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The Dark Side:Stigma in purpose-built senior environments

G Hrybyk, **RL Rubinstein**, **K Eckert**, **AC Frankowski**, **L Keimig**, **M Nemec**, **A Peeples**, **E Roth**, and **PJ Doyle**

Abstract

This paper focuses on stigma in collective living environments for older adults, specifically multi-level campuses. We contrast two design profiles, a purpose-built campus which opened in 1997, and an older setting that grew by accretion over decades. Purpose-built housing is used as originally intended, designed, and constructed; housing built by accretion has been modified over time to meet changing needs and uses. The separation by care levels in both sites is reflected in their cultures as residents and staff relate to physical levels of care through a vocabulary of fear and stigma. Residents of the independent living building on the purpose-built campus refer to the assisted living building, accessed only through a second floor link, as “the other side” or “the dark side.” In this setting we observe stigma assigned to a *place* in the built environment. By contrast, in the older setting built by accretion over the last century, levels of care feature a less-structured clustering of independent living and assisted living, and common areas were shared by residents from multiple care levels. We have observed less stigma *associated with levels of care* in this older building. Grounding our analysis in data drawn from ongoing ethnographic research, we focus on the built environment as it relates to stigma in the social environment. The paper concludes with a discussion of the importance and pervasiveness of stigma in senior environments.

Introduction

Over the past two decades, the US has seen growth in the number and complexity of housing settings for the elderly. These are mostly purpose-built, that is, designed and built to address the social and health needs in housing for older adults. While some buildings are constructed to provide housing for residents needing one particular level of care, many are built as multi-level campuses, such as continuing care retirement communities (CCRCs) that offer a continuum of care with independent living (IL), assisted living (AL), and skilled nursing care. Purpose-built long-term care (LTC) settings are generally designed and used as intended with few additions or substantial changes to the built environment. These more recent housing options stand in direct contrast to older LTC settings to which different proprietors have made changes over time. Often constructed for purposes other than elder care, these traditional settings have been modified with sections added, renovated, or demolished. Thus housing built by accretion has been transformed, sometimes several times, to accommodate changing needs and meet current trends. This paper will compare two

Address correspondence to Gina Hrybyk, Department of Sociology/Anthropology, University of Maryland, Baltimore County, 1000 Hilltop Circle, Baltimore, MD 21250, USA. regina3@umbc.edu.

settings – one purpose-built (The Riverside) and one built by accretion (Stonemont) – and examine the presence and evolution of social stigma in these environments.

We provide a brief introduction to the built environment and stigma in senior housing, present an overview of our field research and methodology, compare and contrast stigma in two multi-level LTC campuses, and finally discuss the significance of this topic and its implications for the quality of life for residents in senior housing. This paper seeks to address the question of how emotions, social categorizations, and other personal and social meanings get attached to physical space within LTC settings. We believe the question must be more thoroughly investigated in studies of housing for the elderly.

The Built Environment in Age-Based Housing

Housing for older adults experienced rapid changes over the last twenty years as assisted living culture morphed into various interpretations of “aging in place.” The social model of assisted living, a change from the medical model of nursing homes, was reinforced both by the types of structures and the arrangement of the buildings designed and built as collective living settings (Carder, 2002). Facilities that had been nursing homes were retrofitted to accommodate apartment-style living with added amenities such as assistance with meals and laundry. The market demand for smaller living spaces combined with opportunities to mingle with age peers drove the development of purpose-built senior housing in the suburban landscape. In CCRCs the benefit of “aging in place” added to the life-style allure. Older adults and their families expected that a move to one of these settings would be the last move, as the setting would provide for their changing needs (Eckert, Carder, Morgan, Frankowski, & Roth, 2009).

Moving into age-based housing is often precipitated by the fear of changes in physical or mental health conditions, be they actual or anticipated. Additionally, changes in health status that require higher levels of care may lead to moves *within* a multi-level facility. These moves within a facility can be seen as representing a degree of loss of control. As one needs more assistance to meet daily needs, one becomes more dependent on others. Family members may be conflicted about moves that are evidence of age-related changes. Both fear and the desire to avoid a higher care level complicate the social dynamics in multi-level settings (Nakashima, Chapin, MacMillan, & Zimmerman, 2004).

