

THE EXPERIENCES OF THE CENTRAL TEXAS ELDERLY  
AND ANIMAL-ASSISTED INTERVENTIONS IN  
ASSISTED-LIVING FACILITIES  
VIA MEDICALIZATION

by

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## **I. INTRODUCTION**

Medicalization is defined as a “process in which personal and social problems and behaviors have come to be viewed as diseases or medical problems that the medical and allied health professionals have a mandate to ‘treat’” (Kaufman 1994, 45-46).

Medicalization is enacted on many diverse populations within the United States, but not much has been written in regards to elderly persons living in assisted-living facilities.

This thesis considers this topic. Drawing primarily on interviews with elderly residents of four assisted-living facilities in central Texas, it considers how these individuals experience the medicalization associated with aging. It further considers how, through Animal-Assisted Intervention (AAI), the residents are offered a means to resist the process of control inherent to medicalization and regain a sense of self.

### **Medicalization**

Medicalization is a socio-cultural concept that creates illnesses and diseases out of normal processes or social problems. A distinct example of medicalization is childbirth. Medicalization has changed childbirth from a normal process of the human body into a highly medicalized procedure. The procedure requires an immense amount of biomedical care (ultrasounds, blood tests, amniocentesis. etc.) from specialized doctors (obstetricians) and the birthing process is advocated by these doctors to take place in a sterile hospital room. The medicalization of childbirth has resulted in constricting an expectant mother's ability to make her own decisions on how she wants to handle her pre-natal care. This includes things such as agreeing to amniocentesis or not and deciding whether to give birth at home or in a hospital setting (Hadjigeorgiou Eleni et al. 2012; Rapp 1998). Additionally, this puts the pressure of being the "gatekeepers" of life on expectant mothers; navigating moral boundaries such as pregnancy termination if the unborn child has Down's Syndrome and limits their control over their own pregnancy (Rapp 1998, 68).

Other examples of medicalization include when social issues, like obesity, fibromyalgia and aging, are co-opted by the medical establishment and thereafter reconstituted as medical problems to be fixed by medical treatments. This may lead to constructive



results, as is the case of fibromyalgia, which resulted in the condition being recognized as a medical disease. The process involved a grass-roots movement to bring recognition to a previously untestable and hence “invisible” experience of constant, chronic pain.

Through internet blogs, chat forums, the publication of self-help books and the formation of a virtual community of sufferers, this movement brought attention to the condition, which ultimately resulted in it being classified as a diagnosable disease, which in turn led to the development of biomedical treatments and pharmaceuticals. Having their symptoms recognized as a disease, termed fibromyalgia, also relieved the sufferers from the stigma they had faced when trying explain a condition they had no medical proof for, which often resulted in their experiences being discounted by medical practitioners as well as family, friends and others (Barker 2002).

Medicalization can also have the opposite effect. It can obscure the underlying social causes of some conditions, thus preventing them from being addressed. Obesity in the US, for example, has recently become a medicalized condition. It is now something that falls under the purview of biomedical practitioners in terms of diagnoses (BMI measurements and body fat assessments for example) and treatment (for instance weight loss drugs, bariatric surgery, and so on). This medicalization of obesity is controversial, however, because by categorizing obesity as a disease, the socio-economic factors, which are often the underlying cause of obesity, are completely overlooked (Moffat 2010).

The concept of medicalization was developed in the 1970s through the ideas and research of Michel Foucault and Ivan Illich; in fact Illich was the first to use the term "medicalization" in 1976 (Illich 1976). Their research focused on how modern medical institutions and advancing medical technologies started to shift the focus of health. According to Conrad (2007), in the last forty years health in the US has increasingly been viewed through a biomedical lens which focuses primarily on biomedical markers of diagnostics. The consequence of this is an increasingly obscured view of patient experiences as well as the underlying social causes of health issues. In other words, doctors and medical institutions started to have the ultimate say in the definition and treatment of "diseases." This shift in perspective or power from individuals to the biomedical industry has only continued to grow as technologies increasingly become

more advanced, and as these advancements are constantly introduced to the public through TV and internet advertisements and other popular media outlets.

Of course medicalization is intimately intertwined with biomedicine. Biomedicine is a form of medical treatment that focuses primarily on pathology and physiological reactions within the body (Hahn 1995). Biomedicine provides the dominant health discourse within the US and forms the basis of medical infrastructure for treatment and diagnostics of disease as well. It is heavily based in science and is less considerate of social or cultural influences (Sargent 1996).

In light of this last point, anthropologists have suggested that biomedical physicians, in general, often hold the ideology that the person is just a body's "occupant" (Hahn 1995,141), and as a result, an individual's experience of a disease or another biological event like a heart attack is not as important as the disease/biological event itself. This perspective is important because it minimizes the experiences of the "patient," ultimately removing the human element from treatment. In this way, biomedicine leaves little room for any other explanations of why diseases exist, sometimes overlooks the experience of sicknesses, and consequently limits options for healing approaches.

### **Medicalization and the Elderly in the US**

In the case of the elderly (defined in this instance and in accordance with the US Census Bureau as anyone aged 65 or over), medicalization occurs in a myriad ways. As described by Kaufman (1994, 46), "The elderly [in the US] are particularly vulnerable to medical management since old age is equated with illness in the public view." This illness, which includes a perception of fragility, impacts how the public views such things as if elderly adults are too old to drive, to the store alone, or even be employed. In fact, the US context, aging "successfully" is viewed as the elimination of the process itself. The idea that someone can delay the effects of aging is perpetuated through the media as well as the proliferation of anti-aging cosmetics, surgeries and other medical therapies. The negative connotation placed on aging in the US, which is common in many Westernized societies but uncommon in most non-Westernized countries including Vietnam and India

(Shohet 2013), may diminish the elderly's perceptions of their intrinsic values and thus play an important role in further dehumanizing them.

The anthropological literature on aging in the US sheds additional light on the cognitive world and cultural context of the elderly. Among the topics that have been addressed in this literature are explanations of what aging means, what institutions exist for caregiving, and how and why particular elderly end up in institutional settings (Conrad 2007; Eckert et. al 2004; Nord 2011; Phenice and Griffore 2012). Cultural understandings of aging, perpetuated by individuals and institutions, are catalysts for medicalizing the aging process in the US (Kleinman 1988; Ng et al. 2015; Robert 1990). As Larkin (2011) explains, medicalization—in this particular case—leads to a perception of aging as a negative experience that should be avoided, and one for which doctors and the entire medical establishment should look for ways to attempt to not just impede but medically halt the process altogether.

