learned the children would not be coming, he left. On two later occasions, the children came, but just as Staff M began to talk in a high-pitched tone, he left abruptly. One time on his way out, Staff M raised her eyebrows and asked (worried) “Are you staying with us?” and Mr. D said, “I’ve got to go. . . . How do you get out of here?” as he pushed the door. Another time when the children didn’t show up, Staff M spoke in a regular voice and Mr. D stayed, translated a German song, and sang actively.

**Adult Day Center E**

**Study Description.**—The observational research in Center E took place over 40 hours during 2 months in 2000. Seven nonimpaired clients were interviewed.
and family consents were easily obtained with assistance from the director.

Clients.—Center E also typically had 35–40 participants daily. The staff-client ratio was good, with often as many as eight staff members present. The clients were mostly older adults who varied in functional ability, with several who were mentally sharp and communicative. A few had mild-to-moderate levels of dementia, and two had severe cases. One of these clients wandered constantly, and the other was confined to a chair with a table restraint. The restrained client was rarely assisted to stand up or walk (only twice), and spent her time pulling out her dentures and manipulating the toys that were stuck to her table.

Environment.—This intergenerational center was recently created, moving older clients from an exclusively adult day center to another building that housed several child day care rooms. The adult room included a large area with chairs and a wall partition separating a dining area, with several long tables. The decor in the senior activity room included a large screen TV, comfortable chairs, recliners along the back wall, and large scale child-oriented decorations on the walls that often had a holiday theme (e.g., a giant leprechaun, Easter Bunny, Easter eggs, an umbrella, fish, decorated egg cartons, bees, 12-foot paper plate caterpillar).

Behavior/Activities.—Ninety activities were observed in Center E, with 50% containing age-inappropriate treatment of seniors. The vast majority of Center E’s activity format had one central mandatory activity, with all clients expected to do the same thing. Occasionally, the staff separated the older clients into two groups (always the same people) and required participation in an activity. This format did not provide autonomy or choice, and clients often appeared withdrawn. The activities were mandatory, with sleepers often woken up. One older male described the single activity and the requirement to participate:

INTERVIEWER: When here at the center, do you have a choice of different activities?
Mr. R: You do what they tell you to do. I don’t have a problem with that.
INTERVIEWER: Do you ever feel bored with the activities in the center?
Mr. R: I used to, but they jib jabbed me around instead of letting me do things myself.

Public disclosure of conditions was observed a few times in Center E, where client private information was announced out loud. For example, as a client was led to the restroom, the staff announced, “We are going to the potty.” When a woman requested decaffeinated tea, the staff explained “so that it won’t give you the runs.”

Clients in Center E were sometimes limited in their opportunities for client–client contact. For example, Mr. B and Ms. R enjoyed patting each other’s hands during an exercise. For no apparent reason, they were separated by Staff 1. At that point, Mr. B fell asleep and Ms. R ceased all participation. These client–client interactions may have been perceived by Staff 1 to interfere with the institutional goals of one uniform activity. This practice may have contributed to the relatively low levels of client interaction observed in Center E.

Intergenerational Program.—Intergenerational contact was very common by design in Center E, with children visiting the seniors twice per day for 30 minutes each time. The clients were introduced as “grandmas and grandpas,” perhaps to make the children more comfortable with the interaction. There were 13 intergenerational observations, with two formats: (a) pairing between a few older clients and children outside of the senior room and (b) group activities in the senior room. In the first option, the pairing of seniors and children sometimes involved toys, but older clients assisted children in play (e.g., flying kites, inspecting plastic insects). This activity format was observed three times and always provided adult roles for clients. The second, more common type of interaction, took place inside the senior room, with children sitting in the front center and adults segregated around the periphery. This interaction combined the staff members from both the child and adult sections, but without exception, the activity was conducted by children’s staff members. Eight of 10 of the group intergenerational activities were deemed child-oriented and quite inappropriate for seniors. One example included a guest visitor with a degree in early childhood education called “The Story Telling Lady.” She told a story about a “crazy old lady.” She emphasized each letter of the spelling “C-R-A-Z-Y!” At each pause in the story, the intergenerational group was expected to yell out “CRAZY!” The children all did this, but none of the older clients participated. In another case, the children’s Staff FD made cow puppets out of lunch bags:

STAFF 2: Ms. M, you can either sit down and do the activity to pass the time before your ride gets here, or you can hang out by the window and worry about your ride.
Ms. M: I will wait by the window and worry. (Standing near the window looking toward the parking lot.)
STAFF FD: Grandmas and Grandpas, do you want to make some cows? (In a baby talk voice. Two clients of 24 raise their hands. Ms. M tries to leave.) She’s acting like a kid when their parents are picking them up. Are you a grown kid?
Ms. M: Yes.

