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THE MICROPOLITICS OF IDENTITY IN ADVERSE CIRCUMSTANCE

A Study of Identity Making in a Total Institution

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This article is about the micropolitics of identity construction by residents in a total institution. Data come from two hundred hours of participant observation during a four-month period of full-time employment as a nurse aide. Interactional analysis of observations suggests that residents' personal narratives, whether real or imagined, become who some residents conceive themselves to be and define residents' expectations for interactional others. Changes in institutional culture occur as staff begin to recognize in interaction the ways residents think of themselves. The narrative accounts and interactional struggles to define self that the author discovered in the institution are not unlike conceptions and processes of identity construction, maintenance, and change that confront all human actors. These accounts provide insight into the liberating possibilities of personal identity claims.

This article is about the micropolitics of identity in adverse circumstance. It is about how narratives structure circumstance in a total institution and how personal identity claims affect individuals in an adverse circumstance. In this article, I focus on individual narratives as having potential for altering institutional characterizations of identities as deviant. I argue that residents of chronic care institutions use narratives to create personal identities and, by these narratives, establish alternative interactional frames. My study is situated in the routine world of Merimore Chronic Care Center, a private, for-profit long-term care facility principally for the aged and mentally ill.[1] Merimore is a facility with modest accommodations and few private rooms, recognized in the county as one of the better chronic care facilities. While some Merimore residents spend as little as a few weeks in respite or recuperative care, most come to the institution to live out the rest of their lives. Center staff provide assistance with the remainder of the residents' life courses.

As all of social life, the world of Merimore Chronic Care Center makes sense because of categories of persons the staff recognize in the institution (Lofland 1969) and because of the predictable interactional frames these categories create for staff and residents (Berger and Luckmann 1966). Merimore staff characterize residents as objects of work (Fontana 1977; Goffman 1961), which they organize into routine

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courses of interaction (Diamond 1992, 159-60; Fontana 1977; Paterniti 1999). Categorical definition and treatment of like-persons permit social and organizational control over institutional work and existence. But more than this, rigid definition of routine work circumscribes institutional identities and, as a result, a narrow range of possibilities for staff and patients, with consequences for both sets of actors (Gubrium 1993).

Studies of institutions and institutional routine have shown that regardless of the emotions and actions of individuals, organizational rules and routine carry far more weight in characterizing interactional encounters and identities than the claims of individual persons in institutions (Goffman 1961; Rosenhan 1973; Roth 1963). Furthermore, studies of chronic care settings indicate that the structure of work in most long-term care settings results in deviant identity labels for residents long after the termination of their institutional careers (Edgerton 1967; Goffman 1961, 1963). These identity categories are cast in staff reports, dictated as a part of getting the work done (Diamond 1992) and as a means of transferring work from one shift to the next (Paterniti 1999; Pithouse and Atkinson 1988).

At Merimore, oral and written reports about residents are part of routine work, directing staff interaction with various categories of residents and legitimating avenues for resident patient control (Diamond 1992, 180-1; Goffman 1961, 128; Paterniti 1999). In fact, reports about residents are a mandated part of organizational rules, a routine circumstance that becomes

> cast into a pattern, which can then be reproduced with an economy of effort and which, ipso facto, is apprehended by its performer as that pattern. . . . Habitualized actions, of course, retain their meaningful character for the individual although the meanings involved become embedded as routines in his [sic] general stock of knowledge, taken for granted by him [sic] and at hand for his [sic] projects into the future (Berger and Luckmann 1966, 53).

It is necessary for staff to be able to create work routines that they, in fact, can take for granted. In so doing, however, they also create and come to take for granted the categories of resident persons defined by those routines (Goffman 1963, 53).

Residents' physical and mental deficiencies that require their institutionalization permit few residents the interactional capital to distinguish

them from the social categories imposed by staff depictions. Still, residents of Merimore put forth their own definitions of self. Residents' definitions of self often vary in content from staff accounts of who they are. These narratives about self are juxtaposed to institutionally prescribed and legitimated reports by staff (Goffman 1961, 201-7; Snow and Machalek 1982, 17). Rather than locating their concept of self in the work routine, residents' own conceptions create a profile not reflected in institutional timetables or medical records. Through narratives, residents construct identities that make sense of self (Riessman 1990) in the world of the institution. Jaber Gubrium (1993, 10) argues that these alternative identities arise from significant past events, relationships, or experiences. In fact, Gubrium (p. 180) found that the aging persons he studied "construct and live in worlds of their own making" as well as in the world of the institution. Merimore residents enact their imagined identities against rigid structure and work-related categories that staff use to make sense of institutional life (see Maines 1977), where they redefine the meaning of past events so that identities and situations have significance to the present (Maines, Sugrue, and Katovich 1983, 163).

Personal narratives serve as one of the most significant elements in the construction and maintenance of self-conception in institutions such as Merimore and dialectically oppose structural elements of social control (Lofland 1969). Residents' narratives and the worlds they create challenge organizationally familiar categories of persons and the taken-for-granted institutional order. Interactional analysis shows that negotiation over self-definition requires negotiation of the social structure, of staff defined routines and taken-for-granted resident identities. Through narratives, institutionalized residents create potential to redefine the social framework in which organizational rules negotiated and carried out by staff characterize residents to be deficient persons, less than fully human (see Goffman 1963, 5). What residents' narratives contribute to institutional existence is the human perspective, as their narratives suggest a personal identity and provide interactional possibilities for altering institutional relationships.