This creates conflict between a person's experience of aging and their ability to make decisions on how to age; given that the public discourse in the US is one of negative connotations and imposes the 'right' way to age. Many elderly are in a battle between individuality and dependence on outside sources to fulfill their needs or treat physiological changes as they age (Kaufman 1994). As a person ages and starts to require more care to fulfill daily tasks (such as remembering bills, bathing without falling and the like) often they are considered too 'frail' and are taken to facilities (nursing homes, assisted-living facilities, hospices); many times by their own families and against their will, where they become 'patients' whose autonomy becomes constricted (Kaufman 1994).

### **Animal-Assisted Intervention**

One of the central questions of this thesis is if and how AAI can provide elderly residents of assisted-living facilities an opportunity to resist being classified simply as elderly patients. AAI is the usage of a therapy animal (usually dogs and cats, but horses and small mammals can be used as well) to enrich a person's life (Chandler 2005; Lee Davis et al. 2015). All kinds of people use or partake in AAI including veterans, prisoners,

children, college students and the elderly (Chandler 2005; McCardle 2011). The purpose of AAI within these populations is to engage them with an animal in an effort to produce a positive response. This can include helping a veteran with PTSD relax, enhancing psychological wellness in handicapped children, or releasing stress from college students during finals and midterms (Chandler 2005; Lee Davis et al. 2015; McCardle 2011; Rovner 2014).

Institutional and individual participation in AAI is directly linked to the relationship people in the US have with animals including dogs and cats. Currently in the US, research has indicated that citizens spend \$30 billion on pets annually, and that 90 percent of pet owners view their pets as family members (Allen 2003). At the same time, it should be noted, that not all cultures, groups or individuals in the US feel the same way about animal-human relationships, or about specific animals. Race and gender, for example, often influence the type of pet owned. Research has suggested that Hispanics and males are more likely to own dogs and are less likely to be cat owners (Schoenfeld et al. 2010). Krause-Parello's research further suggests that females in the US may derive more fulfillment from pet ownership than males, due to their culturally ascribed roles in caregiving (2008). Simultaneously individual experiences and preferences also play a role.

Prior positive pet experiences can influence one's desire to have pets, just as prior negative experiences can result in a resistance to certain pets or pets in general. Herzog and Galvin (1992, 79) state that these attitudes towards animals range from "animals in a positive light (animals as objects of affection, wonder and humor) to... negative themes (animals as threats and victims of animal cruelty)." According to Banks et al. (2008) and Chapman et al. (2011), for example, within some African American populations in the US dogs are disliked due to being attributed to these populations' ancestors' exposure to slave hunting dogs that has trickled down through the generations. Thus, perspectives on animals, which are based on cultural views as well as past experiences and individual preferences, vary greatly within US society. The culmination of these factors has multiple implications for how AAI is received by both individuals and organizations including assisted-living centers.

Literature focusing on AAI specifically tends to concentrate on either quantitative outcomes that measure the biomedical impact of AAI, such as saliva and blood samples that measure hormones for stress and appetite before and after AAI sessions, or limited qualitative outcomes such as whether or not participants in AAI experience happiness or loneliness (Allen 2003; Banks et al. 2008; Berry et al. 2012; Chandler 2005; Engelman 2013; Gilbey and Tana 2015; Havey et al. 2014; Kamioka et al. 2014; Kawamura et al. 2007; Krause-Parello 2008; Kwong and Bartholomew 2011; Latham 2012; Lutwack et al. 2005; McCardle et al. 2011; Mills and Hall 2014; Nordgren and Engstrom 2014; Rovner 2014; Ružic et al 2011; Smith 2004).

Data on elderly populations and AAI is limited, however. In a meta-analysis of the AAI literature by Nimer and Lundahl (2007), the elderly and those living in long-term facilities are vastly under-represented in these studies. Out of the 21 articles that were included in the study, only six examined the elderly and well-being, and only nine articles addressed long-term living residences and well-being. In another meta-analysis (Hosey and Melfi 2014) none of the included articles had a specific gerontological focus. The research reported in this thesis, which considers elderly residents of assisted-living facilities in central Texas, will contribute to this literature by illuminating whether the elderly ascribe value to AAI and how it may play a role in their resistance to medicalization.

### **The Current Project**

The main objective of this research is to examine medicalization including how it is enacted on the elderly persons living in assisted-living facilities in central Texas and how, through AAI, these elderly persons are offered a means to resist the medicalization process. As the literature on medicalization, and the literature on the elderly and AAI suggest, little is known about the experience of medicalization of the elderly as this occurs in long-term care facilities, how AAI may provide a way for the elderly to resist the process of medicalization, and through this how the meanings participants may ascribe to AAI may be affected because of this. This thesis seeks to address these issues.

## **II. THE EXPERIENCES OF THE CENTRAL TEXAS ELDERLY AND ANIMAL-ASSISTED INTERVENTIONS IN ASSISTED-LIVING FACILITIES VIA MEDICALIZATION**

### **Methods**

This study was conducted during the summer of 2015 at four assisted-living communities in Central Texas. Facilities were identified by contacting the local AAT network and being connected to practitioners. These practitioners suggested potential research sites and facilitated contact with administrators of the facilities. Facility A was a small facility located in Sequin. It was located in a rural area and had approximately 60 residents. Facility B was larger than facility A. It was located in San Antonio and housed close to 100 residents. Facilities C and D were part of a network of facilities in the San Antonio area and were also large, housing about 80 residents each. At each of these research sites AAI was conducted once a week.

Mixed methods were used to collect research data including semi-structured interviews, direct observations and surveys. The purpose for using these diverse methods was to provide triangulation of research data. Semi-structured interviews (see Appendix A) were used to ascertain the experiences of participants of AAI, non-participants of AAI, staff at the facilities and the pet therapy facilitators. Observations were used to further clarify the process of how AAI occurs at the assisted-living facilities and to provide context to the interviews. Finally, surveys (see Appendix B) were used to provide detailed information on the residents that were interviewed, including their demographic characteristics and details on their past experiences with animals.

The primary method of data collection for this project was semi-structured interviews conducted with elderly residents of the assisted-living centers. Residents were recruited for the interviews directly by the researcher as she accompanied AAI practitioners to the facilities, through flyers posted at the assisted-living centers, and through snowball sampling. The only exclusion criteria for these participants were the presence of cognitive challenges such as dementia or Alzheimer's. All other elderly patients were able to be included in the study. Topics discussed in the interviews included open-ended

questions about patients' past experiences with animals, why they participated or did not participate in AAI, how they felt during the intervention, whether they could have pets in the assisted-living center or wanted them, and overall opinions of animals. The interviews ranged from fifteen minutes to over an hour.

Semi-structured interviews were also conducted with the medical directors of two facilities and two AAI facilitators. Topics discussed in these interviews included whether or not the respondents felt the intervention was beneficial for patients, why they believed that, and whether or not they recommend AAI. All interviews in this study were recorded and transcribed verbatim.

