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Research Article

# Identity, Semiotics, and Use of Symbols in Adult Day Services

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## Abstract

**Purpose:** This article explores experiences of older adults attending an Adult Day Service (ADS) center. We focus on semiotics, which is ADS clients' use of symbols to communicate with others and to assert their personal and social identities. We refer to the ADS as a semiosphere—a term that refers to the dense, symbolically mediated interactions among this community.

**Methods:** Ethnographers observed and interviewed clients, family, and staff members at the religiously affiliated ADS. They focused on the daily life worlds of those who attended and worked there.

**Results:** We identified three elements through which clients expressed and communicated in semiotic ways, aspects of their identity: (a) music and dance, (b) individual use of a symbol—a doll and, (c) symbolic organization of space through seating patterns at activity tables. Elements were created and shared communally.

**Discussion:** The ADS, as a cultural entity, is itself an illustration of symbolic complexity. Ideologies about aging, dementia, identity, and the ADS' role in improving elders' cognition and health are structured into the setting, forming a semiosphere. Our study revealed that elders, with staff members' help, created a cultural world at the ADS.

**Keywords:** Adult day care, Culture, Dementia, Semiosphere

In this article, we explore experiences of clients attending an Adult Day Service (ADS). We depict the ADS as a *semiosphere*—which refers to the dense, symbolically mediated interactions that occur within a community and is similar to the idea of a *local culture* (Geertz, 1973, 2000). We highlight semiotics in the ADS—how symbols communicate emotion, information, and identity.

The emphasis of ADS research has centered on respite for caregivers (Abramson, 2009; Gaugler & Zarit, 2001). Our focus is on persons who attend ADS, many of whom have diminished cognitive and expressive capacities. We examine aspects of clients' personal and social identities that they create and manage, how they communicate facets of identity that are meaningful to them, and how they, as individuals and a group, co-create the ADS community. Thus, we attempt to understand the content of meanings that are expressed among individuals within the ADS setting.

We explore the relation of clients' identities to their communication through symbols. This theoretical paper asserts that a culture exists in the ADS prior to clients' attendance. It is replete with (a) social thought about age, aging, and dementia, (b) a model of the aging person and, (c) the social construction of aging and dementia. By viewing the ADS as a semiosphere and as clients' communication as semiotics, we explore how clients participate in this construction (Chiu & Windsor, 2015).

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We first examine literature relating to ADS in general, to the notion of personal Identity, social identity, semiotics, and symbolism. We discuss methods used in our research, and present findings through case examples. Finally, we offer a discussion and an implication of our findings.

## ADS in National Perspective

The ADS, as an outgrowth of forms of care for impaired and infirm persons, represent alternatives to traditional nursing home care. ADS settings are community-based and offer a range of services to seniors and younger adults with disabilities. Services include formal activities, health monitoring, meals, socialization, and assistance with ADLs. Data from the National Study of Long-Term Care Providers show that almost one-third of ADS attendees have Alzheimer's disease and related dementias and about one-quarter have developmental disabilities (Dwyer, Harris-Kojetin, & Valverde, 2014). Nationally, about 20% of ADS centers are dementia-specific and approximately 90% are non-profit.

Caregivers, as major stakeholders in the continuation of ADS, are the major focus for ADS research. Thus, the reasons persons enroll in an ADS include: (a) to give respite to responsible family members; (b) to improve client's socialization, and (c) as a preventive measure—the supervised environment theoretically lowers the potential for clients' accidents and hospital admissions (Graverholt, Forsetlund, & Jamtvedt, 2014). Medical monitoring is important to family caregivers of attendees.

Less research has investigated the effect of the ADS on the client, particularly in a socio-cultural context (Abramson, 2009). Significant to understanding how clients interpret the meaning of an ADS for their well-being, is to acknowledge the ADS as a local and national cultural object. Its formation in the past three decades relates to changes in family structure and to the social construction of aging, dementia, impairment, and the stigmatization of these concepts (Doyle & Rubinstein, 2014).