To understand the micropolitics of identity narratives in total institutions, I address the following questions: What kinds of narratives do staff use to define and negotiate routine work in the chronic care institution? What sorts of accounts justify their adherence to organizational rules? What are residents' narratives of self? What role do these narratives

play in distinguishing self from institutional characterizations as "deficient" or "deviant" persons? And what effect do staff-resident narratives have on the routine order of the institution? First, I describe my data and my involvement in the social life at Merimore Chronic Care Center. Second, I characterize life in the institution and the consequences of staff accounts of work for resident identities. Third, I describe residents' definitions of self and examine the sorts of possibilities residents' narratives of self create for both residents and staff. Fourth, I analyze the effects of narratives in adverse circumstances such as the rigid culture of the total institution, and finally, I conclude with some theoretical implications about understanding narratives in adverse situations.

THE DATA AND METHODOLOGICAL APPROACH

Often, social scientists identify human culture and instances of behavior as worthy of study not because certain ways of living and being are familiar but because they seem quite peculiar to our own ways of being. Like other observers in similar situations (Diamond 1992; Fontana 1977; Mesler 1997; Murphy 1990, 57-8; Myerhoff 1978, 251; Shield 1988, 15), I found the chronic care setting, its culture, to be entirely foreign to my understanding of social life: urine, screams from open doors at the end of long hallways, people in wheelchairs scattered in a large open dining area, staring blankly at anyone who entered the room. Merimore Chronic Care Center and its beings were unfamiliar to my own social world. I was relatively young, the residents, relatively old. I had all of my limbs and my senses. Many individuals remained institutionalized because they did not.

Through my employment at Merimore, I came to know the institution, its residents, and workers as both staff member and researcher—both an insider and an outsider to the social world of Merimore. While some social science researchers choose to remain interactionally distant cultural outsiders (for discussion of distortion associated with this perspective, see Miner 1956; Myerhoff 1978), my employment as a nurse aide permitted me a close and rich perspective on human circumstance and the micropolitics of personal definition. I came to the institution for summer employment and became involved in the daily

activities of many of the individuals I describe here through the requirements of my own routine workday as a nurse aide. After a few days of work, I grew curious about how residents of the institution maintained a sense of self under organizational conditions that seemed contradictory to personal identity claims and that overtly discouraged the expression of a personal self-concept.

I wanted to know more about the institution and its residents' identities, so I began to take notes on my world of work. I informed most nurse aides and residents that I was interested in making sense of what it meant to live at Merimore. Some residents and staff understood why I was taking notes. Most lost track of my purpose or did not understand my project when I talked with them about it. "Why would anyone want to study this place?" some asked. Residents seemed pleased with the extra time I would spend in their rooms and showed little or no concern with the actual content of my notes. My occupational responsibilities coupled with the comings and goings of staff, however, made it difficult for me to continue to inform all of the persons at Merimore whom I observed (for further discussion of this issue in her study of draft resisters, see Thorne 1978).

My data come from approximately two hundred hours of participant observation during a four-month period of full-time employment as a nurse aide in a one hundred and thirty bed chronic care institution. During my employment, I jotted brief notes throughout the workday—in the washroom after rinsing out diapers, in patients' rooms after treatments, in line at the kitchen for the meal carts, during every coffee and lunch break, and during staff meetings—notes I reviewed at the end of the workday when I transcribed specific interactions and narratives in detail or when I orally described the events of the day into a tape recorder. I supplemented and validated these data with information gleaned during the course of the day through informal conversations with residents, nurses, nurse aides, activity coordinators, kitchen workers, and janitors, and by critical self-reflection about the character of my own work in the institution.

Through my study of the people at Merimore, I came to know many of the blank stares, unknown to me early in my research, as individuals with conceptions of who they are and were, and with active ways of being that were sometimes disruptive to the routine and systematic happenings in the institution. In the subsequent discussion, I detail my understandings of resident identities not simply as an interactionally

detached social researcher but as a once active participant in a setting structured such that it undermined resident patients' articulation and maintenance of personal identity. Most staff persons struggled with institutional requirements and the realities their work roles imposed not only on the residents but also on themselves. In this article, I emphasize self-definition and the fate of residents at Merimore Chronic Care Center. This, however, does not imply that staff were calculating or entirely willing actors in the circumstances I describe. Accounts of work and organizational rules defined staff identities as they defined residents. Many of the nurse aides at Merimore were lower class women with children. Their lack of education offered them few alternatives to the minimum wage job of nurse aide. As a result, many could not afford to challenge institutional policy or rules. Staff, like residents, had their own strategies for self-preservation. Some of these strategies have been detailed elsewhere (Diamond 1992; Goffman 1961; Paterniti 1999). Here, I describe the world and identities of Merimore residents.

LIFE IN THE INSTITUTION

Residents of Merimore Chronic Care Center lived in a sensory world of which I had little previous experience. As I entered this world, I struggled to make my own sense of it. Breakfast was being served as the aides moved bins of dirty linen to the laundry room. Colorless paint and faded wallpaper provided backdrop for dozens of bodies seated in the open entryway. An older man with dark skin sat tied into his wheelchair with a three-inch webbed belt; he had wet his pants. The sight of his pants made the smell of urine more intense. The man attempted to move himself down the center's corridors with his right leg, casting it out in front of him and pulling back as he leaned forward in a feeble effort to carry his body and the chair. He stopped his chair next to the post where I stood with my completed application. As I tried to get my bearings, he tried to maintain his balance. He took a couple of deep breaths then loudly cleared his throat. I heard a woman scream. The man spit at the post as I moved past him. I reminded myself that it was already well into the summer and that nurse aide was one of the few jobs in town. I heard the man begin to clear his throat again as I disappeared behind the heavy wooden door marked "STAFF ONLY."

At staff orientation, the director informed all trainees that we should think of the people at Merimore as "residents" not "patients." She asked us to use this language so that we might understand Merimore as most residents' permanent home, even though some of them did not recognize the institution that way. As with all total institutions, the center walls demarcated a social world, characterizing the significant others residents regularly encountered and the familiar frames for interaction with those significant others. With the exception of a dozen or so regular family members who visited on weekends or specific week nights after dinner, the staff and other residents constituted the set of interactional others for residents of Merimore. Although many staff members worked double shifts, they left the institution to pursue other rounds of life. This permitted staff a freedom unknown to residents, as the physical walls of Merimore defined the totality of social life for center residents.