Other intergenerational examples further illustrate the lack of involvement among the seniors observed in Center E. During one activity, the children pretended to sleep on the floor as the music sped up and became louder. The children “woke up,” jumped around, while screaming, and it was repeated three times. Three of 24 adults showed an interest in this activity. Afterward, Staff MT said, “Aren’t the chil-
Another client reflected similar sentiments:

With the move to the new building, the older persons changed their environment and gained the intergenerational program. In the transfer, they went from a more diverse setting to one located mostly in one room. The previous building had rooms where clients could go to lie down and rest, but the new center did not. This environment difference was noted in two interviews. Both women commented on the frequency of child visits, overstimulation, disinterest in intergenerational activities, and the inability to physically separate from them:

Interviewer: Are there specific activities in the center you enjoy?
Mrs. G.: No. Not really. They are all too babyish. I don’t like that dropping a penny into your hand. I don’t like the games they play... because they are on a child’s level. I don’t appreciate that a bit... [Later] The activities are geared to small people, to children. I love the children; they are just darling. I think they overkill on it. I have five children of my own. I’m quite elderly, and I don’t appreciate the noise they make. But, I think they could do it once or every other day.... They bring the children in twice a day and that is too much, and there are many of us here that feel that way and have said something to me that this is a bit much. Children are noisy and I think we are beyond that stage. I’m 86 years old and I would like to have a little quiet. They have this game where they throw the ball up and it scream and scream jumping up and down. They’re Darling children, but some of the people don’t like it and they will mention it to me. Well, they try to get you to do the activities, but I’m one of those people that doesn’t cooperate all the time. Especially on those kids games, they just drive you nuts.... If they had a big card game going on, I would like that.

Interviewer: Which activities are least interesting to you?
Mrs. G.: I’m not very interested in any of them. I do like it when they play music and exercise. If it’s the baby stuff and they repeat it constantly, then I sleep. We used to have rooms where we had beds; now, all we have are these recliners, and as a rule, I get one.

Another client reflected similar sentiments:

Interviewer: Would you be interested in discussing your experiences with me today?
Ms. YW: Oh, I guess I would. I like to tell you I enjoyed coming here to the center before they changed and built this new center. We are involved with the children all the time; this cuts out activities that we can do. The children come in twice a day. You have to talk to them, and laugh and listen to their stories. It was very different when we were at the other building; it was better over there. This is a place for recuperating your health; they are so involved with our lives. Every morning and afternoon, we have a meeting with them. It’s only about 7 to 10 cute darling children. They are well trained, and they mind very well. It seems like I’m with them all the time... more than recuperating... from the two strokes I had.

Interviewer: Do you enjoy coming to the center? Ms. YW: Yes, very much. I did before they moved over here to this department.

Interviewer: So, you don’t like it as much now that they moved?
Ms. YW: No, because it involves all the little children instead of adult groups. [Later]... Somewhat it was much better when we were not as involved with the little ones. I felt we were more at ease. Oh, I shouldn’t be telling you this!... There are one or two like me that feel the time with them is interrupting what time we could use... [Later] I don’t want to give the impression I don’t like to be with the children... I do like to, but I do notice that when the children come in, I move back a little, to not get involved... but I haven’t felt good in a while and I want to keep every minute. Oh, I don’t know how to tell you... Once a day is enough. We are older and have been through this with our children and grandchildren, and this is kind of a place to come and relax, listening to music... [Later] I’m never bored, it seems that there is too much sometimes. I think I want to sit quietly, but they got something lined up for me to do. In that other building, they had rooms where you could go in the room, close the door, and have a little nap. Here, we have to stay awake all the time and do what they have planned all day long. Today is unusual, because I’m here with you.