## Personal Identity in the ADS

Generally, persons draw on evidence from the past to maintain distinctive features of a continuing identity over time (Brandstadter & Greave, 1994). Central to a continuing identity is the ability to link personal attributes and past experiences to the present through a biographical construction or life narrative (Reissman, 2001), no matter how truncated or muddled due to memory dysfunction. This linkage also occurs through social interaction and by viewing oneself through others' eyes. Initially, clients attending an ADS may be seen by others (family, staff members, other clients) as persons defined by physical or mental limitations and therefore diminished in social stature (Bergami & Bagozzi, 2000). The ADS may reify such aspects of personal identity and lead to assumptions that the common trait among individuals (some level of impairment) defines the collective. This conjecture reflects stigmatization and "othering" of clients, signaling a general image of older adults as impaired (Doyle & Rubinstein, 2014).

Clients' sense of themselves can be identified through their conversations, interactions, and non-linguistic symbols. In general, people build a culturalized self-concept from available representations they perceive as meaningful. A client in an ADS may perceive herself as a "worker" (as she once was) who enters and exits the facility at the same time each weekday, carries out routine activities, and has "breaks" for lunch and snacks. An additional identity may be imposed by staff members and assumed by clients—that of *patient* who "needs help" to visit a restroom, has her finger pricked to check sugar levels, and is given "physical therapy." Another identity may be that of student, which is usually imposed by administration and staff members to maintain client order, control and safety, and encourage participation in activities.

In the ADS, the constancy of clients' identities may be challenged by dementia, loss of long-term roles, and changes in ADS clientele and staff. Memory dysfunction may disrupt a long-held perception of a continuous self; social rules about how persons interact may be blurred. Yet, personal identity may be re-created or renewed by individuals having "purpose" through daily activities and interactions in a specifically defined setting (Hughes, 2001). It is others' view of an individual that submits crucial information about her identity. The cultural environment shapes the community and each member's identity within that setting. The setting becomes a semiotic community or a semiosphere.

## Social Identity in the ADS

A social identity denotes a sense of belonging to a particular group. The group shares an identity based on communal experiences (Bergami & Bagozzi, 2000). In the ADS, social identity centers on people attending together, revealing their "selves," local meanings, and desire for relationship. A social identity among ADS attendees is formed within daily give and take in activities, interaction, and social deportment, and may reflect how clients have internalized the mission and rules of the ADS.

In context of the broad society outside the ADS, clients may be described as stigmatized persons with impairments. Visitors might see clients with fissured social identities due to assuming that aspects of personhood, such as memory or social graces, are missing (Miesen, 2010); others might perceive impaired social identity as whole, authentic, and enduring (Clare, Rowlands, & Quin, 2008). Although some clients may be incapable of engaging in sense-making dialogue, they may recall an appropriate greeting, social nicety, metaphor or cliché. Cognitively impaired attendees, when recounting the past, no matter how fractured their story, can highlight a significant emotion, incident, time period or person (Ruthirakuhan et al., 2012). The story may be valuable, albeit truncated, and replete with narrative power.

Family members, staff members, other clients, activities, socialization, use of symbols, and a host of factors within the ADS culture become means to enhance personal *and* social identity in the present moment.

### Semiotics and Symbolism

Semiotics can be defined as the study of symbolism and meaning (Chandler, 2002; Singer, 1984; Wiley, 1994). Symbols, including language, are tools that through representation make human interaction possible. For example, a semiotic approach to AD focuses on the communicative abilities of persons and the means by which abilities can be maintained and even improved. We acknowledge the work of Harre, Sabat, and colleagues who grasped a semiotic view of dementia (Harre, 1991, 1994; Sabat, 2005; Sabat, Fath, Moghaddam, & Harre, 1999.

