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# Beyond Bingo

## *A Phenomenographic Exploration of Leisure in Aged Care*

**Evonne Miller**
*Queensland University of Technology*

## Abstract

How do older adults living in residential aged care experience leisure activities? What restricts and facilitates participation? These two research questions guided this semi-longitudinal qualitative research, tracking the lived experience of aged care from the perspective of 20 new-aged care residents over 18 months (average age, 80 years) through repeated in-depth semi-structured interviews. Interview data were analyzed using *phenomenography*, an under-utilized qualitative analysis technique that identifies the variations in how people experience, understand, or conceive of a phenomenon. Phenomenography revealed three qualitatively different ways to understand residents' leisure experience: (1) as a structure for living, (2) creating social connections and (3) maintaining ability. By illustrating the variation and similarities in how these older Australian residents conceptualise and experience leisure in aged care, the findings may help facilitate a more thoughtful understanding that informs theory, policy, and practice.

**Keywords:** *Activities, ageing, leisure, nursing home, qualitative research*

**Evonne Miller** is an associate professor, Creative Industries Faculty, at the Queensland University of Technology. Aspects of this work was supported by BallyCara and the Australian Research Council's Linkage *Projects* funding scheme, to Evonne Miller, Laurie Buys and Nicole Devlin through Grant LP130100036. We acknowledge and thank our industry partner, BallyCara, and all the participants who graciously contributed to this research. Please send correspondence to e.miller@qut.edu.au

## Introduction

Globally, the population is ageing. For the first time in history, the number of older persons will exceed the number of young, with two billion people 65 years or older by 2050 (United Nations, 2000; World Health Organisation [WHO] 2002). In anticipation of such significant demographic shifts, the traditional view of ageing as a time of "decline and loss" is being challenged by contemporary frameworks that promote active, healthy, productive and successful ageing. A defining feature of these frameworks is that ongoing engagement and participation in leisure, encompassing multiple physical, cognitive and social activities, is critical to enhancing quality of life as people age (see Bowling & Dieppe, 2005; Kalache & Keller, 1999). Yet, despite the plethora of research demonstrating the benefits of leisure participation throughout our lives, and particularly in later life, relatively little is known older people's experience of leisure if and when they enter a nursing home, known as a residential aged care facility (RACF) in Australia. This paper addresses this knowledge gap, drawing on the under-utilized qualitative analysis technique of phenomenography to explore and better understand the experience of older people's leisure in aged care.

### Understanding Leisure in Later Life

How leisure is conceptualized varies across studies and disciplines, although it is typically defined to be experience, frequency, or duration of participation in a range of discretionary activities, including social (e.g., choir), spiritual (e.g., church), solitary (e.g., gardening), intellectual (e.g., crosswords), physical (e.g., exercise), and non-physical (e.g., Internet). Historically, the concept of leisure has been viewed as experience, activity, or time, with Best (2010) recently defining leisure experience as the "attempt to fulfil pleasure and desire and about the construction of an identity we feel comfortable with" (p.1). Critically, as Kleiber and colleagues argue (Kleiber, Hutchinson, & Williams, 2002; Kleiber, Reel, & Hutchinson, 2008), leisure may play an important role in facilitating coping and adjustment with negative life events such as injury, illness, or bereavement. Multiple qualitative and quantitative studies have demonstrated the benefits of engaging in leisure, linking participation to enhanced physical, psychological, social, and spiritual wellbeing in later life (for a comprehensive review, see Dupuis, 2008). In particular, the social interactions and connections associated with most leisure activities have been identified as crucial elements that help mitigate social isolation and loneliness among older adults (Toepoel, 2013).

In explaining and understanding how psychological, social, and external contexts affect older adults' leisure participation, researchers have utilized an array of environmental gerontology, psychology, and leisure theories including activity, disengagement, and continuity, selective optimization with compensation, innovation and social identity (e.g., Kleiber, McGuire, Aybar-Damali, & Norman, 2008; Nimrod & Hutchinson, 2010; Strachan et al., 2010). Baltes and Carstensen's (1996) Selection, Optimization, and Compensation (SOC) model offers a lifespan perspective on activity and levels of engagement in later life that acknowledges the losses, limitations and challenges people face as they age: selection is the prioritization of attainable goals, optimization is maximizing resources to achieve goals, and compensation is adapting to limitations. Drawing on the SOC perspective, Kleiber and Nimrod (2009) reported how 20 young-old (mean age of 65 years) Americans' experience of post-retirement leisure involved negotiating multiple constraints (health, caregiving, financial, etc.) to maintain and, in some situations, redefine and expand their leisure participation. Similarly, Genoe and Dupuis (2014) found maintaining leisure participation provided a critical sense of normalcy for community-dwelling older people with dementia, enabling them to sustain and recreate their identities.