These narratives reflect some common themes. First, both women described the adult–child interaction as too frequent. One even suggested that the intergenerational program interfered with her stroke recovery. Second, each woman indicated resentment of the full scheduling of their time with activities and suggested that they would like to have some quiet, unscheduled time. This was related to the third concern, the inability to escape the activities and noise associated with the children. Each woman longed for access to the private resting quarters available in the previous location. They reported an institutional expectation to participate in the central activity and the limited ability to separate from the children. The adaptations they used can be termed anticipatory withdrawal, with behaviors such as sleeping or moving to the back of the room as the children congregate in the front. Other clients also seemed to be withdrawn, as evidenced by the common “emotionless stare,” which involved nonsocial, nonproductive activity (Short-DeGraff & Diamond, 1996).

One day, the children did not come for a scheduled visit. Ms. YW yelled out, “Are the children coming today?” and the staff explained in a disappointed tone the reason why they would not be coming. The staff member seemed oblivious to the reason behind Ms. YW’s inquiry, because that client was discrete about her dissatisfaction with the children’s visits. The clients who complained in our interviews were never observed to discuss the problems openly with staff members, possibly because of fear of negative staff reactions.
In contrast to these women, there were a couple of clients in Center E who appeared to benefit greatly from the social interaction with children. One client seemed to thrive on the intergenerational contact and was regularly surrounded with children when the two generations met. Excerpts of her interview reflected this:

**Interviewer:** Do you enjoy coming here?
**Ms. Pl:** Very much.
**Interviewer:** Why?
**Ms. Pl:** Because I like the children... They let you know you’re still alive... I believe it helps us stay young. [Later]... The children seem to like me, and I can walk into the room and ask “who’s going to play ball with me today?” and six children will throw balls... That’s what I come for... It makes you feel like you’re a real grandma; [Later] I love the children, and if they don’t bring the kids, I’d just as soon stay home and I tell them so.

This client is quite child-interested and appeared to really enjoy the attention of the children. Her interaction in the center was one of choice, because she lived in a related assisted living facility and could stay there for activities or come to this center. Her contact with the children (e.g., suggestions to play ball) shows client initiative, rather than the typical staff-initiated cross-generation contact, with more passive client involvement.

There were speech and behavior patterns associated with the children’s presence in the center. Although most staff members in Center E adjusted their tone of voice differently for adults and children, there were a couple of the children’s staff members who used a uniform baby talk voice to converse with both generations. Further evidence of speech infantilization was observed when staff members used child-oriented reprimands toward the older clients in Center E. These took place even when children were not in the room. One staff member asked an older client, “Do you need to go to time out?” Staff also ordered clients to “be-have!” with labels such as “bad boy.” The opposite was also observed. When Mr. DU was given some candy, he asked, “What’s this for?” and Staff 4 stated, “That’s for being a good boy.” Other staff speech conveyed a “lesson” for older clients, such as the recreation therapist who said to an all-adult audience, “We are going in turns, you must wait your turn, everybody will get one. We are practicing turn taking today.” Speech patterns typically reserved for small children were used on clients, such as Staff 2’s, “We are going to the potty.”

Conceptual Model: Linkages Between Age Appropriateness and Social Participation

A major goal of the social model adult day center is to provide opportunities for social interaction and participation among clients. Programs that foster friendship formation would be considered successful in reaching these goals. Figure 1 illustrates a conceptual model explaining how social participation/ties among older clients may be influenced by a process that begins with infantilization versus age-appropriate activities, environments, and behaviors in centers that include an intergenerational program.

Adult day centers with unigenerational programs, as well as those that also offer additional intergenerational programs, as well as those that also offer additional intergenerational...
nential contact, may either be age appropriate for adult clients or infantilizing. By their nature, intergenerational programs may be more susceptible to child-oriented behavior toward clients, because children are involved and differential treatment of the two generations requires staff knowledge and effort. Our observations indicated that, if the intergenerational program was designed to facilitate choice, mutual interaction, adult status for clients, and mentoring, then it was age appropriate (as observed in Staff L's program in Center B). Other aspects of an age-appropriate center include adult decor, dignified speech, client autonomy, ability to have quiet time, and privacy regulation, which all help clients retain adult status. In our observations, age-appropriate activities, speech, behavior, and environments ultimately encouraged greater client–client interaction, which provided more opportunities for participants to form social ties (that were witnessed and reported in interviews).