Direct observations were conducted at each of the four facilities included in the study. These consisted of the observing of residents for five to ten minutes at a time, for an hour at each facility. Observations occurred twice at facilities A, B, and C. Only one observation was conducted at facility D due to time constraints. Detailed notes were taken in order to capture the body language of recipients and the context of each AAI session. This helped provide the context for unwritten or unspoken aspects of the elderly's experiences with AAI, which surveys and interviews were not able to convey.

Finally, each of the residents interviewed was asked to complete a survey about their experience and life histories in relation to animals. The survey administered was a "Demographic and Pet History Questionnaire" (DPHQ) initially developed by Dr. William Banks in his' work with AAT (Banks et al. 2008). This survey collects information on gender, age, ethnicity and past history with animals. This information helped supplement the life histories of the interviewees in order to make any correlations between those life aspects and the interviewee's responses to the interview questions.

Once all the interview and survey data had been collected, it was analyzed using content analysis. Interview transcripts were coded and then these codes were organized into themes. Comparisons were made between those who participated in AAI and those who did not as well as facility administrators and AAI practitioners. Survey data was used to further facilitate comparisons, for example between varying degrees of past experience with animals.

## Results

While direct observations were performed at all four research sites, interviews (n=23) were only conducted at three sites, specifically: five from Facility A, twelve from Facility B, and six from Facility C. Demographics of the sample are provided in Table 1. While there may appear to be biases in gender and race/ethnicity, it is common for most residents living in assisted-living facilities in the US to be predominantly white females (Krause Parello 2008; Harrington Meyer 1994). For this reason, the sample is not as skewed as a 20 female to three male sex ratio or a 100 percent white sample may at first suggest. Additionally, acquiring interviews with non-participants was challenging as these individuals were hard to locate because they tended to avoid AAI sessions. Only three non-AAI participants were included in the study.

Table 1. Participant Demographics

Age Range in Years	71-100 (86.5 avg)
Female (percent)	20(87)
White (percent)	23(100)
Was personally responsible for a pet	
(as an adult percentage)	21(91)
(as a child percentage)	19(83)
Lived on a Farm (percent)	8(35)
Non-AAT Participants (percent)	3 (13)

All of the participants who were interviewed, including those who chose not to participate in AAI, had some form of experience with animals. Three of these were negative experiences: one was bitten by a dog when she was holding the hand of her two-year-old daughter, another was allergic to anything with fur, and the third was just not interested in animals. In addition eight participants had lived as a child or an adult in a farm setting and had extensive experience with animals.

### Medicalization in Assisted-Living Facilities

Once placed into an institution, the elderly have to negotiate a whole new way of life. This transition period varies from institution to institution and from state to state (Mitty 2004). Most institutions have initial assessments of the needs of the elder, some have care plans while others do not, and all have varying degrees of regulations on staff (some



institutions allow unlicensed workers). Only a “few states require assessment of a resident’s spiritual, social, personal, and/or cultural needs or interests” which intrinsically is tied to a person’s quality of life (Mitty 2004, 153). Henderson and Vesperi (1995) suggest a lack of consideration for these needs is a gross oversight in the care of the elderly, as the elderly rely on the institution staff to take care of all of these needs. The many changes that occur when an elderly person transitions to living in an institution leads to what Kaufman (1994) calls “negotiated compliance,” which ultimately is a form of dehumanization and removal of agency. The level of medicalization the institutionalized elderly experience, is directly tied to the facilities themselves.

Within assisted-living facilities medicalization can occur through having all aspects of the elderlies' lives, including their eating, controlled by strict regulations (Eckert 2009, Nord 2011), and by the elderly being dehumanized through the actions and words used by facility staff, such as being laughed at or ignored (Murphy 1990, NG 2015). Additionally, elderly living in assisted-living facilities tend to be treated more like generic medical patients than multifaceted humans living in a communal setting (meaning alongside members of their age group) (Murphy 1990, Conrad 2007; Murphy 1990). In some assisted-living centers, for example, residents are given anti-psychotic medications, not for the treatment of medical conditions, but to keep the residents docile and more manageable for assisted-living center staff. As Lagnado (2007) reported, “According to [the Centers for Medicare & Medicaid Services], nearly 21% of nursing-home patients who don't have a psychosis diagnosis are on antipsychotic drugs.”

In regards to institutional caregiving, many long-term care options exist for the elderly in the US; the three most prevalent being nursing homes, assisted-living facilities and at-home care. According to a national survey data collected in 2012, there were 16,100 nursing homes, 33,000 assisted-living facilities, and 17,000 home care providers serving 7.6 million elderly in the US (Phenice and Griffore 2012). Many elderly patients rely on Medicaid to pay for their care, but increasingly this does not cover all their medical costs including medications and transportation (Harrington-Meyer 1994). According to Eckert et al. (2004), who conducted a national survey of adults over 65 in the US, most elderly persons have a negative view (perception) of nursing homes and would prefer at home

familial assistance. However, this reaction could be a result of the negative discourses about growing old that are common in the US (Lamb 2014; Ng et al. 2015).

Additionally, gender, race, socio-economic status and familial support all play a role in who ends up in assisted-living facilities (Keysor 1999; Li 2005). According to Keysor (1999), age and gender play the most influential role determining who ends up in an assisted living facility. Women live longer than men, so more women, and particularly increasingly older women, are most likely to live in an assisted-living facility.

Additionally, according Li (2005), race plays an important deciding factor as well. African Americans are “more likely” to be cared for at home by extended family members. While reasons for this are not exactly clear, but both Keysor and Li propose that this may have something to do with lower socioeconomic status among many African Americans.

In this research, the main ways in which medicalization manifested at each of the four facilities were through: restrictive schedules, which facilitated a lack of agency; dehumanizing behavior on the part of facility staff; the use of derogative terminology once again by facility staff; and a lack of agency among the residents, particularly in regards to pets.

### *Restrictive Schedules*

Residents of the assisted-living centers were tightly bound to a routine schedule, which on one hand is supposed to be good to keep them comfortable (Frankowski et al. 2011), but on the other hand is very limiting (Bennett et al. 2015; Buchanan and Bardi 2014; Eckert 2009; Murphy 1990; Nord 2011). At Facility B in particular, adherence to the schedule was well enforced. One resident ended an interview early because she was worried that she was going to be late, and miss lunch. As she described, “And I have to go, I’m surprised they haven’t come after me.” In fact, in many instances interviews were difficult to schedule, due to the restrictive schedules of meals, therapies and activities. Meals were not the only activity that was strictly regulated. Residents at all facilities were only allotted specific times to visit with family, and residents at all of the facilities were physically not allowed by facility staff to miss therapy sessions, unless they were ill.

