

Architects conceptions of the ageing body when designing for residential care in later life

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Bodies and architectural design

- Imrie (2003) 'architects rarely think about the human body' (52-3)
- Architects don't design for '*multiple forms of embodiment*' but the 'normal body' ... '*characterised by geometrical proportions arranged around precise Cartersian dimensions*'
- Technical standards – '*object with fixed measurable parts; it is neutered and neutral, that is without sex, gender, race or physical difference*'

Grosz (2005) feminist philosopher

- Critical of the disavowal of embodiment in architecture and failure to attend to power relations and especially of sexualised and radicalised bodies.
- Contrast – bodies **did** emerge in architects talk about designing for care...
- Possible generational shift – body politics, legislation, inclusive design

Representations of ageing and care

- Prominence of the body in representations of ageing (Featherstone and Wernick 1995, Twigg 2004)
- Care home as a 'discursive anchor' focus on bodily ageing, 'disease, care giving and dying' (Gubrium and Holstein 1999)
- Changing representations of ageing (Gilleard and Higgs 2000, Twigg and Martin 2014), changing design of spaces for later life (Andersson 2015; Laws 1997)

'Buildings in the making: a sociological exploration of architecture in the context of health and social care'

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- 3 year ESRC funded study (August 2015 until July 2018)
- Methods: 'ethnography of practice', visual methods, observations, 'walking interviews'
- Preliminary findings: pilot interviews with 16 architects and designers – supported by fSHI

Imagining the lived body

'I think you start with the body, in a way. Like how you come into a space, how you see it, whether you see it or not, so you're thinking about how someone sees, how someone feels, acoustics. Is it going to be too noisy? Especially with dementia, noise and lighting are key..'

(Interview 11)

Strategies for imagining lived bodies: empathic work

- Empathic work – putting yourself ‘in their shoes’
- ‘Affective labour’ (Pedwell 2014) – design, medicine (Kerr 2013; Shapiro 2008; Suri 2001)
- Like Imrie (2003), self-referential:
 - personal experiences / relatives
 - anticipated care needs
 - physically using their bodies

'My parents live in a little bungalow; my dad's 86, my mum's 84. We think mum's got some sort of early onset dementia... they have carers going four times a day, and that's been a really good example of how they're having to change and how upsetting it is...there's a lovely little round coffee table... which is mum's pride and joy, and it got in the way of the walking frames... You'd have thought we'd asked them to walk across the Sahara to give up this coffee table, that's how important it is to people. And no doubt someday, I'll be the same, that I'll be not wanting to lose something out of my house that is necessary to enable me to get about'.

(Interview 3)

Strategies for imagining bodies: going beyond empathy and personal experience

- Limitations of empathy – distinctions between emphasiser and the ‘other’ (Pedwell 2014)
- Written guidance ‘Stirling Standards’ (University of Stirling 2012), training workshops
- Mock up – bedrooms and bathrooms
- User engagement – often limited and post-occupancy

Constructions of the ageing body

- Reproducing wider discourses/representations of ageing, stereotypes
- Tension between engaging with fleshy, lived body, and reduction of OP to bodily needs and (dys)functions
- Care home – anchoring limited conceptions of embodiment (Gubrium and Holstein 1999)

Leaky, dependent bodies (cf Lawton 1998)

‘...if they need help with everyday tasks, that help should be able to be given to them, discreetly and comfortably. So if someone needs help going to the toilet then they’ve got an en suite there, there’s enough room for the staff to help them [...] if someone has had an incontinence accident and they need to be washed they should have a shower in their en suite, in that privacy, not having to sort of come out of the bedroom down the corridor for everyone to see them [...] “Mavis has wet herself again”. It’s that dignity.’ (Interview 8)

Diseased and declining bodies vs. consuming and active bodies

- ‘Discourse of decline’, biomedical (Gullette 1997):

Yes, it's a disease so they are either a danger to themselves or others so need to be looked after.’ (Interview 2)

- New images of ageing, opportunity, activity (Oberg 2003):

It's a lifestyle, but a very nice lifestyle. You have services, can get three meals a day, are helped with all your needs and your wonderful grounds. So they are big big hotels. (Interview 2)

- Changing ideologies of care, neo-liberal consumerist model (Bromley 2012; Jones and Higgs 2010).

Calculated vs. lived bodies

- Client brief – numerical values, focus on cost-efficiency, profit – number of bedrooms need to make site profitable
 - *‘I’ve found a site how many beds can you get on it?’*
- Regulations – care standards, staff ratio – body reduced to measurements (Imrie 2003)
- Undermining engagement with the lived body, dementia friendly design

Juggling

- 'Juggling' the competing need of stakeholders, different concepts of bodies (Latour and Yaneva 2008)
- Architects work with multiple bodies – conflict, constrain (Mol 2002)
- Clients, planners, regulations and other body workers...

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- ‘...suddenly you’ve got eight other people, all with different agendas [...] who could not agree amongst themselves whether we should have facilities for hoists above the bed [...] or whether we should have movable hoists. [...] And there were so many stakeholders there [...] a physiotherapist, another lady was occupational therapist, another lady was going to be paying for staff to come out and hoist people out of bed, so she wanted hoists because it was quicker than having a mobile hoist, so she was driven by a budget, and the cost of moving people around within the apartments once people had occupied them’ (Int 3).

- the site was such that we could have had a direct entrance from the road on to the first floor, because the site sloped down and that would have worked beautifully. So we were going to have a pedestrian bridge, but the planner took offence, didn't like this idea. This was going to also help the local community come into the building, because we were quite keen, and the client was quite keen, to have a shop that everybody could use in the local community. *We thought fantastic, great, but the planner is like, "Oh bridges? People with dementia? Oh no, you can't have that". We're like, what? "You're kidding me!" Public bridges everywhere, you know. Anyway, so we argued and argued and argued, but actually in the end we were kind of running out of time in terms of the planning process, and the client just said oh, just leave it. Which was a shame, because I think we were almost getting somewhere, and then, but we just had to move (Interview II)*

Conclusions

- Architects do think about the body, and use various strategies to engage with the sensory, diverse, experiencing 'lived body'
- Yet still reproduce dominant discourses and representations of ageing
- Constrained by the competing needs and conceptions of imagined bodies as brought by the many stakeholders who participate in the design process.

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Tensions inherent in a residential care home

- we devised a typical 40 bed nursing home, which looked like a series of three bed houses, three storey, three bed houses, so it looked like, false front doors, so it looked, sitting in the domestic environment like this for example, it looked like a lot of houses rather than an institution, because I think once people go into an institution something happens to them, I think they feel institutionalised and long corridors, you know, mentally it's not good for them (Interview 3)