To date, gerontological leisure research has predominately focussed on the benefits and barriers of leisure, particularly of physically active pursuits among community-dwelling older adults and, to a smaller extent, those residing in independent living units in retirement villages or continuing care communities as they are termed in the United States (e.g., Miller & Buys, 2007; Nathan, Wood & Giles-Corti, 2013; Roelofs, 1999). Surprisingly little literature has documented the experience of leisure for long term care residents in an aged care setting. However, Golant's (2011, 2015) recent emotion-based residential normalcy theory postulates that when an older person is out of their residential comfort zone in incongruent places such as a nursing home, they initiate a range of assimilative (action) and/or accommodative (mind) forms of coping strategies.

What is well known is that the transition to long-term care in a nursing home is a deeply personal and life-changing event, defined by "dramatic changes in physical location, daily routine, social networks, and personal autonomy, as well as residence in an 'accidental community'" (Yamasaki & Sharf, 2011, p. 13). On average, older Australians live three years in a nursing home before death (AIHW, 2009), with facilities maximizing quality of life through a person-centered philosophy of care that places residents' unique wants, needs, and preferences at the centre. Person-centred care draws on biographical knowledge to foster a "continuation of self and normality" (Edvardsson, Fetherstonhaugh, & Nay, 2010, p. 2614), with maintaining and facilitating engagement in everyday activities, such as leisure, a critical way to foster normality and quality of life.

Unfortunately, the small body of research documenting residents' perspectives of living in RACF suggests that "normality" is inactivity, boredom, and loneliness. In a recent systematic review of 31 qualitative studies, Bradshaw, Playford, and Riazi (2012) identified four key themes that affected residents' quality of life in nursing homes: acceptance and adaptation, connectedness, homelike environment, and caring practices. Underpinning residents' enjoyment of daily life, however, is their ability to continue engaging in enjoyable leisure activities. Bergland and Kirkevold (2006), drawing on data from two Norwegian nursing homes, argued that residents make a conscious choice to thrive (or not) in aged care, with a key contributor being participation in pleasant and meaningful activities. Two recent qualitative studies in the United States reported that most residents participated in facility organized activities (primarily bingo, card games, and religious gatherings) but desired more creative, interactive, and intellectually stimulating programming that was more meaningful to their unique life experiences, skills and interests (Choi, Ransom & Wyllie, 2008; Tak, Kedia, Tongumpun, & Hong, 2015). Half of the participants in one study described themselves as depressed and ready to die, explaining the activities were so similar that even the "same cards always won at bingo" (Choi et al., 2008, p. 542). Similarly, residents in an Irish RACF were frustrated with their regimented lifestyle and described how they would often stare out the window, dreaming of their past life full of choices and activities (Timonen & O'Dwyer, 2009). All these studies acknowledged that residents' experience of leisure was impeded by a combination of both internal (e.g., residents' mental and physical health limitations) and external constraints, specifically limited RACF resources (e.g., financial, scheduling, staff).

A growing number of studies have documented the positive impact of implementing a wide variety of leisure activities in aged care, from traditional arts and crafts to more innovative music, dance, gardening, and creative art initiatives (see de Medeiros & Basting, 2014; Genoe & Dupuis, 2014, for reviews). Whether the leisure activity is music (Cottrell & Gallant, 2003), tai chi (Cheng et al., 2012), virtual field trips (Shaunfield, Wittenberg-Lyles, Oliver, & Demiris, 2014)

or altruistic craft activities (creating floral arrangements and cards for a local hospice) (Cipirani, Haley, Moravec, & Young, 2010), residents typically report that the activity reduced boredom and enhanced their quality of life. To date, however, research focused specifically on residents' experience of leisure as part of their day-to-day life in aged care remains limited. This paper addresses this knowledge gap, drawing on the underutilized qualitative data analysis technique of phenomenography to explore two key research questions: (1) What are the conceptualizations of leisure held by older residents in aged care, and (2) What strategies do residents utilize to maintain participation as their health declines.

## Method

This study is part of a larger, ongoing project exploring the lived experience of aged care in Australia, from the perspective of potential and current residents, as well as their nominated family member and service provider (the "Inside Aged Care" project). Drawing on a constructivist paradigm, the theoretical framework guiding this study was phenomenology, which aims to interpret "situations in the everyday world from the viewpoint of the experiencing person" (Becker, 1992, p. 7). In order to unravel and better understand life in aged care, data were collected through multiple in-depth interviews, diaries, workshops, observations and photography. This paper focuses specifically on the leisure experience of 20 long-term care residents, who were interviewed two to three times (with an interval of approximately 6 months) over 18 months.