### *Dehumanizing*

Dehumanizing is one of the emotional ways of control in medicalization by making people feel that they are second class citizens due to their illness(es) through mistreatment and/or being ignored (Johnstone 2013). This process was observed during both observations and interviews. One elderly woman, who was not involved with the interviews, was observed asking facility staff to wash her clothes, one of their regular responsibilities. The staff just laughed at the woman and walked away. They did not tell her that they had already washed her clothes that day. Another stark example of dehumanization came from an interview with Nancy (92 year old female, Facility B) as she described:

The nurse who wouldn't come at first, she told the girl to go on, she'd take care of it [her husband had vomited all over himself and no one was coming to help her clean him up]. She says 'I'll ring the bell and somebody'll come'. Well I knew exactly what was gonna happen, I had been there six years and pushed that bell and nobody came, ever ever ever. So I didn't say anything, she pushed the bell, nobody came, she pushed the bell, and nobody came. And then she was cussing 'Well where are all of them?' Then she pushed again. I let her push it about four or five times. I says, 'I don't like to tattle, but I says there's two showers out there, and it takes one to be in there to shower a person. You go open that door and there's three in there.' Two that she was calling. And she walked over there, opened that door and sure enough there was three. She says 'Why?' and I say 'It's not my business, but you asked and that's why you couldn't get anybody. That's what happens to me every time I get on that bell.' So that proved that to her."

Nancy continued to explain why such instances were allowed to occur, "I like the people. There's a couple of people here...see, we're old and we don't remember anything, that's what some of them think. But that isn't true, there's some of us that do. Most of them don't, but I do and they should realize that some of us do." She further suggested that residents should be treated as humans and as the adults they were, not as invalids or mental cases.

### *Terminologies*

Another example of medicalization of the elderly occurred through the terminology used by facility staff and administrators. Residents, for example, were often be referred to as “patients,” a reflection of the condition of being elderly being medicalized. “Residents” is a much more appropriate and less devaluing term to use, but even this maintains some connotation of medicalization as in residents of a mental facility.

### *Pets in Assisted-Living Facilities*

A final way that medicalization manifested in the assisted-living facilities was through pet policies and residents' perceptions of these policies. Many of the participants who were interviewed in this research had pets before moving into their assisted-living facility. Giving up those pets was a significant change. These participants went from having a pet almost their entire lives, to nothing at all. The assisted-living facilities that were studied did have varying restrictions on pets within the facilities (Table 2); however, those policies were often ambiguous to the residents. When asked if they would like to have a pet at with them at their facility, several participants said yes but that they didn't know if it was allowed. Joe (88 year old male, Facility A), for example, stated, “Well, I would [like to have a pet] but, like I say, we can't keep 'em here.” His assumption, however, was not supported by Facility A's rules, which did allow pets under particular circumstances. This ambiguity may be a result of the initial consultation at the facility being done with only Joe's family members (i.e. without Joe being present) or due to ambiguous communication from the facility staff.

Other residents who realized pets were allowed said they were unable to pay the extra fee. As Charlene (71 year old female, Facility C) stated, “When you first get 'em [a pet] you have to pay 'em [the facility]. You pay about \$50 and they don't charge you monthly. [...] and you have to have water and food for them all the time.” While Charlene correctly understood that residents could have pets at her facility she misunderstood the policy, which actually included a \$263 non-refundable deposit and a \$263 monthly fee--substantially more than the \$50 Charlene said she couldn't afford.

Several other participants expressed, when directly asked how they felt about not having pets at the facility, that it just wasn't the place for a pet. This was because either their rooms at the facility were "too small" or somehow it was discouraged at the facility. As Betty (96 year old female, Facility A) stated, "They don't, they expect us, they don't [want] us to have pets." Gertrude (87 year old female, Facility B) exclaimed, "They don't want you to have them here. You can have them, but you have to go through a lot of rigmarole." Other reasons noted were that the participants themselves felt they were just "too old" or otherwise incapable of caring for a pet at this point in their lives.

Table 2. Pet Policies at the Facilities. (These policies were stated during initial consultation and in the Facility's handbook for the residents)

Facilities	Allow Pets	Restrictions	Deposits/Fees
A	yes	Only small dogs, resident is able to care for it	\$500 non-refundable deposit
B	no	n/a	n/a
C	yes	Only small dogs, resident is able to care for it	\$263 non-refundable deposit, \$263 monthly fee
D	yes	Resident is able to care for it	\$500 non-refundable deposit

Under this line of questioning, many residents expressed remorse when speaking about needing to get rid of their pets in order to move into the assisted-living facility. Some of the residents gave their pets to family; others opted to euthanize them. Some residents even cried when relaying this loss. Joe (88 year old male, Facility A), for example, said through tears: "Well, the thing about it was, that time I had to put her to death, I couldn't stay at the house, and keep her and be here too. I hated to do it, but to me it's better to euthanize a dog, than to go ahead and let her run around looking for a home again." Another participant Theresa (93 year-female, Facility B) stated, "I would have another cat. I would love to have Emily, but I can't [...] I'd have her in here with me." These quotes convey grief about the absence of a pet in the elderly's life and the fact that they have little or no control over their current situation.

### *Lack of Agency*

In terms of AAI, the fact that the residents who did want a pet and could not have one, or did not think they could have one, is a direct example of the medicalization of the elderly in assisted-living facilities, as it shows control over the agency of the resident, as if they

are "infantile" and unable to make this decision for themselves (Murphy 1990). It is a reminder that they had to leave their old life behind and are now under the gaze, and control, of the assisted-living facility.

In this research, it was clear that residents were kept under control by medical staff, which harkens back to the literature about how medicalization creates restrictive boundaries for residents in assisted-living facilities (Buchanan and Bardi 2014; Eckert 2009; Murphy 1990; Nord 2011). However, for a few this was not a problem, as they explicitly said they were "too old" to care for a pet at this point in life as they could not walk it or take care of it and they were quite happy with just the visits from the therapy dogs.

### **A Typical Experience of the Elderly in an Assisted-Living Facility with AAI**

AAI sessions at assisted-living facilities were uniformly organized. Each session would go almost exactly the same regardless of the facility, the pet therapy facilitator involved, or the particular therapy animal present.

The process began when the pet therapy facilitator and therapy animal arrived at the facility approximately ten minutes before the session began. Typical sessions lasted an hour. This time frame was based on the therapy organization's rules, which were in turn based around the animal becoming tired or overwhelmed when visiting for longer than an hour.

Before the session, the therapist would walk the animal to make sure that it didn't need to use the restroom during the session. The facilitator then checked their therapy bag to make sure that it was stocked with incident report paperwork in the event that something happened with the animal and a participant. Additionally, the bag included hand sanitizer or hand wipes for the participants to use after touching the animal, a collapsible water bowl if the animal got thirsty, and treats for the tricks the animal would perform. The therapist kept this bag with him/her at all times during the session.