In recent years, the term *semiosphere* has been introduced. Hoffmeyer (1996: vii) defines semiosphere as a domain that "incorporates all forms of communication." Symbols are understood as infinitely extendable in social life, with the potential to create new forms of meaning and interpretation (Parmentier, 2014).

Many ADS clients have diminished language ability but are able to communicate through use of non-linguistic symbols. Anthropology has paid special attention to the role of non-linguistic symbols in cultural life (Geertz, 1973, 2000), and to the role of interpreting symbols as a component of their expression. The use of symbols bridges a variety of concepts, points to shared understandings, and expresses meaning (Livingston, 1989). Symbols form a conduit between subjectivity and the larger world of communal life.

In the ADS, symbols identify a complex relationship among words and images and that to which they refer. They transfer ideas among various experiential domains. Symbolic action may point to more than one referent or to a referent that holds several layers of meaning. A song or dance, for example, is a set of symbols that can elicit memories of the past or a time period of joy or hardship, and speaks to symbolic complexity (Chavin, 2002).

Clients have an important stake in co-creating, with family, administration, staff members, and each other, the cultural structure of the ADS. Observing clients' social interactions shows many forms and unique combinations of symbols that occur in this semiosphere. Interpreting and analyzing ADS' cultural symbols aids in understanding what is being "said" and how persons with lessened capacities construct symbols. Here, we view symbols not as outcomes of daily life to be measured, but as expressed meanings of an activity, of interaction, and of attending an ADS. Here, where some participants are unable to fully use cognitive or linguistic capabilities, symbolic expression assumes a meaning that is more than the sum of its parts.

## Research Design and Methods

The first setting we visited was Holy Family (all proper names used are pseudonyms), a religiously based ADS in which we conducted research in an ongoing project. The methodological approach we used was qualitative (ethnographic). The goal of this method is to understand personal and cultural meaning and experience. It generally centers on individuals' meanings and systems of understandings, the ways in which people interpret their lives, and the cultural and institutional contexts in which meanings develop. This method proceeds from the axiom that humans create their worlds of meaning and interpret the world around them. This method is descriptive and can be considered hypothesis generating. Our perspective is social constructionism which is the study's overall theoretical approach.

### Data Collection

After meeting Holy Family's director, administrative staff, and program assistants (who work most closely with clients in terms of activities, meal service, assistance with bathroom visits, or boarding ADS van) four ethnographers observed everyday life in Holy Family and conducted interviews with stakeholders. We noted clients' interactions with each other and clients' and staff members' reflexive relationships; each group's words prompted responses from the other. We also interacted with clients and staff members, depending on his or her ability and desire to relate with us. We hoped to learn how each client interpreted her experience in the ADS.

Ethnographers (who were also interviewers) spent a minimum of 2-h periods at Holy Family for an average of four times a week from September, 2014 until August, 2015. One to two ethnographers were on site at least 4 days of every week for the study's duration at Holy Family. Initially, the major task of each ethnographer was participant observation (Keith, 1986) and participating in the daily routine. We were invited to sit in on staff meetings and activity programs. When permitted by the Director, ethnographers participated as informal workers.

After becoming familiar to clients, we began conducting formal recorded interviews. We approached administration, staff members, clients, and clients' key family members to request interview participation. Staff members suggested which clients would have the ability to engage in an interview dialogue. All clients, staff members, and family members who were willing to be interviewed were included in our study.

A major tool of the study was the interview guide (one each for clients, staff members, and family members; the guide used for staff members was tailored to the position at Holy Family), which maintained consistency in data collection. Interview schedules were constructed by research project members and consisted of demographic information and semi-structured and open-ended questions. The interview was a one-time, formal interview that lasted from one-half hour to an hour (or more). The time of the interview was planned in advance at the respondent's convenience. Consent was given by each respondent and recorded

at the interview's start. Our foci were: (a) the meaning of being part of ADS community; (b) interpreting its medical requirements, socialization techniques, and activity programs and, (c) the effect of participation in the ADS community on clients', clients' family members, and ADS employees.