STAFF WORK AND THE TRANSFER OF INFORMATION

Residents at Merimore Chronic Care Center came to the institution because they could not, of their own volition, meet the physical or psychological requirements necessary for daily living. Within the institution, residents distinguished themselves from one another not merely by the presence or absence of limbs, the ability to eat, to dress, to walk, and to engage in conversation but also by whether or not "She smells," "He's too pushy," "She pinches," or "He steals." Staff developed classificatory schemes for residents too. Ordinary tasks such as eating, bathing, dressing, and range of motion—formally encoded as activities of daily living (ADLs)—became types of labor in the institution. At Merimore, staff members recognized each resident to have deficiencies in activities of daily living, and according to resident deficiencies, the staff structured their work routine. In this routine, the human patient constituted the product of work (Diamond 1992; Goffman 1961, 74), and residents, defined by their deficiencies, became a particular type of labor. Institutional work requirements framed interaction as a regimented set of tasks for both staff and residents. Furthermore, staff at Merimore, as in most chronic care and hospital facilities, did not spread the totality of resident-related work across the three, eight-hour shifts. Instead, the greatest amount of resident work occurred during the day shift, when

the bulk of meals, showers, exercises, and social activities took place. Understaffing and high turnover plague many institutions such as Merimore, especially during the day shift when the physical work is demanding and difficult. These facts underscore the perceived necessity of rigid timetables for the accomplishment of work and highlight the constraints on the day staff. As a result of tight schedules, the urgencies and peculiarities of resident patients must be worked into staff-oriented timetables (Roth 1963).

Although during orientation to the facility supervisors instruct staff to attend to residents' psychosocial needs, nurse aides and others quickly learn that work timetables necessitate special attention to the physical aspects of resident-related work and little attention to the psychosocial ones. End-of-shift reports to nurses and other staff members require scant information about the psychosocial condition of residents; rather, they mandate attention to the very basic physical ones (for more thorough discussion of nurse aides and charting, see also Diamond 1992, 130-68). Required charting consists of some ready-made categories for describing a resident's psychosocial condition; yet, nurses criticize aides for making use of those categories to encode their interactions with residents. Head nurses directed staff who charted residents as "combative," "lethargic," or "nonresponsive" to change their representative schema to codes presenting the resident in line with institutionally appropriate classificatory schemes, as indicated in the following excerpt from field notes.

> A few weeks after orientation, Marcia, the nurse charged with training all new nurse aides, called us together to review our end-of-shift chart notes. Flipping through Cynthia's notes, Marcia informed Cynthia that she should *never* chart that a resident is "nonresponsive"; "to the State [of California inspection team], that means they're dead."
>
> Victor, a psychology major at the University, then asked how we might indicate things like depression.
>
> Marcia responded, "It's not your job to describe the residents' psychological states."

Claims that the State—Federal Inspectors of Chronic Care Centers like Merimore—would not look favorably on a particular aide's behavior meant that the charge nurse had forbidden it, regardless of its relationship to actual federal regulation.

Legal and organizational mandates oblige nurses and other staff to transfer information regarding resident care in both verbal and written form at the end of every shift. By legal requirement, nurse aides and other staff—activity directors, physical and occupational therapists—transfer information through very brief notes in resident patients' charts, nurses by more extensive notes and oral reports to nurses on subsequent shifts. The house physician and residents' individual physicians generally review written information and receive condensed oral accounts from charge nurses during their regular monthly visits to the institution. These are the formal mechanisms for discussing resident patients. During the work shift, however, nurses, aides, and other staff members also pass bits of information about residents. They transfer this information while waiting for meal carts, exchanging dirty linens for clean ones, while making up beds, and even while feeding, dressing, walking, and showering residents—often talking about residents as if they were not there.

Both informal reports and formally mandated ones serve the manifest function of describing resident behaviors and treatments. Reports serve the latent function of accounting for staff activity and for characterizing precisely how staff should manage work routines and residents' activities at Merimore (Paterniti 1999). The transfer of information, not only from one shift to the next but between coworkers on the same shift, facilitates the creation and management of routine by workers. And in their management of routine, staff also manage particular kinds of resident identities (Fontana 1977) and come to expect a particular kind of interaction (Berger and Luckmann 1966, Rosenhan 1973).

RESIDENTS AS ROUTINE WORK

Workers' schedules provide an agenda for servicing daily living for center residents; schedules organize social life for both staff and residents through routine activities such as mealtime, shower time, and bedtime. Work agendas highlight residents' reliance on staff for assistance and identify residents according to the demands they place on Merimore's personnel (see Diamond 1992 for detailed examples here). Because the operative goals of the institution favor rigid and systematic routine in the accomplishment of work, additional chores constitute a disruption to institutional timetables and to the achievement of staff-

oriented goals. The staff, however, developed methods for dealing with disturbances to their systematic schedules, as detailed in the following section of notes.

> Breakfast was relatively normal this morning. The usual people refused their trays.... Sometimes Hazel's aide—especially when it's Michele—will refuse Hazel's tray for her [without conferring with Hazel] because Michele reports, "She [Hazel] says it gives her diarrhea, and we [the staff] don't want that."

Diarrhea for Hazel means further work and a less predictable schedule for Michele. Michele's account not only legitimizes the kind and manner of care she offers Hazel, the resident, but does so by evoking assumptions about the operative goals of the center and its workers. These work-related goals prescribe the accomplishment of a specific set of occupational tasks relative to each resident in a given workday.