The pet facilitator and therapy animal generally entered the facility about five minutes before the session. The facilitator signed in at the visitor's book. An announcement was

then made over the intercom system that the therapy animal had arrived and anyone wanting to meet with the animal should come to the main meeting area (usually the communal living room). As participants filed in either with the help of walkers, wheelchairs, or canes, the pet facilitator would take the therapy animal up to each participant. The participant was then able to pet the animal and/or discuss the animal, usually how adorable and well behaved it was.

Some participants wanted the animal sit in their lap or next to them on a couch. This was accommodated by the therapist whenever possible. Seating, however, was typically allocated on a first come first served basis, which meant there was often a line to visit with the animals. Waiting participants would line up their wheelchairs or sit on the seats of their walkers in a line. While interacting (petting, hugging and even kissing) with the animal, many participants also spoke to the therapist about the therapy animal, as well as their previous pets. The therapy animal, depending on the amount of participants, spent approximately five minutes with each participant. If there were fewer participants these interactions could last longer, approximately ten minutes. After spending time with the animal every participant was offered hand sanitizer by the therapist. This was not required, but offered as a courtesy by the pet facilitator.

At facilities B and C, it was also requested that the therapy animal visit certain participants in their rooms. This required more time, usually ten to fifteen minutes per visit. In these cases, the pet facilitator made the rounds in the communal area first and then visited the rooms of those participants who requested a private session with the therapy animal afterwards. Only once, did these extra visits cause the time restriction to be elongated, but only by ten to fifteen minutes. Often participants who spend time with the therapy animal in their rooms were very familiar and close with the therapy dog, and he would jump into their laps wagging his tail, therefore indicating the interactions were not a stressor for him. All of these participants who received this personal attention were individuals who could not ambulate very well or at all. The participant was usually in a recliner or on a bed and requested that the animal sit with them. The facilitator would put the animal up next to the participant, where the participant would pet, hug and kiss the animal depending on their own preferences. Conversations between the participants and

the therapist also occurred and once again centered on the therapy animal and/or the participants' previous pets.

After all visits had been made by the therapy team, participants resumed their normal activities as the therapy team exited the building. Upon exiting, the pet facilitator signed out of the visitor's book.

Of course, not every resident of the facilities interacted with the therapy animals. Some participants opted out of this experience. I observed this multiple times, and in one instance a resident even grimaced at the sight that a dog was present. During interviews, one of these individuals, Nancy (the 92 year old female from Facility B from above), stated that she just wanted to "look" as she had been attacked by a dog earlier in life and was still afraid. Despite this fear, she stated that she still took pleasure from watching others interact with the therapy animal.

### **How AAI Manifested as Resistance to Medicalization**

After analysis of interview, survey and observational data, perceptions of AAI, and the particularly the participant's experiences with AAI in their institutional setting, were determined to be of great importance. These factors culminated into interpreting how AAI can and does provide the elderly in assisted-living facilities a way to combat their medicalized status and the constant control over their lives that comes along with this. AAI became an outlet for participants to regain their autonomy by choosing to participate or not; and by allowing them a forum to reminisce about their lives and reconnect with their selves, through the aide of memories of animals and discussions amongst each other and with the therapy facilitators.

### *Participants' Perceptions of AAI*

All of the participants expressed great satisfaction in touching or petting the therapy animals they interacted with. In fact, most noted this as their favorite part of AAI. Many participants also believed that animals are loving creatures who just want to love, and that having that experience of love meant a lot to them.



All of the participants interviewed who participated in AAI agreed that the visits with the therapy animals were beneficial. Also, these individuals were quick to exclaim that they would recommend AAI or even just having a pet to anyone, because it was so beneficial. However, they described these benefits using non-biomedical language such as “relaxing,” “comforting,” and “love.” To these participants, the benefit was one of a well-rounded nature, one that encompassed the mind and spirit in addition to the body. They further noted that the physiological experience involving the love of a companion made them “feel good.” One participant stated that touching the therapy dog made her feel “like a million bucks.” Another participant who was almost exclusively non-verbal became so excited to see the dogs she tried to get out of her wheelchair while exclaiming “oh lookie!”

#### *Pet Facilitator’s and Director’s Perceptions on AAI*

When interviewed, both pet facilitators and the medical director of Facility C agreed that AAI was beneficial for the residents of assisted-living facilities. Like they did with the residents, these descriptions of the benefits generally focused on the positive well-being and emotional effects that the therapy dogs had on the residents. An executive director at Facility C stated, “I think animals have a certain way of bringing out the love in a person especially the elderly. Sometimes the only way they can express their kindness and love is to stroke the soft fur of an animal.” Only the lifestyle director at Facility A, who stated that AAI is good for residents because, “Positive well-being contributes to faster healing from stress, anxiety, grief, and other issues,” relied on more of a biomedical classification to describe the benefits of AAI.

These individuals also provided in-depth insights to the medicalization of the elderly in assisted-living facilities. The medical director at facility C, for example, noted that she wished she could give everyone a pet, so that they didn’t have to share. She stated that in addition to the pet therapists being constrained by the policies limiting the time therapy animals can spend in a visit, the rigid schedules of the facility itself led to some residents missing out on the opportunity to participate in AAI. This highlights how residents’ agency is constrained in assisted-living facilities.

Both pet practitioners also noted these issues. They felt that due to centers' own scheduling constraints that many residents did not get adequate time to visit or even see the therapy dog. In addition they explained other issues associated with the implementation of AAI in assisted-living facilities, including the facilities not facilitated the AAI visits. Facility C was the only facility that used a common area for AAI visits. In the other facilities pet therapists needed to walk around, visiting residents in hallways and occasionally their rooms.

One practitioner also noted a more general issue associated with the elderly in the facilities she visits with her dogs, the lack of interaction for the elderly in assisted-living facilities. She explained:

There's so little interaction for them (the elderly) in those facilities, you know. I'll give them a hug or something like that too. So it's like they get something back as well, besides petting the dog and that making them feel good, they get a hug because you'd be surprised how many of them don't have human interaction. You know one day I have a lady a hug and she looked up at me, and this was so powerful, she looked up at me and she just had the tiniest little voice and she was a skinny little thin in her wheelchair, and she said, 'Give a hug, go home a hero.'

The practitioner reported that she continues to hug the residents who are receptive because she believes they do not get hugs or human interaction generally. This was supported by the interview with Nancy from Facility B, who explained that the staff don't treat them right, as if they weren't 'all there'. In both instances, this is evidence of the elderly being devalued.