Data were entered into a computer text-base (Atlas.ti). Data included: notes from participant observation; informal conversations with clients and staff members, case studies, team meeting notes (meetings occurred bi-monthly), and transcripts of formal ethnographic interviews for analysis and empirical exploration.

### Data Analysis

Data were examined in ongoing team meetings and throughout and after the period of data collection. During analysis, we operated from a general set of guiding questions, such as: What did clients, staff members, and family members reveal about their experiences at Holy Family? Answers to this question led to a first sort on the largest level of categorization. Broad-level categories were agreed upon through review of ethnographers' field notes and memos and consensus in team discussion during bi-monthly meetings. Meetings reviewed previous weeks' field work and isolated critical questions or issues that arose. New observations or interpretations were explored in future weeks' fieldwork, subjected to validity checks, and used as key topical areas in back-checking materials (Feldman, 1995). Throughout the study we developed a detailed analysis of field materials. The data we present were derived from identifying three uses of symbolic expressions of identity at Holy Family, described below.

## Findings

Holy Family operated under the auspices of a local religious organization. Mass and Bible study were offered once weekly, religious or spiritual counseling and the Sacrament of Reconciliation were available upon request. Prayer was part of the morning ritual. Although religion as doctrine or dogma was not part of daily programming, Holy Family promoted an ethical standard of behavior that filtered into the daily routine. Clients were encouraged to be kind to each other and an environment of courtesy and respect was supported.

Along with medical diagnoses entered into clients' records, each client appeared to have social status within Holy Family that administration, staff, family, and clients co-created and continued to construct day by day. The status was built upon a functional model of the person, i.e., what each client could "do" and how she fit into the existing culture seemed predictive of competence and wellbeing within the ADS. Thus, high function, defined by engagement in activities and compliance with rules, informed social status within the ADS.

Clients attending Holy Family revealed symbolic expressions of personal and social identity. In general, they can be characterized as: (a) clients' perceptions of Holy Family and why they believed they attend; (b) their participation in Holy Family's collectively constructed culture and, (c) their sense of themselves and others in the ADS setting. Other symbolic expressions included: (d) behavior of staff members toward clients as individuals and members of the community and, (e) the organizational structure of Holy Family. A critical component in understanding clients' identities was to examine the communications we witnessed and described in field notes or interpreted through interviews and interaction.

We identified three elements (among others) that clients used to semiotically express meaning and aspects of identity. The first was expression through music and dance. The second occurred in an individual identity symbol which was the use of a doll by a client, Ms. Johnson, to express herself so that others were able to communicate with and about her. The third was the overall symbolic organization of space and social identity through seating patterns at activity tables. The decision to focus on these three symbolic elements emerged from the data because they were integral to Holy Family's activities, socialization, and monitoring of clients. The symbols were significant in interactions among clients, staff members, volunteers, and visitors to Holy Family. Each symbol: (a) was recognized by the Holy Family community; (b) underscored an aspect of personal and social identity among clients and, (c) revealed clients' participation in *creating* the culture of Holy Family. The utilization of symbols occurred within: (a) the programming of activities; (b) the uniqueness of each client's and staff member's personal and social identity at Holy Family and, (c) the facility's physical space.

#### Music and Dance

Music was a staple in the main room at Holy Family, where clients sat at round tables for individual and group activities, exercise, and meals. Musical styles such as Contemporary Rhythm and Blues, Motown Oldies, and popular classics were heard when clients worked on coloring, puzzles, or games. When music "with a beat" was played, some clients swayed their bodies or tapped their feet. Those who were able rose from the table and danced.