Problem conditions, even when directly associated with apparent institutional goals, increase work time needed to deliver treatment to individual residents. Nurse aides repeatedly encountered "troublesome individuals," such as Hazel, and soon recognized their deficiencies as compulsory adaptations to their daily work schedules. Additional responsibilities, such as Hazel's diarrhea, a resident's failing memory, or need for extra feeding time, become hardships workers learn to negotiate with only minimal intrusion to their timetables. Occupational norms and claims to upholding those norms serve as vocabularies of motive for contradictory behaviors regarding resident care (Mills 1940; Scott and Lyman 1968). Such accounts often draw attention to the reasons for resident institutionalization and offer suggestions for how workers should treat particular deficiencies in their practice of work.

Nurses' reports and claims about patients transfer across shifts. The day shift accounts to the P.M. shift for the happenings of the workday, the P.M. shift to the night shift, and the night shift to the day shift. Embedded in these reports about work and residents as the objects of work are directives for interactional stances with residents and other staff members (Paterniti 1999). Field notes on the transfer of information across shifts illustrate how nursing staff frame some resident claims about self and institutional happenings and how residents' definitions of the situation can be consequential to staff descriptions of their identities.

> After Lillian conveyed the work of the day shift to the P.M. nurse, Janet, she remarked that Joan Allen, a ninety-year-old resident, claimed she was "missing four dollars." Janet reports that Joan recently made some claims about missing clothing to the night nurse.
>
> "Beth [the night nurse] left you a note [about the missing clothing], right before [this incident of the missing money]. . . . 'n now it's the money, huh?"
>
> Lillian continued, "Now the weekend she went with her son for Mother's Day. . . . She couldn't find her pearls. She said somebody had taken them. Ok, so Lucy [the nurse aide] went in there [the resident's room] and found them in her drawer." Janet shakes her head.
>
> During report from the P.M. to night shift, Janet talks about Joan Allen's care, adding, "She told Lillian [the day nurse] that she lost four dollars. . . . But I asked her [Joan] about it, and she said it happened a long time ago. . . . So, I don't know how come she just complained today. . . . And then one time, she said that she was missing her pearls, and Lucy found it [sic] in her drawer. We don't know whether she is just kind of confused, or her memory's failing or what."

Collectively, the nurses giving the reports come to the conclusion that Joan's definition of the situation is flawed with respect to the actual happenings at Merimore. Additional commentary by reporting nurses suggests the posture staff should establish toward the resident: that they might question all of Joan Allen's future claims because of her potentially failing memory.

Staff narratives reinforce resident categories and work-oriented courses of action. Institution staff must define resident patients as variously deficient to construct their work schedules; this means that staff do not readily accept residents' narratives about self or social life at Merimore. Yet, some residents' claims counter the plausibility structure of claims made by the staff in that residents' claims introduce another identifier, an alternative possibility for interactional reality, but only if that alternative makes some sense (Schutz 1962; see also Berger and Luckmann 1966, 154-5). Furthermore, residents' abilities and capacities can undermine their own claims. Some residents are only their bodies. Others try laying claim to physical and mental competence—the essence of being fully human—something for which few staff and other residents choose to credit them. For staff to consider alternative definitions of resident patients, residents cannot merely make claims of self-identification but must also construct a narrative about self with a plausible and consistent story line (Goffman 1961, 188-200; Snow and

Machalek 1982; Zimmerman 1974). The inability to construct a plausible story not only undermines a resident's claims about self but also jeopardizes a resident's institutional identity and career, as inconsistencies in residents' narratives and conduct provide support for staff discussions about resident identities and behaviors.

Although staff are permitted to read residents' histories, the hectic activity of the work shift and often incomplete medical and personal histories permit only partial understanding of many residents' situations or reasons for institutionalization.[2]

> I asked Silvia, the Licensed Vocational Nurse (LVN) who worked the P.M. shift on E ward [the psychiatric wing], how Scott Whitman came to the institution. She told me Scott, a white twenty-five-year-old male, was brain damaged in a motorcycle accident. Another nurse conveyed to her that recognizing his misfortune, Scott attempted suicide by jumping from the third story of his parents' house, resulting in greater neurological damage.

Scott's mother came to the center to visit Scott regularly, and she appeared between her regular visits when Scott telephoned her. Although he spoke mostly of his Craftsman tool collection and his work as a mechanic, Scott Whitman would often ask questions such as, "Do you know what day it is?" "Where am I?" and "What state am I in?"

Some days, Scott would wander away from the psychiatric wing and out of the institution, requiring nurse aides or other staff members to track him down and to restrain him physically. Scott needed assistance finding his way to his room and noting which of the three beds in the room was in fact his own; most aides complained about working with Scott because of his disruption to their schedule. Staff did not like to work the section of the wing where Scott lived because they found him difficult to keep track of and requiring too much time and individualized attention.

At the instruction of the director of nurses, nurse aides restrained Scott to prevent him from wandering.[3] Despite aides' efforts to contain him on E ward, Scott's ingenuity and manual dexterity permitted him to untie legally designated restraint knots, allowing him to wander around the center and onto other wards. Some staff and other resident patients believed residents of the psychiatric wing to be strange and potentially harmful. They referred to E ward as "the crazy wing." This meant that whenever other staff members noticed Scott outside of the parameters

of E ward, they would page his nurse aide to retrieve him. Scott's disappearance occurred up to six times per shift, depending on his aide. Out of frustration and a perceived need to keep Scott restrained, aides frequently tied a square knot in the nylon vest restraint that secured Scott in a reclining Gerry chair. Some even remarked, "If you're a mechanic, let's see you get yourself out of this one!" On one occasion, an aide locked Scott, tied to a chair, in the janitors' closet. The aide entertained himself by keeping records of how long it took Scott to work his way out of the restraints and to the door of the closet. Ironically, additional work to this staff member's schedule, generated under his own control, seemed to present no obstacle to his work timetable.