In contrast, programs could inadvertently facilitate social and environmental infantilization of clients. In our observations, environmental infantilization took the form of child-oriented decor, a lack of diversity of settings, inability to regulate privacy, and lack of choice in the center environment. Center E's setting may have sent cues to staff and clients that led to age-inappropriate speech and behavior. Clients were surrounded by child-oriented decor and were sometimes treated as children in a “teacher–student,” lesson format. Older persons spoke only if they were addressed directly, and staff encouraged school-related tasks, reprimands, and childish labels. Activity infantilization included a requirement that clients participate in child-oriented games; play with toys; color with crayons; and listen to children's music, stories (e.g., CRAZY old lady story), and recollect only childhood memories—not adult accomplishments. Choice is a major component of adult activities, and Center E typically used a central mandatory activity format, with few options for alternatives or private conversations.

Speech/behavior infantilization was most often directed by staff toward clients. For example, when the staff in Center E reprimanded clients (e.g., “You are just being a brat,” “Do you need to go to time out?”), they gave them negative reputations, called them child-oriented nicknames (e.g., good boy, Honey Bunny), engaged in public disclosure of conditions, or forced them to wake up, it was considered speech/behavior infantilization.

In an intergenerational program, clients who experience infantilization in conjunction with the child contact may lose their adult self-identity as they are treated as status equals with the children. This loss of identity may lead to adaptation strategies similar to those described by Goffman (1961). Many of the clients in Center E were withdrawn, and two interviews reported planned or anticipatory withdrawal, which corresponded directly to the child visits. Conversion was evident in interviews when two men claimed to be “working” at Center E. These men never assisted the staff during our observations, and they were never encouraged to believe they were working there. Poor cognitive health status may explain this claim, but the men were not confused otherwise. Conversion may have provided a way to distance themselves from client status.

Challenge adaptation strategy is similar to Goffman’s “taking the intransigent line” and illustrated by an exchange in Center E's intergenerational program where one woman blurted out obscenities loudly. It was this behavior that resulted in her removal from the room with the children. Her actions may involve poor cognitive health status, with hostility a common symptom of dementia. However, some clients in good health consciously choose the challenge option, as noted in Ms. G's description of herself as “one of those people who doesn’t cooperate all the time.” This adaptation can have negative repercussions for clients.

Social interaction patterns are represented by staff–client, client–client, or low levels of contact with others. The observations here found the age-appropriate process was much more likely to lend itself to self-motivated client–client interactions. This pattern was observed to be most conducive to friendship formation among clients. Interaction in this process also included staff–client contact that was either client or staff initiated. In contrast, the infantilized process clients had fewer opportunities to interact with each other, which resulted in lower social contact levels among adults and a heavy reliance on staff–client interactions. These involved a staff-initiated question with an expected client response. In Center E, clients often did not respond at all to this form of interaction. The contact level was superficial, for the sake of interaction alone, perhaps as a strategy to pass time. In contrast, in Center B, Staff L expressed interest in each client's personal story. Clients felt comfortable initiating conversations with her, and she in turn would ask them 3–4 questions along the same line. This provided meaningful verbal interaction. In interviews, several of the clients remembered Staff L by name or description, when discussing the things they liked most about the center. So, the interaction between the “staff” and clients can allow for more lively adult-level contact, but typically does not.

Client–client interactions were rarely observed in settings where clients were infantilized, which may be related to the lack of privacy and permission needed to have a conversation. In addition, schedules that are packed with central mandatory activities do not allow the time or autonomy needed to develop strong ties. These patterns set the tone for staff-directed activity, rather than client-directed pursuits or private time. As observed in Center E, client–client interaction may actually be discouraged, similar to how children in a classroom would be prevented from talking to each other. Private conversations may be seen as a disruption of institutional goals, which include conducting a central activity where everyone pays attention. In Center E, Staff 2 said, “I need everyone to keep his or her eyes open so I can tell you are listening to me.”
Strength of ties in the centers was observed to be either weak, acquaintance level (small-talk), or strong (friendship). These bonds were related to the typical type of interaction that existed in the center. The age-appropriate process included autonomy, which provided client-client, and client-initiated contact required for strong ties and friendship formation among participants. In the infantilized process, the staff-initiated contact and full schedule of mandatory activities did not allow for friendship formation and often resulted in weak ties.