### Participants

Three men and 17 women, with an average age of 80 years (ranging from 66 to 93 years), participated. Over half were widowed (55%), with the remaining describing themselves divorced (20%), married (15%), or single (10%). All were Caucasian, from working to middle class socioeconomic origins. On average, residents had 2.45 children (range 0-5) and 4.28 grandchildren (range 0-14). At the first interview, none had a formal diagnosis of dementia, but deteriorating health had motivated the move to aged care and was negatively affecting their attention, cognition, and memory, often demonstrated through discontinuous and fragmented speech. Participants reported a diverse range of chronic health conditions and illnesses, including Parkinson's, arthritis, stroke, cancers, heart disease and hypertension, diabetes, deafness, chronic pain, sensory impairments, muscle weaknesses, and significant head injuries. Participants resided in one aged care facility, located 40 kilometres from Brisbane, the capital city of the state of Queensland, in Australia. The nonprofit facility has 107 aged care rooms and 230 independent living units, with two swimming pools, a small gym, and a coffee shop on a large and attractively landscaped outdoor space that includes gardens, walkways, and a creek. It is located in a suburban area, approximately one kilometre from the beach and four kilometres from the nearest shopping centre, making it difficult for residents to reach these without assistance.

### Procedures

The interviews covered all aspects of ageing in a nursing home, from the admission experience to an array of personal (e.g., emotional, spiritual, social, health), structural (e.g., environmental, design) and cultural (e.g., management ethos, caregiver attributes, etc.) aspects that might affect quality of life in aged care. A "laddered" technique was utilized, with topics gradually becoming more intimate and personal as the resident developed a relationship with the interviewer (Price, 2002). This paper focuses only on the leisure-relevant aspects of the data, drawing primarily from the first two interviews. All participants completed the first interview that included an explicit assessment and discussion of the array of current leisure activities resi-

dents were engaged in, including home activities (e.g., watching television, listening to the radio, reading, working alone on a hobby), "active leisure" (e.g., walking for health, exercises, swimming, dancing, etc.) and "social leisure" activities (e.g., attending arts and crafts classes, attending religious services, playing cards/games/ bingo, etc.). Residents were asked if they engaged in and enjoyed organized activities and what, if anything, hampered or limited the experience. Finally, they were asked if they were still able to do things they like and had maintained or developed any new leisure interests in the last few years. Critically, whilst these areas provided a guide of key issues to be covered during the semi-structured interviews, the semi-structured approach purposely gives the interviewer the flexibility to respond to interviewees' cues, exploring any emergent issues and probing with follow-up questions to fully understand participants' thoughts and opinions.

Standard interview and ethical protocols were followed. Formal ethical clearance was obtained from the university human research ethics committee and written informed consent obtained from each resident prior to the interview. Staff members acted as key contacts throughout the project, explaining the project and sharing project information packages to potential participants—all new residents with the cognitive capacity to participate. Residents were eligible for the study if they were aged 65 and older, had lived in the RACF for less than 12 months at time of the first interview, not formally diagnosed with dementia, and assessed as cognitively capable of actively participating by the manager, in terms of being able to understand and answer questions. Six eligible residents were not interested in participating, and two residents meeting the other criteria were not cognitively able to participate in the interview on the day.

Data collection occurred in idiosyncratic waves since 2012, determined by when an older person entered aged care. This paper draws on data from both the developmental phase (Stage 1: two interviews with 10 residents; 2012-2013, labelled pilot participants [PP] in data) and the larger project (Stage 2: three interviews with 10 residents, as well as their family and nominated staff; 2013-2015, labelled aged care [AC] in data). In Stage 1 participants were interviewed twice, approximately seven months apart (notably, only five completed the second interview as two passed away, two withdrew and one was unable to participate due to a significant decline in health). To reduce fatigue, in Stage 2 participants were interviewed three times, approximately five months apart. As a thank you for participating, Stage 1 participants had the opportunity to have their photograph taken by a professional photographer. In Stage 2, after the third interview, participants were given a $20 gift voucher. Confidentiality was assured by providing each resident with a code number and pseudonym, as well as keeping transcribed interviews in locked cabinets and password protected files. A team of trained sociology, psychology, and gerontology graduate researchers (including the author) conducted the interviews. All resident interviews were conducted in person, on site at the facility (typically the resident's room). Interviews typically lasted 45 to 90 minutes (ranging from 20 to 120 minutes), with notes written during and immediately after each interview. Interviews were audio-recorded and professionally transcribed verbatim. All participants completed the first interview (where leisure activity was a primary focus), but six participants died before the second interview (five from Stage 1, one from Stage 2).