Stigma and the Built Enviroment

Stigma may be defined as the assignment of negative worth and social distancing on the basis of group or individual characteristics. Groups of people or individuals may distance themselves from other groups or individuals based on some negative attribute or social worth, real or perceived (Goffman, 1963; Crocker, Major, & Steele, 1998).

Major and O'Brien (2005) noted, “Stigma is relationship- and context-specific; it does not reside in the person but in a social context” (p. 395). In theory, stigma may be mitigated in senior living settings because other residents are experiencing similar age-related changes. However, in some settings, especially those with a mix of both higher and lower functioning individuals, stigmatizing behavior may be exacerbated as residents and staff monitor

physical or mental declines that mark a person as “going downhill” and may prompt a move to a higher level of care. The genesis of such stigma is found in both the fears stemming from a dreaded and assumed inevitability of decline and in the ease with which we characterize other people as different.

The key to stigma is seeing others as different from oneself; that is, the key is found in the social process of *othering*. We *other* people out of fear, be it fear of *those people* or fear of what we ourselves might become, a form of *self-othering*. Labeling others or characterizing them in some way is part of general social life and as such it is brought into the senior environment by residents, family, and staff. Labeling others as different from oneself is a critical component of stigmatizing behavior. In his 1963 book, *Outsiders*, Becker suggests that we have little control on how we are labeled, but that the power and status of the *labeler* and the *one who is labeled* define social grouping.

Rubinstein (1998) describes how objects and places in the physical environment derive “meaning by the culture into which they are meaningfully embedded” (p.91). We propose that within the two senior housing settings presented here, stigma can be assigned to a specific place. This stigma is reflected in the social context of relationships between and among residents and staff. As a consequence the place itself, along with the people living there, is devalued and to be avoided. Our analytical focus here is how the purpose-built environment of The Riverside and the environment of a century-old structure, Stonemont, influence social grouping and the process of *othering*. We discuss the stigmatizing behavior that exists in two multi-level settings for insight into our over-arching question: How does social meaning such as stigma become attached to a particular space?

The Study upon which this Paper is Based

This paper derives from ethnographic data collected over the course of a five-year study *Stigma and the Cultural Context of Residential Settings*. Names and identifying details of places and people throughout the paper have been changed to preserve anonymity. The central focus of this ethnographic project is to examine the existence and nature of stigma in the larger context of social relations in seven diverse senior housing settings representing a range of living options, e.g., multi-level CCRCs, age-restricted housing developments, and various combinations of IL, AL, and licensed nursing. While for this paper we have chosen to focus our discussion of stigma and the built environment on two of the seven sites, we draw on insights developed in the other settings in which we have worked.

The research team for this project included several PIs, analytic staff, and the five field ethnographers who are co-authors of this paper. In-depth participant observation and ethnographic interviews with residents, staff, and family members presented a grounded view of the social environment. Teams of two or three ethnographers spent an average of six months in each site, sharing with the entire team detailed observations through extensive fieldnotes and exact transcripts of research interviews. Field updates and in-depth case presentation in bi-weekly meetings took place throughout the duration of the study. The team discussions led to a continuous and reflexive examination of the material. Documents were analyzed thematically using codes which emerged from team discussions of transcripts

and fieldnotes. To date we have completed fieldwork in five of the seven sites. Our data include 273 interviews and 376 fieldnotes. For the purposes of this paper 87 transcribed interviews and 141 fieldnotes from the two sites were analyzed. Using the qualitative program Atlas.ti, sections of text labeled with codes *physical setting, belonging or not belonging,* and *exclusion/inclusion* were pulled from the 228 documents. Discussions relating stigma to the built environment at team meetings directed the development of this analysis.