One morning, after opening prayer, pledge of allegiance, and patriotic song, Florence, a senior program assistant, announced Mr. Daniels' birthday. He is an African-American man described in Holy Family's client log as having Down syndrome, and one of the youngest clients in attendance. After everyone sang Happy Birthday, Mr. Daniels hugged Florence who turned on bass-heavy music, adding, "Show everyone your birthday dance!" Mr. Daniels danced between the room's round tables and moved head, hips and feet rhythmically. Ms. Conklin, a 67-year-old European-American woman described in the client log as having mild dementia, danced with Mr. Daniels to the

room's applause. Florence invited Ms. Wilson, an 80-year-old African-American woman with advanced dementia, to dance. Ms. Wilson reached for Florence's outstretched hands and smiled as they danced together. Mr. Patel, a 75-year-old Indian-American man who described himself as depressed, and whose wife also attends Holy Family, smiled and rolled his hips as others clapped. Staff assistants brought seated clients forward to dance. When the music ended, dancers were led back to their seats.

On another day, after Mr. Hartley, the 78-year-old European-American birthday celebrant, "danced as enthusiastically as his limitations [from diabetes] allowed, he began to sing along with a song being played," an ethnographer observed. "At one point a program assistant made a fist and pretended it was a microphone, put it in front of him and encouraged him to continue singing. He did, until the song ended. Everyone seemed to enjoy his performance." This moment brought administration, staff, and clients together as members of a community.

A part-time social worker described the meaning, for her, when she witnessed clients dance.

> At one point they [clients] were all getting up and dancing together and it was so wonderful. [It] was a special moment because you could see the connection—and the joy—just having pleasure in the moment. It was beautiful…they are able to connect. It was like you are not just receiving care from Holy Family; you're with your peers and you're experiencing life together in a meaningful way.

She particularly recalled Bernice Johnson, a 67-year-old African-American client with advanced dementia.

> There's a lot of dignity and beauty…with Ms. Johnson. She's a wonderful dancer. To watch her moving to the music is beautiful. And I feel like [they] are giving [something] to us. My Dad had Alzheimer's, so I think of him [at these times]. As he faded from who he was, there was still his humanity and…his gentleness and giving nature.

Observing Ms. Johnson, the social worker recalled that her father's long-standing personality traits continued throughout his dementia. She recognized that if some of Ms. Johnson's personal traits faded through dementia, other traits, such as her bodily identity and communication with others, continued through dance.

Holy Family invited local performers, such as Duane, to entertain clients. One client described Duane as: "Michael Jackson, aka Duane." An ethnographer described Duane's performance.

> His moves were physical and sexually suggestive. He sang and danced to individual female clients; many danced in their chairs. One man kept time by tapping his cane. When Duane [sang] to Ms. Newman she attempted to dance in her wheelchair. When he [sang to] Ms Brown, she insisted on standing up to dance. Sabrina (program assistant) helped her stand and supported her back while Duane held her and danced.

Clients also communicated, through movement of their bodies and singing lyrics to songs, the agelessness of sensuality and sexuality. One ethnographer described a phenomenon that occurred when music with evocative lyrics or rhythms was played. She said the room became "very attentive" when clients heard the song "At Last," sung by Etta James.

Mr. Lucky, another entertainer who performed at Holy Family, sang Elvis Presley songs and emulated his movements. An ethnographer spoke about the routine's effect on clients.

> The energy in the room changed when Mr. Lucky sang. Clients that responded became animated with gestures like clapping, tapping their feet, or dancing. Ms. Brown lifted her right hand and moved it to the music. She tapped her right foot on the footrest of her wheelchair. Mr. Lucky walked over, knelt down, and sang to her. She uttered sounds that, to me, expressed joy. It was the most animated I've seen her.

Dance, music, and song generated symbolic communication on several levels. They connected clients with each other, with staff members, and with themselves. The remembrance of "oldies" music and dances popular in the 1960s seemed imprinted in their bodies. Clients seemed to show who they had been when songs were first heard or danced to, and who they remain.