In the interview, clients were asked if they could name a specific center friend and whether they had in-depth conversations or mostly small talk. The vast majority in Center E could not identify anyone specifically that they considered a friend (not even a description of someone). Many times they would say, “I’m friends with them all,” “I talk to all of them,” or “Oh yeah, people are friendly;” but, when asked if they could name a specific person, they often said “no.” The exception was the two women who felt overstimulated by the children in Center E, who named each other as friends. That friendship may have developed as a result of their common physical condition or because they both purposefully disengaged from the activity with the children. Ms. G stated, “Most of it is just small talk, but Ms. YW and I converse on many things. I’m a fond friend and I just met her here.” This illustrates a buffer effect that allowed clients to maintain their adult status by interacting on an adult level with another client. In the case of Ms. YW and Ms. G, the friendship included sharing anticipatory withdrawal behaviors that separated them from the infantilizing intergenerational program. The vast majority of clients in Center E reported “mostly small talk.” In contrast, 71% of the clients interviewed in Center B could name a specific friend (some first and last names) and all of those described in-depth conversations.

Finally, the model includes poor health, which could manifest itself through withdrawal, agitation, conversion, or challenge behavioral symptoms. The result could inhibit social interaction and ties in adult day centers. There were clients in the centers observed who suffered from dementia, multiple sclerosis, stroke impairment, or other health problems. Despite age-appropriate settings and behavior, a person who suffers from cognitive or functional impairments may become withdrawn socially or act out in other ways that may mirror Goffman’s adaptation strategies. For example, in Center B, we interviewed Mr. W who suffered from severe multiple sclerosis, which influenced his ability to speak fluently. When asked if he had a close friend in the center he said “no,” and he reported very few conversations with others. On the other hand, he reported that he enjoyed the company of others and got along with everyone in the center. It is suggested here that his health impairment may have negatively influenced his ability to have in-depth conversations and form friendships in the center. In fact, we now know that he may have been in a terminal decline, because he died just 1 week after our interview.

Despite these examples, it should not be assumed that poor health will automatically cause isolation or withdrawal, because strong ties have been observed among demented participants with similar levels of impairment. In Center B, two moderately demented men had a strong friendship and spent each day together. They often discussed leaving the center, and one day they cooperatively left for more than an hour. Strong ties were also observed between dyads with one impaired and one nonimpaired client. So, the model shows a potential connection between poor health and withdrawal, but it does not always prevent friendship formation.

Discussion and Implications

The purpose of this research was to bridge the gap between theory and practice by describing the person–environment linkages related to social interaction in two intergenerational day care centers. Although the results are not intended to be generalizable, the descriptions provide insight into the dynamics of other adult day centers with similar programs (Ward, 1999). The goal of this comparative ethnographic study was to provide an in-depth, holistic understanding of the adult day center culture through observations of the natural environment. Whereas the influences of the intergenerational program cannot be completely separated from the other influences on the center culture, it is suggested that adding a program that combines adults and children has special challenges that should be acknowledged. Namely, clients should be provided with mentoring roles, adult status, and autonomy, and the two generations should not be treated as status equals.

The qualitative nature of these data provided a description of the complexities and nuances of contact among clients and between the generations, as well as an understanding of the importance of environments, staff orientations, institutional goals, procedures, and activities. In addition to the observations, the perspective of the insider was included through guided, open-ended client interviews. Through this method, we were able to determine that clients did not always appreciate the intergenerational contact, and they were aware of choices, privacy issues, and age-inappropriate treatment. A conceptual model was introduced, explaining two pathways (age appropriate vs. infantilized) observed to influence interaction and relationship formation among clients.

The age-appropriate process described in the conceptual model included adult environments, activities, and speech/below toward clients. In addition, it encouraged the retention of adult identity, autonomy, privacy regulation, client–client interaction, and the development of acquaintance level or strong friendship ties. The general culture of Center B most often fit this description, with frequent independent activities in nonstructured groups or client dyads. Interviews provided further evidence of friendship bonds, because most clients could name a specific friend in the center and they often described in-depth conver-
sations with others. This is evidence of the development of meaningful reciprocal relationships, which are an important component of good quality of life in aging services (Kane, 2001). Staff L’s intergenerational program in Center B complemented the age-appropriate center by providing clients with weekly child contact and the option to participate or not. Clients typically assisted children with movement exercises and songs, rather than having the child-oriented activities directed at them as they were in the other intergenerational programs observed. Staff L’s program encouraged feedback, which empowered clients to shape the nature of the adult–child contact and provided maintenance of adult status.