## Analysis

Interview data were analysed with a phenomenographic approach, which focuses on the variation of a specific experience—in this context, the experience of leisure. In contrast to the more well-known phenomenological approach that focuses on the meaning of a specific phe-

nomenon, phenomenography developed from an educational framework and is a second-order perspective that focuses on the *variation* in how people experience, understand, or conceive of a phenomenon (Marton, 1981), and produces a structure of categories of description (see Larsson & Holmstrom, 2007, for a detailed discussion and comparison of phenomenographic and phenomenological analyses). The object of this study is the relationships between the actors (in this context, the older people living in aged care) and the phenomenon (leisure), focusing on the variation in what participants say and how they talk about leisure. Although the conceptions originate from individual interviews, the descriptions in phenomenographic analysis are made on a collective level and reflect variations in 'ways of experiencing', termed the 'outcome space' (Marton, 1981).

After the transcripts were professionally transcribed, the analysis followed Marton's seven analytic steps: familiarization, condensation, comparison, grouping, articulating, labelling, and contrasting. First, transcripts were read and re-read carefully (by a minimum of three members of the research team) to ensure we were extremely familiar with the content. Next, the author identified, extracted and compared the most significant statements made about leisure. In a grouping, comparison and articulating process, similar statements were grouped, with the similarities identified, categories developed and then labelled. Finally, to constitute the outcome-space of the study, similarities and differences were contrasted within categories. This coding process was iterative and, at times, simultaneous. To help ensure accuracy and representativeness, the author had multiple reflective discussions on emerging and final categories in this data categorization process with another member of the project team, who served as a co-evaluator. Multiple exact excerpts from the interviews are included to help readers judge for themselves the accuracy of the "outcome-space."

### Trustworthiness

Methodological rigor and trustworthiness was maintained through several strategies (see Lincoln & Guba, 1985). First, at the onset, the study design and methodology was informed by a thorough literature review and identification of key knowledge gaps. The project is purposely semi-longitudinal in design, with the prolonged engagement in the field enabling open and trusting relationships to develop between researchers and participants. Second, extensive reflexive memos were kept during interviewing, coding and analysis. These provided a sound basis for the continuous exchange of ideas, reflective and critical reasoning, and interpretation of findings among the research team (comprising of two academics, one research fellow, three research assistants, four postgraduate students and three representatives from the aged care facility), ensuring that a culture of reflexive conversations guided both analysis and future research decisions. This collaborative yet self-critical process of peer examination helped ensure that any inherent biases from any one researcher were minimized during data analysis. Third, there were multiple opportunities for member checking, with participants invited to review both their transcripts and project outcomes. As no one in the older cohort accepted this offer, after the second interview all participants were provided with a 2-3 page summary of their "life story" and experience of aged care for comment and confirmation. Additionally, after the last interview, initial project findings were verbally shared and discussed at a group workshop. Finally, to enable readers to judge for themselves the accuracy and representativeness of the analysis, the results section purposely includes multiple excerpts from the raw data. These four steps were designed to increase the trustworthiness of the data, helping ensure the "interpretations of the findings were not figments of the inquirer's imagination, but are clearly derived from the data" (Tobin & Begley, 2004, p. 392).

## Results

Overall, residents were generally very willing to share their thoughts and feelings about adjusting to life in aged care and their experience of leisure. Most were extremely open about the impact of ageing and challenges of managing their declining health, mobility and cognition. A few answered more briefly, struggling to acknowledge, articulate and share their experience of increasing incapacity; as one older man with severe Parkinson's explained, "*it's personal and private things you're talking about*" (AC5; Richard).

### Conceptions of Leisure in Aged Care

The phenomenographic analysis revealed the different ways in which these older adults engaged in leisure (or not) in aged care. Figure 1 illustrates how the experience of leisure in aged care varies according to the presence and interplay between three key categories, termed "conceptions" in phenomenographic analysis (Marton, 1981). The first conception is "structure for living," which emphasises how residents' unique character traits and preferences influenced their experience of leisure. Some thrived in the communal setting of a RACF, whereas others immensely disliked—and actively rebelled against—the structure. The second conception is "social connections," illustrating how leisure provided a mechanism for social interaction. The third conception refers to residents' ability to maintain leisure participation, which encompasses both physical and cognitive health, as well as financial resources and the facility structure (e.g., culture, activity programming and scheduling, staff characteristics). The different conceptions are interrelated, with each domain and inter-relationships, determining these older residents' leisure participation. Each category is discussed in turn in the following sections.