While the general findings of the larger study are complex and beyond the scope of this present paper, germane here is that we did discover stigma and related identity issues, such as self-isolation, in all of the settings in which we have worked. The nature, type, and extent of the stigma varied widely both between and within sites. Many issues related to stigma were contextual and local and thus not generalizable to other settings. We found stigma attached to particular units, especially units for cognitively impaired persons, at several of our research sites. However, even though this finding was consistent across the settings, there were local variations of this unit-specific stigma.

This paper details the local articulations of environmental stigma in two settings. In The Riverside (a modern, purpose-built, multi-level campus) stigma was attached to the assisted living building that included a locked unit designed to house cognitively impaired persons. At Stonemont (built by accretion over time) stigma toward residents in assisted living and cognitively impaired residents, although present, was not as strongly attached to a particular unit in the same manner as it was in The Riverside.

Again, the study aims were to examine and explore the social dynamics of stigma as it operates in multi-level senior living environments. Our ethnographic research methods presented an insider's view of the people who live and work in The Riverside and Stonemont. Through excerpts from fieldnotes and in-depth interviews, we will hear from residents, family members, and staff in both the AL and the IL buildings at The Riverside. Following this, we will similarly examine Stonemont, an affinity-based LTC community. We refer to affinity-based housing as collective living environments where residence is based on a cultural kinship of religious or fraternal spirit. We will explain the culture of the affinity group and explore how shared experiences over the life course may mitigate some of the troubling effects of a move to a collective living setting. We will describe the built environment as we experienced it during our fieldwork, and hear Stonemont residents, staff, and family members describe the social environment in this rambling and often confusing maze of additions and wings.

The cultures of these particular settings appear to be influenced by the physical environment. By contrasting these two sites we hope to show how higher functioning residents, staff, and family members in the purpose-built setting ascribe stigma to the place, as well as to the residents, in assisted living. Additionally, we note how the shared spaces and activities at the setting built by accretion encourage interactions between residents of varying care levels. We assert that any discussion that juxtaposes the built environment with the social environment must be reflexive in nature in that the culture and social dynamics of a place reflect its physical structure and *vice versa*. Stigma can be subtle and require one to

look and listen deeply, or stigma can be overt and so embedded in the place as to evoke a distancing of independent residents from what is jokingly referred to as “the dark side” of assisted living. Using what we have learned at The Riverside and Stonemont we examine the impact of the built environment on social grouping.

Stigma at the Riverside

> “She'll say to me if she loses something or she can't remember something that she knows she should, she'll say, ‘Joan, my memory is getting so bad I don't know what they're going to do with me, but please don't put me away. Please don't put me on that other side.’ … And I mean my mother was adamant that she was not going; ‘I'm not even walking through there. Those people are crazy.’ And I'm like, how do you know? …That's where the hair salon is and I wanted her to get a perm and I finally did. But she kept telling me, no, she wasn't going over; she absolutely would not go over there.”
>
> -- Daughter of an independent resident in The Riverside.

The Riverside's website describes how the founders looked to nostalgic inns and picturesque homes for inspiration to express their senior housing vision. They successfully created a large-scale residential community that incorporates visual cues to an era when the residents were younger. The cultural meaning of Victorian porches and themed gathering places may speak of home – or at least a posh hotel – but seem to confer a somewhat contrived effect to the setting. The tree-shaded walks and quaint common areas appear to mitigate the reality for residents wherein the social and physical manifestations of levels of care reflect their fears of increased dependence.

The campus consists of two buildings connected by a second floor link. Seldom will IL residents venture to visit former friends who have made the transition across the link to AL, and few AL residents visit former neighbors on the IL side. One ethnographer described the stigma she observed:

> “We have learned that despite the attractive link, IL residents remain in their building and noticeably stigmatize assisted living. Many residents refer to AL as ‘over there’ and ‘the dark side.’ IL residents form cliques who sit in common areas and evaluate residents on their side, often speaking loudly, as to who should be ‘over there.’ Residents are labeled for negative traits, such as memory loss, personality disorders, obesity, body odor, and repeating stories. Residents then tell staff who should move to AL. In fact, to these IL residents, all of assisted living is somewhat suspect. The only practical use for the link for independent residents is to provide an inside passage to the hair salon in AL and then back home.”