### *Resistance and AAI*

Resistance, meaning to resist, to push back or deny, can be active or passive. An example of active resistance, which was explained in an interview with Gertrude (87 year old female, Facility B), occurred when she decided to move to another facility because of her dislike of the constant intrusions into her room by the staff of her previous facility and because of the lack of choices on the cafeteria menu. Passive resistance was observed in the many small complaints that occurred during the interviews and through subtle facial expressions observed during the direct observations. One example occurred in an interview as Gertrude (87 years old female, Facility B) explained the tedious relationship

with the staff in order to have a pet, “You can have them, but you have to go through a lot of rigmarole.”. Another form of resistance was observed as elderly residents grimaced when approached by staff to complete some task including in some cases going to lunch.

More specifically, resistance was also noted in regards to "therapies". When asked about therapies, many residents replied they did physical therapy and participated in AAI, but most did not think to include biomedical therapies such as the weekly visits with their primary care doctors. Others refused to acknowledge that they participated in any therapies, including AAI, even though observations contradicted this. Their rejection of the terminology in these cases may suggest a push back or resistance from the medicalization that they are constantly experiencing. Rejecting a word like therapy is a form of resistance; it is passive resistance against the hegemony of biomedical terminology and perspectives.

Resistance was also observed when residents refused to attend the AAI or would not even come out of their rooms when the therapy animals were present, forcing staff to bring them their meals during these times. As one pet therapy facilitator explained, “[the resident] was upset to think [the therapy dog] was going to come over there close to her and it was a verbal, you know, ‘Don't bring that dog over here!’ kinda thing. And of course, I know her name, and I said her name and said ‘don’t worry, don't worry, I'm not going to’.” In another instance, passive resistance was observed when one resident, who could have gotten up and left the room while AAI was occurring, decided instead to stay and make grimacing faces and sighs, to let everyone know she was unhappy about the presence of a dog in the facility.

## Discussion

As described previously, aging is a normal human process that has fallen under the purview of medical practitioners and therapies in the US. It is no longer a natural biological and social process, but rather something that needs to be addressed by interventions to prevent it from occurring, and in cases where these efforts fail and the elderly become too infirm to care for themselves, to be controlled through organizations like assisted-living facilities.

Control of the elderly in assisted-living facilities is a form medicalization. This is accomplished through a variety of mechanisms including restrictive schedules, a lack of privacy and the inability, or limited ability, for the elderly to make choices on their own. Transfer of control over aspects of the elderly's lives is often interpreted by the elderly themselves as being something negative, unless it was their choice to relinquish this power in the first place (Morgan and Brazda 2013). When control is usurped from the elderly by facilities against their will, this is seen as one more aspect of how the elderly are losing their sense of self (Morgan and Brazda 2013). Tinney (2008, 211) explains this lack of control as medicalization as such:

I owe the expression *institutional totalism* to Bowker (1982, 31, 45-47) who following Goffman (1960), identified points of comparison between nursing homes and maximum-security prisons. He concluded that it is the extent to which the medical model of care predominates over the humanistic model of care that magnifies or reduces the degree of similarity between a nursing home and a prison.

The observations and interviews done in this study concur with the notions of control being taken away from the elderly as an agent in medicalization. In fact, the lack of control over one's life appeared to be one of the major complaints by residents in the assisted-living facilities (as seen through Nancy's aggravation with the lack of assistance during her husband's emergency and in the case of one of the residents moving to a different facility entirely, where she felt she would get better treatment and ultimately better control over her life).

Medicalization of the aging is mostly a negative case much like the case of childbirth described in the introduction. It allows the encroachment of medical technologies, pharmaceutical companies and medical institutions into a normal life process, and turns aging into a negative malady and something to be avoided for as long as possible. This is seen in the case of urinary incontinence, which is a normal aging process yet embarrassing for the aging and stigmatized by those who aren't experiencing it. Many products and pills are marketed towards those with incontinence such as adult diapers, liners, and anti-diuretics (Mitteness and Barker 1995).

Sharon Kaufman's research on medicalization of the elderly substantiates the negative aspects of this process. In her descriptions of three elderly persons' transitions to living in assisted-living facilities, she argues that frailty is a socio-cultural construct of the US that influences decisions regarding the care of the elderly, not the original definition of frailty that is defined by medical establishments in instrumental diagnoses of the very old not being able to care for themselves. As a result of this negative discourse towards the very old, implications are made that these individuals can no longer function regularly or dependently in society. This ranges from family members or neighbors enforcing assessments and institutionalization, to the adaptation from independent living to assisted-living, all shaped under the purview of the medical establishment that propagates medicalization.

Kaufman argues that underlying all of this is the dissonance between society's standards of aging and the reality of the process itself, thus making aging no longer a personal experience but a public one, resulting in neighbors and family members initiating institutionalization. This not only adds to the already occurring medicalization of the elderly by their own kin groups, but when they are put into assisted-living facilities the elderly's life are even further controlled and their agency is increasingly restricted.

Ultimately, Kaufman's research is an attempt to broaden the definition of "frailty" and to show the inherent dangers that can occur when negative discourse occurs while discussing normal lived experiences of aging persons. In her conclusion, she makes a perfect point:

“It (frailty) can be understood as a state of being that can be operationalized and measured instrumentally, as a parameter for risk for institutionalization as a socially constructed problem, and as a quality and adaptational (sic) process, one that forces us to reconsider the meaning of independence and dependence in advanced old age.” (56)

As stated in the beginning of this chapter, the literature focusing on AAI specifically tends to concentrate on either quantitative outcomes that measure the biomedical impact of AAI (a perspective that further medicalizes the elderly), such as saliva and blood samples that measure hormones for stress and appetite before and after AAI sessions, or limited qualitative outcomes such as whether or not participants in AAI experience happiness or loneliness (Allen 2003; Banks et al. 2008; Berry et al. 2012; Chandler 2005; Engelman 2013; Gilbey and Tana 2015; Havey et al. 2014; Kamioka et al. 2014; Kawamura et al. 2007; Krause-Parello 2008; Kwong and Bartholomew 2011; Latham 2012; Lutwack et al. 2005; McCardle et al. 2011; Mills and Hall 2014; Nordgren and Engstrom 2014; Rovner 2014; Ružic et al 2011; Smith 2004).

The research presented in this thesis substantiates these findings through the interviews and observations. The quantitative analysis data cannot be confirmed due to the methods used, but qualitative data collected from elderly residents in assisted-living facilities confirms that AAI does make the elderly in assisted-living facilities happier, less lonely, and provides an avenue for them to resist medicalization. Within the setting of assisted-living facilities, medicalization also creates an atmosphere where the elderly feel they have no control over their lives, as institutions impose and dictate their actions. Medicalization contributes directly to ageist cultural discourse, yet simultaneously obscures the fact that before advancements in technology and medicine, much with childbirth and urinary incontinence, aging was regarded as something completely natural. It is not surprising that the reports of negative connotations with the word "elderly" has risen dramatically, as was noted by Rueben Ng et. al (2015) in their analysis of 200 years' worth of words discussing the aging population.