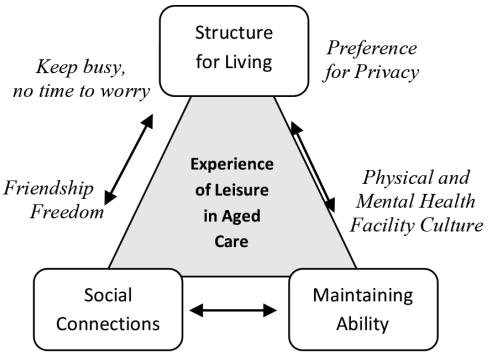


***Figure 1.*** Residents' Experience of Leisure in Aged Care–Conceptual Model

### Conception 1: A Structure for Living: "You Don't Get Time to Think or Worry"

This category describes how the experience of leisure in aged care provided structure to the day, a way to keep busy so there was no *"time to think or worry"* (AC2; May). This was understood in two qualitatively different ways, varying predictably depending on resident's unique personality, character traits and mindset. Some residents adjusted well to their new life in aged care (Conception 1A), describing it as "ex*citing in a way…there is always something to do*" (AC2;

May). A minority (approximately one fifth) disliked everything about living in aged care and, in turn, the organized leisure activities being offered (Conception 1B).

**Conception 1A: A reason to "get up in the morning and get dressed."** Most residents described how leisure provided valued structure to their daily life, with the multiple facility-organized leisure activities (exercise classes, religious services, bingo, craft, concerts, outings, etc.) keeping them busier now than when they lived independently in the community. Although many would have liked a greater diversity, they were simply usually grateful for any opportunity to keep active, break "*the monotony of the day*" (AC8: Martha) and stop them thinking about health concerns and an uncertain future. These residents all acknowledged that you could easily sit back and "vegetate," and that they had made a conscious decision to participate.

> I used to imagine that you'd sort of sit in a corner with a book, and watch a bit of TV. But there is activities going on here every day and that keeps us occupied. You don't get time to think or worry or anything like that. Breakfast is half past seven, exercise is nine, walk is half past nine, bingo is half past ten and lunch quarter past 12. Nail polish at half past one, 'catch-up' at four o'clock, and then dinner. There's concerts, happy hour with beer or wine or ginger ale or lemonade (AC3, Emmie).

**Conception 1B: "Other people enjoy: I am a different type of person."** Conception 1B illustrates how people's unique personalities and preferences influence their "fit" with aged care, with this vocal minority viewing "living in an institution... the opposite to what I would chose"; PP1). They felt the structured activities were stereotypical, of varying quality, and just did not interest them: "Eon't talk about bingo. It's the most boring game I know" [Joy,] and "Bingo, would you be interested in bingo?" These residents described keeping to themselves and acknowledged that "I am a different type of person. All the other people enjoy what they like to do" (AC9; Mary) and "You've got bingo, and you've got musical things, but I don't mix very much…I'm just not that sort of person…I do my book, my crosswords" (PP8). Several residents attributed their lack of interests in organized leisure activities to their unique life history and personality. Interestingly, Katie acknowledged that engaging in activities would facilitate her quality of life. As a singer, however, she could not bring herself to attend the poor quality concerts from volunteer and school choirs: "Everybody doesn't have the same interests. I don't like the concerts they have here. Most people love them. I don't. I used to sing and I can't stand them. I'm not joking. I can't stand them" [Katie].

### Conception 2: Facilitating Social Connections: "You Just Don't Seem to Be Alone"

Conception 2 refers to residents' experience of leisure as a mechanism for social interactions. This was understood in two qualitatively different ways, depicted by one resident's quote: *"You just don't seem to be alone."* The majority described how social interactions underpinned their motivation to engage in leisure activities (Conception 2A), with a minority disliking these social interactions (Conception 2B).

**Conception 2A: Social interaction as valued by-product: "We all get on, have a laugh."** All RACF organized leisure activities, from exercises, concerts/sing-a-longs, arts and crafts to bingo, provided opportunities for improving social interactions and developing friendships. As Emmie explained, she participated in leisure activities, in part, because she enjoys the incidental social interactions.