This facility purports a social model of assisted living care. Services are provided to help older adults adjust to age-related losses, both physical and cognitive. The Riverside assisted living includes a locked Dementia Care Unit (DCU), and we have observed stigmatizing behavior, including labeling and avoidance, aimed at the DCU by the AL and IL residents. However, the most salient stigmatizing discourse that was documented at this site was directed by the residents of the IL toward the AL building and its residents. An excerpt from

an interview with an IL resident demonstrated the stigma attached to the loss of cognitive ability and aimed at AL:

> Respondent: Well, we have an older resident that's really now, is really getting more forgetful. She's been here a while, so they seem to think she'll be going on the other side, but I hope she doesn't because she likes it on this side.
>
> Ethnographer: Now “the other side” - I keep hearing that a lot, that's the Assisted Living.
>
> Respondent: Right.

Another IL resident feels that the AL residents are very different from “them” (IL) because “they” (AL) are “managed by health care workers.” In an interview with an upper-level administrator, the ethnographer probed about residents who make recommendations as to who should be moved to AL. The administrator confirmed that the IL residents will advise the staff, “‘They have to go over to the other side.’ [or] ‘You really might want to look at THAT one.’ You know, and you're thinking, ‘Um-hm, and you're not long behind them.’” Later she continues, “It's fear, it's loss of control… sometimes you have to look at that fear.” A former IL resident now in AL characterized IL as the place “where everybody has their sense.” At another point in the conversation she called IL “the better part.” Still she says “I'm very contented here [in AL] and very lucky.”

The staff at The Riverside was aware of the tendency towards stigmatization and has made attempts to mitigate it. There is no lock on the link between IL and AL, and the doors at both ends are kept open. A few IL residents come over to AL for the morning exercise program, and AL residents will occasionally attend the Bingo games in IL because, as an IL resident explained, “They prefer our method better. We play for money. They play for a bag of popcorn or some such thing.” While there are some shared activities, each care level at The Riverside has a separate activities calendar.

Another IL resident recognized the cultural disconnect, “In a community like this, where you've got the three divisions - residential, assisted and [DCU] communities; that puts up some barriers right away. We don't see that much of people from the other two communities.” An administrator described the culture of stigma, “Over the years it has not changed as far as the stigma of assisted living. The independent living residents do not want to go to assisted living as a general rule. One of the hardest things in our community really is to get people to transition from one area to the next. It's very challenging.”

The Riverside's locked DCU is located in one part of the AL building. Residents who live in other parts of the AL building stigmatize the DCU. Again the phenomenon of *othering* and the desire to distance oneself from devalued housemates were documented by the ethnographers:

> “Staff was in the process of wheeling in residents. One woman placed near the opening of the circle periodically screamed a piercing ‘Help me!’ Ms. Harmon, in a stage whisper, commented that she does that a lot and felt that this woman should be placed in the area [the DCU] for people like that…. She felt this resident had no business living in AL with them.”

The examples above are selected from many interviews and fieldnotes that reiterate the same theme, attributing a spoiled identity to both the building that houses AL and the DCU and to those who live on “the dark side.” With these examples, we see how in collective living segregated by care levels, social meaning may become attached to a particular space.

Stonemont and the Effect of Affinity Based-Housing on Stigma

Stonemont, built by accretion over time, has a dated institutional appearance with various additions, some in matching granite, and some in mismatched yellow brick. Originally a private estate, Stonemont was purchased by an affinity group in the 1920's who renovated and added to the existing mansion to create a home for elderly, indigent members of the group and their widows. Presently “safe and affordable living” in this community is offered to eligible members and their families. Eligibility is determined by membership in the regional affinity group or kinship to a member, with twenty eligible kinship relationships identified. There are three wings, built or renovated at various times and connected by glassed-in breezeways and a maze of interior hallways. While there are no locked areas, certain units have security alarms that are activated when people exit without entering a pass code.