We turn from symbols of dance, music, and song, which clients shared, to the use of an individual identity symbol—a doll. Although the doll was personally meaningful to one client, we posit the doll is one symbol among many used in the ADS to affirm personal identity and foster clients' engagement and interaction.

### Individual Identity Symbol, the Doll

Bernice Johnson, mentioned previously, had attended Holy Family for the past year. The client log described her as having dementia. Holy Family's director gave her opinion of Ms. Johnson:

> She would probably be in the last stages of dementia if I were able to diagnose her. She doesn't really know where she is. She doesn't know the time of day, but she responds to her name being called. In terms of activities, there's not many she participates in because her attention span is short. She likes to dance and responds well to music.

An ethnographer described Ms. Johnson as, "soft-spoken and very friendly" and observed her cradling a baby doll as she paced the main room of Holy Family. She smiled when clients, staff members, and visitors spoke to her. She nodded during attempts at conversation, which diverted her from darting toward the facility's exit. A program

assistant reported, "Somebody gave her [the doll] thinking it would soothe her." Although no one remembered when the doll was introduced to Ms. Johnson, all agreed "it worked."

Staff members and clients also communicated through the doll. Because Ms. Johnson often tried to exit the ADS, clients watched and reported her movements. Mr. Hartley, a 78-year-old European-American man described as diabetic, said that Ms. Johnson disrobed the doll earlier in the day to bathe it. A program assistant brought out a bucket of water. He commented, "She's not hurting anybody." Perhaps because Mr. Hartley felt he was "in on" staff intervention with the doll, he mirrored their reaction. Ms. Porter, a 75-year-old African-American woman who used a walker and cane, agreed. "She dresses and undresses that baby all day long. But it's okay. It keeps her busy." An ethnographer approached Ms. Johnson and asked if she "enjoyed spending time with her baby." Ms Johnson rubbed her stomach and said clearly, "I'm working on it. When I get out the hospital, I will definitely give you a call." These words highlighted a theme in her discourse; she often referred to pregnancy or being hospitalized to give birth.

The relationship between Ms. Johnson and the doll hinted at a desired identity, possibly as mother or caregiver (Miesen, 1993). She constructed this relationship within the boundaries of her dementia and the structure of Holy Family. With help from staff members, *she* created a complex association between memories, needs, and emotions through a system of signification, which included how she and others in the ADS communicated through her care of the doll.

From the symbolism of the doll, we turn to the arrangement of Holy Family's symbolic "living space"—the main room where activities, interaction, and dining took place.

**Organization of Space and Clients' Social Identities**

Clients spent most of the day at the eight round tables placed in the main room of Holy Family. They were the focal point of the ADS due to Holy Family's physical layout. Because daily activity occurred in one large room, the significance of who sat at what table and what occurred there seemed magnified.

Table 8 had "regulars," whose awareness and engagement symbolized the table's identity. Table 8 was called: "The Welcome-Wagon table" because prospective clients sat there when visiting, the "in table" or "popular table" because clients who enjoyed interaction preferred to sit there, if seats were available. Mr. Patel offered another sobriquet. "This is the active table," he reported. Clients at Table 8 made suggestions for future activities and usually attended off-campus field trips to stores and restaurants. Ms. Conklin, a regular at Table 8, was thought by an ethnographer to be "a volunteer because she directed the conversation" at this table. Ms. Conklin recounted her recent move to the assisted living facility adjacent to Holy Family.

> I told them I wouldn't stay in the AL during the day because all they (residents) do is sit around and look at each other. All my friends are over here.

In naming her tablemates "friends," Ms. Conklin showed that a primary benefit of Holy Family was the maintenance of identity through socialization. An aspect of her friendship with Ms. Paulson, a 72-year-old European-American woman who was described in the client log as having dementia, was self-disclosure. One morning she and Ms. Conklin discussed the implications of dementia. Ms. Conklin remarked that alcoholism caused her dementia. "My doctor recommended I keep a journal so I can refer to it for what I forget." Ms. Paulson nodded her understanding and replied:

> I have Alzheimer's. My memory is getting worse. My parents lived long lives and never lost their memories. It's no fun getting Alzheimer's. Because I know my memory is going, being here is a blessing. Everyone is nice here. At this table we laugh a lot.