Staff meet residents, whom they identify as disruptive or incompetent, at the convenience of their own work schedule. By doing so, they sometimes avoid residents whom they believe will reduce control over the work shift. This formula for interaction, however, may have detrimental consequences for "difficult" residents. Hazel Kleweski—a 325-pound, bed-bound resident in her early sixties—often had trouble with her meals, pushing her nurse's call button to alert staff of her digestive complications. Because Hazel rang her call button at each meal, her call light often went unanswered by staff who were trying to assist resident "feeders" during the institutionally designated mealtime.

> This afternoon, I talked with a staff member over lunch about some of the residents at Merimore who had died during my days off. Jessica said, "It was during lunch, ya know, when we're reeeaal busy. As usual, we were still passing trays, and Hazel put on her [nurse call] light. Naturally, Michele [Hazel's usual aide] just ignored it." Jessica noted with a certain matter-of-factness: anyone who had any knowledge of Hazel, her deficiencies, and the work routine would have, of course, followed the same course of action. She continued, "When Michele went in [to Hazel's room] to pick up Hazel's tray, she [Hazel] didn't respond. She wasn't breathing (the aide swallowed). Hazel was dead. Doctor Adams said that it was a heart attack [that killed her]."

Chronic care staff develop a routine schedule for organizing deficiencies and treatment demands into daily work, for providing a predictable framework for interaction and a method to maintain control in an otherwise overwhelming setting. Routine organizational agendas and reports about work-related tasks create consistency; much like the order

granted to persons in ritual encounters (Goffman 1971, 74-5), formal and informal routines allow staff to take their patterns of work for granted. Along with this routinization of work, however, staff members take for granted their methods for processing work and their definitions of residents as work products.

NARRATIVE AND IDENTITY IN INSTITUTIONAL CULTURE

The circumstances of the chronic care center are problematic for two reasons: first, the rigid work structure of the institution allows relatively few alternatives to staff representations of work; and second, residents in the institution have few resources other than language available to them to negotiate interaction. At the chronic care center, where organizational practice eliminates idiosyncratic resident differences, residents' claims to self serve as strategies for personalizing interaction. Encounters between residents and staff allow only sporadic and work-specific exchange, in which the focus of encounters is to service residents' deficiencies. Relaying only partial presentations of self suits the brevity and production-oriented intent of institutional interaction. Like other forms of talk in the institution, residents' claims to self attempt to provide order to interaction, to develop a coherent sense of self and situation. Typically composed of bits of biography—past events, values, actions, and feelings—residents' narratives authenticate personal identity. Narratives give voice to body. Furthermore, residents' claims about self confer more information than a selective presentation of self; some residents' claims provide a personal identity in a situation that "contrasts sharply with some of the 'realities' of [their] condition[s] and how [they] might be viewed" (Riessman 1990, 1199).

Narrative accounts function for residents as the principal tool for establishing an alternative definition of the situation in the institution. Nellie Woods, for example, stated that she "likes to talk" and talked often about the characters she had as friends when she was growing up. Nellie Woods—blind, nearly deaf, and crippled with arthritis—spent her time at Merimore confined to bed. Aides often visited with Nellie, and for every interaction, Nellie had a story. While changing her sheets, I once talked with Nellie about redecorating; she recounted the following:

> I had a friend who was so excited that she had finally painted her room, and she wanted to show me what a nice job she had done. Well, one day, I went to her house, and I saw that she had painted her room *black* . . . of all the colors! Can you imagine? I didn't know what to say! (Nellie laughs.)

In nearly every encounter with nurses or aides who would listen, Nellie recounted an instance at the general store she owned with her husband; her story always began with the same question:

> Have I ever told you the story of Hennie Teet? I haven't? Oh, I like to tell this one. . . . Anyway, Hennie Teet wasn't his real name, that was just a name that people in town made up for him. . . . When Hennie Teet came into the store, I had my back to him. He asked me for ten pounds of oats, and when I turned around, I noticed that his pants were unzipped, and I could see *everything*. Well, I was so embarrassed. . . . (Nellie laughs and shakes her head). . . . So I got him his oats, and when I turned around to give them to him, I couldn't look him in the eye, I just stared at the ceiling! (Nellie laughs) I was sure I told you that one before. . . . I tell *everybody* the story of Hennie Teet.

What is important in the presentation of Nellie's narratives is not the exact information or even the "factual" nature of this information but the degree to which its content provides substance unlike the individual profile constructed by work-related definitions. Even the truth or falsity of past events is not as significant as whether others conceive of residents' narratives as distinctive identifiers in the institution.

Residents' narratives relay more than a profile separate from the center's routine; the narratives convey a self presentation usually unrepresented in medical records. As such, some residents distinguish themselves from their work-defined institutional character and establish an alternative definition for social interaction. Billy Brazil, a resident in his mid-fifties with Chronic Obstructive Pulmonary Disease, talked about his life as a country and western musician.

> I was one of the best. I used to play guitar for Willie Nelson and Johnny Paycheck. Back in those days, I would play my guitar, smoke my cigarettes, and get high on speed. That's why I'm here [in the chronic care institution] you know, 'cause that kind of life gets rough . . . all the smoking and the women and the drinking. . . . That's why I'm stuck here on oxygen at the age of fifty two. . . . But, boy, I had a great life; I wouldn't change a thing.

During the day shift on Sundays, staff gave few showers. When work was slow, some nurse aides visited Billy Brazil's room and encouraged him to play his guitar; others pulled Billy's wheel chair and his portable oxygen into the hallway and requested a performance for residents and staff.