However, while medicalization of the elderly in assisted-living facilities is mostly a negative phenomenon, there are some positives that need to be addressed. Much like the

case of fibromyalgia, there is a positive side to medicalization of aging that may not be apparent at first. All of the rules in assisted-living facilities are in place for safety reasons and to aid in naturalizing such a rapid change of lifestyle for the residents (Eckert 2009). The reason the elderly are in an assisted-living facility is because they cannot be left alone at home, but are not in need of hospitalization. These residents are thus in a liminal state between the "social model" of home and the "medical model" of a hospital (Eckert 2009).

In navigating this space of in-between, there are rules and regulations that need to be put in place to help facilitate safety and a sense of routine or comfortable familiarity, thus the need for a schedule (Eckert 2009; Frankowski et al. 2009). Without this schedule, many elderly may forget to take their medications, not eat regularly, or eat non-nutritious foods. The constant monitoring, while intrusive at times, is in place to make sure that the elderly are safe, that they haven't fallen in the bathroom or experienced some other negative event underlying the efficiency of the institution to provide safe care (Eckert 2009; Henderson and Vesperi 1995).

In terms of AAI, as this research has shown, this practice allows residents of assisted-living facilities to resist medicalization and simultaneously offers them a means to regain a sense of self. The first occurs as residents are allowed to choose whether or not they participate in AAI. The same type of choice is not possible in most other activities they partake in. Eating, for example, is not optional and neither are appointments with biomedical practitioners.

In relation to the latter, AAI provides the residents with a break from their restrictive schedules, and provides them with a chance to reminisce about their past experiences with pets. AAI allows elderly residents of assisted-living facilities a platform with which to discuss who they are, what they used to do, the pets they used to have or not have, and overall life experiences with their fellow residents and the therapy facilitators. This regaining of self and retelling of personal narratives is crucial in helping the elderly navigate the changes that are going on in their lives. It aides in helping them interpret the cognitive world around them (Kleinman 1988, 49). These narratives also allow the

residents an opportunity to regain a sense of self in contrast to the view that they are just “patients.”

In relation to this, AAI gives the residents a chance to break out of their role as “patients” and resist their medicalized state. The therapy animals play a big part in aiding in providing this opportunity. By being able to touch and love the animal, residents have an opportunity to reconnect with an animal. In this sense, AAI allows them to have a pet again, if even for five to ten minutes, every week. This simultaneously allows the elderly to remember and regain their sense of self, while experiencing tactile and emotional stimulation that is beneficial for them physically and mentally. In this way, AAI is much more than just a visit with an animal, it is an experience with which elderly residents of assisted-living facilities are able to regain control and a sense of themselves.



## **Limitations**

Despite the best intentions, this study was limited in several respects. The sample population consisted primarily of white women. While this correlates with demographic information that suggests that women and whites are the persons who most commonly reside in assisted-living facilities, it also suggests that the results are not generalizable, particularly to all elderly within the US.

The study was further limited due to limited access to residents who declined to participate in AAI. Because of this, the data reported in this thesis are biased towards persons who participated in AAI. Experiences of medicalization, agency and resistance might have been different in a more diverse sample.

## **Conclusion**

This study showed how medicalization of aging occurred within assisted-living facilities in central Texas. Restrictive schedules resulted in the residents having little or no control over their lives, including in some cases their interactions with therapy animals.

Likewise, dehumanizing behavior from staff, such as laughing at sincere questions, made the residents feel ignored or inferior. Through examining AAI, this research also explained how AAI can act as a form of resistance to the process of medicalization, by allowing participants (the residents) to have choice over whether to partake or refuse in this activity, which they rarely have in other aspects of their lives in the facilities. Finally, this study showed the benefits of AAI. All participants in this study, with the exception of the few non-participants, found AAI to be very beneficial not just from a biomedical perspective, but in a more holistic way.

### **III. APPLIED COMPONENT**

This research was completed with an applied aspect in mind, to further expand the topic of AAI in the context of the elderly. This study has been presented at both the Annual Anthropological Association National Conference in 2015 and the Society for Applied Anthropology Conference in 2016. I already have offers to publish in a few journals, that I plan to pursue to help spread this information to aide in the advancement of the research on the anthropology of the elderly, the care of the elderly in assisted-living facilities and the research on animal-assisted interventions, along with being added to the Texas State University library. Hopefully through the dissemination of this research, more research will be done to help to continue to fill the gaps in quantitative and qualitative research in all three of those literatures and help the elderly to be seen more as people and animals as more integral in the healing process than previously thought.

At a future date, I am looking forward to pursuing this topic further in a dissertation involving another marginalized population, prisoners, and how AAI/AAT experiences play out within that population. Again, with the motive of furthering the research on marginalized populations and the effect animals have on them through presentations and publication.

## **APPENDIX A**

### **Interview Guide for Recipients of AAI**

#### **Project Statement:**

Thank you for agreeing to share your experience with animal assisted intervention with me. As I mentioned before, I'm interested in understanding your overall experience with the activity – including what drew you to animal assisted intervention and how and why you began attending. During the interview I'm going to ask a few broad questions about this topic; there are no right or wrong answers, I'm just happy to learn any information about your experience that you're willing to share. Do you have any questions at this point?

#### **Confidentiality Statement:**

I want to assure you that I will keep any information you share with me confidential. Do you have any questions about this?

Fantastic, is it alright with you if I take notes during our interview?

#### **Interview Questions:**

##### **Grand Tour Question to get them talking:**

Tell me about your experience with AAI. How did you discover AAI? What caused you to first attend? What causes you to return? How long have you been attending AAI? Do you feel it's better to go alone or with friends?

\*Follow-up for answers concerning the animals (?) –

What attracts you to animals?

What types of animals are your favorites?

What is the best part of the activity for you?

\*Follow-up to going with friends:

Do you discuss the experience afterwards? Where do you and your friends prefer to talk about AAI once it's over?

How does AAI compare to other therapies you have tried?

Though these animals come to visit you, would you prefer you had your own pet here? Why or why not?

Describe to me, in as much detail as you can, your favorite experience attending AAI, from beginning to the end of the session.

Would you recommend AAI to another elderly person who has never heard of it before? How would you convince them to go?

How would it affect you if you were no longer able to attend AAI?