Stonemont today houses people at three levels of care, IL, AL, and a higher needs AL. There are several places where residents of different levels mix in common areas, informally or for shared planned activities. Such places can be thought of as social ecotones defined by Doyle, de Medeiros, and Saunders (2011) as “a tension and transition area between two or more adjacent social environments.” They suggested that these ecotones could “create a bridge” between social groups and “expand social connectedness” (p.9).

During one of the renovations at Stonemont, independent apartments with full kitchens and private assisted living rooms were retrofitted into two wings that had existed as dormitory-style units with rows of beds. The large dining hall on the second floor serves as a link between the two wings and is shared by AL and IL, although IL residents tend to come for the evening meal only. On the AL side of the dining hall, is a sitting area where residents wait to enter the dining room prior to meals. Adjacent to the dining room is a grand hall used for meetings and family gatherings. Another shared space is a large lounge on the first floor where regular, facility-wide Bingo games are held. All of these places serve as social ecotones where it is possible for residents from IL and AL to interact.

The most recent addition to Stonemont is a three-floor wing that includes a terrace level AL and two upper floors for residents who need more extensive care than can be provided in the AL wing. The upper floors also provide temporary rooms for independent and assisted living residents recuperating from hospitalization. This most recent wing appears more like a medical unit than the rest of the campus as an ethnographer describes:

> “The design of the health care unit appears to be from the 1980s with central nurses' stations, wide corridors, and glass walkways connecting back to the historic building. On both floors one and two, I detected strong odors where residents were gathered at the nurses' station. These residents appeared to be among the most

> impaired, cognitively and physically, at [Stonement]. Few people seemed to be in their rooms, and nearly all of the doors were open."

An excerpt from a fieldnote shows how another ethnographer explained the lack of clear boundaries between the care levels at Stonemont:

> "I'm beginning to understand the fuzziness between the terrace level of AL and health care [on the two upper floors of the most recent wing.] It appears as though those in the terrace level of AL want to participate and align more with the AL-IL folks. It makes sense since many of them…were residents there before they moved to the terrace. …When I asked [the activity director] if the terrace was included in the AL-IL calendar, she indicated by her protracted answer that it was an association that she didn't think worked but said, 'They like to be included.'"

In an interview with an IL resident, the fluidity of movement at Stonemont is discussed, as follows:

> Ethnographer: Is there much visiting back and forth do you notice…between the different levels? Like if your neighbor, if someone you know moves, do people go back and forth to visit.
>
> Respondent: Yeah, because there's no problem to go downstairs. Like a real good friend of ours in Assisted Living had to go down on the terrace, which is like the lowest level of Assisted Living, … and we've been down to visit her. Of course, she can't wait to get back to her own room.
>
> Ethnographer: So there's a chance that … people move back.
>
> Respondent: Back and forth. Well, if they have a real bad spell or a fall or something that sets them back then … they used to put them right in health care, but now they try to put them on the terrace, which is the in-between.

While care levels are housed in different areas of the building, there is no locked DCU, though memory of what was once a locked DCU persists. Several years ago, one of the floors of the most recent wing was a locked dementia floor and this floor continues to be negatively regarded. One administrator referred to it as "the ghetto," noting how "nobody wants to go there." Residents who were aware of its history did not want to be placed there and staff continued to make generalizations about residents who lived on that floor. The floor appears to retain this negative cachet from the time it was a locked DCU, despite the fact that residents of varying cognitive abilities are mixed together on both the upper floors of the wing. There seems to be *residual stigma* ascribed to this floor because of its past as a locked DCU.