Residents such as Nellie Woods and Billy Brazil relayed portions of their lives distinguishing them from others with like medical histories, eating habits, and other similarities that become identifiers in the institution's rigid work routine. Unlike tales told by staff during shift reports, residents' narratives counter the "factuality, objectivity, and impersonality" of routine information that within the institution, is made to be an every day, practical concern and accomplishment (Zimmerman 1974, 128). Because resident narratives are dissimilar to the conventional accounts conveyed by the staff, these narratives produce potential tests of staff-structured bases for interaction.

As a result of different demands on their time, residents and staff have conflicting interests: the former have a desire to promote a "noninstitutional" self-identity in the otherwise regimented, mundane, and sometimes inhumane circumstance, and the latter have an interest in fulfilling occupational timetables, using routine identity and work as a means for occupational accomplishment. Residents offer self-depictions that supply less rigid possibilities for interaction in the institution. Staff, however, meet residents' possibilities with much resistance. While one set of actors, the resident patients, tries to make institutional life interesting, the other set, the staff, attempts to control the chaos.

The workers' task of routinizing activities and identities at the center conflicts with the expression of personal identities by resident patients, so that the manifestation of residents' own peculiar identities can be disruptive to workers' routines. Because Nellie Woods enjoyed telling stories, the arduous task of feeding Nellie required a very tolerant aide to assist with intermittent spoonfuls of food while Nellie, the storyteller, told her favorite stories. Others in the institution also made claims to identities whose expressions problematized workers' production-oriented schedules. The following section of field notes provides an example.

> Margaret Olsen, bringing her wheelchair to an abrupt halt in front of the physical therapy door, arranged herself perpendicular to the on coming [pedestrian and wheelchair] traffic and began to read out the letters making up the sign on the door: "P-H-Y."

> Because it was 5:00 P.M., most residents who were able were making their way down to the dining room at the end of the corridor.
>
> "S-I" (She paused, tilted her head to one side and then to the other. She began again.) "P-H-Y-S-I."
>
> Attempting to speed Margaret's self-imposed task and to get everyone into the dining room on time I read aloud: "C. . . ."
>
> The line of traffic to the dining room started building to the right of Margaret; not recognizing it, she turned and said, "Now quit that. I'm just learning to spell. You already know how. . . . I'll just have to start again. P-H-Y. . . ."

Because Margaret Olsen, a sixty-some-year-old woman diagnosed as having multiple personalities, was fascinated with the task of spelling, at meal times, she would ask for some "S-A-L-T" and proudly announce the number of words that she had recently learned to spell, insisting that the staff help her add to her lexicon by teaching her the patterned letter combinations to the items on her tray. When a staff member failed to comply with her request, she would not eat her meal. While staff might simply chart in medical records that a resident ate a meal or had a shower, the validity of these claims can be ascertained directly by way of the resident or noted over time by objective measures of the resident's physical appearance.

Part of routine work involves getting residents to eat their meals. Compelling Nellie Woods to eat required participation and sincere interest in the stories she told. During a period of high turnover in the institution, Nellie refused to eat because she recognized that the only basis for her brief encounters with the staff was to force her to do just that. She would comment on the nurse aide's lack of interest in her story and conclude her tale with "That's it. I've had enough [food]." Then, Nellie would press her lips firmly together and turn her head. Similarly, persuading Margaret Olsen to finish her meal required teaching her to spell words such as *pepper* and *fork*.

Not all residents' claims to personal identity, however, succeed in changing the perceptions or behavior of staff or in complicating otherwise routine work. Residents who emphasize their illness as a marker of their identity do not establish a basis for interaction different from staff-defined identities as work. Take, for example, the claims of Estelle Beebe, a sixty-four-year-old resident with multiple sclerosis:

> Look at this (moves her hand across her chest). I used to be a terrific seamstress. I could sew something faster than anyone in the [textile] shop. I was always up early and in to work by seven, sometimes by six thirty. . . . I nearly supported my family. Now I can't even lift my hand. . . . And it's been getting worse.

Estelle frames her account such that any identity created by the story is immediately discredited by focus on her illness as disruptive to that identity.

Terminal residents and their significant others may discuss illness as a factor for demarcating biographic time and for identifying self (Charmaz 1987, 1991; Corbin and Strauss 1987; Perot, McMurray, and Hedges 1987). Because the characteristics of illness that adhere to and alter personal identity are enacted in the institutional routine, reference to illness as disruptive or problematic legitimizes staff categorization of residents. Estelle Beebe continued with personal reflection on her chronic state and illness-related career.

> I used to be able to move it better than this, and now, I can barely lift the coffee cup. The doctors said I wouldn't live very long, but I've been here for eeelleven years. . . . Whadda they know?!

Although Billy, the country musician, discussed his illness and his resulting institutionalization, he brought to the institution props to support his prior identity of country and western musician. His guitar, harmonica, and country music repertory provided positive markers—identity pegs—of his previous history, legitimizing his identity as a country and western performer (Goffman 1963, 57; Lofland 1969, 174-5; Pestello 1991, 26). Unlike the narrative account given by Billy, Estelle's tale facilitates staff members' definitions of her identity as "unable," a characterization staff employ to construct their timetables.

Residents such as Nellie Woods, Billy Brazil, and Margaret Olsen succeed in challenging institutional definitions because their narratives offer interactional alternatives to routine staff tales. These alternatives are what Goffman (1961, 189) describes as secondary adjustments, personal ways of negotiating organizational categories and institutional careers that provide evidence of identity apart from institutional parameters and definitions. Secondary adjustments permit residents of

Merimore some control in a situation in which they have little (Goffman 1961, see pp. 55, 200), but these adjustments require residents to adhere to their own identity construct in oratory and in action. For this reason, bed-bound patients such as Nellie fashion a personal identity that does not rely on actual support by physical props or body.