### Interview Guide For Opt-Outs of AAI

#### Project Statement:

Thank you for agreeing to share your experience with animal assisted intervention with me. As I mentioned before, I'm interested in understanding your overall experience with the activity – including why you don't chose to go and have you had any previous experience with animals that causes your reluctance. During the interview I'm going to ask a few broad questions about this topic; there are no right or wrong answers, I'm just happy to learn any information about your experience that you're willing to share. Do you have any questions at this point?

#### Confidentiality Statement:

I want to assure you that I will keep any information you share with me confidential. Do you have any questions about this?

Fantastic, is it alright with you if I take notes during our interview?

#### Interview Questions:

Tell me about any experiences you have had with animals (good or bad).

\*Follow-up for answers concerning the animals (?) –

Do you like animals? Why or why not.

If yes...What types of animals are your favorites?

Would you rather have your own pet to interact with than it being a group activity?

Would you consider attending AAI if there were other types of animals to interact with? If so, what kind?

Would you recommend AAI to another elderly person who has never heard of it before? Why or why not.

Does it ever make you feel left out when you don't attend AAI with the other residents?

### Interview Guide for Medical Staff/Practitioners

#### Project Statement:

Thank you for agreeing to share your experience with animal assisted intervention with me. As I mentioned before, I'm interested in understanding your overall experience with the activity – including whether you feel AAI is a beneficial treatment, how do you handle managing the activity, and so forth. During the interview I'm going to ask a few broad questions about this topic; there are no right or wrong answers, I'm just happy to learn any information about your experience that you're willing to share. Do you have any questions at this point?

#### Confidentiality Statement:

I want to assure you that I will keep any information you share with me confidential. Do you have any questions about this?

Fantastic, is it alright with you if I take notes during our interview?

#### Interview Questions:

##### Grand Tour Questions:

How long has this facility (or you) offered AAI? How many residents usually attend? Are there any residents who refuse to attend or just don't care about it? How long have you been managing the AAI here?

\*Follow-up for answers concerning the facility (?) –

Do you know what drove the facility to incorporate AAI?

How long have you been involved in managing or orchestrating the AAI program here? Do you enjoy it? Are there any challenges managing the AAI program?

Would you rather the residents have their own pet to interact with than it being a group activity?

\*Follow-up to residents-

Do you feel that AAI is beneficial to the residents? How so?

Why do you think certain residents always attend and others don't?

Would you recommend AAI to another elderly person or assisted-living facility who/that has never heard of it before? Why or why not.

#### Interview Guide for Practitioners

#### Project Statement:

Thank you for agreeing to share your experience with animal assisted intervention with me. As I mentioned before, I'm interested in understanding your overall experience with the activity – including whether you feel AAI is a beneficial treatment, how do you handle managing the activity, and so forth. During the interview I'm going to ask a few broad questions about this topic; there are no right or wrong answers, I'm just happy to learn any information about your experience that you're willing to share. Do you have any questions at this point?

Confidentiality Statement:

I want to assure you that I will keep any information you share with me confidential. Do you have any questions about this?

Fantastic, is it alright with you if I take notes during our interview?

Interview Questions:

Grand Tour Questions:

How long have you offered AAI? What inspired you to become a pet therapy practitioner? How many residents usually attend a session? Are there any residents who refuse to attend or just don't care about it?

\*Follow-up for answers concerning the facility/facilities (?) –

Do you know what drove the facility/facilities you attend to incorporate AAI?

How long have you been involved in managing or orchestrating the AAI program there? Do you enjoy it? Are there any challenges managing the AAI program?

Would you rather the residents have their own pet to interact with than it being a group activity?

\*Follow-up to residents-

Do you feel that AAI is beneficial to the residents? How so?

Why do you think certain residents always attend and others don't?

Would you recommend AAI to an elderly person or assisted-living facility who/that has never heard of it before? Why or why not.

## **APPENDIX B**

### **Demographic and Pet History Questionnaire (taken from Banks et al. 2008)**

In order for me to understand you needs, I would like to gather information about your background. Please complete the following:

1. Your sex is:

- ☐ Male
- ☐ Female

2. Your marital status is:

- ☐ never married
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

3. Your age is \_\_\_\_\_ years old

4. What is your race?

- ☐ African-American
- ☐ White
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Other

5. What is the highest level that you finished in school?

- ☐ Less than sixth grade
- ☐ Less than ninth grade
- ☐ High school graduate
- ☐ College, 1-3 yrs
- ☐ College graduate
- ☐ Post graduate

6. Before you came to live in this long-term care facility, did you live:

☐ in a home, ☐ in an apartment, ☐ on a farm

### **Pet History Questionnaire**

1. Did you have a pet when you were a child?

☐ Yes ☐ No



2. How old were you when you had your first pet?

\_\_\_ years old

3. Did you grow up with pets?

\_\_\_Yes \_\_\_No

4. If YES; what kinds of pets did you have? (Please check off all that apply)

\_\_\_Birds \_\_\_Cats \_\_\_Dogs

\_\_\_Fish \_\_\_Farm animals

5-Did you have a pet when you lived in your home or apartment?

\_\_\_Yes \_\_\_No

6. If the answer to number 5 is yes, how many years did you have the pet?

\_\_\_ Years

7. When did you first have responsibility for the care of the pet?

A. \_\_\_ Childhood (1-12years)

B. \_\_\_ Teenage (13-18 years)

C. \_\_\_ Young adulthood (19-30 years)

D. \_\_\_ Middle age (31-61 years)

E. \_\_\_ Old age (62 and older)

F. \_\_\_ Never

8. What kind of pet was it?

\_\_\_Bird \_\_\_Cat \_\_\_Dog \_\_\_Fish \_\_\_Farm animal

9. How attached were you to this pet?

\_\_\_Very attached \_\_\_Attached \_\_\_Not at all attached

10. What was your pet's name?

11. What happened to your pet:

\_\_\_Died \_\_\_Gave it away \_\_\_Ran away \_\_\_Other

12. How much time did you spend with your pet as an adult?

☐less than 1 hour per day ☐More than 1 hour per day

13. Was the time spent with your pet in these activities:

☐Enjoyable ☐Not enjoyable

14. Did touching your pet

☐Make you feel good ☐Make you feel bad

☐Make you feel nothing

15. When you felt bad, did your pet

☐Help you feel better ☐Help you feel worse

☐It made no difference

16. When you had your pet, did you talk to your pet?

☐Yes, all the time ☐No, not at all

☐Sometimes

17. Were you able to confide in your pet?

☐Yes, all the time ☐No, not at all

☐Sometimes

18. How much does it bother you that you do not have a pet?

☐A lot ☐A little ☐Not at all

19. What are your reasons for not having pets now?

☐I can't keep a pet at this present place.

☐I am no longer interested in pets.

☐The staff at this facility may not like pets.

20. If possible, would you like to have a pet at this place?

☐No

☐Yes

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