Ms. Conklin agreed. "When you're laughing, you're present in the moment." Both women shared awareness of their dementia. Although Ms. Conklin acknowledged that alcoholism was its cause, Ms. Paulson could think of no reason for her dementia. Ms. Conklin recognized the timelessness of the "present moment." Although she reported that at first she found Holy Family's activities "juvenile," she carved out a role for herself as "knitting teacher," which refuted the "juvenile" label. She reported that "Holy Family keeps me active. It kept me from being a loner which is the worst thing."

An identity that was sometimes imposed by staff members but not always accepted by clients was that of child or student. During activities, clients took directions that were school-modeled. All knew what a program assistant meant when she said, "Put on your thinking caps." With hand motions, clients mimed the program assistant by "fitting" hats on their heads and tying bows under their chins. Although clients followed these instructions, they also resisted "child-like" questions. For example, a local performer began his show the day after Halloween by asking clients if they had gone "trick or treating." One client, Ms. Mayer, a 72-year-old European American woman with spinal stenosis who used a walker, spoke up. "I ain't no little girl. We don't go trick-or-treating."

Table 3 was dubbed the "men's table" by clients. Men who attended Holy Family had various impairments, from dementia to depression to Down syndrome, they often sat together and had inconsistent interactions. At times no one spoke. At other times, the men enjoyed an easy rapport, joking about "ages, girlfriends, and what they had for dinner the night before." Mr. Patel, mentioned earlier, rather than sit at the "men's table," preferred Table 8. After realizing he was the only male who signed up for a "cooking course" offered at Holy Family, he declared, "All the men here are lazy."

When asked about "table regulars," a program assistant reported that people "sit wherever there's a seat available." But when Ms. Porter, who sat at Table 5, was asked if she selected her table, she replied, "No, when I came here they put me there [Table 5]." Ms. Foster, an 81-year-old African-American woman diagnosed with diabetes, hypertension, and used a walker, sat at Table 7. She had chosen her seat carefully:

> I like that spot. The way I'm sitting I see the whole room. I tried sitting someplace else. I didn't like it. The table on the side, I didn't like. I couldn't see the whole room. Then if you sit in the table in front of me, you can't see the people in back of you. So I like where I'm sitting. That's my spot.

The seat Ms. Foster chose offered a scan of the entire room and its occupants. This particular "spot" was known as "Hattie's" and became part of her personal and social identity.

## Discussion

Our article focused on the experiences of clients who attended Holy Family. We explored their use of symbols, such as dance, music, song, a doll, and seating choice to express facets of their identities. In Holy Family, clients' use of symbols was consistent with: (a) finding meaning in present circumstances through the use of partial memories or past roles and identities (Klein, Cosmides, & Costabile, 2003); (b) demonstrating aspects of personal competence, whether through recalling words to a song, dancing, or performing an activity well; and, (c) viewing others as inter-connected through co-membership in a created cultural community. Symbols strengthened clients' identity and self-worth. Despite disability, the body both responded to inscribed memories (Black, 2010; Black, Schwartz, Caruso, & Hannum, 2008) and acted as an anchor and repository for new information. Music may be the call that stirs emotion and movement and increase cognitive abilities by eliciting word recollection. Through music, a client may symbolically return to the self she perceives herself to be or the self she remembers (Braden & Gaspar, 2015; MacKinlay, 2012) that persists into the present.