Stigma was attached to other areas in the medical care unit. Many residents preferred to sit near the central nurses' stations. These areas were referred to by some higher functioning residents as the "sleeping zone." A resident who had come from the independent apartments but was now living in this unit because of mobility issues said, "I call this thing out here 'Death Valley.' The [staff] don't like to hear me call it that but that's what it is." (Roth & Eckert, 2011) Similar to The Riverside's "dark side", Stonemont's "Death Valley" demonstrates the stigma people can and do attach to a place. Yet, we note that the built

environment at Stonemont appears to lessen the power of stigma as it is attached to place. While the nature of stigma in this site built by accretion appears to be less focused on a particular place than in The Riverside, a purpose-built environment, socio-cultural factors may work to mitigate *othering* and must be considered in any discussion of stigma.

Stonemont is embedded within an affinity community where the culture of mutual support encourages relationships among the generations. Clearly, for purposes of anonymity, we cannot disclose the specific affinity group here. Residents who share affiliation with the affinity group share values and experiences passed along within families. These values may also be shared with people who have been indirectly associated with the group through kinship with a member. Membership confers a strong sense of belonging as the director of Stonemont tells us, "You needed to have that early on to make you who you are today and [if you didn't belong,] you don't have an understanding of that because you weren't involved."

Stonemont is adjacent to the headquarters of the affinity organization that, for nearly a century, has hosted events for affinity clubs from around the region. Local clubs associated with the group regularly visit the home. Families attend these traditional events and volunteer their time with Bingo and other activities, even though they may not be related to residents. Many of the residents we met visited Stonemont throughout their lives. This association over the life course influences many of the people who choose to live in the home and may serve to mute any tendency to *other* co-residents.

During interviews several residents mentioned that they came to the home as children or young adults to visit the elders living there. A daughter of a resident told us how her father "had been going there for years because they had events up there. … So we went there." An ethnographer noted that "Mrs. James jumped right in to tell me how she and her husband had selected [Stonemont]. Her father was a [member of the group] and her sister had moved in about three years before they did. She knew the place well before she and her husband decided to move there."

Residents who share a common culture and intergenerational contact with the home may have formed a bond that lessens or diffuses the stigma we have seen at more recently built sites that lack the longevity and cultural connectivity of Stonemont. But not all residents have a strong association with the affinity group. Because various kin of members are eligible, some residents are not themselves members of the affinity group and may be excluded and shunned. One of the administrators explained the social dynamic:

> "For those individuals that it was the brother's wife's niece is the tie to this person coming in, being admitted, there is a barrier there with some residents, especially with the men… where they are reluctant to [include outsiders] – not that they wouldn't talk to them, but they aren't going to include them [because they] don't know what it's all about."

While it appears that stigma exists at Stonemont, we suggest it is stronger in the form of attachment to an individual, rather than to a specific space. In one case, a resident was shunned for his lack of membership in the affinity group. The director told us about Stanley,

whose son was a high-ranking member, but who himself had never joined. Stanley was from a different part of the country and had a distinct regional accent. At Stonemont, Stanley became stigmatized by others. Several residents and staff commented on Stanley's differences from the other men. A resident shared his disapproval of Stanley's behavior noting, “Everybody knows Stanley and what he does,” referring here to his flirtation with some of the women. It appears that Stanley has internalized this stigma, as evidenced by his apparent low self-esteem. He would not agree to a recorded interview. In fieldnotes, an ethnographer described one of her interactions with him:

> “I encountered Stanley by the door, in his usual seat…I again asked him for an interview and he said once again, ‘Why do you want to interview me?’ And I again answered, ‘Because I value your perspective and experiences.’ ‘I'm not worth it,’ he said several times and followed this up with a very plain statement about his being ‘a bum’ …He seemed really sad and small this morning.”

Not only did Stanley not belong to the affinity group but he also did not follow its fixed gender roles and social norms. Instead of socializing primarily with men, Stanley flirted with women. The staff was aware of the situation. The Executive Director explained in her interview how his behavior is inappropriate:

> “And he has some behaviors that are not always appropriate. So there have been complaints because he is not [a member of the affinity group] he doesn't understand how he is supposed to behave…Many of them tie it back to being [a member]… they aren't going to include them because …you're not [a member] and you don't know what it's all about.”