> I have got people my own age and, I don't know, you just don't seem to be alone. You have always got someone. We all get on, have a laugh, you know. On Tuesday they have all the old songs. I go down to that and we sing along. That is the sort of thing I like. But word games and all of that, it's just not my cup of tea. Besides, I can't see the board to try and work it out. And I watch my *Bold and the Beautiful*, too (laughs).

**Conception 2B: "I dislike having everyone in your face."** A minority described conflict between activity participation and associated social interaction with co-residents. This was driven by two main factors: a lifelong personality preference for independence and being alone, as well as a desire to avoid contact with other residents of varying cognitive capacities. The quotes below illustrate this preference, highlighting the sometimes confronting and unpleasant reality of living with older, frailer co-residents experiencing a range of debilitating illnesses and disabilities, particularly dementia. These residents typically withdrew, struggling to convince staff to respect their desire be alone and not engage in activities. For example, 86-year-old Joy (who lost the use of both legs from knees to feet, just prior to T2) attributed feeling depressed to her age and was annoyed that staff were consistently encouraging (in her eyes, bullying) her into participating. One resident described how childhood trauma was unexpectedly impeding her leisure engagement. At age 74, May has only just disclosed her childhood abuse by a nun in the Catholic Church. The facility frequently has religious activities and volunteers, with weekly Mass conducted in the communal living room located less than five meters from her bedroom and a local nun involved with assisting in a number of activities. While this activity brings peace and comfort to most other residents, for May seeing anything religious is a traumatic trigger.

> But this is an example of what I am going through at the moment. Yesterday, we were having a sing-along with some books, and all of a sudden she said, 'Sister will be in later to play the piano.' Well, with that, I just got up and left. I just couldn't front a sister. Nup. I am hoping that will improve [AC2, May].

> Today, there is nobody close to me, no companionship. I dislike having everyone in your face, we are all different personalities and some have dementia and it's a trial. I like to choose the people I associate with. You don't have a choice in a place like this. You don't meet anybody new, you know. You see people you don't like and you have to put up with them every day. It's an effort. I prefer to be on my own and please myself. I don't partake in most of the activities they have because I'm not interested in them. I don't really want to participate in things with other people. I knit, myself, I read myself [AC1, Bertha]

**Conception 3: Maintaining ability: "Do things I can do."** This category covers how residents perceived leisure activities as an important mechanism for maintaining, as much as possible, their physical abilities and mental health. Residents acknowledged, in a matter-of-fact manner, how they could no longer engage in the leisure activities they had previously enjoyed due to their declining health, lack of energy, reduced mobility, poor eyesight, and stiff hands (from arthritis, strokes, etc.). However, they approached restrictions in their ability to engage in leisure activities in two qualitatively different ways: most were accepting, actively maintaining and adapting leisure activities within health limitations (Conception 3A) but a minority were disengaging, either voluntarily or due to external restrictions such as finances and facility characteristics (Conception 3B).

**Conception 3A: Adaptation: "Do things that I can do."** Most accepted their illness, declining functional ability, and health limitations as a natural part of ageing. These residents found other ways of maintaining their participation in preferred leisure activities, identifying alternative activities that replaced past hobbies. For example, many older women frequently described how the process of ageing and the onset of disability and illness meant they could no longer knit: as Joyce noted "[I] used to do all that [knitting], but I got arthritis on my hands." Residents explained they chose to engage in physically and mentally active leisure activities, particularly walking and exercises, to maintain and/or enhance their health. Interestingly, aside from relatively mainstream interests in reading, radio, and TV, Lilian was the only resident to discuss her experience maintaining a lifelong hobby, using her sewing machine in her room. As Joy explains below, she has declining eyesight and her severe arthritis meant she can no longer walk or knit anymore, but she eagerly engages in crafts every Tuesday morning.

> I'm used to doing things and I can't now. It frustrates me a lot. I haven't got that much energy in me lately, my eyes and my body. I get irritated with myself because sometimes I can't do the things that I would like to do and I get mad with myself. I can't walk around, you know, there's not one part of me, really, in my body, that I haven't got arthritis. So I am limited to what I am doing. But they do things that I can do [at exercises], I'm with them, sort of thing, you know what I mean. My body might be going but I have got up here [Joy points to her head].

**Conception 3B: Disengagement: "Say 'no' every time they ask me."** Residents' experience of leisure was also constrained, through attitudinal, physical and situational constraints, as well as organizational barriers within the care environment (e.g., staff availability, restricted scheduling, limited activities on offer) and limited finances. Mary, who could no longer knit, explained how "they want me to go to craft and I am not into crafts … say 'no' every time they ask me… just sit here, watch TV, and do the puzzle. I will go there for afternoon tea, sometimes" [AC9]. Several explained that although they would like to join in on more activities, they felt unable to do so due to a lack of staffing, uncommunicated scheduling changes, or a lack of friends who enjoyed the same activity. For example, Richard explained that he only swims once a week at the moment, as he needs assistance and there are no staff available; similarly, most residents agreed that there was not much happening on the weekends, with Bertha sharing how annoying poor communication about a constantly changing activity schedule was, along with her personal dislike for the "fake jolliness" of some staff.