The infantilization process subjected older clients to child-oriented environments, activities, and behaviors. That process was observed to be systemic in Center E. The child-oriented decor in the adult room was somewhat acceptable, because there were children in the center and the clients could interpret the decor as intended for the youngsters. However, it is argued here that the age-inappropriate setting could send strong cues to the staff, who may then infantilize clients by adopting a “teacher–student” format, or directing reprimands and punishments to clients. The central mandatory activity format provided few opportunities to socialize privately. Solitude was also limited because mandatory activities encouraged participation when clients might prefer to rest, sleep, or daydream. Client interviews repeatedly suggested a desire for an “escape option,” where they could leave the activities (children), lie down, and rest in a private space. Staff-initiated interaction dominated, which curtailed client–client contact and led to weak or acquaintance level ties. Further evidence existed in interviews where many were unable to name a friend in the center and most reported engaging only in surface-level “small talk.” The treatment of children and clients as status equals was the most obvious problem with the intergenerational format in Center E (and Staff M’s program in Center B). Occasional infantilization observed in Center B was related to individual staff member comments or reprimands, but did not seem to be systemic.

Two women in Center E served as buffering agents for each other from the negative effects of infantilization. When the children visited the senior room, both women exhibited anticipatory withdrawal adaptations, where Ms. G slept and Ms. YW moved next to her in the back of the room. By segregating themselves, they provided the privacy and opportunity needed to converse with one another, facilitating the maintenance of adult self-identity. They were the only two of seven people interviewed at Center E who could name a client friend; they described their conversations as in-depth, not small talk. Ms. YW explained that “Ms. G has turned into a very sweet companion and friendship. We can talk together and discuss things.” When asked if she talked to other clients, Ms. G stated, “Yes, Ms. YW, the artist, and we talk a lot of art and she tells me what she has done in the past. . . . She would write stories for the [news]-paper and she wrote a song book. . . . She is very lovely.” Ms. G readily admits that she is “one of those people that doesn’t cooperate all the time.” If these two women had conformed to the rules of their partial institution (i.e., participating in central mandatory activity with children as status equals), they might have suffered from low levels of interaction and weak ties. Other clients had no buffer mechanism in place, and seemed to have few conversations or friendships. Clients subjected to infantilization were often aware of it, which was evident during observations and in the interviews cited earlier. Infantilization awareness can be present, even when a client appears to be enjoying him or herself. Ms. G and Ms. YW described their resentment in our interview, but never presented complaints to the staff. Complaining may be considered a social risk, especially if the staff are the source of infantilization.

Do we want to provide a service where older clients go just to pass time and their caregivers get a break, or should the quality of life be improved by the service? Kane (2001) recently argued the latter and stated that relationships are essential to a good quality of life in care services. It is not sufficient to simply direct behaviors and activities toward clients in aging services. Instead, services should provide enriching experiences that would encourage social participation and friendship formation. Even when clients are cognitively impaired, they are entitled to be treated as adults, provided with meaningful activities, and opportunities to interact. It is impossible for us to know exactly what can and cannot be perceived by these individuals. Kane (2001) argued that those with cognitive impairment may be able to perceive indignities. One woman she interviewed could not coherently answer most of the questions asked, but when asked if her dignity was being respected she said, “That’s just the problem here, they treat us as though we are children!” (Kane, 2001, p. 298). Being subjected to infantilization directly compromises an older person’s dignity and is never appropriate or beneficial. Instead, efforts could be focused on reorganizing caregiving philosophies, behaviors, activities, and environments in aging services to help maintain clients’ adult status. Disabled persons of all ages have mounted a social movement for more dignified treatment (Kane, 2001). The emerging trend recognizes service users as consumers, entitled to quality assurance and services that provide dignity, privacy, and adult-level interaction.

Intergenerational programs in aging services and adult day centers can have very positive benefits for both generations. Although we found some infantilizing environments, activities, and behaviors, the programs studied here can be considered beneficial overall. Both intergenerational and unigenerational programs should be evaluated to ensure that adults are treated age appropriately, and, if they are not, then modifications can be easily implemented. Methods of incorporation should allow for productive roles, choice in participation, and retention of adult status for older persons. The remedy for infantilization in the intergenerational program includes conscious differentia-
tion between adults and children, which could be easily achieved with staff education and training.

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