The stigma attached to Stanley as “the other” was so great that the men who once sat with him in the dining room all left his table one by one. They said they had nothing in common with him. Stanley's case shows how, in this affinity-based setting, individual differences can lead to stigmatizing behavior.

Contrasts Between Two Sites

Although residents at Stonemont are grouped by care levels, the barriers to interaction between residents are not as evident as at The Riverside. Unlike the single link that connects the buildings at The Riverside, there are multiple intersections between care levels at Stonemont. These intersections reduce physical separations between residents of varying care levels. We suggest that the presence of shared spaces, or social ecotones, may diffuse stigmatizing behavior.

Whether driven by the way the spaces are designed or by social factors, for example corporate policy, Stonemont appears to be more socially integrated than The Riverside. The medical unit at Stonemont has its own activities calendar, but IL and AL, including AL in the terrace of the new wing, share a calendar. At The Riverside there are three separate calendars for the three care levels, IL, AL, and the DCU.

The stigma observed at Stonemont seemed more directed at individuals rather than a particular place. There were social cliques and exclusionary behavior, as we have found in

most of the settings we have studied, but these did not seem to have the focus on *place* that was observed in The Riverside (Dobbs, et al. 2008).

Conclusions:Stigma in Housing for the Elderly and its Implications

In *Environment and Aging Theory*, M. Powell Lawton (1998) stated that, “What has been referred to as ‘external stimulation’ has a more direct and immediate association with the environment than do the ‘internal’ aspects'” (p. 17). The external situation of increasing levels of care and dependence as manifested in the built environment is internalized in the anticipated loss of control that threatens the imagined future self. Fear and avoidance of *that place* and *those people* may become embedded in the culture of the setting.

There are many factors that can mitigate or aggravate stigma. Each setting we have studied has unique issues associated with collective living. Senior housing communities, by definition, group people who are experiencing or anticipating age-related loss of physical and/or cognitive abilities. Most residents expect to age-in place, that is, die in the setting. Many residents share cohort memories and values of past times. Why, then, is there a profound and disturbing distancing from housemates who exhibit signs of decline?

When The Riverside was built, its founders envisioned a lovely setting where older adults could transition smoothly from one care level to the next. But in its second decade, the fear and avoidance of the AL building by IL residents negatively influences perceptions of residents who live in Al, and this fear prohibits social interactions. Friends who move from IL to AL are often forgotten: they have moved on. The belief that the move into The Riverside's independent apartment would be the last move, from the perspective of the resident, has been proven false. A move to the “dark side”, though still on the same campus, is possible and often traumatic.

Stonemont may not be as efficient as The Riverside, with its warren of hallways and mixed levels of care, however the interaction that is promoted by the prevalence of social ecotones in shared spaces and shared activities appears to diffuse the stigma that is associated with age-related decline. Stigma does exist at Stonemont, but it appears to be more focused on individuals, particularly among the men, than on physically identified care levels, with the exception of the residual stigma attached to one floor of the health care wing and the “sleeping zones” near the nurses stations. The social ecotones at Stonemont blend IL and AL in ways that cannot happen at The Riverside. Further study is needed to understand how social ecotones in the built environment may promote relationships between groups that would not otherwise interact and in turn, mitigate stigma.

In all the sites in which we have conducted fieldwork for the larger study, we have observed instances when stigmatizing behavior appeared to negatively impact the health of residents. We have seen residents hide evidence of falls, and family members go to great lengths to delay a loved-one's move to higher care levels. We have heard many voices in every site we've studied describe the hurtful effects of exclusion and shunning. This paper described the stigmatizing behavior we observed in two unique sites and how the culture of the places reflects the built environment; how meaning can be attached to physical space.

As we prepare for the increasing number of older adults over the coming years, it is important to consider what we have learned about purpose-built senior housing and how space frames culture and culture reflects space. Understanding how stigma manifests in various physical environments may lead to changes that improve the lives of current and future residents in collective living settings.

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