> They have exercises every weekday, except Thursday; except sometimes on Monday where they stop, but there's no one there to give them and they don't tell you that they are not on … they don't bother telling you they are not on. We turn up there and yeah. I look forward to activities, but I don't think it has helped me to feel part of the community. I can't cope with people who are always noisy and happy, trying to be bright. You should treat people like they are adults, not jolly them up [AC1, Bertha].

Restrictions, imposed on residents by staff as protective measures, also limited residents' autonomy and experience of leisure. For example, Nancy reported she was not allowed to walk outside alone, while Richard was not allowed to use his walker after 2 p.m. because staff thought he was too shaky and tired in the afternoon. Both were very depressed and angry about these restrictions. Finally, participants reported income as impacting choice, access to and experience of both independent and shared activities, with most unable to afford the cost of taxi's or staff salaries (needed to accompany them) to facilitate any off-site activities; as Martha noted, "Oh, it's

a long time since I have been out for a meal" [AC8]. Even those who could afford to go off-site were nervous, explaining how "No, I don't think I would be confident enough. I have lost my confidence in that regard" [AC1, Bertha].

## Discussion

This paper has explored how the experience of leisure is recreated and reconstructed by increasingly frail, older Australians residing in aged care. Phenomenographic analysis highlighted the importance of three distinct yet interrelated conceptions in understanding their experience of leisure in aged care: structure for living, social connections and maintaining ability. The findings were generally consistent with a small body of existing literature, illustrating that different individuals react quite differently to the same aged care environment and that positive adaptation depends upon personal resiliency, optimistic personality traits and a conscious choice to thrive and adopt a positive attitude (Bergland & Kirkevold, 2006; Brandburg et al., 2013; Choi et al., 2008). However, the fine-grained focus on the experience of leisure in the current study provided several new insights and implications for practice, policy and research. From a methodological perspective, the phenomenographic analysis revealed new ways of understanding and conceptualising residents' leisure experience. Whereas more traditional approaches would have focussed on common themes, phenomenography was especially valuable in helping identify and illuminate the variability and differences in residents' leisure experience, revealing that there appear to be relatively finite categories of leisure experience in long term care.

Overall, the findings illustrate the importance of leisure for resident's quality of life, with respect and choice critical: residents valued the opportunity to engage—or disengage from leisure activities—as they desire. Participation in leisure activities was a conscious strategy some residents adopted to provide interest and structure to their daily life, viewing and valuing organized leisure activities as a way to keep busy, organize, and break the monotony of their day. Leisure activities were generally viewed as exciting and making life still worth living, with Emmie recounting her hour-by-hour daily activity schedule. And, on the other hand, while the majority of our sample did not want to complain, not all residents enjoyed bingo or the varying quality of visiting choirs. Some did not want to engage and desired a quieter, more solitary life, whereas others were bored with the limited and somewhat stereotypical activities on offer. Consistent with previous research, there was a general sense that increasing the diversity of interesting and individualised leisure activities, and in particular increasing weekend offerings, would help enhance their quality of life (Bradshaw et al., 2012; Tak et al., 2015; Timonen & O'Dwyer, 2009).

Potentially, the finding that most residents were relatively content with the limited array of leisure activities being offered may reflect generational differences. This cohort grew up during the cataclysmic events of the Great Depression and World War 2, defined by deeply embedded cultural values of thrift, gratitude, and patience. In contrast, future aged care residents—the postwar "baby boom" generation—are likely to have much more demanding expectations regarding lifestyle and leisure activities in aged care; as Pruchno (2012, p. 152) notes, "everything we think we know about the aging process, from . . . the extent to which families will provide support to the decisions that people will make about retirement … has the potential to be altered." With relatively little known about their views, research must explore baby boomers' expectations regarding type, choice, quality, and experience of aged care (see Robison, Shugrue, Fortinsky, & Gruman, 2014). It seems likely that the expectations of future baby boom residents may be similar to that of the disgruntled vocal minority in this sample who very much disliked living in the restrictive and communal RACF environment. Fortunately, advances in technology

may provide a cost-effective way to enhance quality of life for both current and future residents. For example, virtual reality is rarely utilized in aged care but could help facilitate continued leisure engagement among increasingly frail residents, offering a range of immersive, stimulating and therapeutic multi-sensory leisure experiences from visiting the beach to dancing and playing tennis again. Research collaborations between industry, practitioners, designers and older people themselves are urgently needed to explore and test these possibilities (see Molina, Ricci, Albuquerque de Moraes, & Perracini, 2014; Shaunfield et al., 2014).