EFFECTING CHANGE: NARRATIVES IN ADVERSE CIRCUMSTANCE

Identity narratives have consequences for claims about identities and situations. At Merimore, a habitual pattern of work and its accounts typifies staff actions and understandings. Many Merimore residents, however, consider their personal identity as something other than the labels imposed by staff through organizational routine. Residents' various beliefs about themselves and about their current situation reveal how they make sense of self and situation in a social world where their options and power are limited. In that world, their narratives of self symbolically encode who they conceive themselves to be and how they might imagine they ought to be treated given the realities of their past biographies and present circumstances.

Like Nellie, Louise Jackson—a slight but not frail woman of eighty-plus years with weak legs and poor eyesight—enjoyed talking with staff members as they assisted her with the activities of daily living. Louise was confined to her bed, and staff seldom encouraged her to put on fresh clothes, to sit up in her wheel chair, or to leave her room for activities. And even when they did, Louise would refuse. Louise spent her days and early evenings lying in her bed, her face no more than eighteen inches away from her black and white television set, focused on repeat episodes of television programs such as *The Brady Bunch*, *My Three Sons*, *Maberry R.F.D.*, and *The Partridge Family.* She talked about the children on these programs as if they were her own. In much the same way as Nellie found her personal identity in telling stories of her past, Louise found hers in narrating stories of popular television families. "I just love watching kids," Louise would say, coaxing attending staff members to sit at the edge of her bed to watch the program with her as she narrated the events of each episode.

Knowing that institutional rules required staff to change soiled bed linens to prevent resident discomfort and further ill health, Louise

discovered opportunity in institutionally mandated work. Because she seldom succeeded in her efforts to get staff to watch television with her during the busy day shift, Louise obtained staff attention by pouring water from her bedside pitcher into her bed, then ringing her call bell and yelling, "I'm wet." During less demanding shifts and times of adequate staffing, Louise's efforts to secure company succeeded, and frequently, she compelled a staff member to watch portions of her television programs, at least "until the next commercial." Concerns about Louise's health heightened with her large fluid output and increased water intake. But staff preoccupation with her "condition" soon diminished when one staff member saw Louise pour a pitcher of water into her bed.

In only the rarest instance does a resident successfully find personal attention in the staff's routine work schedule. In these rare instances, Merimore staff co-opt a resident's personal definition to assist them with their work routine or to make institutional life less regimented and oppressive. Billy Brazil's talents as a musician frequently found him in the hallways of C ward, entertaining other residents in the institution. On Sundays, staff requested Billy's performance as they charted work notes or when the few visitors from outside the institution appeared. On those days, even the busy day shift personnel danced with residents and with one another to Billy's country and western melodies. These appearances also garnered Billy favors from the staff. Because Billy's condition prohibited him from leaving Merimore, some staff visited his room on their days off, bringing him special meals and an occasional cigarette or can of beer.[4]

By introducing alternative identifiers to workers, residents may create a different means of personal identification and, as a result, other bases for interaction. Furthermore, to encourage resident cooperation in the completion of work-related tasks, staff learned to recognize residents' claims to significant and identifying characteristics and events. This point is illustrated in the following interaction.

> Noting that the staff had not provided Mary Van Ives a shower within the past fifteen days, the P.M. nurse scheduled Mary, a mildly retarded elderly woman diagnosed as schizophrenic, for a Wednesday afternoon shower. When an aide approached Mary to tell her it was her shower day, Mary indignantly responded that Tuesday was her shower day and that she was not going to cooperate with the aide's request to get ready for

a shower. "Now listen. . . . I don't want to take a shower, and I'm *not* going to!"

The aide told Mary that she needed to take a shower and that she should go down the hall to her room to get her clean clothes so that she [the aide] could get started.

"I said '*No*' . . . no, no, no. . . . I'm busy playing my songs." Ignoring the aide, Mary pulls her accordion back against her chest. "Where was I?" (Mary starts playing.)

Mary Van Ives spent most of her days on the psychiatric ward wheeling herself up and down the length of its hallway, playing her accordion and singing church songs or songs from her newly acquired album, the soundtrack from *The Wizard of Oz*. Like Billy, the country and western musician, Mary had the props necessary for maintaining her identity as an accordion player—her record player and albums to provide her an inventory of music and her accordion to play her own renditions of that music. In her encounter with the aide, Mary argues that she views the aide's attempt to get her into the shower as a disruption to her daily routine and to her current course of action.

In one last effort to complete her occupational tasks, the aide returned with some clean clothes for Mary. "You know what, Mary? (Mary stops playing and looks up at the aide.) I really like to sing in the shower. . . . How 'bout you?"

"Well. . . ."

"We can sing together, Mary!"

"Okay, let's go. . . . But first, bring me to my room so I can leave my accordion on the bed." (Mary claps her hands and starts laughing.)

By cooperating with Mary Van Ives' self-proclaimed identity, the aide accomplishes her task; that is, she gets Mary, the singer and accordion player, to take an afternoon shower.

The culture of Merimore exists not merely by organizational rules and tasks but because of how these rules and tasks are framed by narratives and because of how they are interactionally negotiated. As the above encounter suggests, the achievement of work-related tasks cannot merely be prescribed and enacted by workers and their timetables but must be mediated in face-to-face encounters with residents. These encounters involve negotiated identifiers in which competent residents discover the key to self-identity and institutional survival is not in finding conceptions of self through staff depictions but rather in imagining

their own identities in terms of their own stories of self (Frank 1995, 158-9; Maines, Sugrue, and Katovich 1983; Mead 1934). Through narratives constructed with pieces of self from a world outside of Merimore walls, residents exercise some control over interaction and identity; moreover, they achieve some control over their place in the work routine, which if relinquished, could otherwise prove of great circumstance.