Holy Family clients' symbolic identity expressions may have represented core self images by calling up past activities and traits. Ms. Johnson's identity symbol was the doll she was given by staff members and carried through the facility. The doll, as an instrumental symbol, brought meaningful roles and needs from the past into the present, and helped her integrate thoughts and emotions into a symbolic self-view as mother or caregiver. This is similar to Ms. Conklin who viewed knitting in a symbolic way in the ADS. Ms Conklin elevated her long-term skill into a current activity and "non-juvenile" role as knitting teacher (Klein et al., 2003). These symbolic expressions increased the level of interpersonal engagement for Ms. Johnson, Ms. Conklin and other clients and staff members at Holy Family (Braden & Gaspar, 2015; Lin & Lewis, 2015).

Social identities, such as inclusion at a particular table, revealed a hierarchy that occurred as persons distinguished themselves by their capabilities (or lack). Where a person sat (or was placed by staff members) further refined their social identities. The risk at Holy Family was that staff persons might impose an identity on clients to maintain control. An example of this was that most Holy Family clients were required to raise their hands and wait to be escorted to the bathroom by a Program Assistant. Applying this childlike identity disclosed that a goal of the ADS centered on order and client safety (Clare et al., 2008). The imposed and assumed identity of tables at Holy Family provided another layer of symbolic complexity to clients' personal and social significations.

Research has shown that clients co-create the cultural structure of the ADS by forming a community with one another and with staff. Despite disability and impairment, clients forged relationships and developed new roles in the ADS. They expressed key aspects of who they were *and* are (Clare et al., 2008; Kitwood, 1997). While participating in a co-created community, clients revealed a persistent identity. This often was supported by staff members' acknowledgement of each client as an individual and part of the community (Lin & Lewis, 2015).

We acknowledge the ADS as a cultural object of our present day (Giddens, 1990). Just as clients in Holy Family possessed complex symbolic expressions, we viewed the ADS as co-constructing symbolic complexity. Various ideologies about age and aging, dementia, personhood and identity, gender, time, health care, and the role of environment in improving elders' cognitive or physical health were structured into the setting and rendered it as saturated with signification, a true semiosphere. Because all who work or attend the ADS take part in perpetuating or constructing its culture, the ADS may both promote and restrict the imagination of its clients. In the best case scenario, older adults' growth, and development, in whatever stage their cognitive decline, would be prioritized, which requires individualizing and tailoring client activities. This is unlikely when issues of aging and persons who work with the aged and infirm, particularly frontline workers, are not considered the highest social priority in terms of remuneration.

Our study revealed it was elders themselves, often with the best intentions of caring staff members, who created a cultural world at Holy Family. If authenticity, as Biggs (1999, 2005) suggested, exists where "the interior life finds expression through the social sphere," then the person in the ADS is authentic as she resides on the site of the struggle of competing ideologies. In the semiotic realm of the ADS, symbols and representations are important tools used to engage in the struggle against being stereotyped or negated.

## Conclusion

Although the trend among ADS centers is to increase health services to attendees, there is also a shift away from the medical model of the ADS toward a holistic view of clients (NASDA, 2017). Our work represents an interpretive view of the ADS as a cultural setting.

We attempted to broaden the scope of gerontological inquiry to include knowledge of the cultural structure of the ADS and its foundation of meanings, revealed through symbols. The levels of interaction and expression, within and between selves and across lines of status (worker and attendee), time, and identity, render the ADS a complex and meaningful sociocultural setting. It is the work of cultural gerontology to scrutinize how aging and impairment are culturally and socially constructed within the varied contexts of the ADS. The rich language of symbols in the ADS sustains clients' ability to communicate their unique identities through powerful, sharable significations.

Those who seek to interpret elders' array of symbols can learn from the unique vantage of front line workers in communities such as the ADS. One direct care aide said of his engagement with Alzheimer patients: "Once I reach their level, I discover their personal best" (Black & Rubinstein, 2007). Engaging with persons "one on one where they are" (p.S6) meant interpreting the language of a client's body, moods, and various symbols she employed to relay meaning about herself and communicate it to others.

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