The phenomenographic analysis also highlighted how leisure activities were conceptualized as a mechanism to enable (or not) social contact and interactions. Most residents spoke positively about how they now had someone to sit and talk to, contrasting their active social life in aged care versus more isolated circumstances when living independently, alone at home in the community. Although most of the sample conceptualized leisure as a valued conduit for social interactions, participants also identified a conflict between activity participation and the associated social interaction. A small proportion of residents did not want to interact with other residents, primarily due to personality differences, conflicts and the challenges associated with living surrounded by very ill, frail, and sometimes significantly cognitively impaired co-residents. May's description of avoiding activities that involved a visiting nun (due to her memories of past trauma) provides an example of the complexities of communal living, while others described the challenges associated with playing cards with "people with no memory." Interestingly, residents who were most unhappy with the stereotypical leisure activities also often expressed a desire to maintain their independence and privacy. These residents acknowledged their own unique personality traits and preferences meant they did not want to participate in the leisure activities, often describing feeling frustrated by staff continually asking.

To an extent, such findings raise what Hall and Bocksnick (1995) provocatively termed the "continuum of free choice-coercion," whereby coercing or coaxing residents into participating in leisure activities could be a form of psychological abuse. Balancing residents' wish for autonomy (the essence of person-centred care) and knowing that leisure participation will facilitate social, mental, and physical health is an ongoing challenge for RACF staff. A key message from this research is that although resident disengagement from organized leisure may be interpreted as withdrawal or loneliness, it may actually reflect a lifelong personal preference for solitude or a more discriminating attitude toward the application of effort and attention. These residents were content with their own company and desired to maintain this solitude in the communal aged care environment; staff knowing the difference, and responding appropriately, may help preserve residents' quality of life.

With respect to continuity of experience, aside from the relatively generic hobbies of watching television, reading, and walking for exercise, only one resident spoke of maintaining a unique, previous leisure activity (in her situation, sewing). Although unexpected, in many ways, this reflects how the generally poor health of this cohort makes sustaining lifelong leisure pursuits challenging; for example, Lilian lamented that she will never be "excellent" enough to play tennis again, and other older women explained how severe arthritis meant they could no longer knit and they engaged in facility-organized craft instead. This re-interpretation of leisure activities is consistent with recent research by Nimrod and Hutchinson (2010) that found community-dwelling adults with chronic health conditions maintained leisure participation through utilizing an array of selective optimization with compensation, continuity and innovation strategies. In this context, given their increasing age-related cognitive and physical health limitations, some residents were channelling and re-interpreting their skill and interest in knitting into more sim-

ple craft activities. These results also support Golant's (2011, 2015) residential normalcy theory, which highlights how the interplay between the resilience of the individual and their environment determines successful adaption to incongruent places, such as aged care.

In conclusion, this study contributes to the limited body of research literature on the experience of leisure in aged care, helping inform theory, policy and practice. The application of the underutilized qualitative analysis technique of phenomenography has provided unique insight, facilitating a more thoughtful understanding of the leisure experience in aged care. Of course, these findings must be interpreted with the study strengths and limitations in mind. The wider applicability of the findings is limited by the qualitative case study approach, as well as and the sample characteristics: small, non-random, predominantly middle socioeconomic status, white and female residents of one aged care facility located in Brisbane, Australia. A notable strength is the semi-longitudinal qualitative methodology, with all 20 residents interviewed at least twice in their first two years of residence in aged care. This analysis is a first step toward understanding the processes at work as people adjust to life in aged care, with future work more deeply exploring any trajectories of continuity or change over time from the multiple perspectives of residents, family, and staff. Combined, these findings highlight the need for greater awareness of, and sensitivity to, how older aged care residents' negotiating his or her daily life and the relative importance of leisure for their quality of life. A quote from one resident helps to illustrates the critical interplay between attitude, participation and availability of interesting and appealing leisure activities.

> I can either make this home or I can resent it all. It's what you make of it, a place like this. You have to make something of it, or you just resent it. I know [facility] does its best to find interests, but everybody doesn't have the same interests. Because the things that I like, most people don't like here. So I just don't bother going any more [Katie].

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