THE POWER OF NARRATIVES IN EVERYDAY LIFE

> The fabric of meaning that constitutes any single human existence is the "story" we tell about ourselves.
>
> —Victor Turner 1978, xv

Residents' narratives create definitions of self that distinguish them from definitions imposed by staff and their work. Personally constructed definitions of self provide challenges to institutional reality claims typified by work documents and routine (Berger and Luckmann 1966). The important lesson the staff and residents at Merimore teach is that both self and society become known through the enactment of negotiated definitions. Residents' narratives are stories of possibilities for self. They are stories that when manifested in interaction, weave together past lives and self-conceptions, present circumstances, and conceivable futures in the institution. As such, personal narratives grant institutionalized residents interactional capital and simultaneously construct what anthropologist Victor Turner refers to as a social "fabric of meaning."

These personal narratives are not ultimately personal. Personal identity is a social construct; it bears the mark of all things social (Berger 1963; Smith 1996). Residents' identities emerge from layers of negotiation with self (through considering past events, possible futures, and definitions of relevant others in those contexts [Berger and Luckmann 1966; Schutz 1962]); with others (in laying claims to identity [Goffman 1963]; and imagining their attitudes [Cooley 1902; Mead 1934]); and within a context of social organization (Goffman 1961; Roth 1963; Smith 1996). For Merimore residents, personal identity is perceived consequences and possibilities for self; it is what residents might feel

they can claim for themselves and what they envision in interaction with others, given rigid and potentially adverse social circumstance. Identity, however introspective in its imagined possibilities (Cooley 1902; Mead 1934), is a social accomplishment, realized through contestable claims over what identity ought to be.

Collectively, Merimore residents display a culture of diversity and competence for which staff routines do not credit them. Yet, staff identities are tied to these routines as well, as social categories have consequences for all social actors. Goffman (1963) illustrates this in his classic discussion of stigma, in which normative expectations hold all interactants accountable to certain types of performances and in which deviation from normative expectations or ensuring the maintenance of those expectations carries negative consequences. Merimore residents and staff, whatever accounts they provide, show us that social reality is less about what constitutes "truth" than about the kinds of claims honored in social situations (Goffman 1959, 9-10, Riessman 1990, 1195).

Staff and residents at Merimore construct definitions of persons and situations through accounts and legitimations of the social worlds they envision and through the categories that enable them to make sense of those social worlds. In everyday interactions, persons lay claims about self, claims that liberate them from the expected social performances and possible adversity associated with "being" the social categories that others might imagine them to be. In his discussion of deviance and identity, John Lofland (1969) argues,

> It may be that the perspective of the social—of social categorization and control—is destined always to be in a continuing dialectic with the perspective of the human. . . . From the human perspective, the fact of common humanity is enormously more important in determining the sort of treatment we ought to accord one another than is the fact of the convenience which social categories provide in coping with our various proximate problems. (p. 304)

The "human" perspective is a lived experience in which persons, as social objects, are their "local performances" (Berger and Luckmann 1966; Smith 1996, 172). Dorothy Smith (1996) explains that the science of sociology must be situated in a map of local practices. In this map, Smith argues, "Sense, meaning, truth . . . are always the local achievements of people" (p. 193).

Laying claims to personal identity is an ongoing process of social construction, maintenance, and change (Garfinkel 1967; Goffman 1959). And it is a process that confronts all human actors. Since normative expectations frame human identification and presentation in every society (Edgerton 1967, 218; Goffman 1963; Lofland 1969), ethnographers might consider how social actors use language to reclaim identity in "the lived actuality" of adverse situations. Development of humane social terms and policies, therefore, needs to attend to the ways that life worlds matter to how we as a society understand, construct, and carry out contemporary social life.[5] In this arena, ethnographers can make a unique contribution to social policy by eliciting the rich contextual quality of interactions in which personal narratives and their social contexts may provide empirical insight into the particularly constraining aspects of human encounters and social structures and the especially liberating forces of personal claims to identity.

NOTES

1. The name of the center and all of the names that follow are pseudonyms.

2. Resident patients' charts were incomplete due to a number of factors. These factors included the following: too many admissions around the time of institutionalization to do a thorough history of the resident; a high turnover rate among staff, leaving no one to take responsibility for the chart; and the resident's lack of traceable social connections or mental capacity to provide a social history.

3. Nurse aides who refused to restrain a resident found their hours shortened and their regularly scheduled assignments changed without notice. During a day shift, I refused to restrain Scott for wandering because my own previous work experience with him did not suggest to me that restraints were warranted. The next day, I came into work a few minutes before my seven A.M. shift and began rounding with the night aides, assisting them in getting the "difficult" residents—residents requiring more than one aide to lift them out of bed—set up for breakfast.

> The kitchen called "E ward," and I went down to get the cart. The kitchen worker passed me the meal cart, asking me if I knew who was working A ward that morning. "We've called them three times," she grumbled. "I'll check for you," I responded. As I passed the nurses' desk, I inquired who was working on A ward. The charge nurse said, "I put *you* on A ward, and you're *late*. Go get the meal cart." When I arrived with the meal cart on A ward, I discovered that the two regularly scheduled day aides had called in sick. In addition, one of the night aides had not shown up for her shift. All of the residents were still in bed, most lying on soiled sheets.

4. Staff interactions with Billy during working and nonworking hours exemplifies their recognition of Billy Brazil's personal identity claims over his reason for institutionalization. Ironically, some of the same interactions that recognize Billy's personal claims to self—gifts of alcohol and cigarettes and encouraging him to sing for lengths of time—ensure his institutionalization at Merimore.

5. Eliot Mishler (1984) points out that humane medical care can be distinguished from "nice" or "friendly" attention to patients. Humane care, Mishler argues, privileges the patient's "life world contexts of meaning" as a basis for diagnosis, treatment, and general clinical understanding (p. 192). This "voice of the life world" encodes a patient's visions of personal identity.

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